Rhode Island Behavioral Health System Review Technical Assistance

Final Report

July 2021

Faulkner Consulting Group

Health Management Associates

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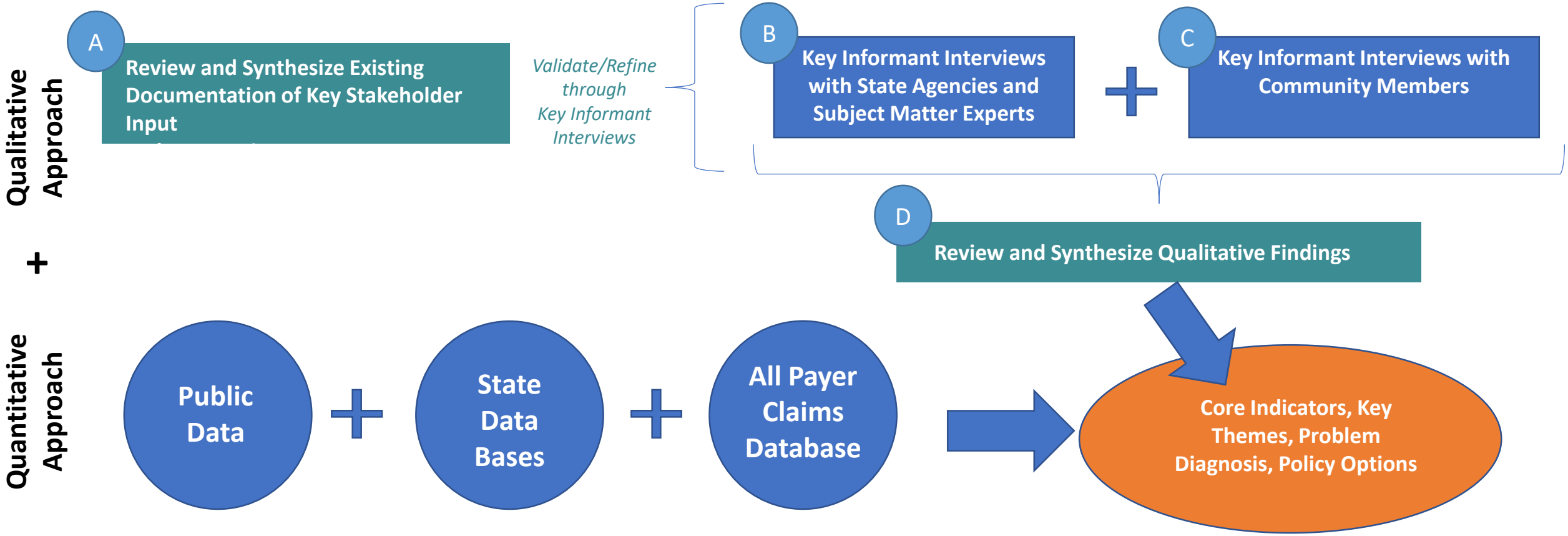
Approach to Behavioral Health Study

The team informed key themes and findings through **a mixed methods approach** conducted from September – December 2020, including **qualitative work engaging stakeholders** from both state agencies and the community, as well as a **quantitative assessment** of Rhode Island's behavioral health system.



Starting Point: Rhode Island has a foundation of prior health system initiatives upon which state policy makers can build policies and solutions to address behavioral health capacity challenges identified in this report. Community members are committed to working with state leaders to advance opportunities that address behavioral health system challenges and underlying drivers of those challenges.

Current Health of Rhode Island's Behavioral Health System: Rhode Island's core indicators – including overdose death rate and substance use rates – indicate significant concerns with Rhode Island's behavioral health system. Challenges with Rhode Island's behavioral health system surface in data related to suicide rate, homelessness rate, emergency department utilization, treatment volume in correctional settings, employment rate of behavioral health clients, and children's behavioral health measures.

Equity in Rhode Island's Behavioral Health System: RI's current behavioral health system does not meet the needs of our community, driven by a history of systemic racism. Throughout the report, metrics tied to racial, ethnic, gender, sexuality, and other disparities are included when such data was provided or available to help distinguish where specific equity-focused improvements are needed in the behavioral health system. Overall, specific data collection is needed to better understand inequities and discrimination in the BH system and should be prioritized within all policy implementation planning.

Key Findings: Through quantitative and qualitative data analyses conducted between September – December 2020, the following findings have emerged:

- Rhode Island has several behavioral health system capacity challenges to address including both gaps in key service lines and a shortage of linguistically and culturally competent providers, that together disproportionately negatively impact communities of color.
- Underlying drivers that perpetuate the challenges described above include:
  - Fragmentation in accountability both across state agencies and across providers, insufficient linkages between services to support care coordination and transitions of care, and a lack of integration between behavioral health and medical care.
  - Payments for behavioral health services largely rely on a fee-for-service chassis that does not account for quality or outcomes.
  - Lack of sufficiently modern infrastructure hinders providers of behavioral health services in Rhode Island, as well as creates barriers for Rhode Island to effectively and efficiently monitor the behavioral health system on an ongoing basis.
- Significant challenges persist in accessing behavioral health services for individuals who are also diagnosed with Developmental Disability (DD). While this report focuses on BH access for the entire population, we acknowledge addressing BH access specific to the DD community is an important next step.

Policy Considerations: While no other states or organizations have found a panacea solution to improve their behavioral health system, several have examples of promising best practices that could be adapted to meet Rhode Island's needs. Nine principles to prioritize policy solutions surfaced: accountability, payment, aligning with community need, systemic racism, standardization, leveraging existing foundation, prevention and recovery, sustainable investing, and regulatory oversight.

Priority Policy Options: Based on our findings, we have identified two priority policy options that address system gaps and challenges identified in our analyses. First, to develop a statewide RI Certified Community Behavioral Health Clinic (CCBHC) program. This RI-specific program model would be designed to provide comprehensive mental health and substance use disorder services to vulnerable individuals throughout the life cycle. Second, to develop a Single Statewide Mobile Mental Health Crisis System as a central part of CCBHC. For each priority policy option, we will develop an implementation plan designed to address the identified challenges in the Rhode Island BH system. We have also identified additional opportunities that represent smaller, easier-to implement improvement.

Ongoing Stakeholder Feedback: We received several comments during the development of this report, and we are grateful to all stakeholders that participated in the engagement and comment process. The final report has been updated to reflect feedback, however, some feedback that was received is applicable to future policy option development. Those comments will be used as we engage in detailed implementation planning work. The state is committed to an ongoing process to engage stakeholders throughout the planning and development process.

"Health of RI's Behavioral Health System": Core Indicators of Incidence, Prevalence and Consumer Need

Legend
Data suggests significant system concern, including outcomes are worse for RI than regional/national benchmarks, and outcomes are worse for non-white individuals
Data suggests moderate system concern, including that outcomes are better for RI than neighbors, but still below ideal targets, and outcomes are better for non-white individuals, but still below ideal targets.
Data does not suggest system concern; ideal state for indicator is achieved.

Findings for each core indicator are summarized below. Section 3 provides detailed data in aggregate and stratified by demographics, when available.

Core Indicators	Status Overall	Race Equity Outcomes	Key Findings
Suicide Rate			RI's suicide rate is two thirds that of the national suicide death rate, and lower than the rate in neighboring CT & MA. However, RI's trend over time is consistent with national average and above both MA and CT. For adolescents aged 15-19, RI had the lowest suicide rate of all 50 states in 2016-2018.
Overdose Death Rate			RI has high overdose rates with overdoses that are increasingly fatal. Drug overdose rates in RI have been higher than MA and CT until 2016. In RI, overdose rates have increased by 70% since 2008. The number of opioid overdose deaths in RI has increased nearly 2x since 2008; RI's rate of opioid overdose deaths in 2018 is 1.6x that of the national average.
Rates of Substance Use			RI has usage rates above the national average for all drugs surveyed except cigarette use. Recovery service utilization varies widely by age, sex, and race.
Rate of Homelessness			Rhode Island's homelessness rate (0.2%) is below both Connecticut and Massachusetts and has been steady since 2010. The number of homeless Rhode Islanders has decreased by 23% since 2013, and 40% among children. Initial indications from stakeholders reflect an increase in homelessness since COVID-19 began.
Treatment volume in correctional settings		No data	Rhode Island has the smallest percentage of adult mental health consumers services in a jail/correctional setting amongst neighboring states and the national average.
Employment in recovery/ post-treatment		No data	40% of adult mental health consumers in Rhode Island are unemployed, less than the national average of 46%, but much higher than the statewide unemployment rate.
Rate of behavioral & emotional problems; Juvenile justice involvement			RI's rate of children with a mental, emotional, developmental, or behavioral problem follows its neighboring states and is slightly better than the national average. RI has the highest rate of juvenile delinquency cases per 100,000 amongst neighboring states; however, the RI rate has decreased by 40% since 2014.

"Health of RI's Behavioral Health System": Core Indicators of Capacity & Utilization

Legend
Data suggests significant system concern, including outcomes are worse for RI than regional/national benchmarks, and outcomes are worse for non-white individuals
Data suggests moderate system concern, including that outcomes are better for RI than neighbors, but still below ideal targets, and outcomes are better for non-white individuals, but still below ideal targets.
Data does not suggest system concern; ideal state for indicator is achieved.

Findings for each core indicator are summarized below. Section 3 provides detailed data in aggregate and stratified by demographics, when available.

Core Indicators	Status Overall	*Race Equity Outcomes	Key Findings
Utilization of the Emergency Dept for Mental Health and Substance Use		No data	10% of ED visits in 2018 had a primary diagnosis related to behavioral health. Substance use visits were overwhelmingly adult, while mental health visits had a higher number of children (27%) than SUD.
Follow-Up Rates for Emergency Dept Visits		No data	Less than a fourth of individuals follow-up within 30 days after an ED visit for SUD-related issues. Only about 40% of Medicaid members had follow-up within 30 days of a MH-related ED visit as compared to two thirds (64%) for Medicare and commercial insurance.
Location of Residential Treatment Services		No data	Half of Rhode Islanders with commercial insurance or Medicare requiring SUD residential services are sent to a state other than RI, MA, or CT.
Emergency Dept and Inpatient Services Utilizations for Medicaid AE Populations with BH Diagnosis		No data	Among Medicaid AE eligible populations, those with a BH diagnosis (non-complex) are 2.4x more likely to use the ED and 6.7x more likely to utilize inpatient services when compared to those without a BH diagnosis. Complex BH program participants are 4.4x more likely to use the ED and 19.9x more likely to utilize inpatient services compared to those without a BH diagnosis.
Service Utilization for Populations with a Primary SUD Diagnosis		No data	Service utilization among populations with a primary SUD diagnosis has recently experienced modern declines in commercial/Medicare populations (-5% per year) and modest increases in the Medicaid populations (+5% per year).
Service Utilization for Populations with a Primary MH Diagnosis		No data	Service utilization among populations with a primary MH diagnosis has recently experienced modest declines in commercial/Medicare populations (-3% per year) and modest increases in the Medicaid populations (+2% per year).

*Data obtained from the All Payer Claims Database and Medicaid are largely incomplete for race, ethnicity, and language.

"Health of RI's Behavioral Health System": Core Indicators of Capacity & Cost

Legend
Data suggests significant system concern, including outcomes are worse for RI than regional/national benchmarks, and outcomes are worse for non-white individuals
Data suggests moderate system concern, including that outcomes are better for RI than neighbors, but still below ideal targets, and outcomes are better for non-white individuals, but still below ideal targets.
Data does not suggest system concern; ideal state for indicator is achieved.

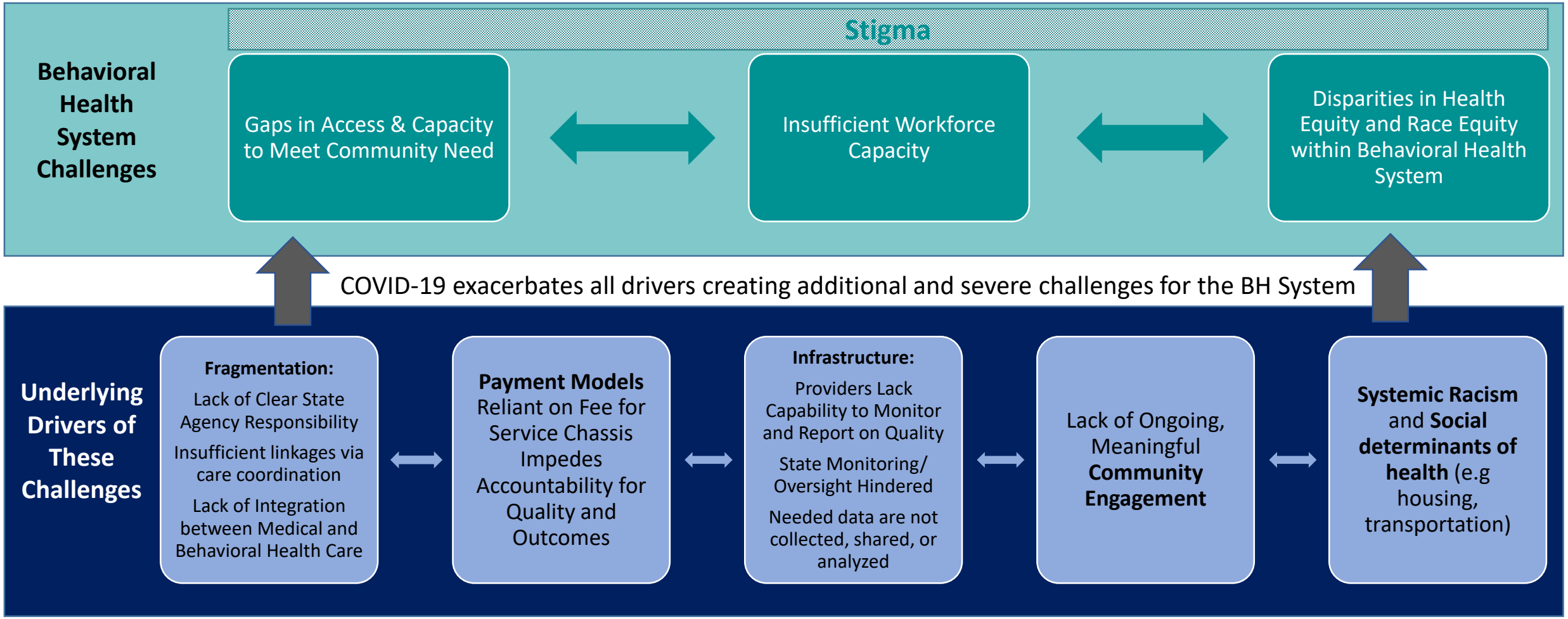
Findings for each core indicator are summarized below. Section 3 provides detailed data in aggregate and stratified by demographics, when available.

