

**REPORT TO THE GOVERNOR AND GENERAL ASSEMBLY REQUIRED
BY SECTION 42-72-5.2 OF THE GENERAL LAWS OF RHODE ISLAND
ON DEVELOPMENT OF A CONTINUUM OF CHILDREN'S
BEHAVIORAL HEALTH PROGRAMS**

Submitted by:

Executive Office of Health and Human Services
State of Rhode Island and Providence Plantations
Hazard Building
74 West Road
Cranston, Rhode Island 02920
(401) 462-5274
Fax: (401) 462-0241

February 1, 2006

TABLE OF CONTENTS

	<u>Page</u>
I. Introduction	5
I.1 Requirements of Section 42-72-5.2	
I.2 How the Departments of Children, Youth, and Families and Human Services Responded to These Requirements	
II. Overview of Medicaid-Covered Children’s Behavioral Health Services in Rhode Island	8
II.1 Eligible Population Groups Services Covered through Rhode Island Medical Assistance	
II.2 Medicaid Services Delivery System for Children.	
II.3 Enrollment of Children SFY – 2005	
II.4 Medicaid Covered Children’s Behavioral Health Benefits	
II.5 Expenditures for Medicaid Covered Children’s Behavioral Health Benefits.	
III. Core Values and Guiding Principles for Medicaid-Covered Children’s Behavioral Health Services in Rhode Island	15
III.1 Core Values	
III.2 Guiding Principles	
IV. Continuum of Medicaid-Covered Children’s Behavioral Health Services	16
IV.1 Services Included in the Continuum of Treatment Services	
IV.2 Definitions of Services in the Continuum of Children’s Behavioral Health Treatment Services	
IV.3 Services Included in the Family Stabilization Services Continuum	
IV.4 Description of Services in the Family Stabilization Services Continuum	
IV.5 Continuum of Child and Family Stabilization Services	
V. Options	25
V.1 Options	
V.2 Oversight	
VI. Implementation Plan	34
VII. Indicators and Program Metrics	36

Appendices

- A. Minutes of H-5829 Children's Behavioral Health Workgroup
- B. Data Subcommittee Inpatient Admissions Analysis
- C. Report of the Subcommittee on Inventory of Mental Health Services/Gaps in Service
- D. Proposed Outline for a Children's Behavioral Health Amendment of the *RIté Care Health Plan Contract*
- E. Proposed Outline for a Medicaid FFS Children's Behavioral Health Request for Proposals
- F. Comments Received on the Draft Report

INDEX OF TABLES AND FIGURES

Page

TABLES

Table 1	Medicaid-Eligible Children Enrolled in RIte Care Versus Medicaid Fee-for-Service as of November 30, 2005
Table 2	Continuum of Treatment Services for Children's Behavioral Health
Table 3	Continuum of Child and Family Stabilization Services
Table 4	Expenditures for Medicaid – Covered Children's Behavioral Health Benefits

FIGURES

Figure 1	Children's Behavioral Health Implementation Plan
----------	--

I. INTRODUCTION

This chapter presents an overview of the legislative directive given to the Rhode Island Departments of Children, Youth and Families (DCYF) and Human Services (DHS) pertaining children's behavioral health services through passage of H-5829 and how the two departments have addressed that directive.

I.1 Requirements of Section 42-72-5.2

The Rhode Island General Assembly has directed the DCYF and DHS to work together to design a continuum of care for children's behavioral health services. Specifically, G.L. 42-72 was amended by adding § 42-72-5.2 that directed the two departments to:

Develop a design of a continuum of care for children's behavioral health services

“DCYF and DHS shall cooperate to develop a design of a continuum of care for children's behavioral health services that encourages the use of alternative psychiatric and other services to hospitalization and reviews the utilization of each service in order to better match services and programs to the needs of the children and families as well as continuously improve the quality of and access to services.

DCYF and DHS shall present a report to the governor and the general assembly no later than January 1, 2006 that fully described this continuum of services and outlines a detailed plan for its implementation, including resource requirements, responsibilities, milestones, and time frames, as well as a set of indicators and program metrics that will be employed to evaluate its clinical and fiscal effectiveness over time. The report shall also describe any and all changes proposed in program oversight or budgetary responsibility for specific services.”

Assure appropriate management of psychiatric hospitalizations:

“(1) Amend contractual agreements with RIte Care health plans to reflect complete responsibility for the management of psychiatric hospitalizations, specifically the development of hospital diversion and post discharge services; and the utilization of crisis intervention services as a requirement for authorization of a psychiatric admission for all children enrolled in RIte Care;

(2) Issue an RFP to identify a contracted entity to reflect complete responsibility for the management of psychiatric hospitalizations, specifically the development of hospital diversion and post discharge services for crisis intervention services as a requirement for authorization of a psychiatric admission for all Medicaid-eligible children not enrolled in RIte Care. The request for proposals shall include a dispute resolution process.”

This report fulfills the requirements set forth above.

It should be noted that the mandate delineated above was part of a broader one under H-5829 that was enacted in 2005. In addition to the foregoing continuum of services and reporting requirements, Sections 40.1-5-6 and 40.1-5-26 of Chapter 40.1-5 of the General Laws of Rhode Island were amended to revise the process for voluntary admission of children to any facility for the “care and treatment for alleged mental disability” as follows:

Change inpatient admission criteria for children who receive publicly funded mental health benefits:

“Any child under 18 who receives medical benefits funded in whole or in part by either DCYF or by DHS may be admitted to any facility provided for by this chapter seeking care and treatment for alleged mental disability only after an initial mental health crisis intervention is completed by a provider that is licensed by DCYF for emergency services, has proper credentials and is contracted with the RIte Care health plan or the state and said provider, after considering alternative services hospitalization with the child, family and other providers, requests prior authorization for the admission from a representative of the child and family's insurance company or utilization review organization representing the insurance company.”

DCYF has formed a separate Emergency Services Workgroup to address this charge. That workgroup is charged with drafting licensure standards for such Emergency Services providers, as described above. These licensed providers would be a required component of the network of any Medicaid/RIte Care Health Plan, Medicaid Behavioral Health Plan, or fee for service Medicaid network.

1.2 How the Departments of Children, Youth, and Families and Human Services Responded to These Requirements

Under the direction of the Executive Office of Health and Human Services, the two departments formed an H-5829 Children's Behavioral Health Workgroup (Workgroup) to implement the General Assembly's charge. The Workgroup was open to interested parties and included representatives from:

- Rhode Island General Assembly
- Executive Office of Health and Human Services
- DCYF
- DHS
- Department of Health
- Department of Mental Health, Retardation and Hospitals
- Department of Education
- Rhode Island KIDS COUNT
- Rhode Island Community Mental Health Centers Association
- Insurers
- Providers
- Advocacy groups

All told, more than 50 individuals participated in Workgroup meetings.

The Workgroup's initial organizational meeting occurred on June 10, 2005, although the Workgroup did not begin meeting on a regular basis until September 30, 2005 when it adopted the following ground rules for its process:

- The meetings are open to the public
- Persons/parties that have a specific concern or point of view need to be present – if you have not expressed your points (either personally or sending of a representative), the group will continue to move on.

- This workgroup is not staffed – come prepared to contribute and work.
- There may be additional workgroups of the larger group.
- Perceptions and responsibilities need to be put aside; this needs to be a fact-based discussion.
- Hold off “solutions” until facts have been examined and possible options have been discussed.
- This is “the table” – all your business should take place here and please honor the discussion and those participating by being accurate if you choose to discuss elsewhere.

The Workgroup had additional meetings October 7, 14, 21, 28, November 4, 18, December 2 and 16, 2005. Minutes of the Workgroup meetings are included in this report as Appendix A. These meetings were chaired by the Secretary of the Executive Office of Health and Human Services, Jane A. Hayward, and, in her absence, by John R. Young, Associate Director for Health Care Quality, Financing and Purchasing of DHS.

There were also the following subcommittees:

- **Data Subcommittee** – Because of an emphasis in H-5829 on inpatient admissions, the Data Subcommittee focused on collecting information from providers, RIte Care Health Plans, and the Medicaid Program on behavioral health inpatient admissions for SFY 2005 and whether these admissions were screened by a community-based provider prior to admission. An analysis of this information is included in this report as Appendix B.
- **Subcommittee on Inventory of Mental Health Services/Gaps in Services** – The Subcommittee on Inventory of Mental Health Services/Gaps in Service developed a listing of what are believed to be the most important gaps in behavioral health services, which, if filled, would make the most difference to the psychiatric hospitalization of children and youth in Rhode Island. The final product of the subcommittee is included in this report as Appendix C.

A draft of this report was circulated to members of the Workgroup for comment. The comments received to the draft are incorporated verbatim into this report in Appendix F.

As could be expected in a group this large and diverse meeting on a topic this complex and vital, discussions within the Workgroup were active. While there was agreement that significant opportunities for improvements to the system of care are needed, a consensus recommendation was not available. In some instances, members urged that more time be given to study the issues. Others urged that it was time to move forward and take affirmative steps to build a more accountable, integrated and family centered system.

The remainder of this report is organized in sections as follows:

- An overview of Medicaid covered children’s behavioral health services in Rhode Island. This includes information on covered populations, utilization and expenditures.
- An overview of the core values and guiding principles adopted by the Workgroup for Medicaid covered children’s behavioral health services in Rhode Island.

- Description of a complete continuum of Medicaid covered children’s behavioral health services, including identification of services that might be more fully developed and/or available in a strengthened system. This includes, for example, services to be delivered by licensed emergency services providers, a service which is intended to divert potential hospital admissions to more appropriate, less restrictive settings. Note that an important organizing distinction used in the presentation of the children’s behavioral health continuum relates to treatment services (including diagnostic screening and medically necessary treatment behavioral health diagnoses) vs. child and family stabilization services.
- Options for the organization of services in the children’s behavioral health continuum. These options are presented in relation to core goals (a) single accountable entity for each child, (b) budget integrity and (c) promising practices/best practices/evidence-based practices.

II. Overview of Medicaid-Covered Children’s Behavioral Health Services in Rhode Island

This section presents a description of the various groups of children eligible for Medicaid, an overview of the service delivery system, numbers of children enrolled, a description of Medicaid covered children’s behavioral health services, as well as utilization and expenditures for Medicaid covered children’s behavioral health services.

II.1 Eligible Children’s Population Groups Covered through Rhode Island Medical Assistance

In November of 1993, the State of Rhode Island was granted a Section 1115 Waiver (11-W-00004/1) to develop and implement a mandatory Medicaid managed care demonstration program called RItE Care. RItE Care, implemented in August 1994, has the following general goals:

- To increase access to and improve the quality of care for Medicaid families
- To expand access to health coverage to all eligible pregnant women and all eligible uninsured children
- To control the rate of growth in the Medicaid budget for the eligible population

RItE Care was designed for the following groups to be enrolled in licensed health maintenance organizations (HMOs, or Health Plans):

- Family Independence Program (FIP)¹ families
- Pregnant women up to 250 percent of the Federal poverty level (FPL)
- Children up to age 6 in households with incomes up to 250 percent of the FPL who are uninsured

¹Originally Aid to Families with Dependent Children (AFDC) and then Temporary Assistance to Needy Families (TANF) FIP is Rhode Island’s program for the TANF-eligible population.

Over time, the populations eligible for RItE Care have expanded, with Federal approval, as follows:

- Effective March 1, 1996, to expand to children up to age 8 in households with incomes up to 250 percent of the FPL who are uninsured
- Effective May 1, 1997, to expand to children up to age 18 in households with incomes up to 250 percent of the FPL who are uninsured
- Effective July 1, 1999, to expand to children up to age 19 in households with incomes up to 250 percent of the FPL
- Beginning December 1, 2000, to transition children in foster care placements² from fee- for-service Medicaid to RItE Care
- Effective January 29, 2003, to transition the following categories of children with special health care needs into RItE Care Health Plans.³
 - Blind/disabled children, and related populations (eligible for Supplemental Security Income, or SSI, under Title XVI of the Social Security Act)
 - Children eligible under Section 1902(e)(3) of the Social Security Act (“Katie Beckett” children)
 - Children receiving subsidized adoption assistance

II.2 Medicaid Service Delivery System for Children

The State of Rhode Island initially made a policy decision to only allow State-licensed HMOs to participate in RItE Care. At the end of 2004 Blue Cross and Blue Shield of Rhode Island (BCBSRI) voluntarily gave up its State HMO license at the end of 2004. In order to assure the availability of choices for RItE Care-eligible individuals, the State changed its policy to allow other than State-licensed HMOs to participate in RItE Care effective January 1, 2005. Non-HMOs must meet the following requirements:

- Be licensed as a health plan in the State
- Be accredited⁴ by the National Committee for Quality Assurance (NCQA) as a Medicaid managed care organization (MCO). (Presently, each of the three health plans participating in RItE Care are included in NCQA’s designation of the top ten Medicaid managed care plans in the nation.)

² Children in foster care are enrolled in RItE Care on a voluntary basis.

³ Children with special health care needs are also presently enrolled on a voluntary basis, as only one Health Plan, Neighborhood Health Plan of Rhode Island (NHPRI) has been willing to enroll this population. NHPRI is also the only Health Plan that has been willing to enroll children in foster care.

⁴ In Rhode Island, all HMOs must be accredited by NCQA. All three Health Plans have full three-year accreditation and received an “excellent” designation from NCQA. Of all the Medicaid plans in the nation, BCBSRI ranked first, UHCNE ranked third, and NHPRI ranked sixth in 2005. Both BCBSRI and UHCNE have their Medicaid product lines accredited, as well as their Medicare product lines.

- Meet certain State regulatory requirements⁵ that HMOs must meet:
 - Have professional services under the direction of a medical director who is licensed in Rhode Island and performs the functions specified in regulation (e.g., oversight of quality management)
 - Make certain enrollees are only liable for co-payments and to have this provision in its provider contracts
 - Meet “preventive health care services” requirements and provide them within time frames set by the HMO, according to accepted standards specific to age and gender
 - Have a quality management program that is accredited

The Health Plans are responsible for providing or arranging for all of the Medicaid-covered behavioral health treatment services for RIte Care enrollees, with some exceptions. The services for which the Health Plans are responsible both programmatically and financially are called “in-plan” services. Health plans are held to access and adequate network standards for in-plan services. Medicaid covered services which the Health Plans are not responsible for are called “out-of-plan” services, which are services paid directly to providers by DHS or DCYF. Health Plans are not accountable for assuring access, availability, or quality for out of plan services, as they are for in-plan contracted services. However, they are required to coordinate with out of plan services by making referrals to services needed by members that are not within the health plan contract.

II. 3 Enrollment of Children – SFY 2005

Table 1 below shows that the majority (75,000) of Medicaid-eligible children under age 19⁶ are enrolled in RIte Care Health Plans. This number has remained stable since 2003.

In addition, 3574 children are enrolled in RIte Share, where DHS pays all or a part of an eligible family’s monthly premium, based upon income and family size, for an employer’s DHS-approved employer-sponsored insurance (ESI). RIte Share provides coverage of all Medicaid benefits as wrap-around coverage to ESI as well as co-payments and deductibles.

Beginning in 2001, Children in substitute care, who are under the responsibility of DCYF, were transitioned from fee for service Medicaid to enrollment in NHPRI. This was done to improve access to and coordination of care, and to assure that care is delivered in a timely manner in the most appropriate setting. There are 2125 children in substitute care enrolled in NHPRI. About half of these children are living in relative or non-relative foster homes in RI. The remainder are living in various residential therapeutic living arrangements in RI. There are 223 children in substitute care who are not enrolled in NHPRI. These include children living in specialized therapeutic residential settings outside of RI.

⁵ *Rules and Regulations for the Certification of Health Plans* (R23-17.13-CHP).

⁷ It should be noted that prior to June 1, 2003, the Health Plans were not responsible financially for in-plan behavioral health services classified by DCYF as seriously emotionally disturbed (SED). Since that date, the Health Plans have been responsible.

Beginning in 2003, DHS began enrolling children with special health care needs into NHPRI, on a voluntary basis. The 9327 children with special health care needs are composed of children eligible because they are enrolled in SSI due to a disability and low income, children enrolled in Medicaid through Katie Beckett eligibility, where they have a disability and need a level of care appropriate for institutional placement, and children enrolled in DCYF's adoption subsidy program. Several thousand of these children have a primary source of commercial health insurance, and are enrolled in Medicaid only for services not covered by or beyond the limits of their employer sponsored health insurance. These children are not eligible to enroll in NHPRI, and remain in fee for service Medicaid, where Medicaid pays providers directly for services delivered to a Medicaid enrollee. The remaining 6000 children with special health care needs have been offered the opportunity to enroll in NHPRI on a voluntary basis. As of 2005, 3775 of these children, when given the choice of managed care or fee for service, have chosen to enroll in the RItE Care option with NHPRI. The remaining 5552 children with special health care needs enrolled in FFS Medicaid includes both children with existing employer sponsored coverage as well as children who have not chosen to enroll in NHPRI. Because only one health plan currently enrolls children with special health care needs, in order to ensure consumer choice per federal requirements, enrollment is voluntary.

Table 1

**Medicaid-Eligible Children Enrolled in RItE Care versus Medicaid Fee-for-Service
Average Monthly Enrollment for State Fiscal Year 2005**

Enrolled In	RItE Care Base Population	Children in Substitute Care	Children with Special Health Care Needs	RItE Share	Total
A RItE Care Health Plan	75,000	2,125	3,775		80,900
Fee-for-Service	437	223	5,552	3,574	9,786
Total	75, 437	2,348	9,327	3,574	90,686

II. 4 Medicaid Covered Children's Behavioral Health Services

- Tables 2 and 3, located at the end of this chapter, list all children's behavioral health services covered in the RI Medicaid program. Table 2 lists services that are delivered to an individual child in order to diagnose a behavioral health condition or to provide medically necessary treatment of a diagnosed behavioral health condition. Table 3 lists children's behavioral health services covered by RI Medicaid that are principally child and family stabilization services.

II. 5 Utilization and Expenditures for Medicaid-Covered Children's Behavioral Health Benefits

Table 4 shows expenditures for Behavioral Health Services covered and paid for under RI Medicaid for all children under 21 in state fiscal year 2005.

Table 4

Children's Medicaid Behavioral Health Expenditures SFY 2005	Children in Substitute Care Arrangements	Children with Special Health Care Needs	Children in Base Rlte Care	Total
Behavioral Health (BH) in plan:				
Inpt BH hosp	\$ 4,927,365	\$10,542,669	\$ 7,191,000	\$ 22,661,034
Outpatient/Professional BH	\$ 1,285,200	\$ 1,373,043	\$ 7,758,000	\$ 10,416,243
subtotal: BH in plan	\$ 6,212,565	\$11,915,712	\$14,949,000	\$ 33,077,277
Behavioral Health out of plan/FFS	-			
Inpt BH hosp	\$ 203,082	\$ 4,266,232		\$ 4,469,313
Outpatient/Professional BH	\$ 26,733	\$ 411,660		\$ 438,393
CIS	\$ 2,260,420	\$ 5,938,734	\$13,674,960	\$ 21,874,114
Residential	\$ 69,298,892	\$23,078,214	\$ 2,878,200	\$ 95,255,306
other BH outpatient/professional	\$ 1,062,709	\$ 3,438,590	\$ 1,818,000	\$ 6,319,299
other DCYF (eg. family stabilization svcs)	\$ 292,897	\$ 68,403	\$ 238,680	\$ 599,980
subtotal: BH out of plan/FFS	\$ 73,144,733	\$37,201,832	\$18,609,840	\$ 128,956,405
Total	\$ 79,357,298	\$49,117,544	\$33,558,840	\$ 162,033,682

Source: MMIS and Encounter Data

The preceding data demonstrate that the State of Rhode Island continues to make a substantial investment in children's behavioral health services, with the most significant amount of this total \$162 M state and federal investment directed toward 24-hour care in residential and group settings (\$95M). In addition, \$27 M is directed toward inpatient care, \$22 M in CIS, and an additional \$26 M in other outpatient/community based behavioral health services.