Core Indicators	Status Overall	*Race Equity Outcomes	Key Findings
Medicaid Expenditures for BH Services		No data	Medicaid expenditures on BH services has been relatively flat from SFY 2012-2017, at 8% of total expenditures.
Medicaid Expenditures for BH Services by Service Line		No data	Medicaid expenditures on BH services has been steadily shifting away from community-based services and toward inpatient services, as inpatient has increased from 29% to 41% of total expenditures from SFY 2012 - 2017.
AE Medicaid Managed Care Expenditures		No data	Within the Accountable Entity (AE) program, one third of Medicaid eligibles have a BH diagnosis and account for two thirds of total expenditures.
LTSS Users with BH Diagnosis		No data	Of those LTSS eligible users with a BH diagnosis, about half (49%) are receiving institutional services (either in a nursing home or public hospital), suggesting an opportunity to rebalance toward less-restrictive, lower-cost community-based settings.

*Data obtained from the All Payer Claims Database and Medicaid are largely incomplete for race, ethnicity, and language.

Problem Diagnosis: Underlying Drivers

Key themes have emerged from quantitative and qualitative research include challenges in the current behavioral health system, and underlying drivers of those challenges. Any policy solutions must address the underlying drivers, otherwise the challenges will persist.



Problem Diagnosis: Major Identified Gaps and Shortages in the Continuum of Care

Gap indicates that there was no evidence in our qualitative or quantitative analysis of the service existing in Rhode Island.
Shortage indicates that while some level of service exists it is not adequate to meet the need of Rhode Islanders with BH/SUD conditions.

Mental Health Services for Adults and Older Adults	Gaps	Mobile Crisis Treatment
	Significant Shortages	Community Step Down Hospital Diversion State Sponsored Institutional Services Nursing Home Residential
	Moderate Shortages	Non-CMHC Outpatient Providers Intensive Outpatient Programs Dual Diagnosis Treatment Crisis/Emergency Care Inpatient Treatment Home Care Homeless Outreach
	Slight Shortage	Licensed Community Mental Health Center tied to accessibility statewide
Substance Use Services for Adults and Older Adults	Gaps	Mobile MAT
	Significant Shortages	Indicated Prevention Correctional SUD Transitional Services Recovery Housing Residential – High & Low Intensity*
	Moderate Shortages	Intensive Outpatient Services Supported Employment

*Between Aug -Dec 2020, between 55-108 people were waiting for residential services.
**Between May-Dec 2020, between 5-31 children and adolescents were waiting for residential svs.

Continuum of Care for BH for Children	Gaps	Community Step Down Transition Age Youth Services Residential Treatment for Eating Disorders**
	Significant Shortages	Universal BH Prevention Services Hospital Diversion State Sponsored Institutional Services Nursing Home Residential/Housing**
	Moderate Shortages	SUD Treatment Enhanced Outpatient Services Home and Community Based Services Mobile Crisis
	Slight Shortage	Emergency Services

Key Message: The gap in inpatient/acute services appears to driven by the lack of crisis intervention and community wrap around support and prevention. Our recommendation is *not* to build additional inpatient capacity, rather to invest resources in better community support to alleviate the bottleneck for the existing inpatient beds.

System Concern Due to Gaps
1. Access to children's BH services is significant challenge for RI families, and for RI providers trying to match treatment level need with available capacity.
2. RI'ers often struggle to access residential and hospital levels of care for mental health and substance use.
3. Capacity and access to prescribers within behavioral health treatment services is mixed.
4. Crisis services are difficult to access.
5. Access to counseling and other professional services in the community is mixed.
6. Access to prevention services is inconsistent and under-funded.

Documentation of qualitative and/or quantitative findings related to gaps and shortages are available in Section 4 of this report.

Foundational Services That Rhode Island Can Build on to Address Gaps and Shortages

- Several services within Adult Mental Health, Adult Substance Use Disorder, and Children's Behavioral Health System Service in the continuum were noted as adequate or sufficient and can be built on to address the identified gaps and shortages; however:
  - Stakeholder feedback that the experience in the community in accessing these services and their sufficiency are directly impacted by payment challenges, quality, staffing, location, and equity in access. We have noted several of these concerns as principles that must be woven into reforms and improvements across the continuum to ensure access across the system is addressed.

- Examples of areas where Rhode Island has made significant strides in recent years in improving the state's behavioral health system include:
  - primary care/behavioral health integration,
  - substance use disorder programming in correctional settings, and
  - improvements in screening and early detection.

- *There were also several services that were included in our analysis across the comprehensive service array throughout the adult and children's continuum that were queried and assessed and were evaluated as adequate compared to the severe shortages and gaps listed on slide 10. It is not our intention to suggest that these services are not in need of improvement or that individuals in RI do not experience challenges in accessing those services.*

Priority Policy Options: Informed by Best Practices

National Model

Section 5:
- Trauma Informed Systems of Care
- Measurement Based Care
- Statewide Screening Assessments and LOC Standards for SUD

Additional Models in Appendix:
- *Integrated Care and Psychiatric Collaborative Care Model (CoCM)*
- *Interventions for SUD in Emergency Departments*
- *Practice Coaching for MAT*
- *BH Workforce Extenders*

State Model

Section 5:
- Certified Community Behavioral Health Organizations– Missouri
- Behavioral Health Integrated Practice Associations (IPAs)
- Pathways Community Hub – Ohio
- Centralized State Agency Oversight – Arizona and Colorado

Additional Models in Appendix:
- *Integrated Managed Care and Integrated Care Network –Washington*
- *Behavioral Health Community Partners – Massachusetts*
- *Center of Treatment Innovation- New York*

Specialty Models

Additional Models in Appendix:
- *Intensive Care Coordination for Youth – Massachusetts*
- *Crisis Stabilization for Youth – Massachusetts*
- *Healthy IDEAS – Connecticut, Massachusetts, New York*
- *PEARLS – New York, Illinois*
- *BRITE - Florida*
- *Mobile Outreach for Seniors – California, New York*
- *Community Reentry from Corrections for Individuals with BH*

Accountable Entities

Additional Models in Appendix:
- *Coordinated Care Organizations – Oregon*
- *Regional Accountable Entities – Colorado*
- *Accountable Communities of Health – Washington*

Other Models Identified by Stakeholders

- *Housing First*
- *Wrap Around Services – Milwaukee*
- *Social Worker Licensure Exemption – Texas*
- *System of Care for Children – New Jersey*
- *One Family One Plan – San Francisco*
- *Hub and Spoke Model - Vermont*

Priority Policy Options: Consider and Leverage Lessons Learned From Existing Investments

BH Link and KidsLink	•**BH Link:** crisis triage center located in East Providence; provides 24/7 hotline + community-based walk-in/drop-off facility for adults experiencing BH crises •**KidsLink**: 24/7 BH triage service/referral network for children
Health Equity Zones (HEZ)	•Founded/coordinated by RIDOH to address SDOH via community-led Health Equity Zones across the state; HEZs link the community to clinical infrastructures and promote place-based strategies to eliminate health disparities
Office of the Health Insurance Commissioner (OHIC)	•**Affordability Standards**: Successful regulatory tool to transform primary care in Rhode Island that can be built upon for a multi-payer transformation of BH •**Market Conduct Examinations (MCEs):** help eliminate disparities between physical and behavioral health care/enforce parity laws •**Care Transformation Plan (CTP):** improve access to BH services
Health System Transformation Program (HSTP) and Medicaid Accountable Entities	•**HSTP**: Partnership between Medicaid/EOHHS and higher education; $129 million over 5 years, allowing for investment in infrastructure toward APMs •Medicaid Accountable Entities: focus on integrated BH/primary care and care coordination to improve outcomes and reduce TCOC
Integrated Health Homes (IHH)/ Assertive Community Treatment (ACT) moved into Medicaid Managed Care	•**IHH**: coordinates services for people with severe mental illness via team-based care, coordinate medical/BH care •**ACT**: multidisciplinary staff work to provide psychiatric treatment, rehab, and support in community settings for people with severe mental illness
Opioid Treatment Program (OTP) Health Homes moved into Medicaid Managed Care	•**OTP:** coordinates care for people with opioid dependence disorder who have/are at risk for another chronic condition; builds linkages to BH providers/PCPs/specialty care/community supports
Family Care Community Partnerships (FCCPs)	•**FCCP**s: DCYF's primary prevention resources; pairs families with CBOs to support children with BH diagnosis through assessment, linkages to community resources, wraparound services and interventions
Local Prevention Coalitions	•Local Prevention Coalitions act as community-focused SUD prevention resources with a range of community-based prevention activities.
Community Based Organizations	•Several CBOs provide critical mental health outpatient services to both adults and largely to children. Many partner with school districts and other community resources under grant funded initiatives.
RIDE Investments	•Currently $22 million in federal grants to support school climate and increase behavioral health capacity at schools. Capacity includes both school employed and community based services connected to schools.
State Innovation Model (SIM) Test Grant Initiatives	•**Pediatric Psychiatry Resource Network (PediPRN):** pediatric BH consultation team to provide same-day case consults to PPCPs (RIDOH via HRSA grant) •**Screening, Brief Intervention, and Referral to Treatment (SBIRT)**: increase screening in primary care, ED, community, corrections (BHDDH via CTC) •**Integrated Behavioral Health (IBH):** conduct universal screening for BH in primary care practices, support BH care coordination •**Community Health Teams (CHTs)**: reduce substance, opioid, and high-risk alcohol use and reduce utilization via CHWs BH clinicians, supported by Medicaid •**Behavioral Health Workforce Development Project**: improve BH provider capacity, recruit/onboard new staff, create a pipeline for a more diverse BH workforce •**Culturally and Linguistically Appropriate BH Services**: workforce development/job training, train in BH •**PCMH-Kids:** extend primary care transformation to children

Principles To Drive and Prioritize Policy Options

1. **Service delivery should align with community need, grounded in health equity and racial equity:** All systems over the full lifespan should be person-centered and trauma-informed. Providers should meet people where they are and be accessible to all. Access should be streamlined, people should be clear about their options for where to receive care, and people should be able to get their needs met through one comprehensive service from the provider of their choice. Data should be shared across service providers to maximize treatment outcomes while protecting confidentiality. Prioritize pathways of care over episodes of care, integrated across medical and behavioral health care services.

2. **Solutions should actively address systemic racism** as an underlying driver of challenges that manifest with the behavioral health system today.

3. **Prevention is better than treatment. Recovery is possible for everyone.** Investments in prevention are a priority. All services should be part of a recovery-oriented system of care.

4. **Invest in sustainable solutions**, including housing, workforce extenders and data capture, analysis, and sharing infrastructure.

5. **Payment:** Payment should drive to outcomes and access to the right care at the right time. Payment and outcomes should be tied together. Payments should be sufficient to sustain workforce, ensure access to services, and make certain practitioners can practice at the top of their license.

6. **Accountability**: For every person with a BH condition, there should be one provider accountable and one state agency accountable for outcomes, while engaging sister agencies to collaborate as appropriate.

7. **Regulatory Oversight:** Right-size regulatory requirements to ensure regulations tie to meaningful client outcomes and accountability. If a current regulation doesn't directly tie to outcomes or accountability, phase it out. Shift from process to outcome management.

8. **Leverage the existing foundation:** Establish infrastructure efficiently by building on Rhode Island's starting point in a manner consistent with RI's size and scale. Any services created to fill the gaps in existing care continuum should be created in the context of a strategic plan for a full continuum of care.

9. **Standardization:** Screening should be universal and frequent; assessments should be standardized utilizing specific tools. Assessment results should track to equitable referrals for services across the continuum of care (risk stratification). Consistent quality measures should be selected and reported by all providers and tied to payment.

Priority Policy Options

We have identified two priority policy options that appear to best: (1) address system gaps and challenges identified in our analyses; (2) consider and leverage lessons learned from existing investments; and (3) align with the prioritization principles

1. Develop a state-specific model design for a statewide RI Certified Community Behavioral Health Clinic (CCBHC) program

Defined federally by the Excellence in Mental Health Act, CCBHCs are designed to provide a comprehensive range of mental health and substance use disorder services, particularly to vulnerable individuals with the most complex needs, throughout the life cycle. States must certify that each CCBHC offers the following services:

- Crisis mental health services including 24-hour mobile crisis teams, emergency crisis intervention and crisis stabilization
- Screening assessment and diagnosis including risk management
- Patient centered treatment planning
- Outpatient mental health and substance use services
- Primary care screening and monitoring
- Targeted case management
- Psychiatric rehabilitation services
- Peer support, counseling services, and family support services
- Connections with other providers and systems (criminal justice, foster care, developmentally disabled providers, child welfare, education, primary care, hospitals, etc.)

2. Design a Single Statewide Mobile Mental Health Crisis System, as a central part of CCBHC

Mobile Crisis is a mental health service which provides the community with immediate response emergency mental health evaluations. Evaluations can be requested by hospital emergency rooms, community providers, families, jails, nursing homes, police, or EMS. These services are available on a 24-hour basis and would be provided statewide through a central deployment vehicle.