Table 2

Continuum of Children’s Behavioral Health Treatment Services			
(1) Children’s Behavioral Health Treatment Services	(2) <u>Current Rite Care In- Plan Benefits</u> Health Plans must provide the full continuum of treatment services to members, (unless the service is on the Exceptions List)	(3) <u>Current Exceptions List</u> (“Out-of-Plan Benefits”) Providers currently bill to and are paid directly by fee-for-service Medicaid; Health Plans are not responsible for assuring access to these services	
		Could be considered for designation as an in-plan benefit	Certain factors (e.g., accountability or authority) make this service appear more appropriate to remain out-of-plan benefits
1. Inpatient	<ul style="list-style-type: none"> Covered 		
2. Observation/Crisis Stabilization/Holding Bed	<ul style="list-style-type: none"> Covered 		
3. Hospital Step down/Diversion Services: ARTS, IRTP, CRAFT	<ul style="list-style-type: none"> Covered, unless on Exceptions List ARTS 	<ul style="list-style-type: none"> IRTP CRAFT 	<ul style="list-style-type: none"> Inpatient DAS
4. Substance Abuse Residential Treatment	<ul style="list-style-type: none"> Covered unless on Exceptions List 		
5. Emergency Crisis Intervention	<ul style="list-style-type: none"> Covered, unless on Exceptions List 		<ul style="list-style-type: none"> DCYF-ordered Emergency Room Child Abuse Evaluation* Child Sexual Abuse Evaluations and Parent Child Evaluations*
6. Partial Hospitalization	<ul style="list-style-type: none"> Covered unless on Exceptions List 		
7. Day/Evening Treatment	<ul style="list-style-type: none"> Covered, unless on Exceptions List 		<ul style="list-style-type: none"> Juvenile Probation Community Day Treatment
8. Intensive Outpatient Treatment (provider-, home-, school-, or community-based)	<ul style="list-style-type: none"> Covered, unless on Exceptions List 	<ul style="list-style-type: none"> CIS: Level 1 Level 2 Level 3 Level 4 HBTS 	
9. Outpatient Treatment	<ul style="list-style-type: none"> Covered, unless on Exceptions List "PRN" Behavioral health treatment under Early Intervention (EI) 		<ul style="list-style-type: none"> Special Education Evaluation and Counseling Outpatient DAS Therapeutic Recreation (not a Medicaid-covered benefit)

Table 3

Continuum of Child and Family Stabilization Services

Current Exceptions List (“Out-of-Plan Benefits”) – Providers currently bill directly to Medicaid fee-for-service; Health Plans are not responsible for assuring access to these services		
	Could be considered for designation as an in-plan service	Certain factors make this service appear more appropriate to remain out-of-plan
1. Basic Information & Support	<ul style="list-style-type: none"> • CEDARR (DHS) • Outreach and Tracking (DCYF) • CASSP (Not a Medicaid-covered service) 	
2. Screenings, Assessment and Referrals	<ul style="list-style-type: none"> • CEDARR (DHS) • Family Outreach Program (DOH) • Early Start (DCYF) • Enhanced Early Start (DCYF) • CASSP (Not a Medicaid-covered service) 	
3. Parent & Child Development and Peer Support	<ul style="list-style-type: none"> • CEDARR (DHS) • CASSP (Not a Medicaid-covered service) • Pediatric Practice Enhancement (not a Medicaid-covered service) 	
4. Intensive, Individualized Child and/or Family Support	<ul style="list-style-type: none"> • Kids Connect (DHS) • PASS (DHS) 	
5. Family Preservation and Support	<ul style="list-style-type: none"> • CES/Enhanced CES (DCYF) • Early Start/Enhanced Early Start (DCYF) • Respite (not a Medicaid-covered service) • Youth Diversion Programs 	
6. DCYF Residential, Short and Long Term		<ul style="list-style-type: none"> • Emergency Shelter • Alternative Living • Group Homes • Staff Secured Group Homes • Interim Residential Care • Supervised Apartments • Supervised Living • Therapeutic Foster Homes • Residential Treatment Centers • Service Networks • Resource Management Network

III. Core Values and Guiding Principles for Medicaid-Covered Children's Behavioral Health Services in Rhode Island

This chapter presents the core values and guiding principles adopted by the Workgroup to put into an appropriate context the continuum of children's behavioral health services described in the next chapter. These core values and guiding principles are adapted from work of Stroul and Friedman⁷ that has been the foundation of the Federal child and adolescent mental health programs for almost 20 years.

Overall, the Workgroup determined that the continuum would need to have the following goals:

- Single accountable entity for each child
- Budget integrity
- Promising practices/best practices/evidence-based practices

III.1 Core Values

The core values adopted for the continuum of children's behavioral health services included the following:

1. The system of care is child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.
2. The system of care is community based, with the focus of services as well as management and decision-making responsibility resting at the community level.
3. The system of care is culturally competent, with agencies, programs and services responsive to the cultural, racial and ethnic differences of the populations you serve.

III.2 Guiding Principles

The guiding principles adopted for the continuum of children's behavioral health services included the following:

1. Children, youth and their families have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs.
2. Children, youth and their families receive individualized services in accordance with the unique needs and potentials of each child and family and guided by an individualized service plan.
3. Children, youth and their families receive services within the least restrictive, most normative environment that is clinically appropriate.

⁷ Stroul, B.A. and R.M. Friedman. *A system of care for children youth with severe emotional disturbances*, (Revised edition), Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center, 1986.

4. The families and/or surrogate families of children and youth are full participants in all aspects of the planning and delivery of services unless such involvement is clearly detrimental to the safety of the child.
5. Children, youth and their families receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing and coordinating services.
6. Children, youth and their families are provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children, youth and families in need of support and intervention is promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Children, youth and their families are ensured smooth transitions to programs and services in the adult service system as necessary as the youth reaches maturity.
9. The rights of children, youth and their families are protected and effective advocacy efforts for children, youth and their families are promoted.
10. Children, youth and their families receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics and services are sensitive and responsive to cultural differences and special needs.

IV. CONTINUUM OF MEDICAID-COVERED CHILDREN'S BEHAVIORAL HEALTH SERVICES

H 5829 calls for the development of the continuum of care for behavioral health and sets forth two specific directions: amendment of contractual agreements with the RIte Care health plans and development of an RFP for an entity with responsibility for Medicaid-eligible children not enrolled in RIte Care. This would establish an accountable entity for the continuum for each child. Related is the question of the range of services within that continuum. The full continuum of children's behavioral health services includes multiple levels of care, ranging from the most restrictive and intensive therapeutic setting to the least restrictive and most family centered community based supports, as well as family stabilization services. In the Workgroup, the full continuum of services was identified. Presentations of the continuum differentiated between Behavioral Health Treatment Services and Child and Family Stabilization Services (shown respectively in Tables 2 and 3 which follow Chapter 2). In addition, an analysis of gaps throughout the continuum was completed by The Inventory of Services and Gaps Subcommittee, and is presented in this chapter.

Within the continuum, some services are presently within the scope of the RItE Care contracts. A fundamental question is the scope of services that would be included in contracts with any accountable entity. The existing “in plan” and “out of plan” service distinctions were used as a framework for looking at that question. Additionally, there was an analysis of gaps or needs within the existing continuum of care in Rhode Island. The Emergency Services Intervention screening and assessment services to be licensed by DCYF would be an essential element of the continuum.

IV.1 Services Included in the Continuum of Treatment Services

Table 2, following chapter 2, shows the overall continuum of Medicaid-covered behavioral health treatment services. Column 1 delineates the components of the continuum, which goes from the most intensive, most restrictive setting – inpatient – to the least intensive, least restrictive setting – outpatient. Column 2 describes the continuum in terms of RItE Care in-plan benefits as “covered” unless the service is on the “Exceptions List”, meaning that the service is out-of-plan and the RItE Care Health Plans are not presently responsible for them.. The Exceptions List is Column 3, and is divided into two components:

- Services that could be considered for designation as an in-plan benefit
- Services that appear more appropriate to remain as out-of-plan benefits

It must be noted, however, that this demarcation was for discussion purposes among the Workgroup participants. The two components of Column 3 taken together are actually the current out-of-plan benefits for RItE Care.

There was a general consensus among the participants in the H-5829 Children’s Behavioral Health Workgroup on the components of the treatment services continuum. However, there were not any consensus recommendations among the members of the Workgroup concerning shifting any treatment service components between in- and out-of-plan coverage.

IV.2 Definitions of Services Included in the Continuum of Children’s Behavioral Health Treatment Services

This section defines each one of the services along the treatment continuum (Table 2). The definitions are denoted by the source documents from which the definitions came, except as noted for Outpatient Services, as follows:

- *Rhode Island Medical Assistance Provider Manual (“1”)*
- *Attachment O to the RItE Care Health Plan Contract (“2”)*

The **treatment** services in the continuum are defined as follows:

- **Inpatient (2)** – Services provided in a hospital or freestanding detoxification facility staffed by licensed physicians (including psychiatrists) with 24 hour skilled nursing in a structured treatment milieu for the treatment of individuals with a mental health or substance abuse disorder of sudden onset an short, severe course who cannot be safely or effectively treated in a less intensive level of care.

- **Observation/Crisis Stabilization/Holding Bed (2)** – A secure and protected, medically staffed, psychiatrically supervised program designed for those individuals who, as a result of a psychiatric disorder, are an acute and significant danger to themselves or others, or who are acutely and significantly disabled and cannot meet their basic needs and functions, and who require extended observation in order to determine the most appropriate level of care and to avoid acute inpatient hospitalization.
- **Hospital Step-down/Diversion Services (2)** – A community based short term hospital step-down or diversionary service which provides complete multidisciplinary psychiatric evaluation and treatment in a staff secure setting offering high levels of supervision, structure, restrictiveness and intense treatment on a 24-hour basis. Acute Residential Treatment⁸ is utilized on a short-term basis for children and adolescents who require this level of short term psychiatric intervention in order to stabilize them within their community.
- **Substance Abuse Residential Treatment (1)** – This is a 24 hour supervised treatment program that is designed to provide the necessary support and address the substance abuse treatment needs of Medical Assistance recipients with substance abuse problems. Covered services include detoxification, rehabilitation, mental health, childcare, and care coordination services when provided by qualified staff. Qualified staff must provide these services in accordance with a written plan of care. Such plans of care, or initial assessments of the need for services, must be recommended by a physician or other licensed practitioner of the healing arts.
- **Emergency/Crisis Intervention (2)** – 24 hour/7 days a week face-to-face care management and intervention of an individual experiencing a behavioral health crisis. Such crises include an imminent, real, and significant risk of serious harm to self or others that requires immediate treatment. The activities are conducted by an appropriately licensed behavioral health provider in a hospital emergency room, residential placement setting, the individual's home, police station, or other setting.
- **Partial Hospitalization (2)** – A short-term, comprehensive, multidisciplinary psychiatric program that serves as a therapeutically supported alternative to or step-down from inpatient care. Partial Hospital Program is designed to provide stabilization of acute, severe, mental illness.

A PHP requires daily psychiatric evaluation and treatment comparable to that provided by an inpatient setting. A PHP may be provided by either hospital-based or freestanding facilities and are available 6-9 hours a day at a minimum of least 5 days per week.

For children and adolescents, a PHP provides services similar to hospital level care for those who have a supportive environment to return to in the evening. As the child decreases participation and returns to reliance on community supports and school, the PHP consults with the caretakers and the child's programs as needed to implement behavior plans and/or the monitoring or administration of medication.

⁸ This is the ARTS definition in Attachment O to the *RIte Care Health Plan Contract*.

- **Day/Evening Treatment (2)** – A structured program focused on maintaining or enhancing current levels of functioning and skills while maintaining community living. Children and adolescents who no longer require active medically based services may have significant residual symptoms that require extended interventions to overcome. The goal of day/evening treatment is to assist members with behavioral health disorders to achieve and maintain their highest level of functioning and work toward appropriate development goals. The services provided include: individual and family behavioral health therapies; psychosocial and adjunctive treatment modalities including rehabilitative, pre-vocational and life skill services to enable the individual to attain adequate functioning in the community.

The program operates for a minimum of three hours/day, 3-5 days/week and includes the following services: diagnostic, medical, psychiatric, psychosocial and adjunctive treatment modalities including rehabilitative, pre-vocational and life skill services to enable the individual to attain adequate functioning in the community.

- **Intensive Outpatient Treatment (2)** – A clinically-intensive structured outpatient program for individuals similar to a Day Treatment offering short-term day, evening, or combination which consists of intensive treatment within a stable therapeutic milieu for those individuals who can be safely treated in a less intense setting than a partial, day or evening program but require a higher level of intensity than that available in outpatient therapy.
- **Outpatient Treatment⁹** – These are clinical diagnostic and treatment services to individuals with mental or emotional disorders. Services include, but are not limited to: assessment and evaluation; psychological and neuropsychological assessment and evaluation; individual, family, couple, and group therapy; medication treatment and review. Except for medication treatment and review, clinician’s services do not include those services that are part of another community mental health service, such as psychiatric rehabilitation program components and crisis intervention.
- **CRAFT** – Residential Program for children and adolescents with Severe Emotional Disturbance operated by Bradley Hospital. The program functions as a step down from inpatient, as a diversion program from inpatient and as a residential placement from the community.
- **Diagnostic Assessment Program (DAS)** – The DCYF provides Diagnostic Assessment Services (DAS) for youth referred through the Family Court to determine the appropriate level of service for disposition by the Court on wayward/disobedient petitions. The DAS is an inpatient program, up to two weeks, during which time children and youth are evaluated based on their presenting issues. This evaluation includes psychological and psychiatric assessments when necessary. The DAS program also does have out-patient services.

As Table 2 shows, there are a variety of services or programs unique to Rhode Island that are included within some component of the treatment services continuum. Below are some illustrations of this:

⁹ Described by what is in the *Medicaid Provider Manual* under “Clinician’s Services”.

- **Childrens Intensive Services (2)** -- This program is designated to provide the necessary support and treatment to a child or adolescent and family (substitute or natural) to allow the family to remain intact, thus preventing the need for long-term residential or hospital psychiatric care on the part of the young person

Services covered under this program include, but are not limited to, the following:

- Assessment and evaluation
- Family therapy
- Medical treatment and pharmacotherapy
- Intervention with schools
- Recreational activities
- Individual counseling and psychotherapy
- Group therapy
- Intervention with child welfare
- Juvenile justice/local police
- Other systems affecting the youth

All of the above services are rendered in the natural environment of the youth and family as well as in office settings. The frequency of contact is determined by the level of need exhibited by the family. An average case requires approximately 5 hours of a clinician's time per week.

- **HBTS (Home Based Therapeutic Services)**¹⁰ – Provides intensive home and community services to children up to age 21 with severe behavioral health, developmental or physical disabilities. These services are provided by trained paraprofessionals following a prescribed treatment plan and under the supervision of licensed clinicians. HBTS services related to behavioral health would be part of the behavioral health continuum.
- **Psychiatric Response Network (PRN)**¹¹ – PRN delivers psychiatric evaluation and treatment services to children and adolescents in the custody of DCYF and who reside in any one of several residential programs in Rhode Island. PRN services include psychiatric evaluations, performed at the residential program site by board certified child/adolescent psychiatrists. In addition, these physicians and a clinical nurse specialist also provide follow-up medication management visits on site.
- **Early Intervention**¹² – Covered as included within the IFSP, consistent with Article 22 of the General Laws of Rhode Island.

It should be noted that within a number of these components of the continuum, an array of services may be contained within them. For example, the Outpatient Treatment component of the continuum contains the following services for individuals with substance abuse disorders:

- **Counseling Services (1)** – Counseling Services refers to those services provided to Medical Assistance (MA) recipients for the purpose of evaluation, treatment and

¹⁰ Rhode Island KIDS COUNT. 2005 *Rhode Island KIDS Count Factbook*.

¹¹ Definition used by NHPRI.

¹² Per Attachment A of the *RItE Care Health Plan Contract*. Health Plans are responsible for the first \$5,000 of such benefit costs, then any additional services are covered by Medicaid FFS under the stop-loss provisions of the *RItE Care Health Plan Contract*.

rehabilitation of problems directly related to substance abuse. Counseling services may be provided in residential (halfway houses and therapeutic communities) and outpatient treatment settings and are reimbursable only when provided in accordance with a treatment plan approved by a program clinical director. Counseling services include individual and group therapy and necessary counseling provided to Medical Assistance eligible family members and Medical Assistance eligible significant others as documented in the client's plan of care.

- **Methadone Maintenance Services (1)** – Methadone Maintenance Services are provided for the purpose of treating MA recipients with opiate dependency. Methadone maintenance services will be provided in outpatient treatment settings and are reimbursable only when provided in accordance with a treatment plan approved by a program clinical director.

The EOHHS believes it important to clarify the set of Medicaid-covered behavioral health treatment services that may be provided by the local education agencies (LEAs) in Rhode Island that is referenced in Column 3 under “Special Education”. The Federal Government has allowed schools and school districts to submit claims for reimbursement from state Medicaid programs for certain services since 1989. The State of Rhode Island enacted G.L. 40-8-18 in 1992. Amended in 2000, this general law enables LEAs to enroll as Early and Periodic Screening Diagnosis and Treatment (EPSDT) providers with the Rhode Island Medical Assistance Program. Enrolling as a provider allows an LEA to submit claims for services provided within its programs. This means that the Medicaid program may reimburse an LEA for certain services provided to a child who is Medicaid eligible and most of the services reimbursable are identified through the special education process by the development and implementation of Individualized Education Plans (IEPs).

IV.3 Services included in the Family Stabilization Services Continuum

The State of Rhode Island also provides a continuum of child and family stabilization programs and services. This service continuum is listed in Table 3. Services within this continuum are further defined in Section IV.4, below.

IV.4 Description of Services in the Child and Family Stabilization Continuum

- Outreach and Tracking – Programs that provide community based monitoring and outreach services, including group and in-home family counseling, organized recreation activities, linkages to schools and vocational resources (definition from DCYF) (DCYF service currently)
- CASSP Family Services Coordinators – Child and Adolescent Services System Program provides a community-based family-focused, inter-disciplinary model for care coordination for seriously emotionally disturbed children and youth. (DCYF service currently)

- CEDARR Family Centers- Can help children with special health care needs and their families with their need for information, professional assessment, specialty clinical evaluation, care planning, coordination of services, and ongoing referral assistance and support. Specific services include: initial family contact, initial Family Assessment and basic services and supports, system mapping and navigations, resource identification, eligibility assessment and application assistance, peer family support and guidance, specialty clinical evaluation, treatment consultation, Family Care Plan (FCP) development, Family Care Coordination Assistance (FCCA), Family Care Plan review and revision, and crisis intervention services. (DHS service currently). CEDARR Family Center services related to behavioral health would be part of the behavioral health continuum.
- Family Outreach Program – home visiting program targeted at at-risk children and families.(DOH service currently)
- Pediatric Practice Enhancement – A program funded by a DOH grant that provides family advocates to Pediatric medical practices. The grant is operated by RIPIN. (DOH service currently)
- KIDS CONNECT – (formerly Therapeutic Child and Youth Care) This is a specialized service designed to provide specialized supports and services to allow children with special health care needs to participate with typically developing peers in licensed child and youth care settings. It is designed for children who have previously been dismissed from or unable to participate in child care settings due to their special health care needs. Services are provided by trained paraprofessionals under the supervision of a licensed clinician. The licensed clinician develops an individualized therapeutic integration plan for each child receiving the service. Licensed child care agencies can be certified to provide this service. (DHS service currently). KIDS CONNECT services related to behavioral health would be part of the behavioral health continuum.
- PASS – Consumer-directed personalized services and supports provided in home and community for children with special health care needs. Family selects and trains a community-based worker who is then hired by a certified provider to provide a set of services to child. Individualized plan is developed for each child which is designed to assist the child in three key domains: ability to accomplish essential activities of daily life, ability to make life preserving decisions, and ability to participate in social roles and social settings. A licensed clinician is employed by the certified agency to ensure plan is medically necessary and to monitor ongoing plan implementation. (DHS service currently). PASS services related to behavioral health would be part of the behavioral health continuum.
- Respite – Temporary care provided to an individual for the purpose of providing a period of relief to the primary caregivers. Respite is used to decrease stress in the homes of persons with disabilities or handicaps, thereby increasing caregivers’ overall effectiveness. (DHS currently has a very limited respite program for developmentally delayed children)

- Youth Diversion Programs - Provides community-based monitoring and outreach services including group and in home family counseling, organized recreation activities, linkages to schools and vocation resources. Referrals typically come from police departments. (DCYF service currently)
- Group Homes – A structure and supportive community-based group living environment to prepare youth for reunification, foster care, transitional or independent living. Usually includes 6 to 10 children or adolescents per home and may be linked with a day treatment program or specialized educational program. On-site therapeutic services – ongoing and crisis – are integrated into the residential settings. (DCYF service currently)

IV.5 Gaps in Treatment and Family Stabilization Services along the Children’s Behavioral Health Continuum

The Subcommittee on Inventory of Mental Health Services/Gaps in Service examined the gaps in services that have the most effect on psychiatric hospitalization of children and youth. In other words, what are the services which, if they were more available to children and families, would have the most likelihood of reducing the need for psychiatric hospitalization. The subcommittee began this examination by identifying gaps in the following three areas:

- Gaps in service that are often encountered by community mental health organizations
- Gaps in service that were identified by NHPRI which caused them to develop new mental health services and programs for their members
- Gaps in services particularly for children and youth in substitute care.

In its final product, the subcommittee delineated the following gaps in service:

- In the inpatient arena, the following were considered to be needed:
 - Community-based services need to begin and continue to work with the child and family while the child is hospitalized and/or in residential treatment.
 - Community-based services should be included in inpatient and/or residential discharge planning meetings, along with families and child re: regarding services needed upon discharge to ensure a plan and adequate capacity.
- Short-term (1-3 days) crisis - stabilization / holding beds – a 24 hour/7 days a week level of secure and well-staffed care (with 24/7 evaluation and intake) that is not hospital based.
- High-level hospital step-down or diversion services, which were considered to be in short supply
- Extended clinical residential treatment programs (2-6 months), which were considered to be in short supply

- In the outpatient arena, the following were considered to be in short supply: child psychiatrists, clinicians trained to treat clients with developmental disabilities and behavioral health disorders, and general clinicians

The subcommittee also considered there to be a need for the following:

- Respite services
- DCYF and/or DHS should develop a policy requiring community representation at hospital/ residential discharge planning meetings with families.
- DCYF needs to amend existing contracts with residential providers to ensure that case management is provided to children/youth for 3-6 months upon discharge.
- All residential providers need to develop policies that would support family involvement when re-unification with the family is the ultimate goal.
- A process for accountability/quality assurance that ensures families are consistently provided with opportunities for feedback in regards to access, and ultimately reaching their desired outcomes of child and family well being must be put into place.
- The various services within the behavioral health continuum must be linked to one another, and planning for such linkages must be done in partnership with families.
- Lack of resources in communities, including inadequate workforce and insufficient “flexible funds” to support non-traditional services such as therapeutic recreation, basic needs (food, clothing, utilities etc.), camp scholarships, mentors, respite and youth groups that are specific to youth with behavioral health challenges.
- Develop a certificate program for HBTS, PASS, and Respite providers.
- A behavioral health assessment should be added to the screening process that occurs when a child transitions from Early Intervention to public school.

Finally, nine cross-cutting issues were identified by members of the subcommittee:

- Geographic range of services – That is, some programs might exist but they do not exist in enough communities or regions of the State to serve the children/youth and families that need them.
- Capacity – That is, some programs exist but do not have the capacity to serve the numbers of children/youth and their families who need them.
- Staff – Hiring and retaining a qualified staff/workforce will be critical in both expansion of existing services and the development of new services.
- Consistent Screening Process – All children, regardless of insurance, coverage should have a consistent screening process.

- Ensure that a common “glossary” of services is used in all policy and program discussions.
- Need to be attentive to what benefits are covered under Medicaid, as well as which are in-plan and out-of-plan RIte Care benefits.
- All of the “dots” in the continuum need to be connected – child and family, treatment programs, family and communities.
- With the exception of the DCYF milieu and room and board costs, all of these services need to be managed by the Health Plans and management entity for the children in FFS Medicaid.
- Performance standards should be developed and implemented so that outcomes at each level care should be examined to ensure goals are attained. The development of the standards should include the family.