Priority Policy Options: The Value Proposition for CCBHC and Mobile Crisis Proposals

Many of the gaps identified in this study could be addressed by a statewide Certified Community Behavioral Health Clinic (CCBHC) model

Gaps Identified

1. Insufficient workforce capacity
2. Disparities in health and racial equity
3. Lack of direct connection between payments and quality outcomes
4. Fragmentation of BH services for RI families**,** with problematic division of child and adult BH services
5. Growing SUD problem
6. Lack of comprehensive statewide mobile crisis services *(addressed in separate section)*
7. Minimal availability of co-located, integrated MH and SUD services to more effectively treat individuals with co-occurring MH/SUD disorders.
8. BH-related medical overutilization
9. Lack of community engagement

Goals Addressed by CCBHC Model

a) Maximize federal support in the form of matching funds and other revenue opportunities.

b) Expanded access to assessment, treatment, and referral

c) Focus on equity issues

d) Application of evidence-based, trauma informed, and measurement-based care (foundations for VBP)

e) Coverage throughout the state for all ages

f) Emphasis on MH/SUD care in one location

g) Required 24/7 mobile crisis services

h) Focus on community-based intervention

i) Coordination for all communities accessing the BH system, including the I/DD community

CCBHC Service Delivery Model

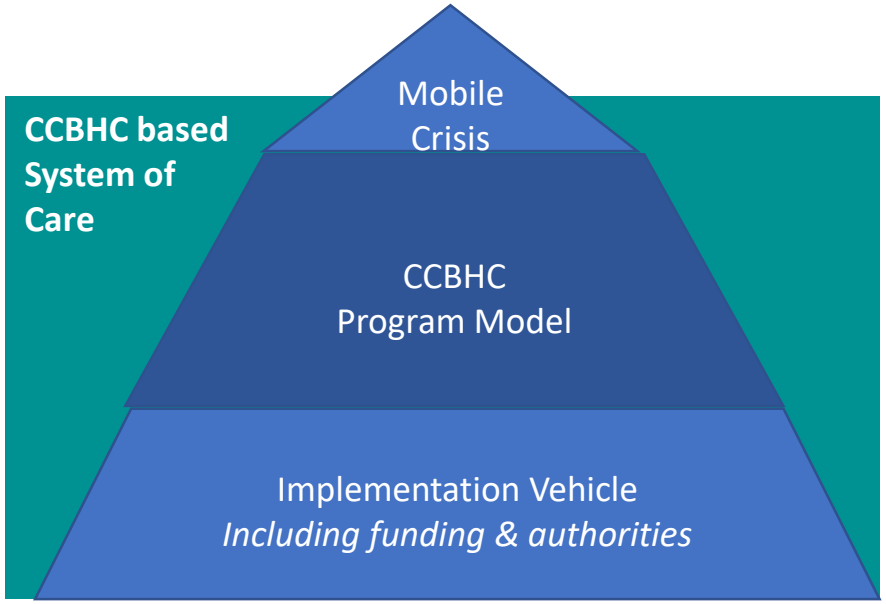
- Serves as an **entry point** for timely, high-quality mental health and SUD treatment across the continuum
- Provides **extended hours** (24/7/365)
- Provides care **across the lifecycle** for all ages (children, adults, and older adults), including:
  - Crisis stabilization for youth as well as adults
  - Drop offs from local law enforcement
  - Telehealth
- Includes MOUs for **community partnerships**
- **Competency** (language and cultural) for highest need, most disenfranchised communities
- Provide **engagement and care coordination**
- Supports the move **toward value-based payment**

Detail of Two Synergistic Policies

To address problems diagnosed through gap analysis with policy solutions that most closely align with the state's principles, team recommends further exploring the following policies via implementation plan development. **These policies are not necessarily stand-alone independent options, but rather mutually reinforcing to address RI's challenges in BH system**:

1. Design a Single Statewide Mobile Mental Health Crisis System as central part of CCBHC

- Prioritize critical capacity gap identified in Task 1 AND Enable the efficient implementation of CCBHC.
- Reduce need to transport individuals in crisis to inpatient settings of care.
- Integrate the implementation plan with existing efforts to reform the children's mental health system and other BHDDH initiatives in this area.



2. Program Model Design for CCBHC

Develop a state-specific program model design for a statewide RI CCBHC program.

- RI-specific program model designed to provide comprehensive mental health and substance use disorder services to vulnerable individuals throughout the life cycle.
- Plan will incorporate an approach to payment for outcomes for CCBHC participants.
- Include base requirements (to the extent applicable) and any mods/ additions determined necessary to address RI's unique needs.
- Include programmatic design - required staffing, governance, care coordination, integration elements.

Supporting Implementation Vehicle – Funding and Authorities

Determine the best policy vehicle(s) for implementation and associated funding mechanisms.

- Include options for leveraging federal support/participation and approaches to state financing.
- Plan for multiple funding streams and implementation approaches, including both short and long-term financing options and phased implementation model.
- Include specific agency grants, congressional appropriations, state plan amendment, waiver options, and demonstration programs. Explore requirements and timing for various funding options.
- Will explore funding for upfront & ongoing CCBHC support for state, plan, and provider partners, including infrastructure investments.

Additional Opportunities Identified in Stakeholder Interviews

Several additional opportunities that represented smaller, easier-to implement improvements were identified by stakeholders and should be considered by Rhode Island government as ways of improving access and quality of BH services.

Regulatory Flexibilities:

- Several stakeholders indicated that regulations and licensure requirements outsize the funding/payment tied to BH services in Rhode Island and recommended a "rightsizing" effort to ensure the field of BH remains attractive and viable in the State.
- Corrections settings leverage transitional care units (TCUs) to assist in the stepdown of individuals who are experiencing acute mental illness. Providers outside the correctional setting recognized the benefit of having this flexibility to ensure appropriate, supported treatment for individuals with acute BH conditions. Flexibilities granted as a result of the pandemic support the use of flex units. Many stakeholders would like to see these flexibilities made permanent and the implementation of TCUs to assist in BH management.
- Relatedly, facilities would like to leverage and expand the ability to "switch" bed capacity based on surge demand for certain services (particularly recommended in a children's context).
- Additionally, many stakeholders indicated they would like to see allowances and flexibilities provided during the COVID-19 pandemic, including telehealth reimbursement, made permanent.

Licensing/Workforce:

- Licensing reciprocity, particularly with neighboring states such as Massachusetts and Connecticut, was identified as a way of providing workforce flexibility.
- Recommendation that the Rhode Island Social Worker licensing exam should be offered in languages other than English.
- Rhode Island needs to identify more places for training/mentoring that are accepting/friendly to non-white providers with different lived experience.
- Student Loan repayment for particular needs in BH (bachelor's level counselors, LPNs) that are currently excluded from repayment programs and the easing of requirements of existing student loan repayment programs.

Emergency Services and Correctional Recommendations:

- To ensure better transitions of care, there should be flexibility in setting the release date from correctional/residential settings to ensure linkage to care can be made before Friday-Sunday.
- To support meaningful community diversion, the state should develop reimbursement for ambulances when hospital is not destination.

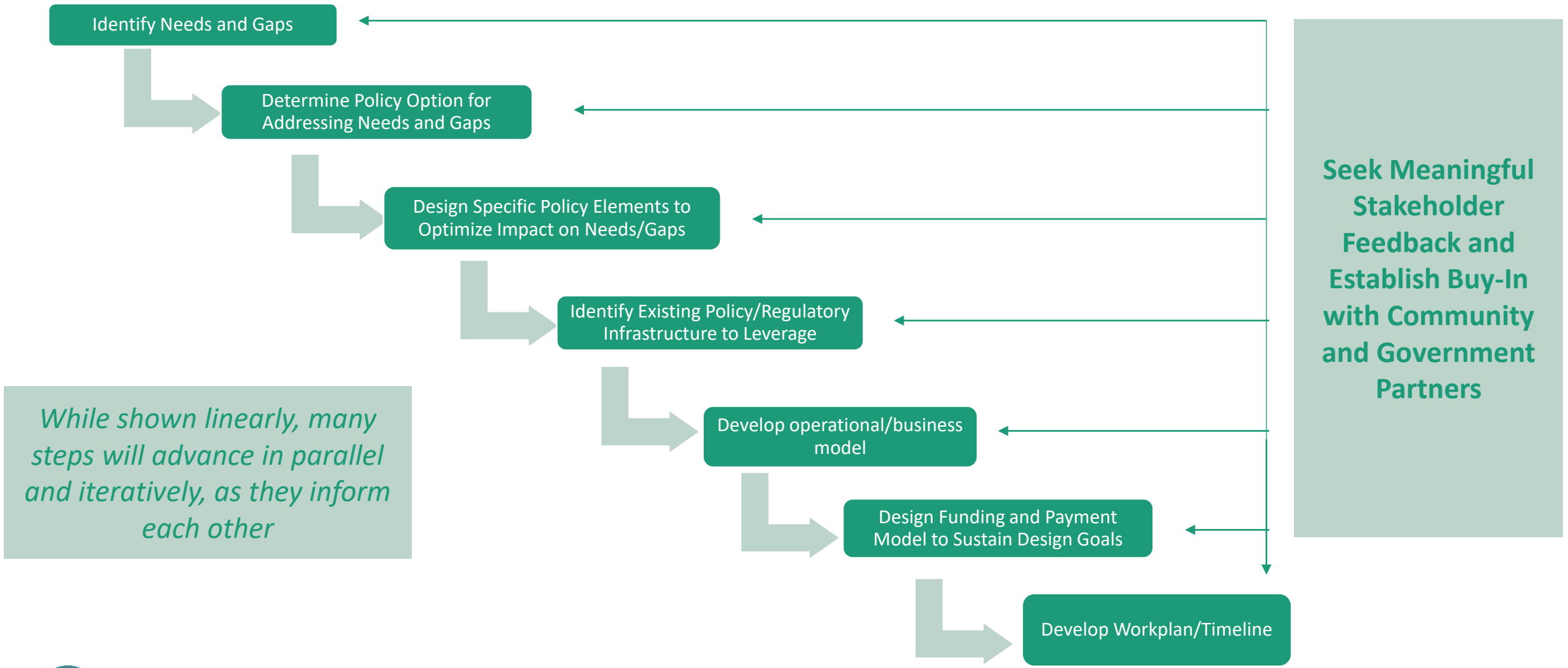
KidsLink:

- There is a need for more education and training to gain buy-in and endorsement of KidsLink to ensure referrals meaningful in terms of hand off for service.
- Need to extend KidsLink triage functionality to additional communities.
- KidsLink needs additional interpreter services for non-English speakers.
- There are gaps between KidsLink and suicide prevention work at CMHCs (and other program offerings)
- There was feedback about the possible expansion of KidsLink/BH Link to more communities in RI. In addition, stakeholders felt there was important infrastructure in both KidsLink and BH Link on which to build for needed programming, such as mobile crisis intervention.

Consumer Engagement:

- BHDDH should create a Consumer Affairs Office to improve consumer engagement and address concerns from consumers interacting with RI's BH system

Approach to Implementation Plans



While shown linearly, many steps will advance in parallel and iteratively, as they inform each other

CCBHC Implementation Plans: Key Elements

Priority Policy Option 1:
State-specific model design for a Statewide RI CCBHC

I. Statement of Need: Identified Gap
- Why CCBHC
- National Evidence
- Other State Action

II. CCBHC Program Model Considerations
- Approach to Development
- National Program Model Overview (Starting Point)
- Rhode Island Specific Model Considerations

III. CCBHC Operational Model Considerations
- Participants
- Administrative oversight
- Data and Metrics
- Performance Specifications

IV. Leveraging Existing RI Programs/Projects
- Starting Point: Current CCBHCs, CMHOs, and AEs
- Additional RI Programs/Projects
- Current Medicaid Covered Services

V. Generating Community Stakeholder Buy-In
- Approach to Stakeholder Input
- Key Participants and Activities

VI. Authorities
- Two Options: SPA, 1115 Waiver
- Other State Approaches
- Process & Timeline

VIIa. Payment Model: Case Studies
- State Defined CCBHCS Payment Model - Texas
- Federal PPS Model

VIIb. Payment Model: Rhode Island Options
- Payment Model Goals and Principles
- Three model options, considerations & assessment

VIII. Potential Federal Sources of Revenue

IX. Workplan/Timeline

Appendix:
- **CCBHC Program Model**
  - Service Requirements Detail
  - Organizational Requirements Detail
- **Other State CCBHC Implementation Case Studies**

Mobile Crisis Implementation Plans: Key Elements

Priority Policy Option 2:
State-specific model design for a Statewide RI Mobile Crisis System

I. Statement of Need: Identified Gap
- Why Mobile Crisis Services
- National Evidence
- Other State Action

II. Mobile Crisis Services Program Model Considerations
- Approach to Development
- National Program Model Overview (Starting Point)
- Rhode Island Specific Model Considerations

III. Mobile Crisis Services Operational Model Considerations
- Participants
- Administrative oversight
- Data and Metrics
- Performance Specifications

IV. Leveraging Existing RI Programs/Projects
- Starting Point: Current Mobile Crisis Services , CMHOs, and AEs
- Additional RI Programs/Projects
- Current Medicaid Covered Services

V. Generating Community Stakeholder Buy-In (*Slides 20)*
- Approach to Stakeholder Input
- Key Participants and Activities

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- Other State Approaches
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VIIa. Payment Model: Case Studies *(Slides 23-26)*
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- Federal PPS Model

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VIII. Potential Federal Sources of Revenue (*Slides 30)*

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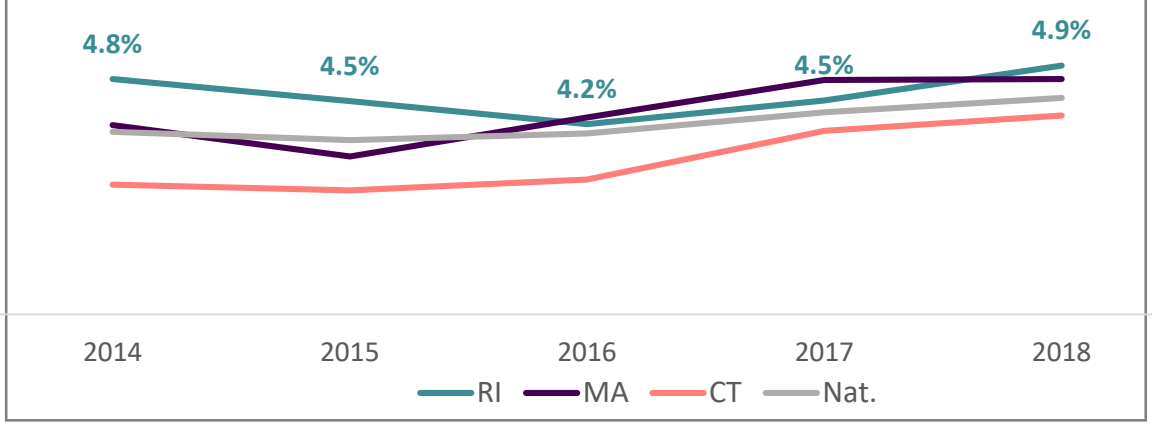
Rhode Island's prevalence of mental illness has not changed significantly over the past 5 years.

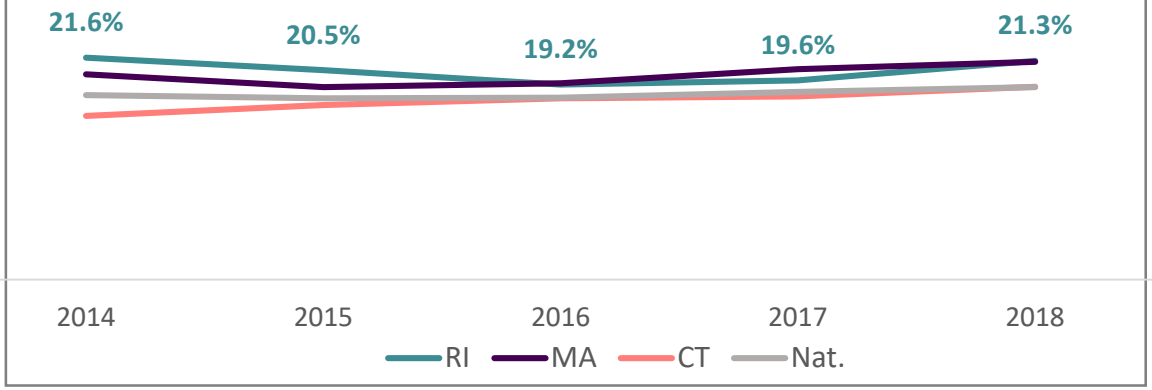
Percent of Individuals who Reported Experiencing a Serious Mental Illness in the Past Year, by State, 2014-2018[1]



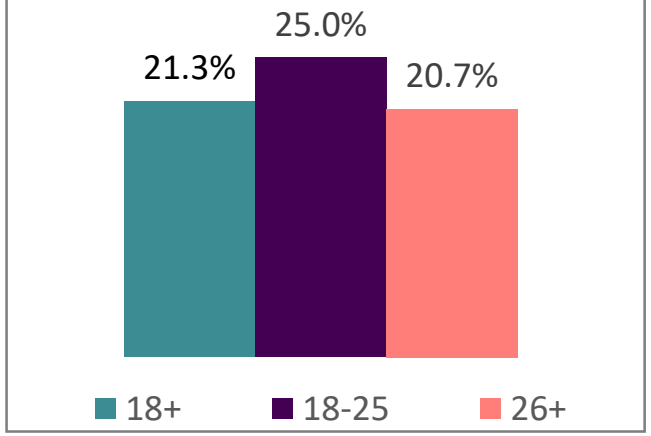
Key Takeaways:

- Consistent with regional and national benchmarks, Rhode Island has seen similar levels of prevalence of individuals with serious mental illness and individuals with any mental illness as Massachusetts, Connecticut and and the US overall.
- Young adults (age 18-25) have a higher prevalence of serious mental illness as well as any mental illness than other age groups in Rhode Island.
- Likely to see increased mental illness incidence and prevalence in 2020 due to COVID.
- From a survey of the impact of COVID-19 on adults aged 30-80, there was a nearly 1 day increase in "alcohol consumption over the past month" from June 2019 to June 2020[2].

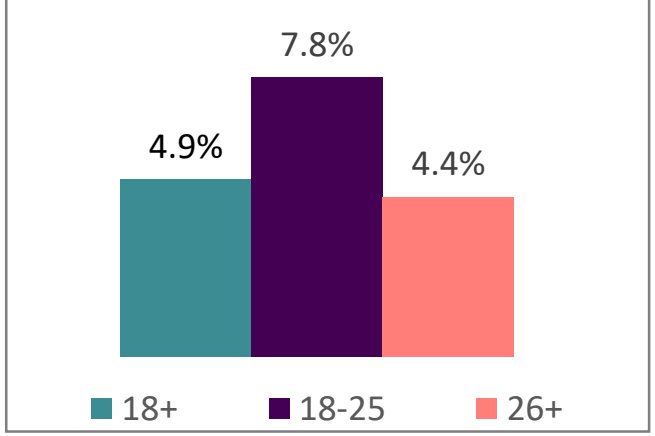
Percent of Individuals who Reported Experiencing Any Mental Illness in the Past Year, by State, 2014-2018[1]



% of Individuals with Any Mental Illness, by Age, RI, 2018[1]



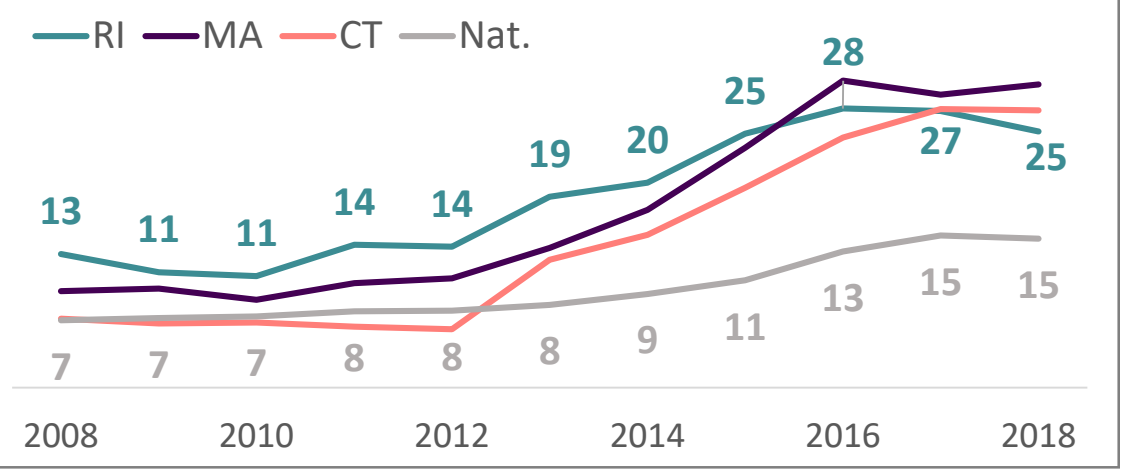
% of Individuals with Serious Mental Illness, by Age, RI, 2018[1]



Source 1: National Survey on Drug Use and Health: Model-Based Prevalence Estimates, SAMHSA, https://pdas.samhsa.gov/saes/state
Note: Serious Mental Illness (SMI) aligns with DSM-IV criteria and is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. Estimates of SMI are a subset of estimates of any mental illness (AMI) because SMI is limited to persons with AMI that resulted in serious functional impairment. These mental illness estimates are based on a predictive model and are not direct measures of diagnostic status.
Source 2: JAMA Network Open, Changes in Adult Alcohol Use and Consequences During the COVID-19 Pandemic in the US

Rhode Island's prevalence of overdoses and deaths due to substance use, especially from opioid usage, has increased problematically over the past 10 years.

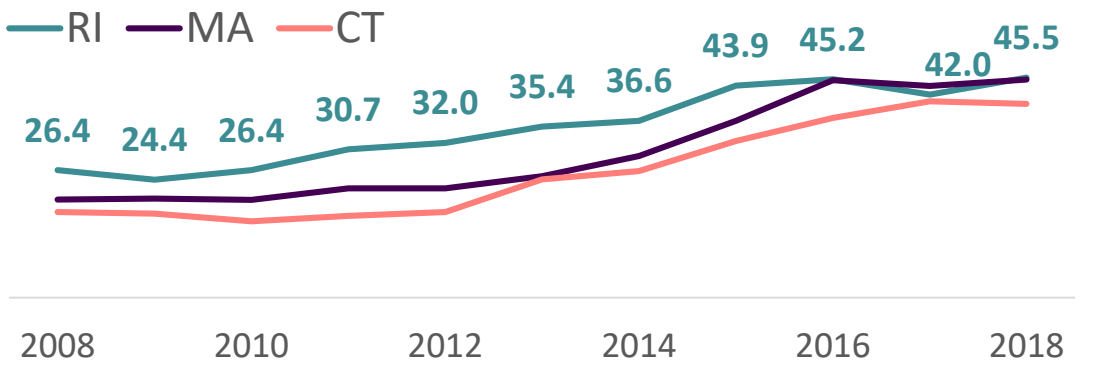
Opioid Overdose Deaths per 100,000 People, 2008-2018[1,N]



Key Takeaways:

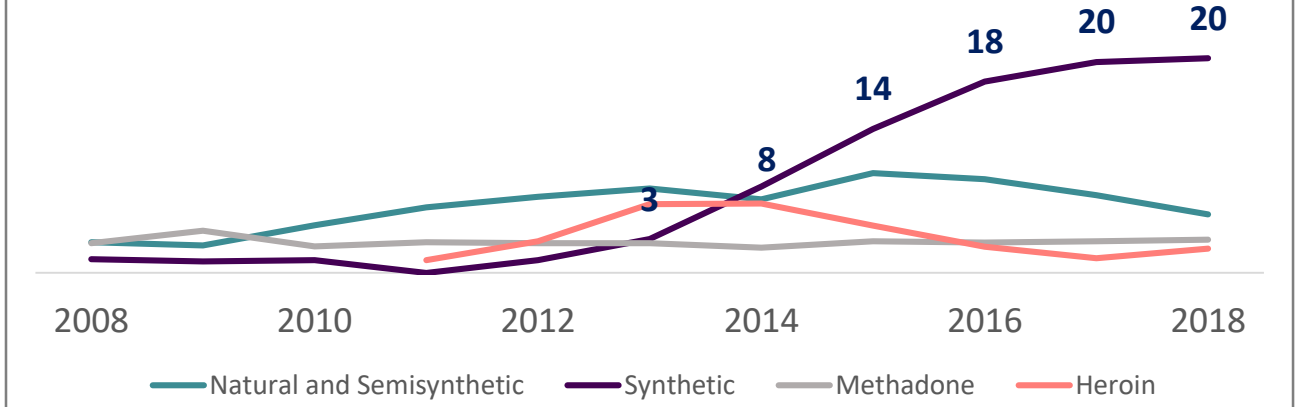
- The number of opioid overdose deaths in RI has increased nearly 2x since 2008; RI's rate of opioid overdose deaths in 2018 is 1.6x that of the national average.
- Alcohol or drug-related death rates in RI were higher than in MA and CT until 2016. In RI, rates have increased by 70% since 2008.
- Synthetic opioid overdoses (such as fentanyl) have accounted for most of the opioid-related deaths since 2014 and have increased 2.5x since 2014.
- EOHHS's December 2020 presentation to the Governor's Overdose Task Force found that: "Recovery is fragile for anyone, at any time - but fentanyl, COVID anxiety and isolation, discrimination and disparities, as well as institutional mistrust are devastating to those finding their way."

Alcohol- or Drug-Related Cause of Death per 100,000 People, 2008-2018[2]



Note: Excludes drug-related homicides.

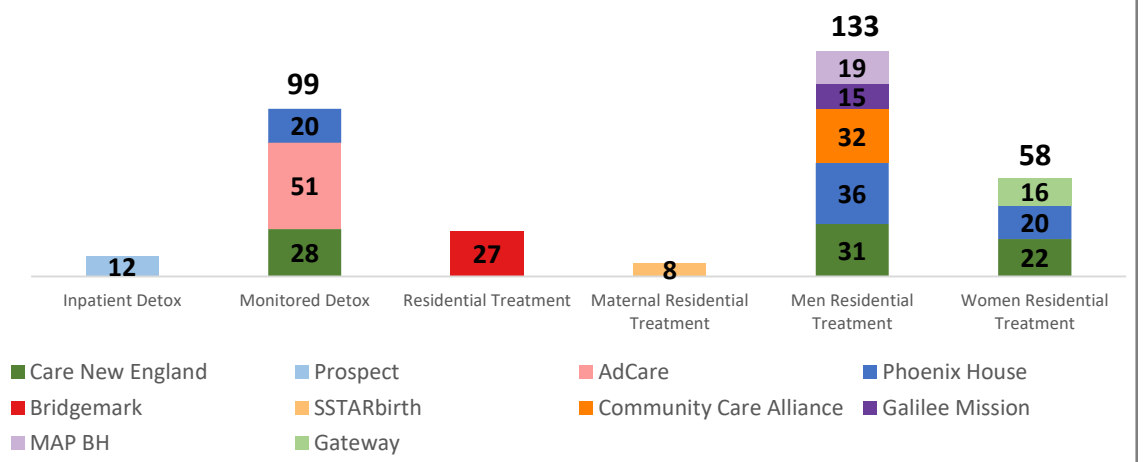
Opioid Overdose by Type of Opioid per 100,000 People Rhode Island, 2008-2018[3,N]



Source 1: State Health Facts, KFF, https://www.kff.org/other/state-indicator/opioid-overdose-deaths/
Source 2: Wide-ranging Online Data for Epidemiologic Research, CDC, https://wonder.cdc.gov/
Source 3: https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-type-of-opioid
Note: N superscript denotes that the data was normalized.

Starting Point: Rhode Island has 337 inpatient and residential beds for substance use, 434 beds for mental health, and 386 group home beds.

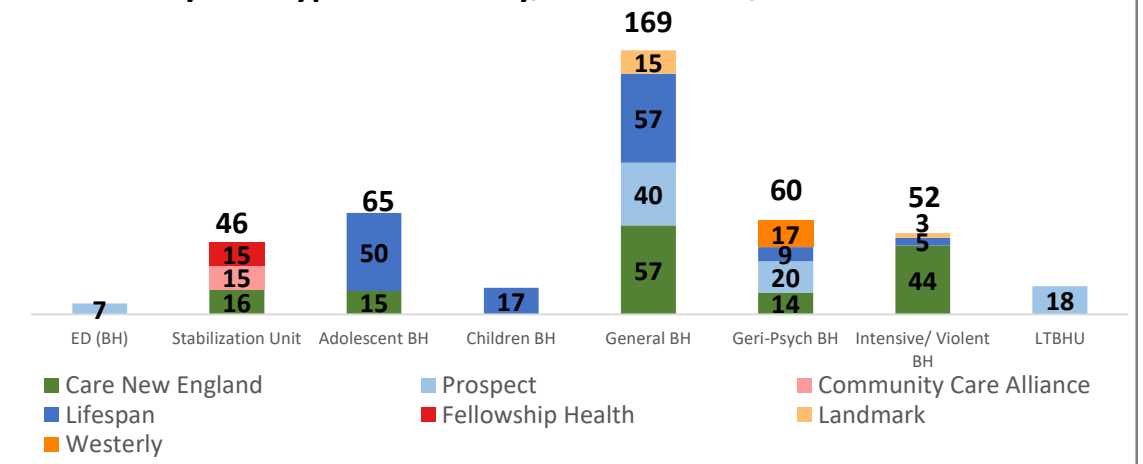
SUD Beds by Bed Type and Facility, Rhode Island, October 2020[1]



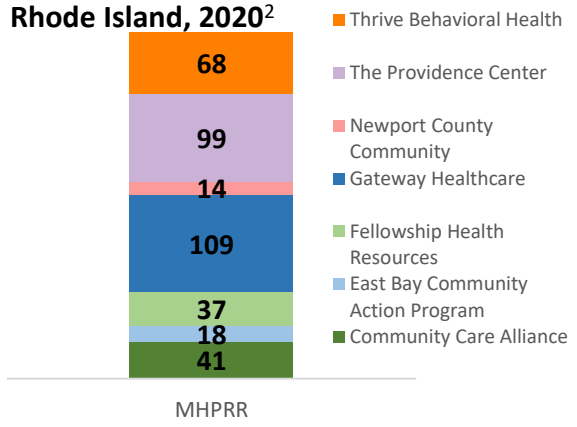
Key Takeaways:

- In Rhode Island, ten organizations have licensed substance use inpatient and residential beds and seven organizations have licensed mental health beds.
- Rhode Island's hospital systems comprise 32% of substance use and 93% of mental health beds.
- High demand for inpatient services/SUD and MH Beds may indicate a lack of available services in less restrictive, more appropriate lower levels of care.
- As a result of COVID, Rhode Island faces a current challenge of having sufficient medical ICU and hospital beds that are also acceptable for BH needs.
- RI has 40% more psychiatric beds per 100,000 people than MA, but only 75% of the beds in CT.