Appendix C to this report contains the final document prepared by this subcommittee.

V. OPTIONS

Since the Workgroup did not arrive at a consensus on the in- and out-of-plan components of the children’s behavioral health treatment services continuum, with this report, the EOHHS is defining two specific options for consideration. The EOHHS believes that any option selected should embrace the goals adopted by the Workgroup that were delineated in Chapter III as follows:

- Single point of accountability for services for each child
- Budget integrity
- Promising practices/best practices/evidence-based practices

Irrespective of which option might be selected, the EOHHS will be the oversight body for Medicaid-covered children’s behavioral health services in Rhode Island. As such, the EOHHS would serve as the overall policy-setting body, would ensure accountability, including financial accountability and program outcome measurement, and would also ensure coordination if more than one State department were an accountable entity.

V.1 OPTIONS

These options are presented in no order of preference.

- **OPTION – Create a Carve-Out of All Medicaid covered Children’s Behavioral Health Treatment and Family Stabilization Services to one or more new accountable entity(s).**

This option incorporates the overall directives of H5829:

H5829 directs DHS and DCYF to:

- A. Develop a design of a continuum of care for children's behavioral health services
- B. Assure appropriate management of psychiatric hospitalizations
- C. Change inpatient admission criteria for children who receive publicly funded mental health benefits

Some States have carved out behavioral health services entirely from the State's Medicaid managed care programs and have entered into separate management contracts with an accountable entity for those services. Under this option, DCYF would be vested with authority and responsibility for the in- and out-of-plan treatment services in Table 2, as well as child and family stabilization services on Table 3. Under this option, all children's behavioral health services would be removed from the RIte Care Health Plan contracts. All funds (including State matching funds) for the in-plan services in Table 2 would need to be shifted from DHS to DCYF. DCYF would need to contract with a single, accountable entity to manage the services in the full continuum of behavioral health treatment and family stabilization services. That entity would need to meet all of the Medicaid managed care requirements in 42 CFR 438, (as the RIte Care Health Plans do now). To assure budget integrity, the single, accountable entity should be at full or partial risk for the costs of providing these treatment services, requiring that the single, accountable entity meet the requirements of 42 CFR 438.6 for actuarially sound capitation rates. DCYF would be responsible for maintaining budget neutrality for behavioral health services covered by Medicaid for RIte Care enrollees, as is required under the RIte Care 1115 waiver. In order to take on these responsibilities, DCYF would require infrastructure capability not currently present. DCYF is currently investigating this issue.

Under this option, DCYF would also be responsible for managing the children's behavioral health treatment benefit not just for Medicaid-eligible children enrolled in Medicaid FFS but for those in RIte Care as well.

Under this option, DCYF would be accountable for managing services and budget for Medicaid-covered children's behavioral health treatment (Table 2), as well as for the behavioral health components of child and family stabilization/ family preservation services (Table 3) within the children's behavioral health continuum.

A. DCYF would be responsible for ensuring that every child enrolled in Medicaid in Rhode Island with a behavioral health diagnosis will have timely and appropriate access to an accountable comprehensive system of behavioral health screening, diagnosis, and treatment services, as well as family support services.

- These services will include:
 - 24 hour emergency assessment/crisis intervention and stabilization provided by Emergency Services Providers, licensed by DCYF
 - acute inpatient hospitalization, (screened by licensed Emergency Services providers),
 - step down and short term alternatives to hospitalization including acute therapeutic 24 hour treatment services and partial hospitalization/day treatment,

- structured therapeutic day/after school treatment programs to serve as a bridge between acute/intensive treatment and outpatient treatment,
- intensive outpatient treatment,
- traditional outpatient treatment including diagnostic evaluation, psychological testing, individual therapy, family therapy, group therapy, and medication management, and
- an array of flexible, community and home based support services provided by a community-based, mobile, multidisciplinary team.

Such contract with qualified behavioral health organizations will be amended to provide the full scope of coordinated behavioral treatment services (listed on Table 2) to enrolled children, using an adequate, qualified network of providers. This will ensure a single point of accountability for all behavioral health screening, diagnosis, and treatment services. Currently, these are multiple points of accountability, as described in Table 2, which creates gaps in service availability and timeliness. The lone exception under this option would be the behavioral health services (i.e., Special Education Evaluation and Counseling) provided by the Local Education Agencies (LEAs). These latter services are provided solely under the auspices and control of the LEAs and are to develop Individualized Education Programs (IEPs) or as essential parts of IEPs. As such, they would not make sense to bring under the purview of the Health Plans.¹³

This contract will also include responsibility for a coordinated, community-based, statewide system of prevention, family preservation, and family support services. Such system will ensure that all children and families in Rhode Island at risk of disruption and instability will be provided/offered a coordinated, appropriate, timely community-based set of family preservation and family support services, as follows:

- Every child and family at risk of disruption to family stability and safety (e.g. at risk of child and family incarceration, violence, abuse) will be provided with /offered a coordinated community-based set of family preservation and family support services.
- Such services will include child and family preservation and stabilization services, including the behavioral health components of family stabilization services listed on Table 3.
- This system will have adequate capacity to serve families at risk statewide
- These support services will also be provided as needed as a “wrap around” to therapeutic behavioral health services for children receiving comprehensive behavioral health treatment
- These support services will also be provided/offered to children and their caretakers who are living in group homes, foster family, and other out of home settings.

¹³ It should also be noted that these services operate under separate guidance from the Federal Government because their allowability as a Medicaid expense is part of Federal education legislation (i.e., Individuals with Disabilities Education Act, or IDEA).

B. DCYF would be responsible for developing and implementing contract(s) directly with nationally accredited, qualified behavioral health management organization(s) which will contract for and provide the full scope of coordinated behavioral health diagnosis and treatment services (as listed above) for all Medicaid enrolled children. This would include children enrolled in fee for service Medicaid, children enrolled in RItE Care, children in Substitute Care, and Children with Special Health Care needs. This accountable entity/organization, will be accredited by NCQA and will satisfactorily meet the administrative, access, and quality standards for Accreditation of Managed Behavioral Healthcare Organizations This will be implemented through a competitive procurement and contracting process. Emergency Services Providers, licensed by DCYF, will be a required component of networks, ensuring that children are appropriately screened and placed in the most appropriate setting within the network, including 24 availability to appropriate alternatives to hospitalization. RItE Care contracts would be amended so that Health Plans would only be responsible for physical health services for children under age 21. RItE Care Health Plans would no longer have responsibility for children's behavioral health care, but would continue to be responsible for providing behavioral health care to the 40,000 parents enrolled in RItE Care.

C. DCYF would be responsible for licensing and oversight of Emergency Services providers, ensuring that children are appropriately screened in a crisis, and placed in the most appropriate setting within the network, utilizing the network's contractual requirement to develop appropriate, adequate capacity for appropriate alternatives to hospitalization. DCYF has additional responsibilities pertaining to CIS, licensing of outpatient services and residential treatment standards.

- **OPTION - DHS would be accountable for Medicaid-covered children's behavioral health treatment (Table 2), while DCYF would be accountable for child and family stabilization/ family preservation services (Table 3) within the children's behavioral health continuum**

This option incorporates all specific directives of H5829:

H5829 directs DHS and DCYF to:

A. Develop a design of a continuum of care for children's behavioral health services

“DCYF and DHS shall cooperate to develop a design of a continuum of care for children's behavioral health services that encourages the use of alternative psychiatric and other services to hospitalization and reviews the utilization of each service in order to better match services and programs to the needs of the children and families as well as continuously improve the quality of and access to services.”

B. Assure appropriate management of psychiatric hospitalizations:

“(1) Amend contractual agreements with RItE Care health plans to reflect complete responsibility for the management of psychiatric hospitalizations, specifically the development of hospital diversion and post discharge services; and the utilization of crisis intervention services as a requirement for authorization of a psychiatric admission for all children enrolled in RItE Care;
(2) Issue an RFP to identify a contracted entity to reflect complete responsibility for the management of psychiatric hospitalizations, specifically the development of hospital diversion and post discharge services for crisis intervention services as a requirement for authorization of a psychiatric admission

for all Medicaid-eligible children not enrolled in RIte Care. The request for proposals shall include a dispute resolution process.”

C. Change inpatient admission criteria for children who receive publicly funded mental health benefits:

“Any child under 18 who receives medical benefits funded in whole or in part by either DCYF or by DHS may be admitted to any facility provided for by this chapter seeking care and treatment for alleged mental disability only after an initial mental health crisis intervention is completed by a provider that is licensed by DCYF for emergency services, has proper credentials and is contracted with the RIte Care health plan or the state and said provider, after considering alternative services hospitalization with the child, family and other providers, requests prior authorization for the admission from a representative of the child and family's insurance company or utilization review organization representing the insurance company.”

DHS would be accountable for Medicaid-covered children’s behavioral health treatment under this option (Table 2), while DCYF would be accountable for behavioral health-related child and family stabilization/ family preservation services (examples on Table 3) within the children’s behavioral health continuum.

A. DHS will be responsible for ensuring that every child enrolled in Medicaid in Rhode Island with a behavioral health diagnosis will have timely and appropriate access to an accountable comprehensive system of behavioral health screening, diagnosis, and treatment services.

- These services will include:
 - 24 hour emergency assessment/crisis intervention and stabilization provided by Emergency Services Providers, licensed by DCYF
 - acute inpatient hospitalization, (screened by licensed Emergency Services providers),
 - step down and short term alternatives to hospitalization including acute therapeutic 24 hour treatment services and partial hospitalization/day treatment,
 - structured therapeutic day/after school treatment programs to serve as a bridge between acute/intensive treatment and outpatient treatment,
 - intensive outpatient treatment,
 - traditional outpatient treatment including diagnostic evaluation, psychological testing, individual therapy, family therapy, group therapy, and medication management, and
 - an array of flexible, community and home based support services provided by a community-based, mobile, multidisciplinary team.

B. DHS would be responsible for contracting with RIte Care Health Plans, for Children in RIte Care, Substitute Care, and Children with Special Health Care needs who

voluntarily enroll in a Health Plan. RItE Care Health Plans will continue to be required to contract with an accountable entity/organization, which is accredited by NCQA and satisfactorily meets the administrative, access, and quality standards for Accreditation of Managed Behavioral Healthcare Organizations.

- Such contract with qualified behavioral health organizations will be amended to provide the full scope of coordinated behavioral treatment services (listed on Table 2) to enrolled children, using an adequate, qualified network of providers. This will ensure a single point of accountability for all behavioral health screening, diagnosis, and treatment services. Currently, these are multiple points of accountability, as described in Table 2, which creates gaps in service availability and timeliness. The lone exception under this option would be the behavioral health services (i.e., Special Education Evaluation and Counseling) provided by the Local Education Agencies (LEAs). These latter services are provided solely under the auspices and control of the LEAs and are to develop Individualized Education Plans (IEPs) or as essential parts of IEPs. As such, they would not make sense to bring under the purview of the Health Plans.¹⁴
- Health Plan contracts will reflect responsibility for the development of a qualified, adequate provider network and services to meet the full continuum of service needs of the covered population, including development of services which would provide timely, appropriate access to alternatives to psychiatric hospitalization.
- Health Plans will be responsible to assure that each child receives timely care in the most appropriate, least restrictive setting, and smoothly moves through the continuum of care in the most appropriate manner given the child's condition and environment.
- *Amendment to the RItE Care Health Plan Contract:*
Appendix D contains an outline of a proposed amendment to the *RItE Care Health Plan Contract* to reflect the changes to the contract that would be required under this scenario.

C. DHS would also be responsible for developing and implementing contract(s) directly with nationally accredited, qualified behavioral health management organization(s) which will contract for and provide the full scope of coordinated behavioral health diagnosis and treatment services (as listed above) for children enrolled in fee for service Medicaid. This will be implemented through a competitive procurement and contracting process. This will assure children in FFS Medicaid will have access to an adequate, qualified network of providers. Emergency Services Providers, licensed by DCYF, will be a required component of such networks, ensuring that children are appropriately screened and placed in the most appropriate setting within the network, including 24/7 availability to appropriate alternatives to hospitalization.

- Medicaid Fee-for-Service Request for Proposals (RFP)

¹⁴ It should also be noted that these services operate under separate guidance from the Federal Government because their allowability as a Medicaid expense is part of Federal education legislation (i.e., Individuals with Disabilities Education Act, or IDEA).

Appendix E contains an outline of a proposed Request for Proposals (RFP) to incorporate Medicaid FFS children's behavioral health treatment services.

D. DCYF will be responsible for licensing and oversight of Emergency Services providers, ensuring that children are appropriately screened in a crisis, and placed in the most appropriate setting within the network, utilizing the network's contractual requirement to develop appropriate, adequate capacity for appropriate alternatives to hospitalization. DCYF has additional responsibilities pertaining to CIS, licensing of outpatient services and residential treatment standards.

E. DCYF will be responsible for developing and implementing a statewide accountable system of behavioral health-related family support services. Such system will ensure that all children and families in Rhode Island at risk of disruption and instability will be provided/offered a coordinated, appropriate, timely community-based set of family preservation and family support services, as follows:

- Every child and family at risk of disruption to family stability and safety (e.g. at risk of child and family incarceration, violence, abuse) will be provided with /offered a coordinated community-based set of family preservation and family support services.
 - DCYF will contract for a coordinate, community-based, statewide system of prevention, family preservation, and family support services.
 - Such services will include family preservation and stabilization services, such as those detailed on Table 3.
 - This system will have adequate capacity to serve families at risk statewide
 - These support services will also be provided as needed as a "wrap around" to therapeutic behavioral health services for children receiving comprehensive behavioral health treatment
 - These support services will also be provided/offered to children and their caretakers who are living in group homes, foster family, and other out of home settings.
 - This system will be implemented by DCYF through a competitive procurement and contracting process. This will assure all children in RI will have access to an adequate, qualified network of providers.
- **OPTION - Establish a Comprehensive Continuum of Treatment within the RIte Care Contract by Moving Out-of-Plan Treatment Services In-Plan.**

The RFP for behavioral health services for Medicaid eligible children would mirror this continuum.

The RIte Care Health Plans are in their 12th year of being responsible financially for some of the services in the children's behavioral health **treatment** continuum (i.e., in-plan services) for 90 percent of the children in enrolled in Medicaid in Rhode Island. The Health Plans are fully at

risk financially for these services for 93 percent of the children enrolled in RItE Care. Even for the seven percent of children enrolled in RItE Care for which NHPRI¹⁵ is not fully at risk financially, the plan is paid a provisional monthly capitation rate (called a “working rate”) that is reconciled on a quarterly basis to the actual costs of providing services to children in substitute care and children with special health care needs. It should be noted that the “working rate” and quarterly reconciliation are for all Medicaid-covered services for these children, not just for behavioral health services.

A logical extension of this experience would be to vest the RItE Care Health Plans with responsibility for managing all services in the children’s behavioral health **treatment** continuum. Put another way, under this option the Health Plans would be responsible financially for managing the provision of all in-plan and out-of-plan services (i.e., the “Current Exceptions List”) shown in Table 2. The lone exception under this option would be the behavioral health services (i.e., Special Education Evaluation and Counseling) provided by the Local Education Agencies (LEAs). These latter services are provided solely under the auspices and control of the LEAs and are to develop Individualized Education Plans (IEPs) or as essential parts of IEPs. As such, they would not make sense to bring under the purview of the Health Plans.¹⁶

As part of its broader obligations in response to H-5829, DCYF has been developing children’s behavioral health emergency services standards in order to license behavioral health providers to provide assessment and crisis intervention services. DCYF has additional responsibilities pertaining to CIS, licensing of outpatient services and residential treatment standards. If this option were adopted, the RItE Care Health Plans would be required to contract with DCYF-licensed providers for these emergency services to assure the competencies sought through the contemplated licensing changes. Alternatively, Health Plans could be required to meet emergency services standards through amendment of the *RItE Care Health Plan Contract*.

To assure budget integrity, the Health Plans would be either at full- or partial-risk for the in-plan services (including those being moved from the Current Exceptions List to in-plan). Any risk arrangements would need to meet the requirements of 42 CFR 438.6 for actuarially sound capitation rates, as they are required to be presently under RItE Care. In addition, any amounts (including State matching funds) for out-of-plan services to be moved in-plan would need to be shifted from DCYF to DHS.

As part of this option, Health Plans would be required to accept for enrollment all categories of RItE Care-eligible children including children in substitute care and children with special health care needs.

DHS would be responsible for Medicaid-covered children’s behavioral health **treatment** under this option. DCYF would, however, maintain its “family preservation” role in children’s behavioral health for the **child and family stabilization** services continuum as was shown in Table 3.

V.3 Oversight

¹⁵ NHPRI has been the only Health Plan that has been willing to enroll these children.

¹⁶ It should also be noted that these services operate under separate guidance from the Federal Government because their allowability as a Medicaid expense is part of Federal education legislation (i.e., Individuals with Disabilities Education Act, or IDEA).

The state's Office of Health and Human Services will be responsible to provide oversight and monitoring to ensure full compliance of all requirements under any option selected. This oversight role will include:

- Ensuring appropriate accountability and coordination among state agencies
- Holding each payor accountable for developing adequate community based capacity to provide the full scope of services in a timely manner and in the most appropriate, least cost setting.
- Standard setting; data collection and reporting; performance evaluation; ombudsman; satisfaction surveys, compliance reviews and enforcement, and outcome evaluations.

VI. IMPLEMENTATION PLAN

This chapter presents a proposed implementation plan which follows from the work to date of the Workgroup. Figure 4 shows the implementation plan in graphical form. This assumes a decision is made to pursue a certain option during February.

Figure 4

Activities	March	April	May	June	July
Option : Create Carve-Out from RItE Care <ul style="list-style-type: none"> • DCYF prepares RFP for a responsible entity to manage all Medicaid children’s behavioral health services, including behavioral health screening, diagnosis and treatment as well as /family preservation services. This would include all Medicaid covered behavioral health services currently paid through both RItE Care and fee for service. • DHS prepares amendment to RItE Care contract to remove responsibility for all children’s behavioral health services 		██████████			
Option : Amend RItE Care Contracts; Issue RFP for FFS Medicaid <ul style="list-style-type: none"> • DHS prepares amendments to the RItE Care health plan contracts to reflect responsibility for full continuum of children’s behavioral health treatment services, including Emergency Services providers licensed by DCYF as well as development of intensive community based services as an alternative to psychiatric hospitalization. • DHS prepares Continuum of Behavioral Health Treatment Services RFP for FFS children • DCFY prepares RFP for family stabilization services network • DCYF prepares licensure standards for Emergency Services providers 		██████████			
Option: Full Continuum of Behavioral Health Treatment in RItE Care and include full Continuum <ul style="list-style-type: none"> • DHS prepares amendments to the RItE Care contracts to reflect responsibility for the full continuum of children’s behavioral treatment services including Emergency Services providers licensed by DCYF as well as development of intensive 	██████████				

Activities	March	April	May	June	July
community based services as an alternative to psychiatric hospitalization. <ul style="list-style-type: none"> • Prepare continuum of behavioral health treatment services RFP for Medicaid FFS children. • DCYF prepares licensure standards for Emergency Service providers. 					
Issue all RFPs; make RIte Care contract changes; issue licensing standards for Emergency Services (DCYF and DHS as appropriate, depending on option selected)					
Award/finalize all contracts; license providers (DCYF and DHS as appropriate, depending on option selected)					
Refine indicators and program metrics and develop implementation schedule for producing them (EOHHS)					

VII. INDICATORS AND PROGRAM METRICS

This chapter presents the recommendations for indicators and program metrics. Because H-5829 focused on inpatient behavioral health, the recommended indicators and program metrics are similarly focused.

The recommended indicators and program metrics are as follows:

- Aggregate Medicaid dollars spent on children's behavioral health each State Fiscal Year
- Medicaid dollars spent per member per month (PMPM) spent on each component in the continuum of behavioral health treatment services each SFY
- Inpatient children's behavioral health admissions/1,000 member-months for each SFY
- Inpatient children's behavioral days/1,000 member-months for each SFY
- Average length of stay for children's behavioral health inpatient admissions each SFY
- Utilization/1,000 member-months for other children's behavioral health treatment services in the continuum each SFY
- Applicable Medicaid HEDIS[®] behavioral health measures¹⁷
- Children's behavioral health inpatient readmissions/ children's behavioral health inpatient discharges each SFY
- Enrollee satisfaction with children's behavioral health treatment services each SFY
- Complaints, grievances, and appeals concerning children's behavioral health each SFY
- Number of emergency services evaluations/assessments completed before inpatient admissions each SFY
- Number of diversionary service referrals made and utilized each SFY
- Number of children in medical board beds for psychiatric reasons each SFY

As the implementation plan in Chapter V showed, both baseline and trended indicator and program metrics data would be prepared annually for each SFY.

¹⁷ Rite Care Health Plans are required to be accredited by the National Committee for Quality Assurance (NCQA) under NCQA's Medicaid managed care organization (MCO) standards. HEDIS[®] reporting is required by NCQA and the Rite Care Health Plans provide their HEDIS[®] data annually to DHS.

APPENDIX A

Minutes of H-5829 Children's Behavioral Health Workgroup

H-5829 Emergency Svs. Children's Behavioral Health Workgroup

MEETING NOTES

September 30, 2005

10:30 a.m.

Office of Health & Human Services Conference Room
74 West Road/Hazard Building

Attendees: Dale Klatzker, Janet Anderson, Kevin Savage, Steven J. Patriarca, Diane Miller, Ann Martino, Elizabeth Earls, William Hancur, Jill Beckwith, Ken Pariseau, Jeffrey Taylor, David Lauterbach, Mark Montella, Murray Blitzer, Ronald A. Lebel, Dr. Elizabeth Wheeler, Peg Malone, Margaret Holland-McDuff and John Young

At the opening of the meeting, those present introduced themselves and the proposed agenda was discussed. There was a brief of the previous meeting (6/10/05). There was agreement that these meetings are open to the public with the note that if someone 'sits at the table, they need to be prepared to stand and work'.

The points of H-5829 was reviewed; specifically noted was the due date of the report to the General Assembly – January 1, 2006; gives the group 3 months to complete its findings/report. It was agreed that a timeline of the next three (3) months needed to be developed as well as list of future meetings with their general topics of discussion.

Discussion Points

GROUND RULES:

1. Again, the meetings are open to the public – there will be no invitations.
2. Persons/parties that have a specific concern or point of view need to be present – if you have not expressed your points (either personally or sending of a representative), the group will continue to move on;
3. This workgroup is not staffed – come prepared to contribute and work;
4. There may be additional workgroups of this larger group;
5. Perceptions and responsibilities need to be put aside; this needs to be a fact-based discussion;
6. Hold off 'solutions' until all facts have been examined and possible options have been discussed;

**H-5829 Emergency Svs.
Children's Behavioral Health Workgroup
September 30, 2005 Page 2**

7. This is 'the table' – all your business should take place here and please honor the discussion and those participating by being accurate if you choose to discuss elsewhere.

ADDITIONAL REPRESENTATION:

1. Parents/Parent Organizations
2. Persons exhibiting diversity

FIRST PHASE DISCUSSION/EXAMINATION:

1. Values & Principles – 1st Agenda Item at next meeting (10/7/05) – all agreed that this first item should not occupy the entire time allotted for the meeting
2. Data elements, collection & analysis – 2nd Agenda Item
3. Development of therapeutic & philosophical approaches and the criteria to be used to judge them- i.e. kinds of services needed to accomplish objectives
4. Supply and distribution of services and their demand
5. Prevailing myths and mis-perceptions

NEXT MEETING:

- Values & Principles - please bring validated current & applicable System of Care Values & Principles
- Data to support fact-building – bring descriptions of data available to each participant as well as available summaries and data reports

H-5829 Emergency Svs. Children's Behavioral Health Workgroup

MEETING NOTES

September 30, 2005

10:30 a.m.

Office of Health & Human Services Conference Room
74 West Road/Hazard Building

Attendees: Dale Klatzker, Janet Anderson, Kevin Savage, Steven J. Patriarca, Diane Miller, Ann Martino, Elizabeth Earls, William Hancur, Jill Beckwith, Ken Pariseau, Jeffrey Taylor, David Lauterbach, Mark Montella, Murray Blitzer, Ronald A. Lebel, Dr. Elizabeth Wheeler, Peg Malone, Margaret Holland-McDuff and John Young

At the opening of the meeting, those present introduced themselves and the proposed agenda was discussed. There was a brief of the previous meeting (6/10/05). There was agreement that these meetings are open to the public with the note that if someone 'sits at the table, they need to be prepared to stand and work'.

The points of H-5829 was reviewed; specifically noted was the due date of the report to the General Assembly – January 1, 2006; gives the group 3 months to complete its findings/report. It was agreed that a timeline of the next three (3) months needed to be developed as well as list of future meetings with their general topics of discussion.

Discussion Points

GROUND RULES:

8. Again, the meetings are open to the public – there will be no invitations.
9. Persons/parties that have a specific concern or point of view need to be present – if you have not expressed your points (either personally or sending of a representative), the group will continue to move on;
10. This workgroup is not staffed – come prepared to contribute and work;
11. There may be additional workgroups of this larger group;
12. Perceptions and responsibilities need to be put aside; this needs to be a fact-based discussion;
13. Hold off 'solutions' until all facts have been examined and possible options have been discussed;

H-5829 Emergency Svs.
Children's Behavioral Health Workgroup
September 30, 2005 Page 2

1. This is 'the table' – all your business should take place here and please honor the discussion and those participating by being accurate if you choose to discuss elsewhere.

ADDITIONAL REPRESENTATION:

1. Parents/Parent Organizations
2. Persons exhibiting diversity

FIRST PHASE DISCUSSION/EXAMINATION:

1. Values & Principles – 1st Agenda Item at next meeting (10/7/05) – all agreed that this first item should not occupy the entire time allotted for the meeting
2. Data elements, collection & analysis – 2nd Agenda Item
3. Development of therapeutic & philosophical approaches and the criteria to be used to judge them- i.e. kinds of services needed to accomplish objectives
4. Supply and distribution of services and their demand
5. Prevailing myths and mis-perceptions

NEXT MEETING:

- Values & Principles - please bring validated current & applicable System of Care Values & Principles
- Data to support fact-building – bring descriptions of data available to each participant as well as available summaries and data reports



H-5829 CHILDREN'S BEHAVIORAL HEALTH WORKGRO

Friday, October 7, 2005

10:30 a.m.

Office of Health & Human Services Conference Room
74 West Road, Cranston, RI 02920

Attendees:

Diane Miller

Charles Staunton

Kathryn Nicodemus

James DiNunzio

Dan Egan

Linda Johnston

Ken Pariseau

Liz Wheeler

Elizabeth V. Earls

Wm. Michael Johnson

Janet Anderson

David Lauterback

Mark D. Bevelander

Jill Beckwith

John Young

David Balasco

Mark Montella

William Hancur

Diane Giarrusso

Steven J. Patriarca

Maria Sekac

Christopher Counihan

Kevin Savage

Dale Klatzker

Tricia Leddy

Margaret Holland McDuff

Murray Blitzer

Jeff Taylor

Pamela Watson

Eileen Naughton

Elizabeth Burke Bryant

Jane Hayward opened the meeting with a request from the group for their suggestions of any additional representation to the table specifically parent organizations and persons exhibiting diversity; and asked for those suggestions to be e-mailed to Chris O'Connor for the next meeting.

Discussion Points

➤ Values & Principles

It was suggested using 'Appendix D: Values and Principles' as a template for this group. There was extensive discussion around the room and the additions as goals are:

- Single accountability for each child
- Budget predictability --- As agreed by the group present, changed to: Budget Integrity
- Promising practices/best practices/evidence based practices.

A revised 'Values & Principles' are attached for review and comment.

Data

As had been agreed at the September 30th meeting, the group was reminded that gathering data and what the are objectives should be the first step. There was an exchange around dollars and how they are directed and the possible need to redirect or reinvest from one service to another; as well as what the ability of the state to reallocate existing funds. It was determined to have the facts guide the group before any commitments are made as the right approach at this point in the process. Therefore, discussions around the ability to reallocate funds are off the table, for now.

Additional comments/discussions/questions were around what information is already available, such as national benchmarks, the state-wide hospitals discharge data sets that may be available through the Department of Health, diagnosis specific data – both in-patient and out-patient – that is available in Rhode Island as well as other states that can be shared, as of 7/1/05 all the Centers submit monthly reports which could be helpful. An added suggestion was discharge planning profile information that has already been OK'd and could be used as a pilot for this specific project and could provide gap analysis data and step-down analysis.

It was asked how DD kids/population is going to be handled? Will it be a separate component? There are those that have both. Everyone was open to suggestions – it is difficult to separate behavioral health issues from developmental disabilities. There are those who have both issues, and there are tremendous resources for those kids in the DD system with behavioral issues. As a recap, there are fewer kids with many more resources; this is an issue that was agreed on that needs to be reviewed as well.

It was determined that in order to coordinate what data we need, it might be good to compile what questions we need the data to answer. The meeting continued with more exchanges around what types of data and how they would be sorted/teased out.

Another discussion point was regarding the data for the kids in psyche hospitals and where they were immediately before their admission and where did they go after they were discharged, what dollars are spent on medical boarding as well as the length of the stay.

Those questions can be answered as long as there is a claim paid; the coding needs to be reviewed. An example of this is when a child is admitted and discharged from Hasbro and then is immediately admitted to Bradley, the Hasbro stay may not show up as a medical boarding and there is a need to look at those variables. Readmissions and time between admissions, prescriptions and if those data points would be available were discussed. Per the discussion, this should all be doable by Thanksgiving.

Over the next 12 weeks a determination needs to be made around what the data will show that we don't already know, need to have budget predictables, need to know where the dollars go and levels of service; make assessment prior to admission – it may be more appropriate to find alternatives to hospitals, to divert length of stay. Adding dollars doesn't necessarily help with the effective alternatives. What is the demand that is not applicable for hospitals?

Additional statements/questions continued with points made around clinical judgment and about the kids that had no placement (as alternative to hospital stay) and where should they go?

Prescriptions? Will that information/data be available? The response was that if it is fee for service data it may be available, but not for specific prescriptions.

What about the uninsured? Difficult to find as some are underinsured or have exhausted what insurance they had; then there may be those who drop out of their insurance plans intentionally because they cannot afford payments.

What is the end point for the data? What is the goal? Our purpose is to assure that the report is fact based rather than what our thoughts and opinions are.

As a recap for expectations, the legislation charges DCYF & DHS with presenting a report due no later than January 1, 2006, to include:

- 'develop a design of a continuum of care for children's behavioral health services that encourages the use of alternative psychiatric and other services to hospitalization and
- reviews the utilization of each service in order to better match services and programs to the needs of the children and families as well as continuously improve the quality of and access to services.
- ...to fully describe this continuum of services and outlines a detailed plan for its implementation, including resource requirements, responsibilities, milestones, and time frames, as well as a set of indicators and program metrics that will be employed to evaluate its clinical and fiscal effectiveness overtime.
- (1) Amend contractual agreements with RIte Care health plans to reflect complete responsibility for the management of psychiatric hospitalizations, specifically the development of hospital diversion and post discharge services; and the utilization of crisis intervention services as a requirement for authorization of a psychiatric admission for all children enrolled in RIte Care; and
- (2) issue a request for proposals to identify a contracted entity to reflect complete responsibility for the management of psychiatric

hospitalizations, specifically the development of hospital diversion and post discharge services for crisis intervention services as a requirement for authorization of a psychiatric admission for all Medicaid-eligible children not enrolled in RIte Care. The request for proposals shall include a dispute resolution process.

Homework (to be e-mailed to Chris O'Connor & to be prepared as a handout):

1. Additional representation at the table – names, affiliation, telephone & e-mail addresses
2. Data specifics – what questions you want answered
3. Your contact person (with contact information) for data

Meeting Notes submitted by: Christine O'Connor @ the Office of Health & Human Services,
462-5274.



H-5829 CHILDREN'S BEHAVIORAL HEALTH WORKGROUP

Friday, October 14, 2005

10:30 a.m.

EDS Conference Room, 171 Service Road, Warwick, RI

Attendees:

Diane Miller

Kathryn Nicodemus

Wm. Hancur

Dale Klatzker

Wm. Michael Johnson

Steven Patriarca

Elizabeth V. Earls

Pamela G. Watson

Rep. Eileen Naughton

Janet Anderson

Chris Counihan

Jane Hayward

Ken Pariseau

Nancy Hermiz

Peg Malone

Tricia Leddy

James DiNunzio

Murray Blitzer

Maria Sekac

Diane L. Giarrusso

David Balasco

Dan Eagan

Linda Johnson

Jill Beckwith

Jeff Taylor

Mark D. Bevelander

Mark Montella

Elizabeth Burke Bryant

Recommended amendments/changes to October 7, 2005 Meeting Notes:

Goals need to be added to the Values & Principles with items 4 –6 listed under the Core Values to be put under newly added Goals. Agreed by the group. Amended/final copy attachment to be sent via e-mail.

An inquiry was presented around the now remaining 10-week timeframe for a report to the General Assembly and the possibility of a more realistic timeframe. The concern is that this timetable is not sufficient to make all the necessary assessments.

Jane said that she would be happy to go back to the Chairman, however, she reminded the group that these discussion have been going for quite some time now and the Chairman was very specific about this report.

DISCUSSION POINTS

- An assessment needs to be done, one that is less restrictive – is there an available alternative? Who are these kids and what are their needs? Were some examples the questions? It was noted that we need to identify the problem first; we are trying to focus on solution first which will not be productive.
- Standardized process – follow through on where they are being placed may be what is being asked; need to look at other alternatives and how long.
- Assessment Piece/ Person – Who would contact the insurer? And with regard to point of entry, what if hospital does this directly/first, what happens then?
- There is 60% going in without evaluation now, our concern is that decision is being made to admit without community-based services. *Option:* link with community-based resources. What is the extent/array of those services? At this time these services are not available; however, we are in the process of doing that. But, the supply is not there.

If services are not available then what is done? The hospital will be the placement of last resort (putting the cart before the horse).

RESOURCE DEVELOPMENT PIECE

Do we need a list of what is available now? With the timeline for the report January and with implementation in May, is there time for a possible audit of what exists in the community now?

- The suggestion of a Preliminary Report – not necessarily a conclusive report, be a possibility? Not a delay in preparing report – just an interim report was raised again.

At this point in the meeting it was suggested that a list of Goals for today's meeting be identified. They were:

1. Values √
2. Homework
3. Define what is currently available
4. What report should be called and
 - a. Is it possible that it can be ready for January?
5. List of services – in addition need list of what is open – filled and unfilled and what is actually needed

Suggested # 3 clarification: Are some children in hospitals treated there because no appropriate and available levels of care are present in the community?

Discussion continued around length of stay, and then onto step-down. Can this be done without going into medical records? How long is the delay? There were questions around DD youth and that data. DCYF and Beacon said they could provide the data for DD youth.

Need to try to do what is possible rather than what is not with questions back to data; experiences and decisions that need to be made as well as the need to be sure that there are alternatives to hospital stays.

Need to review the gaps and know that those needs have been looked at. Possibility of community-based facility as alternatives and what that focus should be should be agreed to.

- The issue of the RFP was brought to the table, as still needing to be addressed – as well as an evaluation. Will that be ready by January 1, 2006?

The conversation continued with statements around the data needing to be the first step to making informed decisions; and again, what the questions should be and what the potential data sources are. And do those same questions apply to both RIte Care and Medicaid? The next question was if there were differences? The sentiment and answer by the table was yes.

- The main issue is that kids get appropriate care at appropriate times etc.
- Possible consideration was that the RIte Care contract may need to be changed; and that it is not the be-all and end-all.
- What will be the impediments to building on the ‘outside’? What will the issues around that type of residential placement be? Some specifics that would need to be considered are education, financing, host towns, may not be happy, as has been the experience with the new Training School project.
- What are those impediments specific to residential? Those potential barriers need to be in the report as well. Need for qualitative data.
- With regard to community-based beds the types of beds needs to be determined. There is an understanding that they are all the same, and that is not necessarily true. We need to look at the family situations, and what the diagnosis is, there are some kids that might not need to be placed if there were some supports in place for the family. Or if there is a need for placement, the families may still need some type of support. Issues that need to be considered is that fact there may be a family member who is the cause of some of the problems and therefore being in that home clearly is not appropriate. Some examples of additional demographics for consideration would be gender, age, and ages of other kids in the family home, etc.
- Need to find data resources within the community mental centers.
- A Discharge Summary Profile was the next topic of discussion. There are kids who have a need for more bundled services while other don’t. It would be helpful to look at the path the kids take through the system; such as where they were prior to placement and that history, as well as where they may or may not go in the future.

- Moving forward to drafting the report some questions put forth were, how do we want to do an inventory? Do we want to look at System of Care Report? It might give us some categories; good start point to use what you have and then add to it. And what should the format be? . Kids are by placement? Where will 'data dig down' happen?

- It was determined that it might be a better use of time for a Sub-Group/Work-group convene in order to tease out the particulars of the data. It was offered that any persons who wanted to participate could and that Tricia Leddy and Janet Anderson would be coordinating.

- Additional questions for data are: what the population will be looking like in the future. Numbers for ESL, income levels and what will these types of data tell us for future needs. Need to look at the whole picture/story. See what else the data says other than the obvious. Cultural differences will also be helpful in planning for future needs as well where we are now. We need to be aware of what needs are not being met and if there are those kinds of services out in the community. It was added that having a clinician do a review of the data might give a different point of view that might be helpful as well.

Those who are interested in participating in the Sub-Group, a meeting has been scheduled for Wednesday, October 19, 2005 from 11:00 a.m. –12:30 p.m. @ OHHS Conference Room @ 74 West Road, Cranston – please rsvp to Chris O'Connor by return e-mail.

Next week's possible agenda items:

1. Inventory
2. Gap analysis after the inventory.

3. What are the other tasks of the Bill?
 - a. Report due date of 1/1/06
 - b. Contract amendments to Rlte Care
 - c. RFP for fee for svcs. Kids
 - d. Requirements for regs, not all of the above is due by 1/1/06 – but there is a timeline through to May 2006.

Meeting Notes submitted by Christine O'Connor, OHHS, 462-5274



H-5829 CHILDREN'S BEHAVIORAL HEALTH WORKGROUP

Friday, October 21, 2005

10:30 a.m.

EDS Conference Room, 171 Service Road, Warwick, RI

Attendees:

Diane Miller

Kathryn Nicodemus

Wm. Hancur

Dale Klatzker

Wm. Michael Johnson

Steven Patriarca

Pamela G. Watson

Rep. Eileen Naughton

Janet Anderson

Chris Counihan

Jane Hayward

Ken Pariseau

Nancy Hermiz

Peg Malone

Tricia Leddy

James DiNunzio

Murray Blitzer

Maria Sekac

Diane L. Giarrusso

David Balasco

Dan Eagan

Linda Johnson

Jill Beckwith

Jeff Taylor

Mark D. Bevelander

Mark Montella

Elizabeth Burke Bryant

Patricia Martinez

David Lauterbach

Kevin Savage

Sharon Kernan

Linda Johnson

Maria Sekac

The notes of the October 14, 2005 meeting were reviewed for comment with the recommended changes to the following:

- Add Elizabeth Burke Bryant to list of attendees
- Adopt the Values, Guiding Principles & Goals as final
- Change wording on Page 3 – the portion listed as Suggested #3
changed to...

To: are some children in hospitals treated there because no appropriate and available levels of care are present in the community?

Tricia Leddy from DHS and Chris Counihan from DCYF reported to the group the findings to date of the Data Sub Group.

This sub group had met twice since October 14, 2005 and would continue to meet each week just prior to the full workgroup meetings on Fridays.

The meeting continued with explanations and comparisons from both Tricia and Chris on the specifics of the attached handout and the items listed.

- ❖ Issues brought up were the total number of children served and of those who are publicly funded. Tricia responded that there are approximately 80,000 kids who are publicly funded;
- ❖ What is the number are of the privately funded.
- ❖ The approximate 90,000 do not have similar needs or risks. As an example, the Fee for Service -/NHP are high risk.(Children with Special Health Care Needs.)
- ❖ There are approximately 13,000 special health care needs: sub-care, sub-adoption as well as the Katie Beckett/SSI
- ❖ There is a population of approximately 73,000 RIte Care children that is distributed between NHP/United and BCBS, which are low risk although some RIte Care members in these plans may be high risk, but not identified as Children with Special health Care needs.
- ❖ What is the number of kids in Katie Beckett and how is RIte Care distributed among NHP/United & BCBS?
- ❖ The Community Mental Health Centers indicated that in a crisis situation and care is required, it is provided and do not necessarily ask what coverage children have.
- ❖ More specific data will be provided at the next meeting.

It was agreed that the Data Workgroup will continue to ‘drill down’ to pinpoint where in that 90,000 are the highest number of foster care and in-state foster care (residential). Some of this information is already in the Medicaid Annual Report.

The next was children with special health care needs and where do the developmentally disabled (DD) with psych fall.

A child in SSI breaks out to 1/3 in psych, 1/3 with serious mental illness/emotional disturbances and 1/3 are DD; this is a result of a random sample of parents.

- ❖ It was asked if there was any information on first time admissions and repeat admissions. It might need to be located manually, but yes it could be available.
- ❖ The next step in the conversation was looking at the kids who re-admit and what that profile looked like. Wording for the questions might be around what is the utilization of psych beds and at what ages? What are the patterns of care, specifically who is using the systems. *For that information the claims need to come back from the hospitals.*
- ❖ With regard to the Community Mental Health Centers (CMHC), can they run that data and cross tab? As an example, South County kids and where they are coming from, how they show at emergency rooms and where they were prior to the hospitalization as a suggested frame for the data question. The claims data could show that.
- ❖ If there is not a history with the CMHC the emergency rooms at the hospitals will do that assessment.
- ❖ Do the emergency rooms call the insurers? Do they want an assessment done? Beacon/Qualidm/Insurers need to approve before there is an admit to a hospital; pre-admission screening.

Emergency Svs. V. Emergency Assessment

1. CMHC do emergency assessments to see what they need; it is contracted through United, Beacon, NHP and BCBS
2. If they meet hospital level of care, contact for pre-authorization, what are the clinical issues – need to meet criteria
3. No one is admitted without prior authorization.

It was decided that a flow chart showing the process people that through to an admission would be helpful.

- ❖ It was asked if those who are evaluated and not admitted would also be available and where do those kids go? If sent home, the hospital was not required to contact the CMHC. If the alternatives don't exist, and not the hospital but not sent home either, what should the alternative be? If the person doing the assessment with not alternative placement to a hospital, then it would be an admit. And how are these services attainable after hours?

The next step with regard to 'next level' questions was who has agreements / contract with the CMHC? With insurance companies? With hospitals?

It was stated that the response from the CMCH is always good but they are only called 1/3 of the time. Insurers don't make those calls to the CMHC the hospitals make those referrals/evaluations. Generally they are called after an assessment is made; however, there is not a standard path to follow.

A point brought to the group was that in the case of a suicide attempt, it is initially a medical issue and then goes over to a psych issue initially. From Hasbro's perspective, should a call be made to the CMHC, they at times don't have the ability to respond, there are times when there are time constraints which goes to available resources. This situation is not exclusive to the child population, it also occurs in the adult population.

It is the hospital's responsibility to admit as there is the issue of physical liability and their responsibility if a kid is in danger to himself, they have to admit.

What about a mobile crisis team member and their authority at the hospitals? What is their ability to actually go in to see that patient and what do hospital by-laws say that allow that person in to do a face to face. There actually have been discussions with hospital legal counsel on this specific issue. One option being discussed is the possibility of sharing in the liability with the hospitals since it would be a joint decision when they are part of the decision making process.

Additional issues that need to be discussed are that there is not an appeal process in place disputes or for denials. It was suggested that this should be a parking lot issue for future discussions.

It was determined that there should be an inventory compiled of existing services, and what the most expedient process is. Is this a sub group task to answer these questions. The System of Care Report is readily available and would give a sense of the investment/start point.