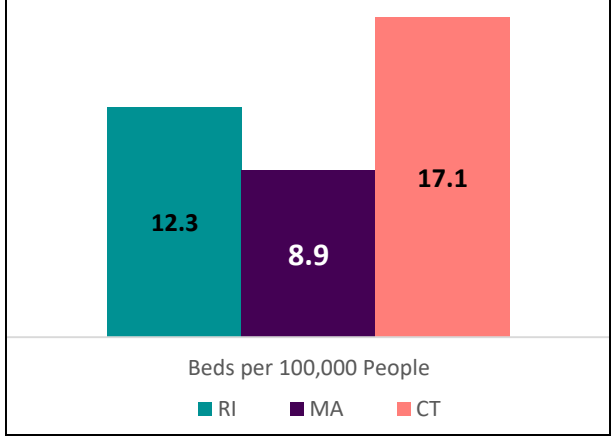
MH Beds by Bed Type and Facility, Rhode Island, October 2020[1]



Group Home [Mental Health Psychiatric Rehab Residences (MHPRR)] by Facility, Rhode Island, 2020[2]



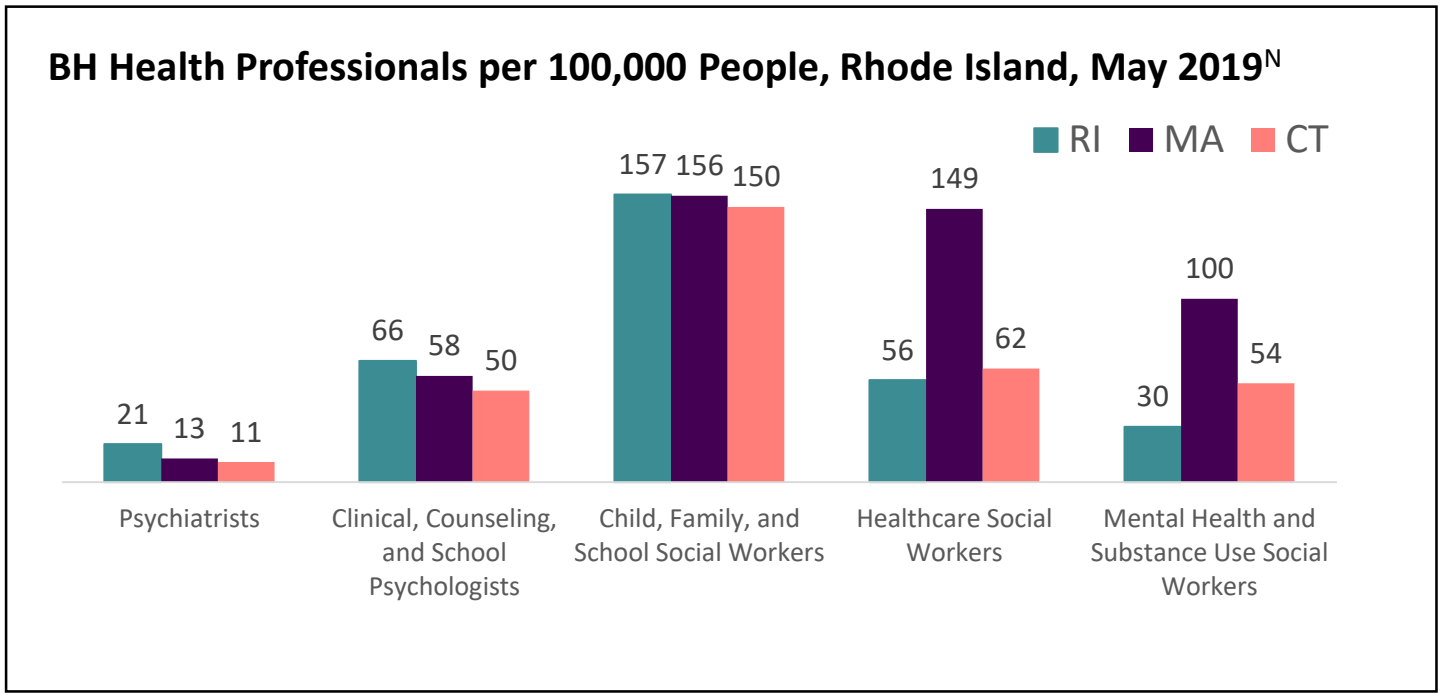
Public Psychiatric Beds per 100,000 People, 2016[3]



Source 1: https://www.ribhopenbeds.org/, data downloaded 10/1/2020
Note: Two locations (St. Mary's Home for Children and Caritas House) are not captured.
Source 2: MHPRR Providers and Bed Counts, BHDDH, data pull December 2020
Source 3: Treatment Advocacy Center, State-Specific Data, https://www.treatmentadvocacycenter.org/browse-by-state/

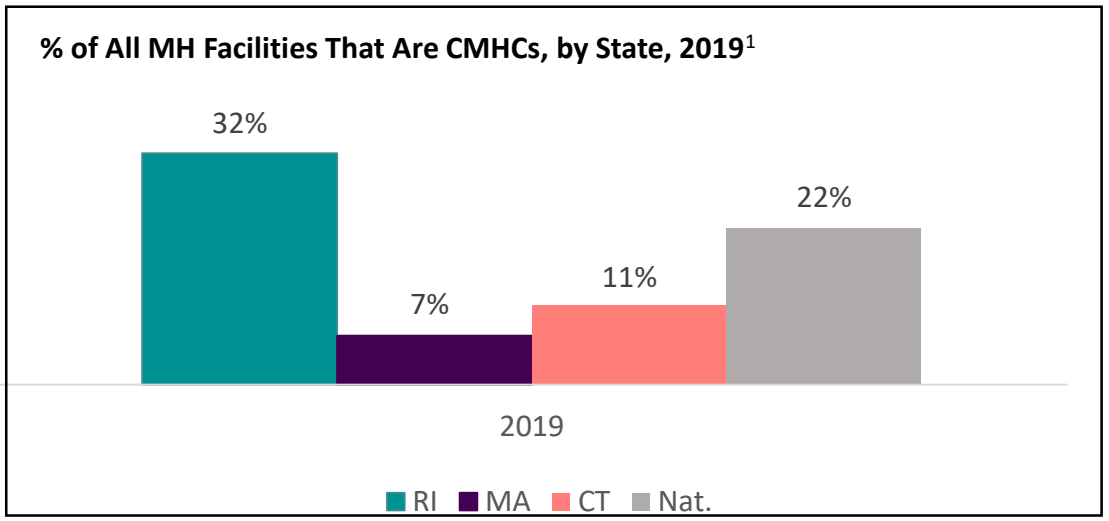
Rhode Island has 21 psychiatrists per 100,000 people, and 157 child, family and school social workers per 100,000 people.

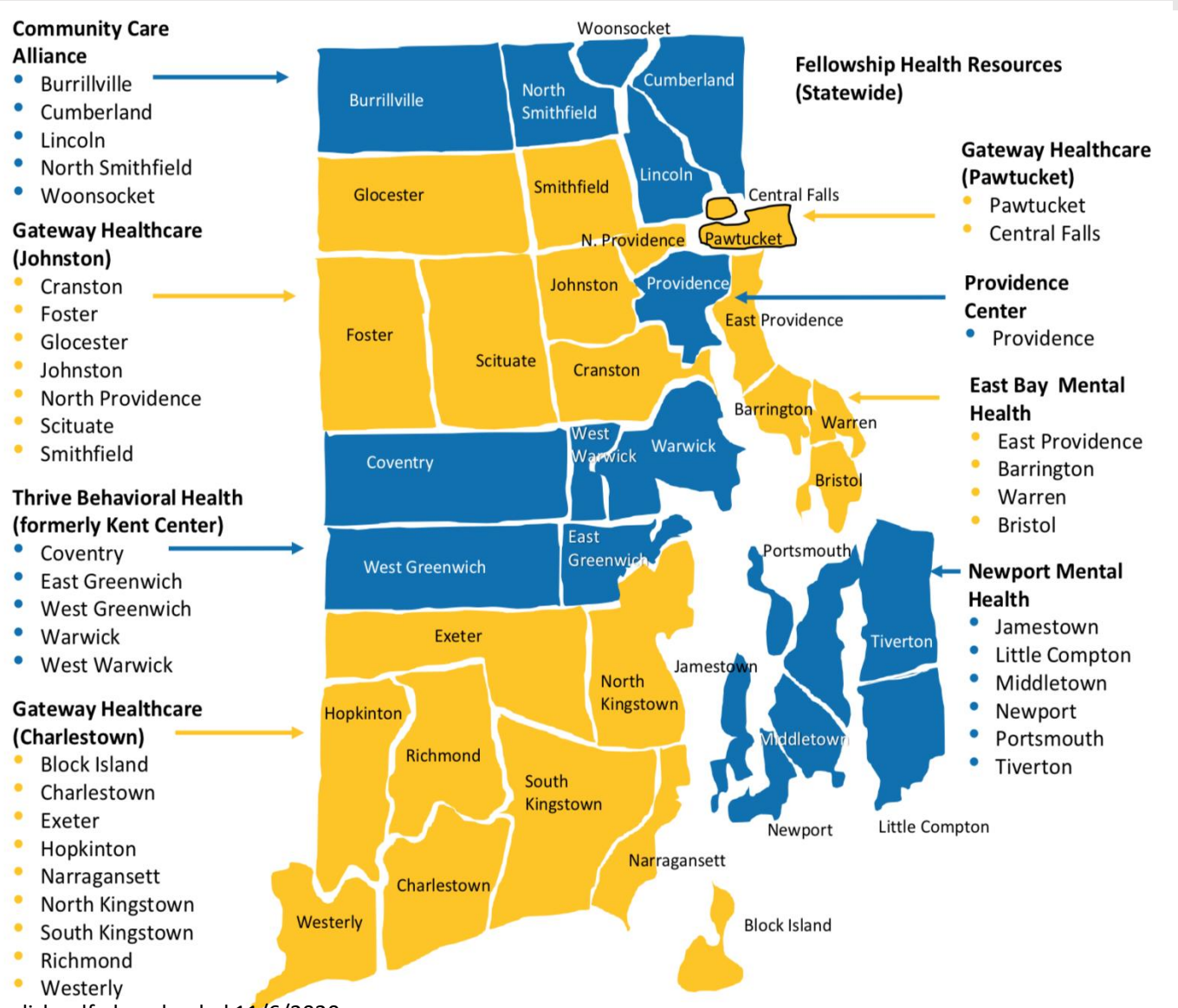
These data reflect Rhode Island's starting point for BH professionals (regional benchmarks for these professions are included in Section 4: Key Findings).



Note: Only active licenses counted. Population data taken from 2019 census . "N" superscript denotes that data was normalized based on US Census Population Data.
Source: https://www.bls.gov/oes/tables.htm

RI's BH system is heavily concentrated in the CMHC system.



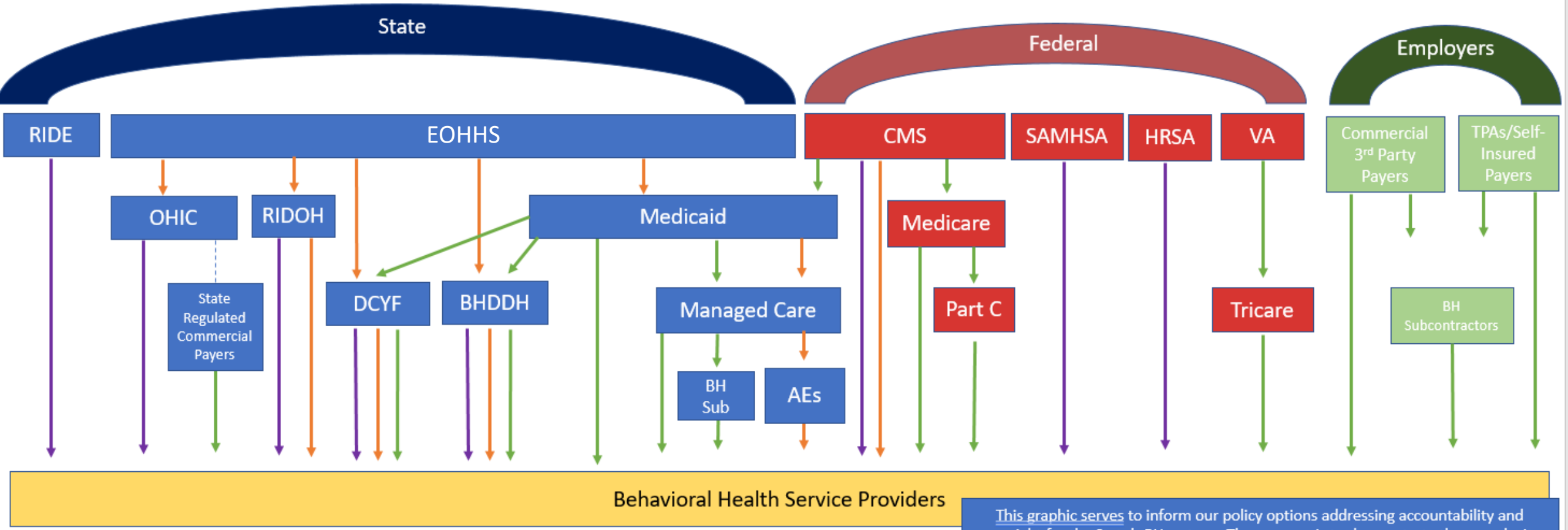


Source 1: https://bhddh.ri.gov/mh/pdf/CMHC%20Information_map_English.pdf; downloaded 11/6/2020
Source 2: SAMHSA, NMHSS, https://wwwdasis.samhsa.gov/dasis2/nmhss.htm, Table 4.2b
Source 3: RI Medicaid MMIS Data Extract, Jan 2020

Foundation: Payment System and Payment Models in Rhode Island

- **In 2016, Rhode Island's legislature moved funding for community behavioral health services from BHDDH to EOHHS/Medicaid to integrate within Rhode Island's Medicaid managed care program**.
- **Most behavioral health services are reimbursed on a fee-for-service basis through managed care plans.** Exceptions to fee-for-service based reimbursements include the Integrated Health Home program, the Opioid Treatment Program Health Home, Centers of Excellence, and Assertive Community Treatment.
- **Most of Rhode Island's payers subcontract administration of behavioral health benefits** to vendors such as Beacon Heath Options or Optum.
- **Work remains for Rhode Island's payers to meet required mental health parity rules.** Through Market Conduct Exams, where OHIC reviews plans' network adequacy and works with plans to ensure that prior authorization requirements and utilization reviews are not overly burdensome such that they impede achieving parity, OHIC found concerns with payer compliance with mental health parity. Improvements have been made since the start of the Market Conduct Exams.

Foundation: Behavioral health providers may have several different sources of funds for services from federal, state, and private payers.



Service Payments[1]

Program Appropriation[2]

Grant Funding

[1] Service Payments refer to traditional reimbursement via claims-based and/or service-based payments received as revenue by providers through a contractual agreement or participation in the Medicaid program.

[2] Program Appropriation refer to line-item budgetary appropriations dedicated at the program level or need category, received by providers through their licensure, other designation, or participation in a program separate from traditional reimbursement received from governmental or private payers.

[3] Each MCO has their own product lines that have different rules and in some cases co-pays which creates additional administrative burden for providers

This graphic serves to inform our policy options addressing accountability and oversight for the State's BH system. The purpose is to demonstrate the complexity of current funding and payment streams directed at BH providers across the state. The graphic does not intend to suggest that all BH providers equally rely on these various payment and funding streams to the same degree or level. It also important to note that each funding stream identified in the graphic typically bring their own outcome, quality, and regulatory reporting requirements which further increases complexity in the system.

FCG

HEALTH MANAGEMENT ASSOCIATES

Building From Recent Stakeholder Feedback

Much work has been done in recent years to both understand the gaps in Rhode Island's behavioral health system, as well as to address them. Before beginning our assessment, we reviewed source material from a wide range of diverse stakeholders to establish Rhode Island's starting point. Several key themes emerged from past stakeholder feedback, which guided our qualitative work.

Source Material:

- ✓Truven Report (2015)
- ✓EOHHS Healthcare Workforce Transformation Report (2017)
- ✓Report to Governor Gina M. Raimondo, Improving Behavioral Healthcare for Youth in Rhode Island (Response to EO 18-03, 2018)
- ✓Duals Demonstration Stakeholder Engagement (2019)
- ✓Exploring How the RI SIM Program Impacted the Quadruple Aim -- Provider Satisfaction Evaluation (2019)
- ✓OHIC Integrated Behavioral Health Work Group (2019)
- ✓Provider Capacity Building Initiative (2019)
- ✓Safety Net Financial Stabilization Work Group (2019)
- ✓Rhode Island Foundation Report (2020)
- ✓Miller Commission Testimony (2020)
- ✓Milliman Report, Behavioral Health Comparison Rate Development (2020)
- ✓HHS Reopening Planning – COVID-19 (2020)
- ✓EOHHS' presentation to the Governor's Opioid Taskforce (2020)

Stakeholders Captured:

- Providers – BH providers and PCPs
- Advocates
- State Officials
- Actuaries/Healthcare Consultants
- Researchers
- Health Plans
- Hospitals/ED

Summary of Findings from Past Stakeholder Engagement

These themes emerged from the analysis of previously documented stakeholder engagement, as described on the prior page:

Rates / Payment Models

- Payment models could be revised to reduce billing/administrative burdens on providers and to better incentivize referrals/BH and medical integration/care coordination
- According to BH providers, rates are too low/payments insufficient and providers are operating at a loss
- Financial stability of provider organizations a concern, exacerbated by COVID-19
- Many providers are highly sensitive to changes in billing cycles

Capacity / Workforce

- Workforce shortages have led to a lack of capacity to meet BH need; challenges with employee recruitment/retention have resulted in high turnover rates among BH providers
- A lack of qualified providers (particularly for community-based services/in assisted living and children/youth and geriatric providers)
- Shortage of linguistic and culturally competent providers to meet community needs; Black, Latinx, and Asian providers underrepresented

Accountability / Responsibility

- Need for greater coordination across state agencies (BHDDH, DCYF, Medicaid, OHIC, RIDOH) to align policy goals and resources
- Organizational accountability mix across state agencies not distributed in a manner that leads to optimal, cost-effective health outcomes
- Need to further emphasize data collection on quality and outcomes, as indicators of a well-functioning BH care delivery system

Care Coordination

- Care coordination resources may exist, but often there are duplicated care coordination efforts that may result in conflicting guidance to people receiving services
- A need for more effective care coordination and options counseling for clients; many still "fall through the cracks"

Integration between BH and Medical

- Lack of integration between BH/medical (especially among adults); many administrative, logistical, and billing/payment challenges with integration
- Success stories of BH/medical care and care coordination from SIM-funded initiatives (IBH, SBIRT, PCMH-Kids)
- Stigma associated with accessing behavioral health care remains an ongoing challenge

Health Equity

- Ensuring equitable access to BH care is a priority for the state
- Yet, disparities exist in both health outcomes and in access to BH care, by
  - Race/ethnicity
  - Age
  - Gender
  - LGBTQ+
  - Geography
- Shortage of linguistic and culturally competent providers to meet community need
- Health equity cross-cuts all other themes

Gaps in Services / Continuum of Care

- Lack of capacity for outpatient care and services in the community, which can lead to unnecessary utilization of more restrictive and more expensive levels of care (i.e. emergency department visits, inpatient care) and longer length of stay for inpatient care
- Need more investment in step-down services
- Need more investment in prevention/early intervention, especially for children – current system is much more reactive than proactive

COVID-19 has impacted all themes, especially on capacity/workforce.

Recent Investments and Innovations in Rhode Island

BH Link and KidsLink	•**BH Link:** crisis triage center located in East Providence; provides 24/7 hotline + community-based walk-in/drop-off facility for adults experiencing BH crises •**KidsLink**: 24/7 BH triage service/referral network for children
Health Equity Zones (HEZ)	•Founded/coordinated by RIDOH to address SDOH via community-led Health Equity Zones across the state; HEZs link the community to clinical infrastructures and promote place-based strategies to eliminate health disparities
Office of the Health Insurance Commissioner (OHIC)	•**Affordability Standards**: Successful regulatory tool to transform primary care in Rhode Island that can be built upon for a multi-payer transformation of BH •**Market Conduct Examinations (MCEs):** help eliminate disparities between physical and behavioral health care/enforce parity laws •**Care Transformation Plan (CTP):** improve access to BH services
Health System Transformation Program (HSTP) and Medicaid Accountable Entities	•**HSTP**: Partnership between Medicaid/EOHHS and higher education; $129 million over 5 years, allowing for investment in infrastructure toward APMs •Medicaid Accountable Entities: focus on integrated BH/primary care and care coordination to improve outcomes and reduce TCOC
Integrated Health Homes (IHH)/ Assertive Community Treatment (ACT) moved into Medicaid Managed Care	•**IHH**: coordinates services for people with severe mental illness via team-based care, coordinate medical/BH care •**ACT**: multidisciplinary staff work to provide psychiatric treatment, rehab, and support in community settings for people with severe mental illness
Opioid Treatment Program (OTP) Health Homes moved into Medicaid Managed Care	•**OTP:** coordinates care for people with opioid dependence disorder who have/are at risk for another chronic condition; builds linkages to BH providers/PCPs/specialty care/community supports
Family Care Community Partnerships (FCCPs)	•**FCCP**s: DCYF's primary prevention resources; pairs families with CBOs to support children with BH diagnosis through assessment, linkages to community resources, wraparound services and interventions
Local Prevention Coalitions	•Local Prevention Coalitions act as community-focused SUD prevention resources with a range of community-based prevention activities.
Community Based Organizations	•Several CBOs provide critical mental health outpatient services to both adults and largely to children. Many partner with school districts and other community resources under grant funded initiatives.
RIDE Investments	•Currently $22 million in federal grants to support school climate and increase behavioral health capacity at schools. Capacity includes both school employed and community based services connected to schools.
State Innovation Model (SIM) Test Grant Initiatives	•**Pediatric Psychiatry Resource Network (PediPRN):** pediatric BH consultation team to provide same-day case consults to PPCPs (RIDOH via HRSA grant) •**Screening, Brief Intervention, and Referral to Treatment (SBIRT)**: increase screening in primary care, ED, community, corrections (BHDDH via CTC) •**Integrated Behavioral Health (IBH):** conduct universal screening for BH in primary care practices, support BH care coordination •**Community Health Teams (CHTs)**: reduce substance, opioid, and high-risk alcohol use and reduce utilization via CHWs BH clinicians, supported by Medicaid •**Behavioral Health Workforce Development Project**: improve BH provider capacity, recruit/onboard new staff, create a pipeline for a more diverse BH workforce •**Culturally and Linguistically Appropriate BH Services**: workforce development/job training, train in BH •**PCMH-Kids:** extend primary care transformation to children

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"Health of Rhode Island's Behavioral Health System" – Core Indicators

To facilitate assessing gaps in RI's behavioral health system, one important step is to assess "core indicators" of how well components are functioning together as an overall system. The following categories of "core indicators" are included, citing the rationale for why each core indicator category is relevant to the Health of Rhode island's Behavioral Health System:

Core Indicator Category	Metrics	Rationale
Suicide Rate	(1) Suicide Deaths (2) Suicidal Ideation	High suicide rates and high suicidal ideation are indicators of a lack of access to appropriate care.[1]
Overdose Death Rate	(3) Drug Overdose Deaths (4) Overdoses due to Opioids (5) Alcohol- or Drug-Related Deaths	High overdose death rates are an indicator of a lack of access to appropriate prevention and harm reduction services and quality treatment and care. [1]
Rates of Substance Use	(6) Substance Use Rates (7) COVID-19 Impact on Alcohol Usage	Higher utilization rates indicate higher need for treatment supply and efficacy of prevention programs. [2]
Rate of Homelessness	(8) Homelessness	Higher rates of homelessness may indicate lack of access to appropriate care. [3]
Treatment volume in correctional settings	(9) Living Situation of Mental Health Consumers	High rates of behavioral health care provided in correctional settings may indicate lack of access to appropriate care in the community.[3]
Employment -- recovery/post-treatment	(10) MH Employment	Low employment rates among individuals in recovery or post-treatment may indicate a lack of access to appropriate community-based services and stigma associated with people with behavioral health diagnoses.[2]
Children & Families: Behavioral & emotional problems	(11) High Schoolers Who Felt Sad or Hopeless in the Past Year (12) High Schoolers who Use E-Vapor Products (13) Mental health indicators for adolescents	Higher rates of behavioral and emotional problems may indicate ineffective prevention and/or inadequate treatment resources. Higher juvenile justice involvement may indicate gaps in treatment system. [1]
Utilization of the Emergency Dept for Behavioral Health	(14) ED Utilization (15A & B) ED Follow-Up Rates for SUD and MH	Higher rates of utilization of ED for BH & SUD needs reflect lack of access to community-based crisis services and treatment. [2]
Health system costs & utilization	(16) SUD/MH Utilization by Location (17) SUD Service Utilization (Commercial/Medicare) (18) MH Service Utilization (Commercial/Medicare) (19) SUD Utilization (Medicaid) (20) MH Utilization (Medicaid) (21) Total BH Expenditure (22) BH AE Expenditure (23) BH and the LTSS Population	Increasing overall total cost of care for their complex BH population is an indicator of lack of access to appropriate care. [5]

1. Center for Disease Control. **2.** SAMHSA. **3.** NAMI. **4.** NSCH; OJJDP **5.** IBM Watson Commercial Claims and Encounters Database and Milliman Consolidated Health Cost Guidelines Database, 2017, https://www.milliman.com/en/insight/How-do-individuals-with-behavioral-health-conditions-contribute-to-physical

"Health of RI's Behavioral Health System": Core Indicators of Incidence, Prevalence and Consumer Need

Legend
Data suggests significant system concern, including outcomes are worse for RI than regional/national benchmarks, and outcomes are worse for non-white individuals
Data suggests moderate system concern, including that outcomes are better for RI than neighbors, but still below ideal targets, and outcomes are better for non-white individuals, but still below ideal targets.
Data does not suggest system concern; ideal state for indicator is achieved.

Findings for each core indicator are summarized below. Section 3 provides detailed data in aggregate and stratified by demographics, when available.

Core Indicators	Status Overall	Race Equity Outcomes	Key Findings
Suicide Rate			RI's suicide rate is two thirds that of the national suicide death rate, and lower than the rate in neighboring CT & MA. However, RI's trend over time is consistent with national average and above both MA and CT. For adolescents aged 15-19, RI had the lowest suicide rate of all 50 states in 2016-2018.
Overdose Death Rate			RI has high overdose rates with overdoses that are increasingly fatal. Drug overdose rates in RI have been higher than MA and CT until 2016. In RI, overdose rates have increased by 70% since 2008. The number of opioid overdose deaths in RI has increased nearly 2x since 2008; RI's rate of opioid overdose deaths in 2018 is 1.6x that of the national average.
Rates of Substance Use			RI has usage rates above the national average for all drugs surveyed except cigarette use. Recovery service utilization varies widely by age, sex, and race.
Rate of Homelessness			Rhode Island's homelessness rate (0.2%) is below both Connecticut and Massachusetts and has been steady since 2010. The number of homeless Rhode Islanders has decreased by 23% since 2013, and 40% among children; however unsheltered, chronic, and veteran homelessness have grown substantially over the same time period. Initial indications from stakeholders reflect an increase in homelessness since COVID-19 began. Black and Hispanic individuals experience homelessness at a significantly higher rate than whites.
Treatment volume in correctional settings		No data	Rhode Island has the smallest percentage of adult mental health consumers services in a jail/correctional setting amongst neighboring states and the national average.
Employment in recovery/ post-treatment		No data	40% of adult mental health consumers in Rhode Island are unemployed, less than the national average of 46%, but much higher than the statewide unemployment rate.
Rate of behavioral & emotional problems; Juvenile justice involvement			RI's rate of children with a mental, emotional, developmental, or behavioral problem follows its neighboring states and is slightly better than the national average. RI has the highest rate of juvenile delinquency cases per 100,000 amongst neighboring states; however, the RI rate has decreased by 40% since 2014.