Suggested three (3) scenarios:

1. CMHC often in the position of wishing they had other places to go – placements, quick interviewing – get real information on the gaps
2. NHPRI and their experiences building their system
3. Children who are in sub care and are the most likely to need help

Elizabeth Burke Bryant agreed to lead this new sub group to review the inventory issue. As with the Data Sub Group, all are invited to participate and asked to speak with Elizabeth. It was suggested that a glossary of terms be compiled in order for everyone to be familiar with the terminology – speak the same language.

Additional point for review would be to look at the time of day a person presents with issues. Those who arrive at 3:00 a.m. are very different than those who arrive at 3:00 p.m.; and most people are seen at night and are often times the most difficult cases.



H-5829 CHILDREN'S BEHAVIORAL HEALTH WORKGROUP

Friday, October 28, 2005

10:30 a.m.

EDS Conference Room, 171 Service Road, Warwick, RI

Attendees:

Diane Miller

Kathryn Nicodemus

Susan Stevenson for Dale

Klatzker

Wm. Michael Johnson

Steven Patriarca

Elizabeth V. Earls

Pamela G. Watson

Janet Anderson

Chris Counihan

Jane Hayward

Ken Pariseau

Nancy Hermiz

Peg Malone

Tricia Leddy

James DiNunzio

Maria Sekac

Diane L. Giarrusso

David Balasco

Elizabeth Burke Bryant

Dan Eagan

Linda Johnson

Jill Beckwith

Mark D. Bevelander

Mark Montella

David Lauterbach

John Young

Holly Garvey

Jorge Garcia

Vivian Weisman

Elizabeth V. Earls

Jill Beckwith

Kevin Savage

Denise Achin

Sharon Kernan

Steven Patriarca

Chairman Steven Costantino

Jim Spink

Jane Hayward

The Data Sub-Committee had met again since the last meeting and reported out with an overview and status on their progress. They are continuing to review the data collected and the various levels for the data 'drilldown' that have been accomplished to date. Specifics were around Rlte Care benefits and the RFP. The focus of the sub-committee to data has been around what we already have.

Some of what have now is information from DCYF around sub-acute psych/step-down has been created by Beacon/ARTS. NHP data interface presented with much overlap. Staff is looking at the Rlte Care data and that fits in. They are also looking at various categories of who is served and what are those costs. There was further discussion around those who are enrolled in the basic Rlte Care.

Of the 2300 substitute care children, 100 are out-of-state placements. Previously there were several hundred in out-of-state placements that number is down to around 80. Will be looking at high utilizers by where they are – residential v. foster care; large difference in utilization. NHP has done an analysis in residential looking at who have been in out of state and how have been in state.

It was noted that there are approximately 10,000 kids with special health care needs; high risk population from a utilization point of view. Broken down to: 1/3 Developmentally Disabled, 1/3 Behavioral Health & 1/3 Physically Disabled. Categories of kids that are high estimated utilizers are:

- ❖ Foster/residential care
- ❖ Out-of-state placement
- ❖ SSI

Tricia Leddy to provide clarification/specifics for this portion of meeting notes.

The topic of the Training School kids was brought to the table and what those numbers look like. It was stated that the data for the children in the Training School is not necessarily available; talking only about the Medicaid world. It was explained that most of these children were Medicaid eligible before and most likely will be Medicaid eligible after their release. They are treated at the Training School while there; they are not without coverage. And it was pointed out that the average stay at the Training School was approximately six (6) months to one (1) year; not a stable number for data tracking purposes.

However, the fact that there is Medicaid eligibility before and after their stay at the Training School does not speak to the therapeutic relationships that are broken while there, lack of continuity in treatment. We should be looking at keeping them enrolled in RIte Care or find a different mechanism for paying for their treatment.

The group reviewed a RIte Care Benefits handout with explanations and questions. The topic for discussion was language. There were clarifications around what were in plan benefits. It was suggested that some headings will be duplicative and those should be collapsed into one. The list needs to be simple and concise.

The RIte Care contract amendment was another discussion point as well as which RIte Care benefits under the waiver are services offered but not required but are offered under enhanced funding. Some children that fall under Medicaid are mandatory and there are some that are optional, such as pharmacy, which by federal requirements is an optional benefit. Waiver and state plan is rapidly going away. There are many that are covered under state plan or EPSDT.

It was requested that a list be put together for the group that would show what is required vs. what we think is the right thing to do. Provide data on: RIte Care, Foster Care, SSI, Katie Beckett with columns for services consumed, number of units and what that cost will be. DHS also has a brochure with information on Medicaid, most on that list are mandatory because of EPSDT.

The question was asked if the sub-committee data was going to be brought to the larger group all at once or on an 'as we go' basis.

The meeting continued with further discussion and explanation of the RIte Care Benefit handouts.

The need for a flow chart to show the path/process was suggested and the question of who are the kids to be looked at by the data sub-committee.

It was discussed and determined that Elizabeth Earls & Tricia Leddy would work on this for the next meeting. Added to the task/question around where are they coming from and where are they going to.

Next Meeting:

It was asked if data on where a child is referred from when going to the hospital (Bradley) as well as the ability to tell if a child comes from Hasbro to Bradley – that data will be available per Mark Montella

A question around Hasbro emergency room, community only or private provider as well? John Young was not sure how we could get the private pay data. Elizabeth Earls stated that knowing who and where they come from, having the whole picture, would be very helpful. Beacon & NHP goes by claims. Where does Hasbro & Bradleys admissions come from? Getting that information would be through chart review and be very labor intensive.

Next Meeting Agenda:

- I. Data Group will have data back
- II. Flow Chart



H-5829 CHILDREN'S BEHAVIORAL HEALTH WORKGROUP

Friday, November 4, 2005

10:30 a.m.

EDS Conference Room. 171 Service Road, Warwick, Rhode Island

Attendees:

Denise Achin	Chris Counihan
Diane Miller	Janet Anderson
Mark Montella	James DiNunzio
Steven Patriarca	Holly Garvey
Dale Klatzker	Jill Beckwith
Margaret Holland McDuff	John Young
Wm. Michael Johnson	Kevin Savage
Elizabeth V. Earls	Sharon Kernan
Ken Pariseau	Dan Egan
Dawn Wardyga	David Balasco
Jim Spink	Linda Johnson
Kathryn Nicodemus	
David Lauterbach	
Nancy Hermiz	
Peg Malone	

Per Jane Hayward, John Young served as facilitator of this morning's meeting. He opened the meeting with a review of last week's meeting notes. He also notified the group that in two (2) weeks, November 18th, following this meeting for those who are interested a Katie Beckett review meeting regarding changes in approach and eligible.

The meeting notes from October 28, 2005 were approved with minor changes.

The data group gave a status report on where they are in their process. With some points made around the numbers as they pertain to the Community Mental Health Centers (CMHC) and that data that was reviewed. Some numbers from the 1st quarter were that of the 342 children 60% were adolescents with the majority being female. The meeting continued with discussion around where those children were coming from? Schools? Specifics around the numbers for special needs; 22 % were Rite Care and 72% were sub acute care kids. The data sub-committee was asked to look at the total number of admits specifically 0-7 day timeframe.

It was asked how many went into in-patient and how many were not emergency services evaluations.

John Young summarized what we have right now:

- ❖ Data measures kids in some way
- ❖ Data does or doesn't tell us what services
- ❖ Data source
- ❖ And are counting the data once

It was brought to the group again that we all call the various services by different names and we will know *some* things not necessarily all things.

It was asked again what questions should this data answer – still need that list – specifically telling us what we need to know.

Measure what services they receive; and more importantly what they don't receive;

Service capacity – what do we have now

Cross match work of the two (2) sub-committees/workgroups.

What about the unduplicated children? Different data from different sources.

We do know: 90 – 100 children are admitted monthly and that 1/3 of them are evaluated by CMHC. And that measures what? Where did those kids go if not admitted?

Generally from hospital to resident – those that bounce back and forth, what are those numbers?

At this stage in the meeting John suggested the group think through five (5) questions each to be presented for discussion compile one, joint, agreed list for the collected data to answer.

The attached document is a list of the discussed and agreed questions.

Following the question-brainstorming portion, the meeting continued with a review/brief of the work done to date by the Inventor sub-committee. There was some discussion around respite services and John Young offered that there was some work/document done by DHS approximately 3 years ago with regard to respite service definitions and that DHS will

make that document available to this group. The Inventory sub-committee reporting closed with the thought that there is a need to look at the overall continuum and need to look those gaps.

The next item for discussion / briefing was the chart done by Elizabeth Earls who stated that the chart show the system as it exists now. It was suggested to the group that there should be a conversation about what isn't in the system and how it overlaps.

At the close of the meeting it was brought to the group what the possible next steps and items for next week's meeting should be.

They are listed below:

1. What questions do we want data to answer?
 - Complete?
 - Clear/accurate
 - What we will we use it for?

2. Refine/finalize services inventory/gap analysis

3. Discussion: connect services/inventory gap
 - ↓
 - Data
 - [Size of the service]

For November 18, 2005:

Decision on extended time for the December 2, 2005 meeting

For December 2, 2005:

- * Begin to outline the report – **January 1, 2006 deadline to meet**
- * Scope: Contract & RFP (s)– **As required by the statute**

QUESTIONS DATA COLLECTED SHOULD ANSWER

(DD/non-DD// Risk/projected

risk)

1. What are largest group admitted? [Diagnosis, living arrangements, age]
2. What services do kids → hospital ← home receive? [Link gaps to services used]?
3. Services x Diagnosis [age & staffing availability/capacity]?
4. Emergency Room (ER)/Hospital/Boarders [# of days]?
5. How many kids to directly to psych hospital?
6. “Source” of first (1st) admits/re-admits [living arrangements]?
7. Average cost per ER episode, psych hospital episode, CMHC cost (of all)?
8. Basis for intervention (beyond diagnosis)?
9. Rate of [1st admit, admission by assessor source & re-admit]{assessed but not admitted phone calls}?
10. Insurance status [prevention rate & benefit package/coverage/missed RIte Care eligibility] [RIte Care, Fee for Service] (TPL (third party liability)
11. Barriers to discharge – what services if available in community and not go to hospital.
12. Staffing (#’s by skill set, program setting, geography, credentials)



H-5829 CHILDREN'S BEHAVIORAL HEALTH WORKGROUP

Friday, November 18, 2005

10:30 a.m.

EDS Conference Room, 171 Service Road, Warwick, RI

Attendees:

Diane Miller	Kevin Savage
James DiNunzio	Dale Klatzker
Dan Egan	Tricia Leddy
Linda Johnston	Murray Blitzer
Ken Pariseau	Jeff Taylor
Elizabeth V. Earls	Peg Malone
Wm. Michael Johnson	Mark Bevelander
David Lauterbach	Elizabeth Burke Bryant
Mark D. Bevelander	Sharon Kernan
Jill Beckwith	Don Williams
John Young	Holly Garvey
David Balasco	Loren Sidman
William Hancur	Monique Stanley
Steven J. Patriarca	Cathy Ciano
Maria Sekac	Laura Jones
Christopher Counihan	

Per Jane Hayward, John Young from DHS served as facilitator of this meeting.

The meeting opened with a brief welcome and a review of the previous meeting minutes with additions to the *Attendee List* and some minor changes. Those final draft minutes will be forwarded to the members.

The next agenda items were the Sub Committee reports to the Workgroup. Jill Beckwith stated that the 'Inventory/Gaps' Sub- Committee met again She explained the revisions and decisions made by the sub committee regarding the service definitions presented. Jill also informed the group that the glossary would be sent out with the continuum. There were no substantial comments.

The next agenda item was a report out from the Data Sub- Committee with a question around how we should gather data in the future and quantify data from the past; how would that be handled?

Next was a review of the flow chart distributed by Elizabeth Earls - 'Current Portals for Children/Youth in Psychiatric Crisis in the Community'. The document had been created by a few of the CMHOs for a previous meeting, but served as an excellent depiction of how and where children presented for psychiatric hospitalization.

Additions to the document will be:

CEDARR Family Services,
HBTS,
EI (Early Intervention) and
Services provided by LEA's.

There was a discussion around who is served by the above - listed services and programs. It was explained that CEDARRS provide care coordination services across families, HBTS works with some children who may have medical complications, developmental disabilities and/or behavioral health issues, EI also works in the behavioral health area. The child identified as the one needing and receiving services may not be the only person in a family unit who needs services. For example, a sibling may need some help as a result of problems within the home environment. CEDARR does not provide direct care; however, care coordinators may work with the family while waiting for other services to be started.

It was asked where the CASSPS fit in? Members explained that the process of distinguishing between the roles and functions of CEDARRS versus CASSP is an ongoing one.

Pediatric Practices Role of Therapeutic Recreation -- what is Medicaid funded and what is not? It was asked if that should be added now?

Additions to the List:

- Emergency Crisis Intervention
- Crisis Residential Treatment
- Intensive out patient treatment
- Community out- reach services

David Lauterbach offered to look at the CASSP – federal monograph – and will review and bring back to the group. John Young agreed to get that to David before the next meeting.

It was asked of the group again if this list of services work for the continuum and correlate with the flow chart done on ‘Current Portals’

For clarification purposes it was asked, as it currently exists?

- The response was the continuum as it should exist.

Mentorship under community bases services?

- Should be added to the list.

There was some discussion around the Service Inventory/Gaps Committee handout. Elizabeth Burke Bryant gave a more detailed explanation that included the process of once a child are in a hospital and working with the family to get the child home --- that process has not been delineated as a services but it is very necessary—translates into or the same as a discharge planning.

Liz Earls talked about access to about CIS services for the family when the identified child is in the hospital. CIS Programs are no longer allowed to receive reimbursement for working with the family while the identified child is hospitalized.

RIGL 38-2-2(4)(i)(K)

John Young asked about family therapy being different from collateral treatment? Should collateral be added? Explanation: Medicaid child (parents are uninsured with mental health and substance abuse problems and has meds, if part of that therapy the therapists determines the parents need to be present in the session.

Liz Earls brought to the table the scenario of a child who are is in crisis, who is hospitalized. The siblings, who remain at home, could be traumatized by what has occurred, but there are barriers to treating them. David Lauterbach agreed and continued with a question around the status of the rest of the family; and the possibility of a family member being a contributor/ or part of the problem?

- Additional point to be noted around discharge planning/procedures: In-patient and out-patient billing could not occur on the same day. It was suggested looking at Best Practices for typical, or next steps to take.

It was brought to the group for consideration an example of a specific situation around residential treatment and the need for consistency of treatment; specifically having some of the same professionals who treated the child while he/she was in the residential program, continuing to treat that child on a temporary/or transitional basis upon that child's discharge from residential treatment. It was noted that once a child is discharged those people who the child has come to trust and has developed a relationship with are cut off and often times the child reverts back to his/her original condition. It was asked if it is possible for that social worker to stay involved? The hospital and community based interaction ends once the child is discharged.

The next point was one around discharge meetings with parents and hospital personnel. There is no one from the community in these meetings at the beginning of the discharge process. It would be helpful if they would be there from the beginning. The group was informed that there is no way for a community person to know until the hospitals notify them.

Diane Miller informed the group that she runs the Care Planning Department at Butler Hospital and we (Butler) always invites the necessary outpatient providers and agencies (as available) from the community to do effective and appropriate discharge planning.

Don Williams from DOH stated that the RIte Care Plans and Medicaid are exempt from the utilization review act. Diane Miller asked what the appeals process

RIGL 38-2-2(4)(i)(K)

would look like; he would not clarify during the meeting. There were clear statements made that there are other state statutes that need to be considered in looking at this entire process to include the use of mobile crisis teams.

At this point in the discussion it was stated/suggested that this is more than simply care coordination; an accountable entity needs to be in place– someone to over see this as a whole from the beginning or start of the process.

The next question was around integration with substance abuse systems and its role or addition. At this time in the process it was suggested that staying to the concept right now is the priority.

The conversation went back and it is noted that CEDARR, HBTS, EI & LEA's do all deal with not only child affected but also additional children in the home environment as well.

Wrap around services & CASSP ties in? Yes? Could there be a leap to all children or does that make it too confusing?

Several elements listed are not just behavioral health? And do they need to be added? It was stated that it would be great to see all children. And it was asked, what children specifically? It was clarified to the medically challenged, developmentally disabled or developmentally delayed.

It was suggested that the task of this group is quite complicated as it stands right now and asked if this could be one of the topics added to be reviewed/discussed at a later date.

And additional point made was around going to a comprehensive system of care and not include developmentally disabled or kids with medical complications, how are they going to be organized? – this is a logistic issue and needs to be considered as well.

The discussion continued around those children that are at risk and the disruption and instability to that family.

The concern for behavioral health is for those kids that a diagnosis as well as those children who are at risks for problems– those issues/problems that are almost expected or predictable. Those children are not Medicaid eligible.

Preventative Services were discussed and determined to be kept separate. Those monies needed should come from grants, foundations etc. If it is put together or combined with treatment, it will get squeezed out. There are situations when prevention gets twisted into Medicaid and the concept gets lost.

Is there a breakdown of behavioral health children that are using HBTS/CEDARRS; how are they administered?

It was explained that Early Intervention (EI) children on medicals is relatively low – it is an in service plan.

The group was asked about linking this to the bill and the task at hand, crisis assessment and how is that being related to the Bill? It was noted that they are all valuable, but where and when will the list end?

An explanation was that there are two (2) parts; the first is Crisis and the second is Continuum >2-part treatment

John Young stated that there may some items on the board [document at the end of these notes] that are responsible for linkage but not hold any responsibility for; as an example, a linkage over to school services, not things that are necessary part of the managed care entity.

The conversation continued around, what is it we need to do at that point in time when we are evaluating a child; these things are all important but are they most important links?

Again, John Young noted what the responsibility/ charge is:

- Amend RIte Care health plan contract and
- Develop RFP

With regard to the information/data needed, Bill Hancur felt that those questions were not going to be answered with these lists. The discussion continued around that point and then moved on to the issue of residential beds and that the numbers indicate that certain groups have preference and gobble up those beds.

John Young explained that who residential beds go to are decided by treatment, child welfare and safety.

RIGL 38-2-2(4)(i)(K)

It was asked how does moving them in-plan within RIte Care, how does any of that affect anything else?

The response was the need for clear understanding if the best service for that child has the authority.

Difference between populations; clearly categories of children with utilization patterns. Specifically long term residential is different from acute.

It was asked how could that be done? And that we really need to look at those numbers. With certain/specific categories such as foster and sub care are in residential longer and using those beds, which may be appropriate but they are still using those beds and there are other kids who may need a bed but on a short term basis. This not to say that foster may be getting just what is appropriate, but still need to allow at the list.

Ideal system of Care for all kids---kids in crisis/needs. Need would have come from community based services.

Available and sufficient capacity and confidence level in the evaluation; who will convey to the family that they are where they need to be.

[please fill in – chris o’connor was not in the room for a portion of this discussion]

What is the list of essentials? Build system capacity to build outcomes

The group continued to discuss the time commitment involved with how extensive and deep the research/background is going to go. There is a time frame and deadline of January 1, 2006. The issue of UR law was also brought to the table and the exemption and what that means to providers.

It was noted that there are many, many pieces and layers to this very important issue and that having the overall picture will be very helpful; not all the people involved know and are familiar with all the aspects of this issue. It is important to have a clear overall understanding to be able to meet the task.

Next Meeting: 12/2/05

List of Issues

Extend time for meeting? Agreed by the group.

Will first agenda item for that meeting be the contract or RFP?

December 6, 2005 meeting- First Draft of the Report

Look at other sources?

Have glossary?

Identify what services go into?

Next meeting will be @ 10:30 a.m. – and go to 1:00 p.m.

The Full List will be reviewed in the first 20 minutes of that meeting.

WHITE BOARD LIST

*CEDARR Family Centers

*HBTS [System of Care]

*Lea Services

Pediatric Project Practice Enhancement

- Therapeutic Recreation
- Emergency Crisis Intervention
- ART
- Intensive Outpatient Treatment
- Community Support Services
 - Mentorship
- Family Treatment/Family Stabilization

*Wrap around Services & Supports

*Substance Abuse Treatment



RIGL 38-2-2(4)(i)(K)



H-5829 CHILDREN'S BEHAVIORAL HEALTH WORKGROUP

Friday, December 2, 2005, 10:30 a.m.

EDS Conference Room, 171 Service Road, Warwick, Rhode Island

Attendees:

Jane A. Hayward

John R. Young

David Balasco

Don Williams

Steven J. Patriarca

Murray Blitzer

David Lauterbach

Loren Sidman

Nancy Hermiz

Peg Malone

Ken Pariseau

Dale Klatzker

Jim Berson

Katherine Powell

Denise Patnode

John Digits

J. Clement Cicilline

James DiNunzio

Linda Johnson

Dan Egan

Michael Johnson

Diane Giarrusso

Jill Beckwith

Bill Hancur

Jeff Taylor

Kevin Savage

Holly Garvey

Jorge Garcia

Rick Jacobson

Peter Gillen

Pamela Watson

Margaret Holland McDuff

Denise Achin

Diane Miller

Elizabeth V. Earls

Susan Duffy

Elizabeth Burke Bryant

Sharon Kernan

Janet Anderson

Jane Hayward opened the meeting with brief welcoming remarks and asked those attending to introduce themselves, as there was quite a large group in attendance at this meeting. Following introductions, the group was asked to re-review the draft minutes for comments/corrections. It was requested and agreed to have additional time to review and send any significant additions/corrections via e-mail to Christine O'Connor.

Jane then went onto the next agenda item, which was to review the one page Summary of Legislation provided by Jill Beckwith. There was extensive discussion and concern expressed around the wording of Numbers 1 & 2. It was explained that the wording was taken directly from the legislation and that the intent of this document was to provide clarification/definitions for the actual legislation; the wording within the legislation itself has obviously not been changed by this group. With regard to Number 3, Bill Hancur again discussed/pointed out that their providers are not licensed by the Department of Children, Youth & Families (DCYF). It was added that a distinction also needed to be made regarding the Mobile Treatment Team.

Regarding licensure of outpatient behavioral health services for children: Janet Anderson of DCYF explained that DCYF now had the legislatively approved responsibility to license organizations providing children's outpatient behavioral health services, including emergency services. MHRH previously held this responsibility, but with the revision of its licensing regulations, transferred this responsibility to DCYF as MHRH no longer funds outpatient children's mental health services.