"Health of RI's Behavioral Health System": Core Indicators of Capacity & Utilization

Legend
Data suggests significant system concern, including outcomes are worse for RI than regional/national benchmarks, and outcomes are worse for non-white individuals
Data suggests moderate system concern, including that outcomes are better for RI than neighbors, but still below ideal targets, and outcomes are better for non-white individuals, but still below ideal targets.
Data does not suggest system concern; ideal state for indicator is achieved.

Findings for each core indicator are summarized below. Section 3 provides detailed data in aggregate and stratified by demographics, when available.

Core Indicators	Status Overall	*Race Equity Outcomes	Key Findings
Utilization of the Emergency Dept for Mental Health and Substance Use		No data	10% of ED visits in 2018 had a primary diagnosis related to behavioral health. Substance use visits were overwhelmingly adult, while mental health visits had a higher number of children (27%) than SUD.
Follow-Up Rates for Emergency Dept Visits		No data	Less than a fourth of individuals follow-up within 30 days after an ED visit for SUD-related issues. Only about 40% of Medicaid members had follow-up within 30 days of a MH-related ED visit as compared to two thirds (64%) for Medicare and commercial insurance.
Location of Residential Treatment Services		No data	Half of Rhode Islanders with commercial insurance or Medicare requiring SUD residential services are sent to a state other than RI, MA, or CT.
Emergency Dept and Inpatient Services Utilizations for Medicaid AE Populations with BH Diagnosis		No data	Among Medicaid AE eligible populations, those with a BH diagnosis (non-complex) are 2.4x more likely to use the ED and 6.7x more likely to utilize inpatient services when compared to those without a BH diagnosis. Complex BH program participants are 4.4x more likely to use the ED and 19.9x more likely to utilize inpatient services compared to those without a BH diagnosis.
Service Utilization for Populations with a Primary SUD Diagnosis		No data	Service utilization among populations with a primary SUD diagnosis has recently experienced modern declines in commercial/Medicare populations (-5% per year) and modest increases in the Medicaid populations (+5% per year).
Service Utilization for Populations with a Primary MH Diagnosis		No data	Service utilization among populations with a primary MH diagnosis has recently experienced modest declines in commercial/Medicare populations (-3% per year) and modest increases in the Medicaid populations (+2% per year).

*Data obtained from the All Payer Claims Database and Medicaid are largely incomplete for race, ethnicity, and language.

"Health of RI's Behavioral Health System": Core Indicators of Capacity & Cost

Legend
Data suggests significant system concern, including outcomes are worse for RI than regional/national benchmarks, and outcomes are worse for non-white individuals
Data suggests moderate system concern, including that outcomes are better for RI than neighbors, but still below ideal targets, and outcomes are better for non-white individuals, but still below ideal targets.
Data does not suggest system concern; ideal state for indicator is achieved.

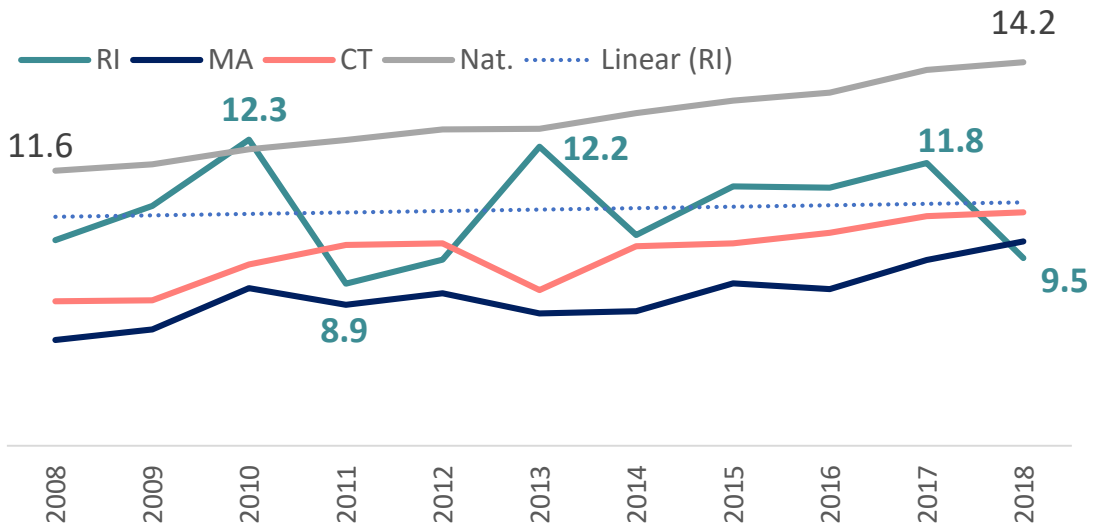
Findings for each core indicator are summarized below. Section 3 provides detailed data in aggregate and stratified by demographics, when available.

Core Indicators	Status Overall	*Race Equity Outcomes	Key Findings
Medicaid Expenditures for BH Services		No data	Medicaid expenditures on BH services has been relatively flat between SFY 2015-2017 at $226 million per year.
Medicaid Expenditures for BH Services by Service Line		No data	Medicaid expenditures on BH services has been steadily shifting away from community-based services and toward inpatient services, as inpatient has increased from 29% to 41% of total expenditures.
AE Medicaid Managed Care Expenditures		No data	One third of Medicaid members eligible for the Accountable Entity (AE) program (31%) have a BH diagnoses and account for two thirds (66%) of total AE Medicaid Managed Care expenditures.
LTSS Users with BH Diagnosis		No data	Of those LTSS eligible users with a BH diagnosis, about half (49%) are receiving institutional services (either in a nursing home or public hospital), suggesting an opportunity to rebalance toward less-restrictive, lower-cost community-based settings.

*Data obtained from the All Payer Claims Database and Medicaid are largely incomplete for race, ethnicity, and language.

(1) RI's suicide rate is trending higher than CT and Massachusetts, though lower than the nation.

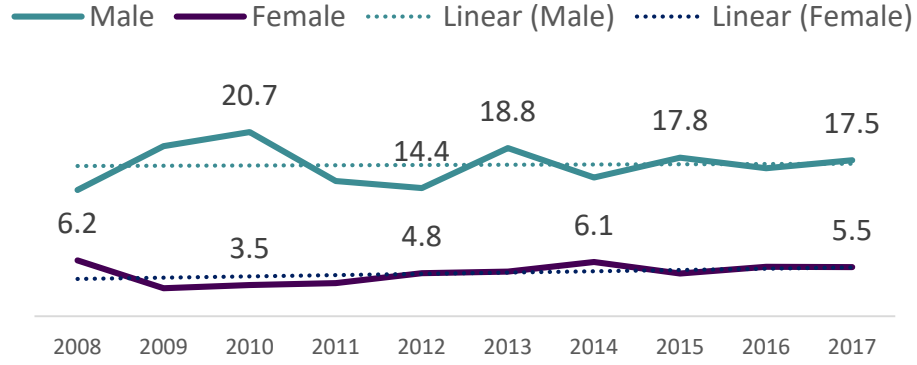
Suicide Deaths per 100,000 people, 2008-2018[1]



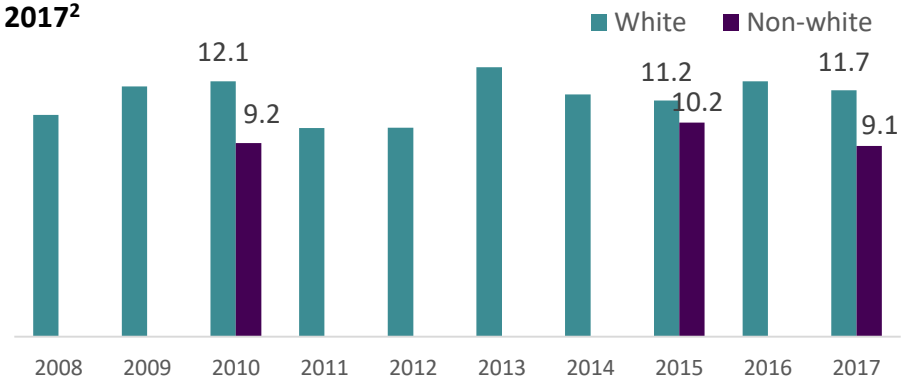
Key Takeaways:

- RI's suicide rate declined in 2018 to 9.5 per 100,000 from a high of 12.3 per 100,000 in 2010.
- RI's total suicide death rate is 3rd best in the nation (only behind NJ and NY)[3]. However, RI's linear trend line is above both MA and CT over the last 10 years.
- In 2018, suicide deaths per 100,000 were 3.6x higher among males than females.
- In 2017 the suicide rate in RI was 28% higher among whites than non-whites.
- The 45-54 age group has a higher suicide rate per thousand compared to other age groups in RI.

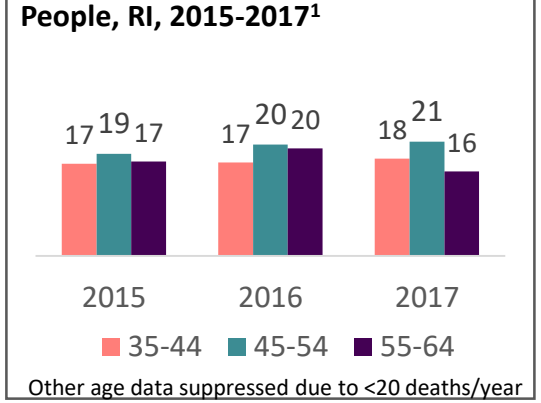
Suicide Deaths by Gender per 100,000 People, RI, 2008-2017[2]



Suicide Deaths by Race per 100,000 People, Rhode Island, 2008-2017[2]



Suicide Deaths by Age per 100,000 People, RI, 2015-2017[1]

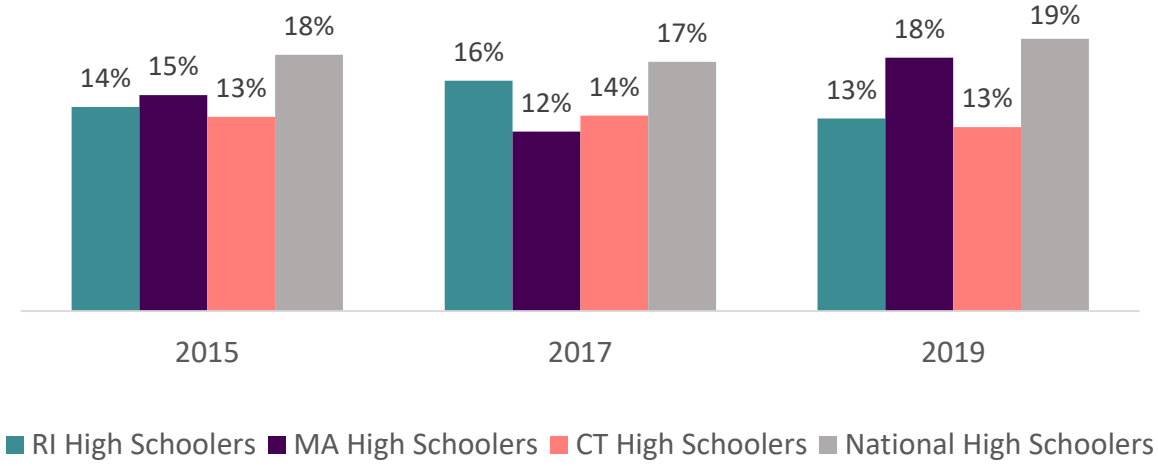


Other age data suppressed due to <20 deaths/year

Source 1: State Health Compare, SHADAC, http://statehealthcompare.shadac.org/trend/211/suicide-deaths-per-100000-people-by-total;
Source 2: National Violent Death Reporting System (NVDRS), CDC, https://www.cdc.gov/violenceprevention/datasources/nvdrs/
Source 3: Suicide Mortality by State, CDC, https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm

(2) Southern New England high schoolers consider suicide at a rate lower than the national average.

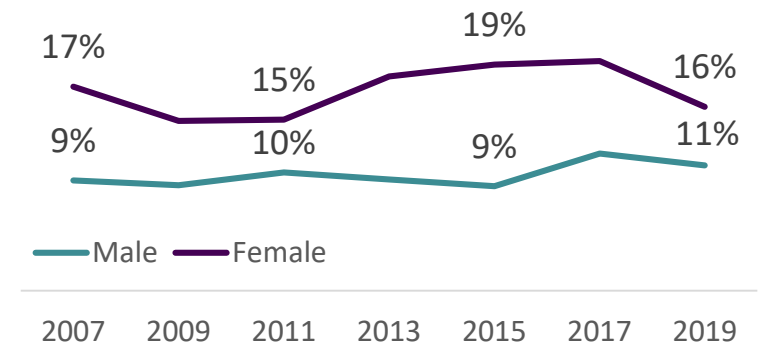
% of High Schoolers and % of Adults who Considered Suicide in the Past Year, Rhode Island, 2013-2017[1]



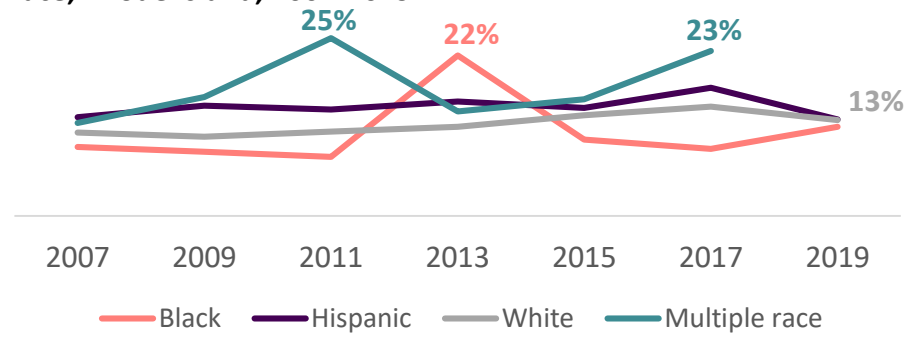
Key Takeaways:

- Southern New England high schoolers consider suicide at a rate lower than the national average. The percent of RI students considering suicide has declined slightly from 2017 to 2019. RI has the smallest rate of teen deaths by suicide (5 per 100,000 people) in the nation[3].
- Female high school students are between 1.5x and 2x as likely to consider suicide as their male peers.
- Multiple race students have higher rates of suicidal ideation; in 2017, they were 1.5x more likely to consider suicide than white peers.
- Almost 40% of bisexual students seriously considered suicide in the past year; 4x the rate of straight students.
- According to the Crisis Text Line, RI ranks 7th in the nation for crises regarding anxiety/stress, 14th for depression/sadness-related crises, and 7th for gender/sexuality-related crises. Additionally, RI has the most depression- and gender/sexuality-related crises in New England[2].