Janet noted that health plans credential clinicians. DCYF will license the programs.

The meeting moved on to the next agenda item for discussion, which was the Continuum of Behavioral Health Treatment Services hand-out/table. John Young explained that the services and programs listed in the handout reflected those services that had been identified over the course of the meetings. As indicated in the handout, the group was being asked to discuss whether or not those services, listed as out-of-plan, should be moved in-plan. John Young suggested that the group start the process by going around the room for initial thoughts and/or comments. He noted that DHS and DCYF had had an initial meeting to develop the list of services to be considered, as well as the criteria for consideration. He further noted that the departments recognized that this was a very complicated process and that it had taken several people eight (8) hours to

develop the list and criteria, and to bring the discussion to this point; and he acknowledged that this group is now being asked to try to review/comment in an (1) hour and recognizes that this a daunting task.

Committee members again raised the concern regarding the fact that this report must be submitted on January 1, 2006, and that it was not necessarily a realistic deadline. Jane Hayward explained again to the group that this was a requirement made of DHS & DCYF by legislation and she did not feel that the date of submission was negotiable with the General Assembly. She clarified that the report was from the two departments, and will not be a report from the task force.

Going back to the table/hand-out, it was suggested moving forward and trying to frame items for the purposes of today's meeting. John Young suggested a process for determining members' thoughts on the respective services. An "absolute no" would be expressed by a 'thumbs down', "yes" would be a 'thumbs up'; and "neutral" or "not sure" would be indicated by a thumb held 'straight across'. Consensus is not necessary. . John reviewed the criteria with the group: the service should show some relationship with the continuum; it has to make sense with hospitals or discharge planning, from a diagnostic perspective, it should meet 'medical necessity criteria'. If we are going to ask insurers to manage a service, they need to be able to ensure that the service is there to approve. There needs to be:

- Single authority and;
- Some discussion if the incentives are aligned/appropriate.

The meeting moved on to clarification of language and it was suggested that while looking at the 'Core/list', having the Glossary of terms readily available for a reference might make the task somewhat easier.

Process for the List and support for that. For those folks who are definitely opposed, they need to explain why; it also needs to be recognized that it is possible that there are some people that cannot be moved. And in the end if we cannot come to an agreement after further discussion, you need to state why you are not in agreement and sign your name / take ownership of opposition and send it to the General Assembly.

Jane asked if there were any comments on the process? There were none.

The next question from the group was around if funding came through Medicaid and DCYF. John Young answered that services are paid for by either DHS or DCYF.

There was also a question around the logistics of decisions and what happens if there is dissent? Jane Hayward explained again, that the legislation required the departments (DHS & DCYF) to submit a report on January 1, 2006. The group had been convened to provide input in order to make informed decisions; but again, ultimately the departments are responsible for the report. And the plan is that the report will include information from interested parties who participated.

Bill Hancur stated that he understood that they were here as a group to write the report. Jane Hayward responded that it was made very clear from the beginning of this process that we need and want input from people around the table; however, the departments are responsible for writing the report as stated in the legislation. The departments (DHS & DCYF) will try very hard to work with the committee to reach some consensus on the content of the report but in the end we may say the departments recommend “x” but the committee is recommending “X & Y”.

There was a question with regard to the voting process as to what should be on the list. For example, the Hospital Association has a number of people involved within its organization; it is uncomfortable voting on behalf of its members without speaking with them first.

John Young stated that there needs to be a certain level of ownership with folks’ responses/ decisions.

It was asked if there would be an ability to abstain from the voting process.

Elizabeth Earls asked for clarification with regard to folks not agreeing with a decision regarding a specific service, and the request that that be expressed in writing. For example, if 92 percent of the group disagrees, is the issue off the table, or does 92% of the membership all need to write letters? Or will the report simply reflect that 92 percent of the group did not agree with that item.

It was clarified that ‘yes’, the report will reflect that 92% were opposed, but letters explaining the opposition are still needed. John Young continued that there are issues influencing individuals’ opinions that never get out of this room. This is the time and the place for those concerns to be stated, as there may not be an opportunity like this again for a very long time.

Dale Klatzker stated that in reviewing the list, there are many things here for consideration that has major social policy implications to the system. He

wondered if the group might focus on those items that absolutely reflect the task in the legislation, and then give additional time to some of the broader tasks. He used an analogy of a breadbox versus part of a loaf.

John Young reminded folks of Number 5 on the 'Core Decision' paper that refers to reasonableness. However, if after all the meetings over the course of several months a consensus on a particular option is not feasible, using reasonableness may be a cop-out.

Discussion continued on the process and the lack of time left to meet the January 1, 2006 deadline.

Dale Klitzker asked what happens at the end of this process? Might it be too big to manage?

Jane & John agreed that there will be many, many details that will follow the report. But at this time, we need to focus on what can be managed going forward, like the issues/list and setting a timeline.

Recognizing the complexity of the report John Young offered HBTS as an example that should be fairly easy to work through. The first questions to be asked would be what it is, who it services. He stated/answered that it services a couple of groups, as well as providing family support and habilitation needs. Could it be considered as an in-plan service? For all kids, for some kids, move all in or some in? Those are discussions we need to have. Referred to footnote.

Cathy Ciano asked if this pertains to Rite Care Children only or all children? John Young said that it is for publicly funded only.

Cathy followed with a question around what happens to those children who do not meet those criteria? How do we create a full continuum? John stated that this legislation and task is for publicly funded only at this point.

As the meeting moved towards closing, the task of deciding what is on the list and what is not and how that was going happen was brought to the table.

Diane Miller stated that she would feel more comfortable going back to the Hospital with this list and reviewing it with them to get their thoughts/concerns and bring it back to the group. Diane Giarrusso agreed that coming back next week would be more helpful as some folks are not the decision makers for the group(s) they represent.

As discussed and agreed, the committee will come back next week after they have all had time to review the list with their people and reach a consensus with their people and are better informed.

Following the process for next week and referring to the 'Continuum Table', John Young discussed clarification around In-Plan services and what should be on the list of services and how to go about doing it. As the meeting continued, David Lauterbach said that the task has changed, with regard to alternatives to hospitalization and that it has gone more over to the continuum. It's difficult as there are too many to talk about with the whole system by January; it's beyond scope and time frame we are given. As an example, CEDARR or CASSP being in or out, David did not believe that he was in a position to decide that now. Keeping the children from un-necessarily long hospital stays is reasonable. John Young again referred back to Number 5 for right now. And suggested a walk through of a couple items now and defer to next week for a more in-depth conversation. And possibly decide what should not be on the list.

Jane confirmed with the group that next week (December 9th) the committee would come back prepared to make decisions.

All agreed.

Moving forward, John Young offered CASSP as an example and went on to say that some states have identified funding to support services that are a part of the CASSP initiative John has not been able to determine a Medicaid vehicle to fund CASSP. That said, this shouldn't stop us from trying, and even if quite possibly we have to pay for it with state only funds. Using this as an example, John said that we would have started out with this item as a 'no' because of the funding issue, but it could go to a 'maybe' if there could be a mechanism for the funding.

The discussion continued around the set of services that is under the continuum of care.

David Lauterbach went on to say the feds take existing programs, takes kids with wrap around funds- builds capacity - CASSP is a philosophy.

Bud Cicilline stated that CASSP is insurance blind and it comes from or through commercial funding.

There continued to be discussion around CASSP and what its primary charge is and how it relates to funding issues.

Bringing the meeting to a close, Jane reviewed the status of the meeting as well as expectations for the December 9th meeting. Jane also wanted to make the committee aware that the departments are going to begin putting together an outline of the report; recognizing that there will be gaps/holes; but they do need to get started. They will not be working on the contract amendments or RFP.

It was asked if this committee would be signing off on the report.

Jane responded again, that the report will be coming from the two (2) Departments, per the legislation, and the intent is to say that they worked with the community groups; however, there needs to be an understanding that there may be differing opinions.

Next Meeting: Friday December 9, 2006 – 10:30 a.m.

AGENDA: As discussed and agreed, the committee will come back next week after they have all had time to review the list with their people and reach a consensus with their people and are better informed.

Jane confirmed with the group that the committee will come prepared to make decisions.



H-5829 CHILDREN'S BEHAVIORAL HEALTH WORKGROUP

Friday, December 16, 2005

10:30 a.m.

EDS Conference Room, 171 Service Road, Warwick, Rhode Island



Attendees:

J. Clement Cicilline
Chris Stephens
James DiNunzio
Denise Patnode
Jim Pinel
Katherine Powell
Richard LeClerc
Peg Malone
Ken Pariseau
Nancy Hermiz
Holly Garvey
Laura Jones
Monique Stanley
Cathy Ciano
Mark Montella
Don Williams
David Balasco

Dan Egan
Jan Anderson
Chris Counihan
Kevin Savage
Chris Staunton
Diane Giarrusso
Maria Sekac
Diane Miller
Jill Beckwith
Elizabeth Burke Bryant
Jeff Taylor
Mark Bevelander
Kathy Nicodemus
Linda Johnson
Peter D. Bari
Pamela Watson

Jane opened the meeting with introductions around the table and followed with a brief of the expectations for this meeting; which would be to come to an agreement on the contents of the report due to the General Assembly January 1, 2006.

The specific task required by the General Assembly is submit a report developing a continuum of children's behavioral health programs, amend contractual agreements with RIte Care health plans and to issue a RFP identifying a contracted entity to reflect complete responsibility for the management of psych hospitalizations. Jane continued the discussion around the technique we were going to use as we move forward, and again, amend the RIte Care Contract and what an RFP would look like, and what grouping of these services can be managed together. The purpose of proposed straw polling this morning is to reach a consensus on all points, some points or no point; and if there is no consensus reached, how can we get these to a 'maybe', get some sense of where we are.

Jane continued saying that John Young will be moving us through this process. The meeting continued with John Young reviewing what the full continuum needs to look like, as well as what the focus of the legislative front door or back door; John asked that folks look at this in that context. He discussed again the technique/process and explained that it needs to be fairly concrete. As an example, if there are going to be issues with mixed feelings but not strongly opposed could those options still move forward and; for those who strongly oppose, what would needed to happen to resolve their concerns. First task is writing the report of what process is. We need to be clear about what it is. One example would be additional dollars that would be needed; we are not here to say yes or not to that, the groups have already stated that in coalitions. John asked the group again if there are any questions or comments about the process of this report.

John was asked, just to be sure, what the question(s) to answered were. The question(s) are what are the services that deserved to be managed with accountability under an umbrella-not in plan, only what is logical to be a single set of services with common principle and improve services.

It was asked if the system of care and the continuum as the same thing? John's response was the continuum as what was discussed.

The meeting discussion continued around common principles – multiple entities, common principles, common discussion and possibly some procurement.

There was further clarification around out of plan and what should be moved in; and common management structure with common principles – not by who.

The group continued to discuss the process and wording with regard to best practices and what services should be received and what is in or out of plan.

John explained again this is not voting; this is straw polling to see if there is any level of consensus; we are trying to back away from that working, if in/out of plan continues to be better for people.

Some folks stated that they can't get beyond the funding issue. Specifically, if at the end of this we want something to be here, there is some danger if it's not clarified with our current funding; it could be very good, if it's moved into some other management it could be dangerous.

John responded that that couldn't be addressed until we discuss the issues. There are some services listed that do not exist now or are not funded. If you oppose this because it's not currently funded and that is why you are saying say that.

The discussion/questions continued around the room around funding and those concerns by the group. The group was reminded of the direction by the legislation of defining additional services.

Bill Hancur again brought up the issue of considering the cost and that being addressed with regard to submitting the report.

There was also concern expressed with regard to the strategic impact this would have. John Young responded that this had been asked at several meeting and should be been stated before this point in the process.

Some individuals felt that they were not given that opportunity; they felt that their systems are very under-developed and therefore are very concerned about taking dollars from another behavioral structure; and need to work with the existing structure.

Cathy Ciano contributed to the discussion that funding obviously is important, but the legislation is about change, people get caught up in the process, we need to advocate change, we cannot make changes before its implemented we are getting stuck in the process, and that at this point we need to get to some kind of agreement in order to move forward.

It was asked if the recommendations and funding issues be separate, could those be reviewed first? There are questions that cannot be answered, and can this report be reviewed prior to being submitted to the general assembly?

Jane Hayward reminded the group that there is a very short timeline to do the fiscal report; and did not think she could guarantee that she could do that. We can put in the report that there is real concern from this group around the fiscal impact. Straw poll of what the elements of a continuum of care should be but if we are going to elaborate on specifics, if we go down to what the minimal qualifications are, where I get confused is common principles.

John Young explained that there are three (3) RIt Care health plans, two (2) state departments and the legislation suggested once the three (3) Rite Care health plans part of our discussions over time have been all behavioral health services out of RIt Care and have them managed by a state agency or by an administrative service, as in other states; he continued that all those are possible but cannot move forward until we define what those services should be; move dollars or investment the state needs to make.

Make a listing of what may/may not be questions of what are services and do we have them all. And contract addendum, terms and continuing of an RFP, if we cannot give a scope as Jane asked.

John continued that the purpose of these discussion is to get input from you. He was asked if a proposal is made that these services are these services the ones that should be in the continuum? And additional question was and be managed by an entity? -- a vote that is should be managed would mean: utilizing review, not common goals – should be a goal by an entity. These things to exist, voting on these will get us where? Part of the problem is that of a lack of trust. The goal keeps changing. My concern is that our vote will be included in the report, the voting will be easy.

Janet Anderson if there is agreement on the vote, then discussion becomes part of the process. The report needs to have what the next steps are.

Mark Montella brought his concern/question around the importance of the vote; his concern is understanding the ground rules. In the first meeting, John, you asked folks – would like individuals to participate and engage in political conversations in the interest of moving forward [the system is not optimally designed, we can all agree on that] I appreciate the departments' efforts --- appropriate moving forward if you decide you do not agree, then form minority report or choose not to participate. I worry that the issues were data, continuum and oversight comments and how do they get us here. I still do not see how that 3-pronged approach will get us where we need to be. My concern is that I may not agree or change later and then have it be said that I participated... It almost forces us to abstain and then see what the report says.

Another member stated that they recognize that the report is important and that it is about creating a system of care for families.

In response to folks' concerns, Jane replied that she was hearing that you (group) are not comfortable with straw polling – have not heard anything else. I am proposing given that there is not a consensus, the departments go back and frame the reports. I will ask the Chair for an extra ten (10) days to frame the report and get it to the committee. I have no intention of playing 'gottcha'; we have all struggled, we are not ready to move forward. The best proposal is to put something together and get it back to you. Jane also suggested that if a subgroup is interested in putting together a minority report that would also be an avenue.

Jane was asked if this group could reconvene; she responded that whatever the groups' pleasure is, as long as she could get an extension.

Again, Bill Hancur raised his concern around the timeframe for the report; which Jane explained again was determined by the legislation not the departments.

As the meeting moved toward closure, some folks stated that there were great strides made as a result of these meetings and it was made very clear what needs to have attention paid, to leave now would be then saying the system is 'OK' and that this was a waste of time. This legislation was designed to force the departments to cooperate; this is

a good start. It was suggested that the group use this time now to see what could be discussed/determined while the request for an extension of the report is with the Chairman.

Ken Pariseau added that if you look at the 1st page left column, 1-8 are the type of services that are needed to ensure kids at high risk are. These are the things we need to focus on as it relates to legislation and would add to the list: residential facilities with high clinical needs, needs to be better managed, frequently in/out of hospital- clinical management with community based services. It was added that for some children in the hospital, some of these services may help upon discharge but not significantly enough, may need another level of services upon discharge; possibly step down, not a shelter or group home.

The meeting continued around the needs of those children not quite ready to go home, those that do not need to stay in the hospital and not ready to go home either; that place in between. The sub committee was looking for a name/term for that 'it'. It was asked if the resident needs to have cognitive/psycho therapy within their mists? All need intensive outpatient services, we can agree on that. The discussion continued with a question on what is not in here is the slightly acute – not long-term, but medium-term. Some points were around families with residential – there are no connections between home and the facility. The children go directly from the hospital to the community. Before these children come home, have a piece that connects them to the community, not just the child but also the whole family. How are these children going home – there is not a need for more facilities? Elizabeth Earls brought the point of workforce issues – where do we find these clinicians – people who want to work 24/7. It was agreed that this needs to be in the framework.

As the meeting closed, again the concern around process for a smoother transition with the community is needed; community representation at discharge planning sessions was stated.

Jane Hayward closed the meeting stating that she would request an extension of the Chairman.

WHITEBOARD

Common Principles: CASSP

Common Direction – Goal

- Best Practices – what does research say?
- Fiscal/Continuum

‘In the Continuum’ = it would be managed & needs to be in the system

ES Needs/Priorities

- Acute Residential
- Short term Crisis Stability.
 - Need a range of these
- Enhanced OP Services
- Respite
- Services that link Hospital treatment w/Home treatment – family
- Commitment to building the community-based services needed to maintain children in community
- Acute/Short term & Long term
- Workforce Issues
- Flesh out categories of what is needed – better organized, better managed, better access
- Develop a policy where community providers are present at discharge planning.

APPENDIX B

Data Subcommittee Inpatient Admissions Analysis

APPENDIX B

Data Subgroup Inpatient Admissions Analysis

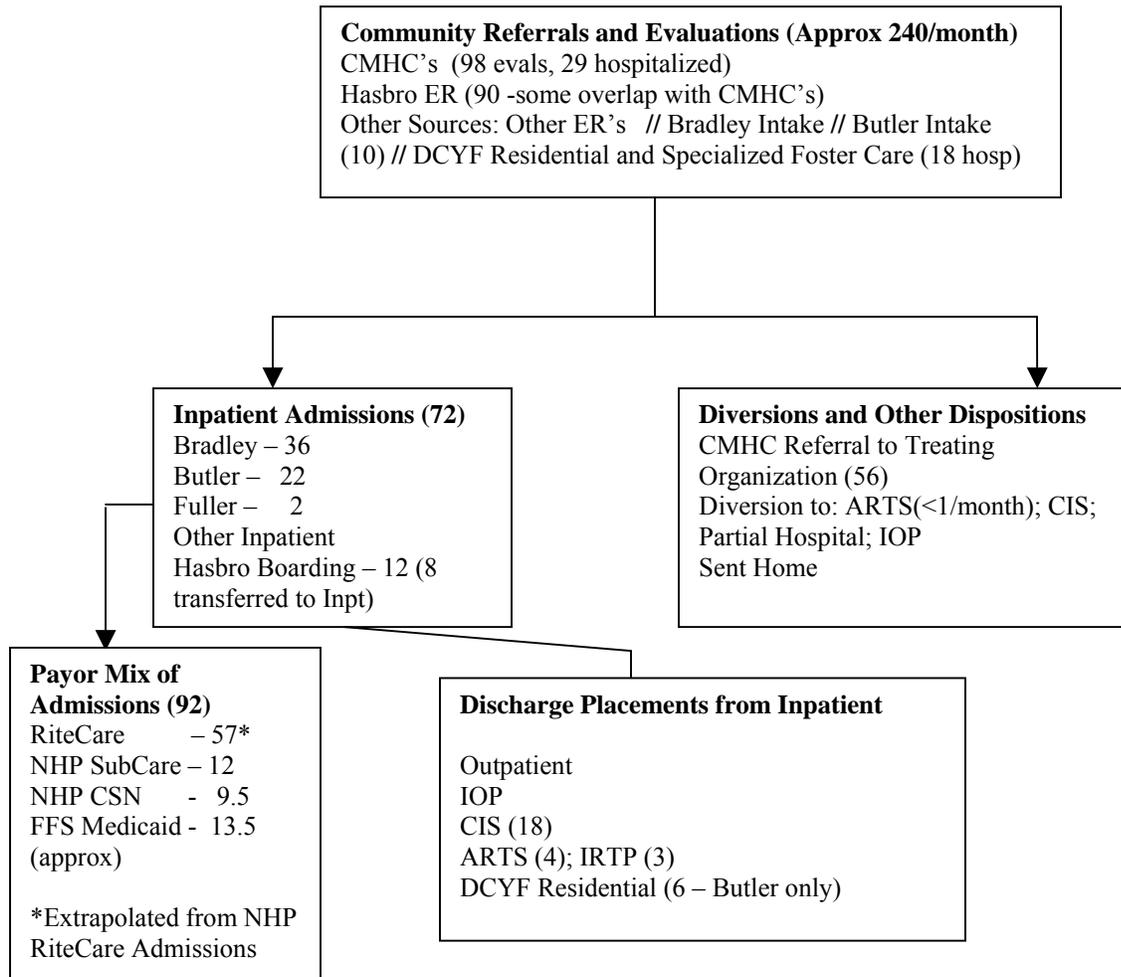
Problem Statements

There are between 70–90 publicly funded admissions to inpatient psychiatric facilities each month. Of these admissions:

1. Less than one-third of children with publicly-funded insurance who are admitted to an inpatient psychiatric facility receive a face-to-face evaluation by a community mental health provider.
2. There are no 24-hour diversionary programs such as Crisis Stabilization/Observation and Acute Residential Treatment to serve as alternatives to inpatient psychiatric admissions.
3. There are children who are ready to leave the inpatient psychiatric facilities for community programs but remain inpatient. Due to the lack of appropriate intensive community based step down services.

Flow Chart of Monthly Volume of Publicly Funded Children Receiving Emergency Psychiatric Services: Admissions, Diversions, Dispositions, and Payor Mix

See attached sheet for explanation of calculations and assumptions and additional detail on Payor mix and source of referrals. These figures represent MONTHLY AVERAGES so there are discrepancies between admissions to inpatient and admissions by payor mix.



APPENDIX C
**Report of the Subcommittee on Inventory of Mental Health
Services/Gaps in Service**

APPENDIX C

Subcommittee on Inventory of Mental Health Services/Gaps in Service

Amended Version – January 2006

Goal: To provide an intensive community-based continuum of behavioral healthcare that will effectively enable children to be appropriately stepped-down or diverted from inpatient psychiatric level of care.

Level of Care	Services that are Currently Available <i>(Either in-plan or out of plan)</i>	Services that are Needed <i>(Services that don't exist, but should; services that don't exist with sufficient capacity; services that don't exist with adequate geographic distribution.)</i>
Inpatient		<p>Community-based services need to begin and continue to work with the child and family while the child is hospitalized and/or in residential treatment.</p> <p>Community-based services should be included in inpatient and/or residential discharge planning meetings, along with families and child re: services needed upon discharge to ensure a plan and adequate capacity.</p>
Short-term crisis stabilization		<p>Short-term (1-3 days) crisis - stabilization / holding beds – a 24/7 level of secure and well-staffed care (with 24/7 evaluation and intake) that is not hospital based.</p> <p>(These beds could be located in an ARTS facility to assure staff secure environment and oversight by physician/ psychiatrist. ARTS and IRTPs may be relatively effective as short-term crisis stabilization interventions if they are of high quality and have a strong therapeutic and family-focus.)</p> <p>Increased utilization of newly expanded capacity of Bradley Crisis Service (as of December 2005) to do short-term urgent (within 48 hours) crisis intervention and short-term treatment</p>

Level of Care	Services that are Currently Available <i>(Either in-plan or out of plan)</i>	Services that are Needed <i>(Services that don't exist, but should; services that don't exist with sufficient capacity; services that don't exist with adequate geographic distribution.)</i>
		of children who do not already have a therapist and/or psychiatrist.
High-Level hospital step-down or diversion	<ul style="list-style-type: none"> • ARTS • IRTP (These services are generally provided for 1-6 weeks)	Currently very limited access to ARTS beds.
Intermediate clinical (CRAFT-like) Residential Treatment Program		More extended clinical Residential Treatment programs (2-6 months)
Residential Treatment Services	<ul style="list-style-type: none"> • CRAFT (6-12 months) • DCYF Residential Programs 	DCYF Residential Programs with more clinical management oversight*
<i>Partial Hospital Treatment Services</i> <i>(Does not need to be provided in a hospital setting)</i>	<ul style="list-style-type: none"> • Several community PHPs established. • All ARTS will have an attached PHP 	

Level of Care	Services that are Currently Available	Services that are Needed
Intensive Outpatient Treatment Services	<ul style="list-style-type: none"> • Traditional facility-based intensive outpatient services (could be day or evening) • Non-facility based Intensive Outpatient Treatment (“IOP without walls”), including mobile treatment services and Psychiatric Response Network (PRN) • Enhanced Outpatient Services (EOP) for both DD and non-DD populations • CIS (all levels) HBTS 	
Outpatient Services		<ul style="list-style-type: none"> • Need for more child psychiatrists • Clinicians trained to treat clients with DD and BH • General clinicians • Need for more home-based interventions that fall in the gap between “CIS-types” and “HBTS-types” of treatment. • Need for more of a range of clinical expertise and approach in outpatient treatment. • Need to significantly expand family therapy based approaches.
Other		<ul style="list-style-type: none"> • Respite services • DCYF and/or DHS should develop a policy requiring community representation at hospital/residential discharge planning meetings with families. • DCYF needs to amend existing contracts with residential providers to ensure that case management is provided to children/youth for 3-6 months upon discharge. • All residential providers need to develop policies that would support family involvement when re-unification with the family is the

Level of Care	Services that are Currently Available	Services that are Needed
		<p>ultimate goal.</p> <ul style="list-style-type: none"> • A process for accountability / quality assurance that ensures families are consistently provided with opportunities for feedback in regards to access, and ultimately reaching their desired outcomes of child and family well being must be put into place. • The various services within the behavioral health continuum must be linked to one another, and planning for such linkages must be done in partnership with families. • Lack of resources in communities, including inadequate workforce and insufficient “flexible funds” to support non-traditional services such as therapeutic recreation, basic needs (food, clothing, utilities etc.), camp scholarships, mentors, respite and youth groups that are specific to youth with behavioral health challenges. • Develop a certificate program for HBTS, PASS, and Respite providers. • A behavioral health assessment should be added to the screening process that occurs when a child transitions from Early Intervention to public school.

***DCYF Residential Treatment programs need stronger clinical management by the management entity to ensure:**

- The child’s clinical treatment needs above and beyond the milieu treatment are being met. These clinical services are generally those covered under the RIte Care health plan behavioral health benefits (Psychiatry, individual, group and family treatment)
- The child (and the facility) is linked in with the intensive community based services that need to be utilized by the facility to stabilize and maintain the child in the community setting.

Cross-cutting issues that must be considered in the above continuum:

- 1) Geographic range of services – i.e. some programs might exist but they don’t exist in enough communities or regions of the state to serve the children/youth and families that need them.
- 2) Capacity – i.e. some programs exist but don’t have the capacity to serve the numbers of children/youth and their families who need them.
- 3) Staff – Hiring and retaining a qualified staff/workforce will be critical in both expansion of existing services and the development of new services.

- 4) Consistent Screening Process – All children, regardless of insurance, should have a consistent screening process.
- 5) Ensure that a common “glossary” of services is used in all policy and program discussions.
- 6) Need to be attentive to what benefits are covered under Medicaid, as well as which are in-plan and out-of-plan RIte Care benefits.
- 7) All of the “dots” in the continuum need to be connected – child and family, treatment programs, family and communities.
- 8) With the exception of the DCYF milieu and room and board costs, all of these services need to be managed by the health plans and the 4th management entity for the children in FFS Medicaid.
- 9) Performance standards ought to be developed and implemented so that outcomes at each level care should be examined to ensure goals are attained. The development of the standards should include the family.

Key Points to Consider for H5829 Legislation for Report to General Assembly

1. DCYF and/or DHS need to consider the development of a policy requiring community representation at discharge planning meetings with families whether they have a child leaving a hospital, or residential facility. This will serve as a mechanism to ensure that comprehensive planning has been done for successful reintegration of children/youth back to their home and community.
2. Thoughtful planning for how the services within the behavioral health continuum will be linked to one another, needs to happen in partnership with families. Whether a child/youth is moving from least restrictive to more restrictive levels of care, or from more restrictive levels of care to less restrictive levels of care, there must be a seamless process in place. Currently the “Dots” in the continuum do not connect creating significant gaps in service delivery that all too often perpetuate crisis that could otherwise be avoided if a real “System” was in place.
3. Communities continue to struggle with lack of resources that are needed to receive and respond effectively to children/youth returning to their communities from institutional care. Workforce issues have been identified across the entire continuum, and the need to increase “Flexible Funds” that support those non-traditional services that have helped to prevent a child from leaving their community as well as keeping them home once they have returned from hospital or residential care. The CASSP System of Care has historically been the recipient of those flexible funds, however they are very limited and can help only a small number of children and families. These dollars pay for services that no other funding source can support. A few examples of these services are Therapeutic Recreation, Basic needs (food, clothing, utilities etc.), Camp Scholarships, Mentors and Respite. Additionally, Youth Groups that are specific to youth with behavioral health challenges have been very successful with a peer to peer support model, and creating ways for youth to develop both self advocacy and social skills in an environment that is both responsive and supportive to their needs. More funds must be available for local communities to develop these groups.
4. A recommendation in reference to the workforce issue particular related to HBTS, PASS, and Respite providers, would be to develop a certificate program that would support more of a career path and could get at the retention issues that currently exist.
5. DCYF needs to amend existing contracts with residential providers to ensure that case management is provided to children/youth for 3-6 months upon discharge. This is currently not a practice that exists within the residential provider world, however this is a change that desperately needs to happen. In addition, all residential providers need to develop policies that would support family involvement when re-unification with the family is the ultimate goal. Treatment must occur within the context of each family, “family centered”, as opposed to the more traditional “identified client” approach. Children can not be “fixed” and then be reunited with their family. This is a cultural shift in practice that needs to happen across the entire continuum of services. It is imperative for providers to understand the impact that a child/youth with behavioral health challenges can have on the entire family, across all life domains. All families need to have the opportunity to be served and supported with an approach that allows them to heal together.
6. There must be a process for accountability/quality assurance that ensures families are consistently provided with opportunities for feedback in regards to access, and ultimately reaching their desired outcomes of child and family well-being. There must be a comprehensive evaluation built into this “New System” to continue to inform us about what

is working, or not, and continue to build and strengthen the services system as we move forward.

7. A recommendation in terms of the child outreach screening that is a current practice when a child is transitioning from Early Intervention to public school, would be that a behavioral health assessment is included. Currently this does not exist as part of the screening process.

Key Points 1-7 were prepared by the Parent Support Network in collaboration with the Rhode Island Parent Information Network.

APPENDIX D

Proposed Outline for a Children's Behavioral Health Amendment of the *Rite Care Health Plan Contract*

APPENDIX D

Proposed Outline for a Children's Behavioral Health Amendment of the *Rite Care Health Plan Contract*

1. Purpose and Effective Dates
2. Section 2.02 Licensure/Certification
3. Section 2.06.02.05 Coordination of Care
4. Section 2.07 Coordination with Out-of-Plan Services and Other Health/Social Services Available to Members
5. Section 2.07.04 Department of Children, Youth And Families/Department of Health/ Department Of Human Services Special Programs
6. Section 2.08.03 (and all subsections) Mental Health Providers
7. Section 2.08.04 (and all subsections) Substance Abuse Providers
8. Section 2.09 Service Accessibility Standards – to the extent any new in-plan children's behavioral health services require an addition or change
9. Section 3.05.03 Contractor Certification of Licensure/Certification
10. Attachment A Schedule of In-Plan Benefits
11. Attachment B Schedule of Out-of-Plan Benefits
12. Attachment J Contractor's Capitation Rates
13. Attachment N Special Terms and Conditions
14. Attachment O Mental Health and Substance Abuse Services
15. Attachment P Payment and Reconciliation of Medical Expenses of Capitation for Children with Special Health Care Needs
16. Attachment Q Care Management Protocols for Children with Special Health Care Needs
17. Attachment R Payment and Reconciliation of Medical Expenses of

Capitation for Children in Substitute Placement

18. Signatories

APPENDIX E

**Proposed Outline for a Medicaid FFS Children's Behavioral Health
Request for Proposals**

APPENDIX E

Proposed Outline for a Medicaid FFS Children's Behavioral Health Request for Proposals

CHAPTER ONE

- 1.01 DESCRIPTION OF RHODE ISLAND MEDICAID PROGRAM
 - 1.01.01 Overview
 - 1.01.01.01 Rhode Island Medicaid
 - 1.01.01.02 Children's Behavioral Health under Medicaid
 - 1.01.01.03 Goals for the Contract Period
 - 1.01.02 Program Management and Oversight
 - 1.01.02.01 Responsible Agencies
 - 1.01.02.02 State Policies and Procedures
 - 1.01.03 Initial Service Period
- 1.02 ELIGIBILITY AND PROGRAM ENROLLMENT
 - 1.02.01 Eligible Groups (Type and Number)
 - 1.02.01.01 Eligibility of Children In Substitute Care
 - 1.02.01.02 Children With Special Health Care Needs
 - 1.02.01.03 Other Eligible Children
 - 1.02.02 Eligibility Determination
 - 1.02.03 Guaranteed Eligibility
- 1.03 REQUEST FOR PROPOSALS ORGANIZATION
- 1.04 READINESS REVIEW

CHAPTER TWO

- 2.01 PROCUREMENT PROCESS
 - 2.01.01 General
 - 2.01.02 Issuing Agency and Officer
 - 2.01.03 Procurement Timeline
 - 2.01.04 Submission of Written Questions
 - 2.01.05 Documentation
 - 2.01.06 Bid Submission
 - 2.01.06.01 General
 - 2.01.06.02 Public Opening of Bids
 - 2.01.06.03 Oral Presentation
 - 2.01.06.04 Technical Proposal: Identification of Qualified Bidders
 - 2.01.06.05 Technical Proposal: Clarifications And Revisions
 - 2.01.06.06 Request for Proposals Amendments
 - 2.01.06.07 Contract Awards
 - 2.01.07 Additional Rules of Procurement
 - 2.01.07.01 Cost of Preparing Proposal

- 2.01.07.02 Ownership and Disposition of Proposals
- 2.01.07.03 Withdrawal and Re-Submission of Bids
- 2.01.07.04 Independent Price Determination
- 2.01.07.05 Sub-Contracts and Joint Proposals
- 2.01.07.06 Protest of Intended Award(s)
- 2.01.07.07 Bidder Debriefing
- 2.01.07.08 Freedom of Information and Privacy Act
- 2.01.07.09 Code of Ethics and Professional Behavior
- 2.02 TECHNICAL PROPOSAL
 - 2.02.01 General
 - 2.02.02 Transmittal Letter
 - 2.02.03 Section 1: Background and Understanding
 - 2.02.04 Section 2: Provider Network
 - 2.02.05 Section 3: Quality Improvement Plan
 - 2.02.06 Section 4: Utilization Review
 - 2.02.07 Section 5: Plan for Non-HMO (if applicable)
 - 2.02.08 Section 6: Encounter Data Submission
 - 2.02.09 Section 7: Reinsurance Plan
 - 2.02.10 Section 8: Exceptions to the Model Contract
 - 2.02.11 Section 9: Additional Supporting Information for Bidders
- 2.03 COST PROPOSAL
 - 2.03.01 General
 - 2.03.02 Bidder's Cost Proposal Requirements

CHAPTER THREE

- 3.01 EVALUATION COMMITTEE
- 3.02 EVALUATION PROCESS
 - 3.02.01 General
 - 3.02.02 Technical Evaluation
 - 3.02.03 Cost Evaluation
 - 3.02.04 Final Selection and Awards
 - 3.02.05 Special Terms and Conditions

CHAPTER FOUR

- Technical Proposal Attestation Form
- Technical Proposal Disclosure Form
- Technical Proposal Certification Regarding Warranty Against Brokers' Fees
- Technical Proposal Certification Regarding Reinsurance
- Technical Proposal Certification Regarding Lobbying
- Technical Proposal Certification Regarding Drug-Free Workplace Requirements
- Technical Proposal Certification Regarding Environmental Tobacco Smoke
- Certification Regarding Independent Price Determination

APPENDICES

APPENDIX F
Verbatim Comments on the Report Draft

APPENDIX F

Verbatim Comments on the Report Draft

“Rhode Island children with special needs and their families have significant unmet needs for information, objective professional assessment, care planning, care coordination, referral assistance and support.” (CEDARR Website)

Summary: CEDARR is a promise – a promise made to families by the state after a multi-year collaborative planning process – to provide families with an objective perspective about the strengths and needs of their child, independent recommendations for where to get needed services, and the support and information required to enable parents to assess these services for their children in a system of care that is fragmented and under-resourced. Making CEDARR an in-plan service for the publicly funded continuum of behavioral health care services for children would break this promise in several ways.

1. Putting CEDARR In-Plan Threatens its Ability to be Comprehensive

CEDARRs serve children with a diversity of needs – behavioral, developmental, autism spectrum, physical, and technology dependent diagnoses and conditions. Putting CEDARR in plan for behavioral health makes no practical sense: CEDARR cannot be in plan for behavioral but out of plan for the other disability categories. Furthermore, DHS’s own data on the CEDARR eligible population indicates that a significant percentage of children have multiple diagnoses. If CEDARR were to go in plan, children with dual diagnoses would be receiving both in a plan and out of plan services under CEDARR – CEDARR would have two masters (DHS and the MCO) for the same child. This is unworkable and creates the divisions in service that CEDARR was formed to prevent and avoid.

2. Administrative Costs Will Increase and Services Will Decrease

Having managed care companies administer CEDARR would be to create a second “gatekeeper” to oversee CEDARR’s gatekeeper role. This would add immediate costs to the system as the plans would need to bring on sufficient care managers to monitor 1200 children currently enrolled in CEDARR. At a caseload of 60 children with special health care needs, this would necessitate the plans bringing on 20 additional care managers plus administrative costs. The initial financial impact would be to increase costs by more than \$1 million in personnel expenses alone. In order to control costs, managed care organizations will be required to cut rates, reduce care, and eliminate services.

3. CEDARR's Independence Assures a System with Checks and Balances to Support Families

Families helped to found CEDARR in order to assure that they could receive independent evaluations and assessments of their children and support to access needed services. In its independent role, CEDARR performs a balancing function that works with parents, State agencies, Local Educational Authorities, insurance companies, community resources, and service providers to sort through the competing financial, organization, and clinical agendas and priorities to find the best solutions for children with special health care needs. That CEDARR be independent and be seen as independent is critical to its success. Families need to know that their child has an independent advocate that is not beholden to any particular interest and has an arms length relationship from these different interests.

To put CEDARR in plan would breach this promise of independence—managed care (HMO or other) entities with a financial interest in the outcome and recommendation of these evaluations would now control the evaluation process. This is why it makes sense to have CEDARRs be independent entities from its founder/owners, maintaining an arms length relationship, and why it makes sense to keep CEDARRs independent of managed care companies.

4. CEDARR Certification Standards Work

CEDARR is able to do what it does from a service perspective because of the flexibility offered by DHS. CEDARRs do not need to meet NCQA or other external, national requirements whereas the managed care entities do. So, to put CEDARR in plan would be to put CEDARR under NCQA and other standards that could adversely impact families and service providers. MCO's typically do not reimburse for services provided by individuals who are not independently licensed, but do typically force providers to undergo mountains of administrative paperwork and long delays to get staff credentialed in order to have services reimbursable.

In addition, while there may be variability between the three CEDARRs, that variability is nowhere near as wide as the variability between the three health plans in the state that would be each responsible for administering a CEDARR benefit for eligible members. There is already great variability between the three health plans with some demonstrating tremendous flexibility

5. Managed Care Companies Do Not Have the Capacity or Credibility to Administer CEDARR

Families of children with special health care needs battle with the insurance and managed care systems on a daily basis to get the services they need for their children. CEDARR's are effective advocates and allies of parents while collaborating effectively with managed care companies. CEDARR independence is essential for this to continue. Otherwise, the

managed care and insurance companies will play the dual and conflicting role of supporter of families and denier of treatment and benefits.

The health plans have not demonstrated their ability to be creative and flexible with their requirements, claims platforms, and care management approaches to accommodate the CEDARR model. Plans vary in their rigidity and ability to orient their sometimes nationwide systems to reimburse innovative services. They also tend to be very short term focused, not recognizing the episodic and sometimes chronic needs of some families to obtain long term services.

Finally, much of the above relates not only to CEDARR Family Centers, but also the direct CEDARR services – HBTS, PASS and TCYC. In each case, families would not be assured the consistency of service across health plans nor would provide have a consistent experience working under the authorizations of the three plans. This variability is not good for children with special health care needs and their families.

Source: Kathryn Nicodemus

COMMENTS FROM REPRESENTATIVE NAUGHTON

REPORT TO THE GOVERNOR AND GENERAL ASSEMBLY REQUIRED BY SECTION 42-72-5.2 OF THE GENERAL LAWS OF RHODE ISLAND ON DEVELOPMENT OF A CONTINUUM OF CHILDREN'S BEHAVIORAL HEALTH PROGRAMS

Over the past three decades there has been an increased understanding of the importance of the early years for the future development of all children. The landmark 2000 Institute of Medicine (IOM) report, *Neurons to Neighborhoods*, synthesizes a growing body of research from the neurosciences, child development and education, and presents a series of recommendations to assure that all children have the opportunity to realize their potential. To optimize the development of all children, certain inputs are not optional but are required including:

- Structured, dependable, nurturing relationships with parents and other caregivers;
- Families with adequate resources to provide safe, nurturing, healthy, and educationally supportive environments;
- Health care, developmental, and education services that help parents promote the optimal development of their children, and identify and mitigate potential risks and problems at the earliest and most effective possible juncture.

Recognition of the need to develop a comprehensive strategic plan for a new approach to behavioral and mental health developmental services pathways should lead us to examine the existing system of screening, surveillance, assessment and intervention for children with developmental, behavior, and mental problems.

Traditional approaches to behavioral mental health developmental services have relied on a neuro-maturational framework in which neurological functions are regarded as being essentially “set” at birth and unfold over time. The healthcare focus has been on children’s deficits, with intermittent screening being used in an attempt to document a level of deficit that will trigger eligibility for additional services. Such assessments often focused on the child in isolation, and emphasized elicitation of his or her demonstrable abilities. As we move forward, we must recognize the strengths and weaknesses of the neuromaturational model and broaden the scope and increase the flexibility of services in a manner that captures the complex interaction that occurs between the child and the care-giving environment on development as well.

There is also a growing convergence in beliefs that the means to achieve the optimal development of all children will require multi-sector, multidisciplinary, systems-building initiatives that can address the needs of individual children as well as the context of their families and communities.

National Education Goals Panel (NEGP, 2001) redefined and re-framed the concept of “school readiness” to include schools being ready for children, families and community supporting the transition to school, and children being ready to attend school. As part of that definition a child’s readiness for school was no longer defined around simply

academics- but in terms of their overall physical, emotional, cognitive, language and social development during the first 5 years of life.

As multiple sectors that provide services to guarantee and enhance the health and behavioral mental health development and school readiness of all children become more unified in vision and purpose, there is an opportunity to improve the delivery of health and other services, and to integrate these services into more responsive and effective systems of early childhood care. There are few multidisciplinary training programs thereby limiting opportunities to practice collaborative care. Most service models are also highly influenced by neuromaturational and disease model philosophies, which limit their effectiveness for the vast majority of children without clinical disorders, but who may have risks requiring primarily preventive services. The healthcare system and healthcare providers are only one of a number of service systems that need to be actively engaged if the desired outcomes of healthy developmental and school readiness for all children are to be achieved.

In Rhode Island there is an opportunity to design a system of behavioral mental health developmental services which draws on neurological, social and psychological development. Complex interaction occurs between the child and the care-giving environment. Building on existing resources we can address all aspects of child development with potential lifelong benefits for the children themselves, and extensive benefits to the wider community. The RI Chapter, American Academy of Pediatrics, RI Child Psychiatric Association, and the Successful Start group from DOH are looking into assessment tools for developmental and behavioral/MH concerns.

If every child with a neurodevelopmental problem is identified early, if effective interventions are implemented promptly and if every child, to the best of his or her potential, enters school healthy and ready to learn, then tremendous benefits to society will ensue. Cost savings could be expected not only in the health sector but also in spending on special education, and in the juvenile justice system.

Gaps in Current Services

- Children with prenatal substance exposure , children of mothers who are depressed, and children in foster care often fail to receive developmental services.
- Children who fail developmental screening tests but who pass diagnostic tests are generally ineligible for services, yet they continue to perform lower as a group on intelligence and achievement tests.
- Although Early Intervention provides services for children in the 0-2 range who are at risk of developmental delays, once those children reach the age of three years they transition out of services and are ineligible for other publicly funded programs. Often these children do not receive services again until kindergarten entry.
- Few practitioners are equipped to identify infant mental health problems, or mother-infant interactional problems and there are limited referral resources to manage these issues.
- There is insufficient funding for preventive services, especially in mental health. There is insufficient objective evaluation and surveillance during early childhood for mental health

- Childcare providers and preschools could play a greater role in developmental surveillance but lack tools and connectivity to other services.

February 1, 2006

Ms. Jane A. Hayward
Secretary
Executive Office of Health & Human Services
State of Rhode Island
Providence, Rhode Island 02903

Re: Report on the Development of a Continuum of Children's Behavioral Health Programs

Dear Secretary Hayward:

Thank you for the opportunity to respond to your report to the General Assembly on the Development of a Continuum of Children's Behavioral Health Programs. Given the less than 24-hour time frame to submit comments the Hospital Association of Rhode Island (HARI) submits the below concerns/issues following a quick review:

- Unrealistic time frames for implementation of this act to include issuing the RFP for a behavioral health vendor, amending all RiteCare contracts, developing and implementing regulations to certify mobile crisis clinicians, designing a denial and appeal process, and building resources sufficient to meet the hospital diversion expectations. (These items are not inclusive of all requirements of the Act).
- Data and inventory information was very informally developed and analyzed and most likely not comprehensive and also inconclusive. For example, data was not consistently gathered by all parties. Another example is the information on listings of behavioral health services in the community to be used as alternatives to inpatient hospitalizations does not include an evaluation of capacity and usage to determine availability of such services.
- Difficult to determine effectiveness of the mobile crisis teams when the regulations establishing clinician credentials and scope of the clinicians function have yet to be established. Experience in regulatory process is that development and actual certification of individuals takes considerably more time. This concern was also voiced by Donald Williams of the RIDH who is responsible for a majority of the regulated health care providers in the state.
- Concern that mobile crisis clinicians will not understand the boundaries of their practice. Additional concerns regarding their ability/authority to enter emergency rooms to assess care and direct care. There are also many questions regarding their role in the utilization review and denial process.

Ms. Jane A. Hayward
February 1, 2006
Page Two

- Language on page 24 of the report suggests that hospitals do not currently provide appropriate behavioral discharge planning. When this statement was presented in the larger workgroup, hospital providers took issue. HARI contends that this is not the case and most behavioral discharge planning issues revolve around the lack of step down options for the patient being discharged.
- Cross cutting issues on page 26 of the report need to be addressed prior to the implementation of the requirements of this act.
- Facets of the Options presented in this report compromise the continuity of care and therefore compromise the quality of care. (e.g. removal of behavioral health as part of RiteCare health plans) are a concern.
- HARI as well as other workgroup participants repeatedly raised the concern regarding insufficient availability of behavioral health resources in Rhode Island. The statute clearly states that regardless as to whether this act is fully implemented as of May 1, 2006, hospitals will be issued AND reimbursements if inpatient criteria is not met, even if there are no safe alternatives to hospitalizing of the state funded patient.
- The options presented in the report were not presented or discussed in the larger workgroup. Not all aspects of these options are clear and would require further clarification to fully understand each proposal's impact.
- None of these options will serve to improve the resource issue, reduce unnecessary psychiatric hospitalizations, reduce the number of children in need of acute inpatient behavioral health care from boarding in a med/surg bed or reduce the overall "cost" of care. These options appear to simply shift the cost to hospitals with additional financial risk to health plans in some cases.

The Hospital Association of Rhode Island hopes the above points are viewed in the cooperative spirit in which they are submitted and requests an opportunity to submit additional comments once a thorough review of the report has been completed. Please let me know how such comments should be submitted.

Sincerely,



Daniel P. Egan
Vice President, Government Relations
cc: Edward Quinlan, President, Hospital Association of Rhode Island

February 1, 2006



Jane A. Hayward
Secretary
Executive Office of Health & Human Services
Hazard Building
74 West Road
Cranston, Rhode Island 02920

Dear Secretary Hayward:

Rhode Island KIDS COUNT is pleased to offer our initial response to the draft “Report to the Governor and General Assembly Required by Section 42-72-5.2 of the General Laws of Rhode Island on Development of a Continuum of Children’s Behavioral Health Programs” that was distributed yesterday to members of the Children's Behavioral Health Workgroup.

As you know, Rhode Island KIDS COUNT was an active member of the Workgroup. Our organization is committed to working toward a system that offers improved access to a continuum of appropriate behavioral health care services for children and their families in Rhode Island, as well as to reducing unnecessary psychiatric hospitalizations of children.

Although much of the text and Implementation Plan refers to only two options, we would like to offer the following comments on the three options presented in Section VI (Options) of the draft report:

- OPTION 1 – Create a Carve-Out of All Medicaid covered Children’s Behavioral Health Treatment and Family Stabilization Services to one or more new accountable entity(s). (Draft page 27.)

Comments on Option 1 – This option appears to offer a solution that contradicts the direction that Rhode Island has been taking toward integrated primary health care for children. It is well known that good physical health is inextricably linked with mental health and dental health – and Rhode Island KIDS COUNT believes and best practice shows that the benefits system needs to reflect the integration of primary care and behavioral health care.

Rhode Island KIDS COUNT, therefore, would not be in support of this option.

- OPTION 2 - DHS would be accountable for Medicaid-covered children’s behavioral health treatment (Table 2), while DCYF would be accountable for child and family stabilization/family preservation services (Table 3) within the children’s behavioral health continuum. (Draft Page 30.)

Comments on Option 2 – This option appears to re-arrange the division of responsibility for various children’s behavioral health treatment and children and family stabilization/family preservation services between DHS and DCYF from what exists now, but it maintains a division.

rikids@rikidscount.org
www.rikidscount.org

While most of the behavioral health services that are currently “out-of-plan” would be moved “in-plan” (as denoted in Table 2) in this option, it seems to imply that DCYF would have management oversight for Emergency Services. While we believe that DCYF should continue to have the responsibility of licensing providers of Emergency Services, we believe that not having Emergency Services as part of the continuum of treatment services under the management oversight of the health plans moves us in the wrong direction of building a continuum. In contrast, Option 3 appears to designate oversight responsibility for Emergency Services to the health plans.

As you know, under the current system, some behavioral health services are “in-plan,” while others are “out-of-plan.” This means that the management responsibility and resources are split among managed care plans and the state departments. This division has resulted in fractured care coordination and a lack of resources that have a negative impact on the adequacy and quality of behavioral health services available to children and families.

Also, as shown by the data presented to the Workgroup and in this draft report, a significant portion of spending for behavioral health services is for children who are in residential care. Because many children who are admitted for psychiatric hospitalizations come from and return to residential care, it is critical that the health plans have clinical care oversight of their treatment plans. This would ensure compliance with the core values and guiding principles for children’s behavioral health and access to the full continuum of behavioral health services.

Rhode Island KIDS COUNT believes that in order to most effectively manage unnecessary psychiatric hospitalizations and their associated costs, as many of the elements of the continuum of behavioral health services as possible need to be under the purview of the health plans. This would enable the health plans to best manage clinical care and resources, while more effectively meeting the needs of children and families.

Therefore, Rhode Island KIDS COUNT would support most of Option 2, but not the component that would provide DCYF with oversight of Emergency Services. We also would want to see a component added to Option 2 that would provide clinical care oversight of children in residential care by health plans.

- OPTION 3 - Establish a Comprehensive Continuum of Treatment within the RIte Care Contract by Moving Out-of-Plan Treatment Services In-Plan. (Draft page 33.)

Comments on Option 3 – We believe that there is significant overlap between Option 2 and Option 3. A major difference appears to be that under this option, health plans would have oversight for Emergency Services. Rhode Island KIDS COUNT believes health plans should have oversight for this type of service.

We do have several concerns about issues that are raised in Option 3, however. One concern is that Option 3 implies that children in substitute care would be enrolled across all three current RIte Care health plans. Because this vulnerable population has highly specific needs, it is the position of Rhode Island KIDS COUNT that children in substitute care would be best served by being enrolled in a single health plan that has expertise in ensuring access to care for this

population. We believe that moving these children out of a single plan would be a step backwards from the improved access to health care services that Rhode Island has achieved for children in substitute care over the past few years.

We also believe that Children with Special Health Care Needs are also a population that require special service capacities of a health plan. We would want more information on how the two current RIte Care health plans who do not enroll Children with Special Health Care needs would respond to these requirements and ensure adequate care coordination and access to specialty services.

Rhode Island KIDS COUNT would support Option 3 if the considerations raised here are addressed.

Finally, we would like to note that there seems to be a paucity of data on the number of children receiving each type of behavioral health service, the movement of children between behavioral health services, and the positive or negative outcomes of behavioral health treatment.

We would like to offer the assistance of Rhode Island KIDS COUNT in further exploration of available data and in the development of new data collection, analysis, and dissemination strategies for children's behavioral health.

We look forward to continuing to work with you to discuss and address the details of the implementation plan. Please do not hesitate to contact either of us if we may be of further assistance.

Sincerely,

Elizabeth Burke Bryant
Executive Director

Jill Beckwith
Policy Analyst



February 1, 2006

Secretary Jane A. Hayward
Executive Office of Health and Human Services
Louis Pasteur Bldg.
600 New London Avenue
Cranston, RI 02920

Dear Secretary Hayward:

Thank you for permitting Neighborhood Health Plan of Rhode Island to comment on the children's behavioral health treatment service options EOHHS is offering the Governor and General Assembly for consideration. We appreciate the efforts you have led to achieve consensus and foster appropriate public discourse on this important policy matter.

Neighborhood remains committed to the Workgroup goals of identifying a single point of accountability for services for each child, further improving fiscal and budget integrity and promoting best practices/evidence-based practices. These concepts are achievable and we welcome the opportunity to discuss any related RIte Care contract amendments.

With that context in mind, we firmly believe that a coordinated care model that includes medical as well behavioral health treatment needs to be a part of whichever children's behavioral health option is selected. Primary care often includes the provider meeting the behavioral health needs of these children. Dividing up medical and behavioral care risks fragmenting an already fragile system.

Regarding the identified options:

Option 2 – Bringing more children's behavioral health services into DHS, potentially under the coordination of the RIte Care plans:

This option increases Neighborhood's ability to develop and manage a more comprehensive, integrated system of care. It enables our care management team to manage the full continuum of behavioral health services. We believe this will produce better health outcomes and more cost effective services. If the state intends to hold our plan more accountable both clinically and financially, we need to be able to manage the whole continuum of behavioral health services.

As a component of increased health plan management of the full continuum of behavioral health services, the health plans need to be able to have clinical management oversight of their members in residential care. This will ensure more effective assessment, treatment plan development and

integration with the array of community based behavioral health services offered by the health plans. We believe it will also significantly reduce the number of hospital admissions and readmissions from the group care facilities.

We are left with many concerns and questions that would be important to consider:

1. As a health plan working with these populations, experience shows historical data is important for both sides to enter into a sound risk sharing arrangement.
2. The role of DCYF in emergency services. Option 2 seems to allow DCYF to play the primary role in licensure, assessment, disposition and oversight of the system. Option 2A appears to put them in the position of licensing providers and creating standards, but leaving the clinical services and network development issues to the health plans. We can use their licensed providers; however, if there will be both clinical and financial accountability for the health plans, we need to be able to manage and coordinate the clinical services, disposition and transition through the continuum of care.
3. This report contains only an outline of proposed changes to the RIte Care contract. We would have to understand the detail of the expectations, starting with the Service Accessibility Standards, etc.
4. We are concerned that the critical need for coordinated ownership of both clinical services rendered in the group home setting, and those clinical services rendered as current Health Plan services, was not addressed.

Option 1 – Remove children’s behavioral health services from DHS, and place under DCYF:

To reiterate, Neighborhood Health Plan of Rhode Island supports a comprehensive coordinated model of care that includes medical and behavioral health treatment. Any other model would reverse the significant improvements that have been made over the past few years through care integration. Option 1, in its current form, does not support this integrated system of care.

If the intent is to assure that responsibility rests with one entity or a behavioral health specialist, you could effectively modify Option 1 by including medical services as well.

Thank you again for including Neighborhood in this public process and for your efforts to improve health and access to care in Rhode Island.

Sincerely,



Mark Reynolds
Chief Executive Officer



February 1, 2006

Jane Hayward
Executive Office of Health and Human Services
State of Rhode Island and Providence Plantations
Hazard Building
74 West Road
Cranston, Rhode Island 02920

Dear Jane:

Thank you for the opportunity to respond to the document titled "Draft Report to the Governor and General Assembly on the Development of a Continuum of Children's Behavioral Health Programs" forwarded by your office on January 31, 2006. Given the short time frame in which to submit comments (Noon on February 1, 2006), Butler Hospital will focus its response on key elements related to this report.

In spite of the efforts by the Department of Health and Human Services (DHS) and the Department of Children, Youth, and Families (DCYF), implementation of this act to include issuing the RFP for a behavioral health vendor, amending all RiteCare contracts, developing and implementing regulations to certify mobile crisis clinicians, designing a denial and appeal process, and building resources sufficient to meet the hospital diversion expectations by May 1, 2006 is unrealistic. In addition to time limitations, the following subject matter outlined in the report is also of concern:

- Data and inventory information is inconclusive. For example, information on listings of behavioral health services in the community to be used as alternatives to inpatient hospitalizations does not include an evaluation of capacity and usage to determine availability of such services.
- Difficult to determine effectiveness of the mobile crisis teams when the regulations establishing clinician credentials and scope of the clinicians function have yet to be established. Note, all Options proposed by DHS include use of the mobile crisis teams. Based on my review of the related regulations being proposed by DCYF for these mobile crisis clinicians it appears that they will be functioning as clinical evaluators, case managers and utilization managers creating a potential conflict of interest.
- Language on page 24 of the report suggests that hospitals do not currently provide appropriate discharge planning. When this statement was presented in the larger workgroup, hospital providers took issue with such



345 Blackstone Boulevard, Providence, RI 02906
Affiliated with the Brown University School of Medicine
(401)-455-6200, TDD/TTY (401)-455-6239

002

CARE PLANNING

02/01/2006 WED 12:23 FAX 4556298

an assertion. It is unclear as to why this statement remains as part of the report.

- Butler Hospital agrees with the list of nine cross cutting issues on page 26 of the report, but emphasizes the need to address these issues prior to the implementation of this act.
- Any aspect of the Options presented that promotes the total separation of accountability of medical/surgical and behavioral health care could compromise continuity and quality of care. (e.g. removal of behavioral health as part of RiteCare health plans).
- The report does not reflect many providers' and health plans' continual concern throughout the workgroup process regarding the lack of behavioral health resources as alternatives to hospitalization for the child and adolescent population in Rhode Island.

Two key questions remain unanswered as the state moves forward with the implementation of this act. How can health plans be contractually required to develop a network of non-inpatient behavioral health services and require access to such services if such services do not exist? What is the rationale in financially sanctioning a hospital by issuing Administratively Necessary Day (AND) reimbursement when a patient is admitted or remains in the hospital because there is no available safe alternative lesser level of care?

Butler Hospital is committed to finding the least restrictive setting in managing patients that enter its facility. We hope to be able to continue to work with state agencies to continue to provide cost effective quality health care.

Thank you for the opportunity to submit our comments.

Sincerely,



Diane Ferreira Miller, RNc

CC: Patricia R. Recupero, JD, MD
Walter Dias, COO

67 Cedar Street
Suite 1
Providence, RI 02903-1042
Voice 401-273-0900
Fax 401-273-0959
www.riocmho.org

Council Members

East Bay Mental
Health Center, Inc.

Gateway Healthcare, Inc.

The Kent Center

Newport County
Community Mental Health
Center, Inc.

NRI Community Services, Inc.

The Providence Center

Riverwood Mental Health
Services, Inc.

South Shore Mental
Health Center, Inc.

President/CEO

Elizabeth V. Esais, MA

**Rhode Island Council of
Community Mental Health
Organizations, Inc.**

February 1, 2006

Report to the Governor and the General Assembly Required by Section 42-72-5.2 of the General Laws of RI on Development of a Continuum of Children's Behavioral Health Programs

Introduction: The RI Council of Community Mental Health Organizations appreciated the opportunity to participate in the H.5829 Children's Behavioral Health Workgroup. The Council and its members have a long-standing commitment to building and sustaining a system of care for children and families, and this was evidenced by our participation in the larger workgroup, as well as participation on both of the sub-groups.

History: The organizations represented by the Council have been the primary providers of publicly funded children's behavioral health services for over 20 years. Community mental health organizations (CMHOs) provide emergency/crisis response 24 hours per day/seven (7) days per week, regardless of whether or not the client and family are known to the organization. CMHOs staffs are credentialed by DMHRH and hospitals to provide emergency response within the hospital emergency rooms.

CMHOs provide Children's Intensive Services (CIS). CIS was originally developed by DCYF in 1993, and the CMHOs were the major providers of this service. At that time, DCYF eliminated other long term care programs for families (ICBT, primarily) and used the funds to create CIS. With the creation of CIS, the Department authorized the CMHOs to screen all potential, publicly funded child psychiatric admissions. The goal at the time was to reduce inpatient utilization by offering community-based alternatives where appropriate and possible. The Program did reduce hospital utilization; however, with the onset of Rite Care, DCYF and CMHOs were no longer able to screen hospital admissions to determine hospital diversion possibilities. Responsibility for emergency screens was spread across the Health Plans and its network of providers, with some responsibility remaining with DCYF for those children with Medicaid Fee for Service. CMHOs continued to provide emergency screens, but it was no longer required for those children with Medicaid.

CMHOs also provide what most would consider traditional outpatient mental health and addiction treatment services to children and families. CMHOs accept both Medicaid and commercial insurance.

Recognizing that the demand for state funding for health care services was increasing, the Council believed it was important to measure the quality of the services provided by its members to determine if they were actually improving health quality in the lives of the children and families receiving the service. Therefore, in 2000, the Council and its member organizations embarked on an effort to identify an outcome measurement that could be used with the CIS program. For a few years, DCYF had required CMHOS to complete the Child Behavior Checklist (CBCL) on each child entering CIS; however, research and experience had shown that though this was an excellent assessment tool, it was not a tool that could measure outcome.

The Council and its members recognized the importance of measuring outcomes in order to determine if the Program was meeting the expected treatment goals. The Council invested significant time and resources in identifying a tool; organizing training on how to use the tool (Child and Adolescent Functional Assessment Scale – CAFAS); and providing ongoing rater-reliability training to protect the integrity of the data.

Both the Council and DCYF in its partnership with Yale University collect the CAFAS data from the CMHOS' CIS programs. The data has consistently shown that those children who participate in CIS treatment exhibit marked improvement. Because CIS is a vital component of RI's existing children's behavioral health care system, it is important to understand that the program has proven to be effective for the population it serves while the State considers how it might re-structure and enhance the system.

Report Response: The Council understands the importance of having a coherent system of care for children and their families. As representative of the major providers of care, the Council has advocated for many years for a more comprehensive array of services, including increased capacity of existing services, in order that families have available to them in a timely way, the services that would best address their child's needs. It is why the Council invested significant time and energy in the process leading up to this Report.

As noted in the report, though all came to the table with a shared commitment to improving the behavioral health system for children and families, there was not consensus on how best to achieve this. It would be wrong to conclude that consensus wasn't achieved because of vested interests. The reality is that individuals and organizations approach the solutions based on their experience and perspective, and those experiences are legitimate. **Everyone did agree** that

- the gaps that exist in service types and service capacity were at the heart of the problem; and
- Rhode Island's child behavioral health care system, like every other state, is struggling to recruit and retain qualified practitioners at every level.

Each of the Options offered in the Report would require a significant amount of re-organizing of both the management and delivery of children's behavioral health services. This re-organization may eventually provide the State more information as to how it is spending its investment on children's behavioral health services. What it won't do is address the issue of gaps in service array and capacity. Further, it has the potential of exacerbating the workforce issues.

The State of Rhode Island is in the process of planning for the fiscal year 2007 budget, and by all accounts it will be one of the most difficult budgets faced by the State in many years. The State's deficit is compounded by the fact that the Federal Government is making major cuts in critical health and social service entitlement programs.

Each of the Options proposed in the Report will result in some amount of existing funds being identified for the planning and re-organizing called for by the Report. There is a very real argument to be made, based on experience, that once the newly created or re-organized management entities take on their new roles and responsibilities, additional funds will be needed for administration. At a time when funding for services is already stretched to the limit, and facing cuts, these Options offer little hope for actual improvement to service capacity.

Jane A. Hayward
Secretary
Executive Office of Health & Human Services
(O) 462-5274 (Fax) 462-0241

>>> "Laura Jones" <jones@ripin.org> 2/1/2006 9:07 AM >>>

Jane,

I read the report and I want to clarify what I meant on the Key Points to consider document (page i of the appendix), number 7.

I also attended the meeting on December 2, Could you add my name to the attendance.

Currently Early Intervention screening and intake process does not screen for behavioral health nor does child outreach screening. Many children do not qualify for early intervention based on the current eligibility criteria who are experiencing behavioral health problems. These children are not getting the early treatment they could benefit from. When they turn three, if they continue to have problems they are then screened through child outreach. Child outreach does not screen for behavioral health so the children are not moved to the next level which is evaluation through their school districts. Many children are being expelled from preschool due to behaviors. The preschools do not have the expertise to manage these children. Many working parents are forced to stay home with shier child until they start public school causing financial hardship on many families. The children then start kindergarten with many of the same issues they experienced earlier in their development. Early screening and evaluation and treatment is needed for these children. The families and the preschools need support by professionals during this sensitive period.

Laura Jones
Rhode Island Parent Information Network

Phone 742-1321