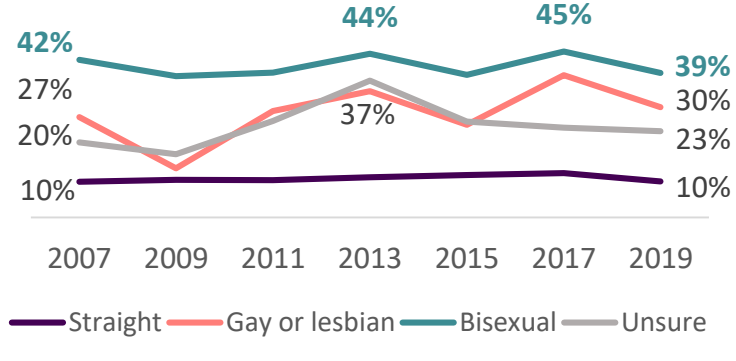
% of High Schoolers who Considered Suicide in the Past Year by Sex, Rhode Island, 2007-2019[1]



% of High Schoolers who Considered Suicide in the Past Year by Race, Rhode Island, 2007-2019[1]



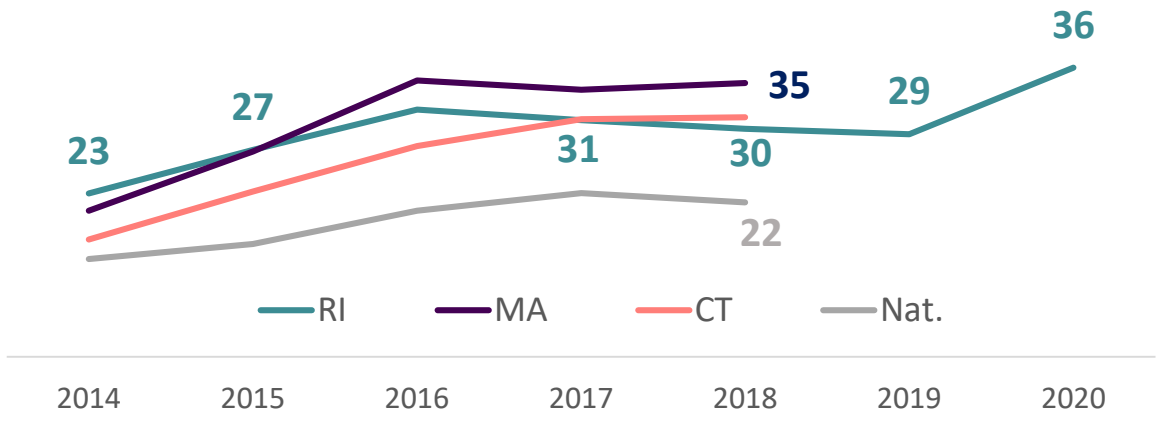
% of High Schoolers who Considered Suicide in the Past Year by Sexuality, Rhode Island, 2007-2019[1]



Source 1: Youth Risk Behavior Surveillance System, CDC, https://nccd.cdc.gov/youthonline/App/Default.aspx
Source 2: Crisis Trends, Crisis Text Line, https://crisistrends.org/
Source 3: Teen Suicide, America's Health Rankings, https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/teen_suicide/state/RI

(3) The 2020 overdose death rate is a 24% increase from 2019.

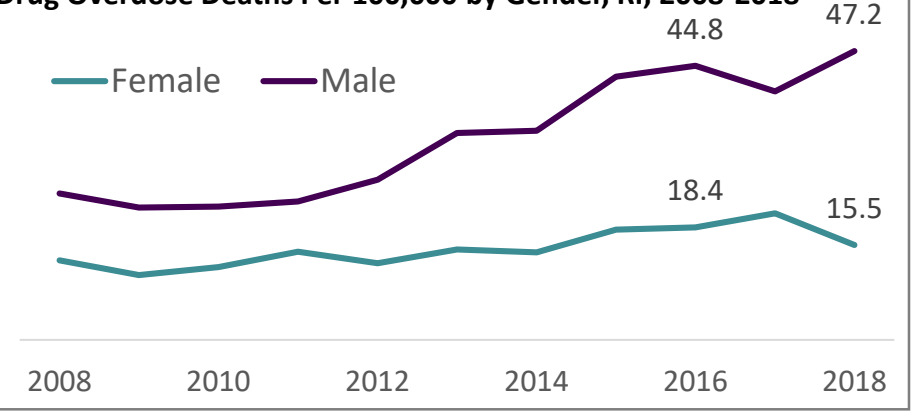
Drug Overdose Deaths per 100,000 People, 2014-2020[1,2]



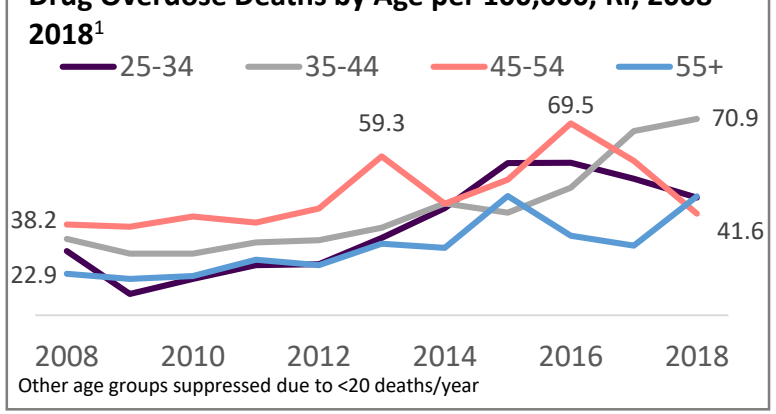
Key Takeaways

- Drug overdose rates in RI have been similar to MA and CT rates until 2018, where there was a drop in death rates. Rhode Island's 2020 overdose rate is a 24% increase from 2019.
- In 2018, 35-44-year-olds had the highest rate of overdose at a rate about 1.5x that of other age groups. The rate of overdose for this age group has increased 110% since 2008.
- White individuals have a higher rate of overdose than other races; in 2018, their rate of overdose was 1.8x that of Hispanic individuals.
- EOHHS's December 2020 presentation to the Governor's Overdose Task Force found that: "Recovery is fragile for anyone, at any time - but fentanyl, COVID anxiety and isolation, discrimination and disparities, as well as institutional mistrust are devastating to those finding their way."

Drug Overdose Deaths Per 100,000 by Gender, RI, 2008-2018[1]

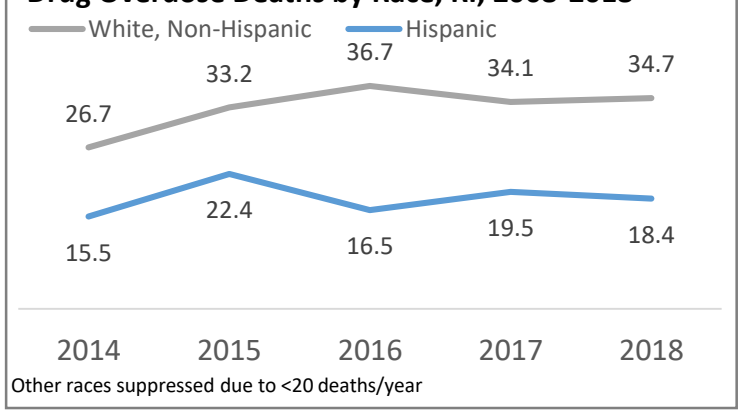


Drug Overdose Deaths by Age per 100,000, RI, 2008-2018[1]



Other age groups suppressed due to <20 deaths/year

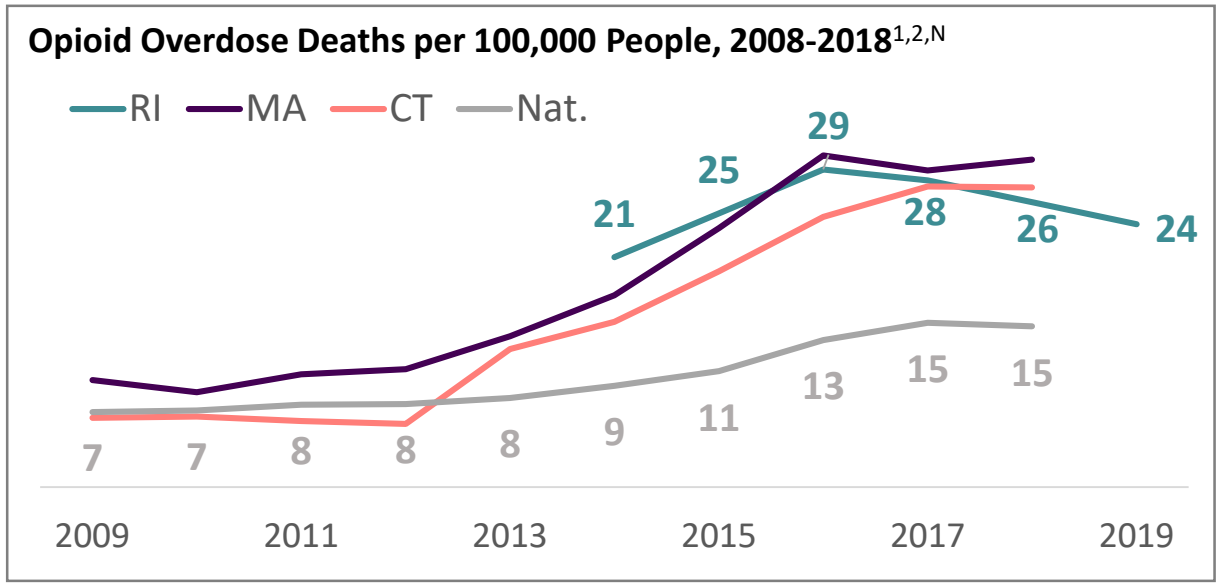
Drug Overdose Deaths by Race, RI, 2008-2018[1]



Other races suppressed due to <20 deaths/year

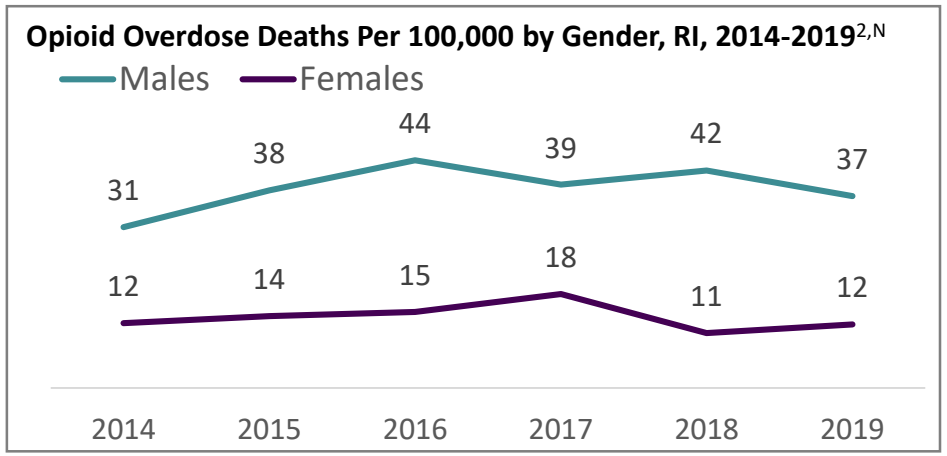
Source 1: Wide-ranging Online Data for Epidemiologic Research, CDC, https://wonder.cdc.gov/; data taken using Multiple Cause of Death (MCD) 1999-2018 data request
Source 2: RI values come 4/15/2021 Providence Journal article "OD deaths hit record high in RI"
Note: Excludes drug-induced homicides.

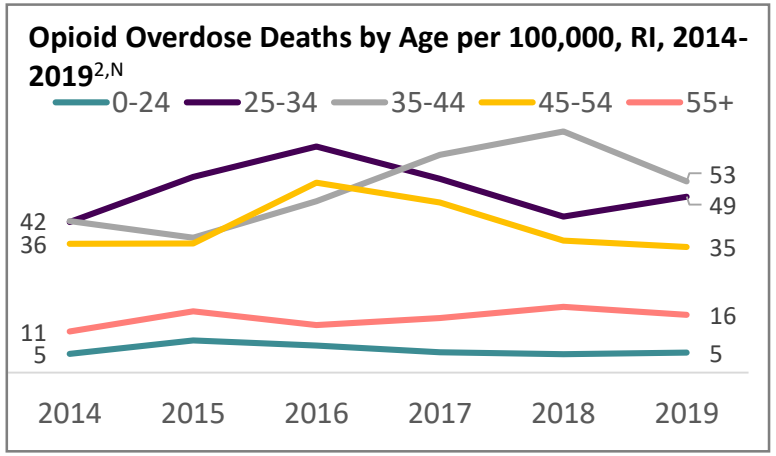
(4) RI's rate of opioid overdose deaths in 2018 is 1.6x that of the national average.

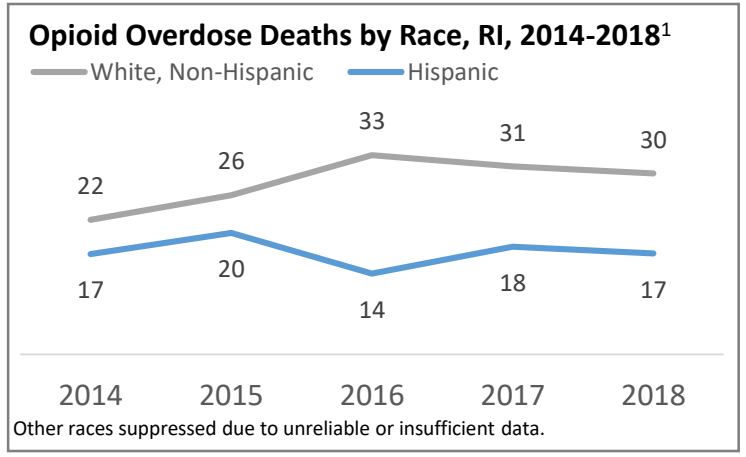


Key Takeaways

- RI's rate of opioid overdose deaths in 2018 was 1.6x that of the national average.
- RI's rate is higher than the national average of 15 but lower than the rate in MA (30) & CT (27).
- Males have a 3.1x higher rate of opioid overdose in 2019 compared to females, up from 2.6x in 2014.
- Overdoses increased by 1.25x from 2014 to 2019 among those ages 35-44.
- White individuals have a 1.7x higher rate of opioid overdose deaths in 2018 compared to Hispanic individuals.

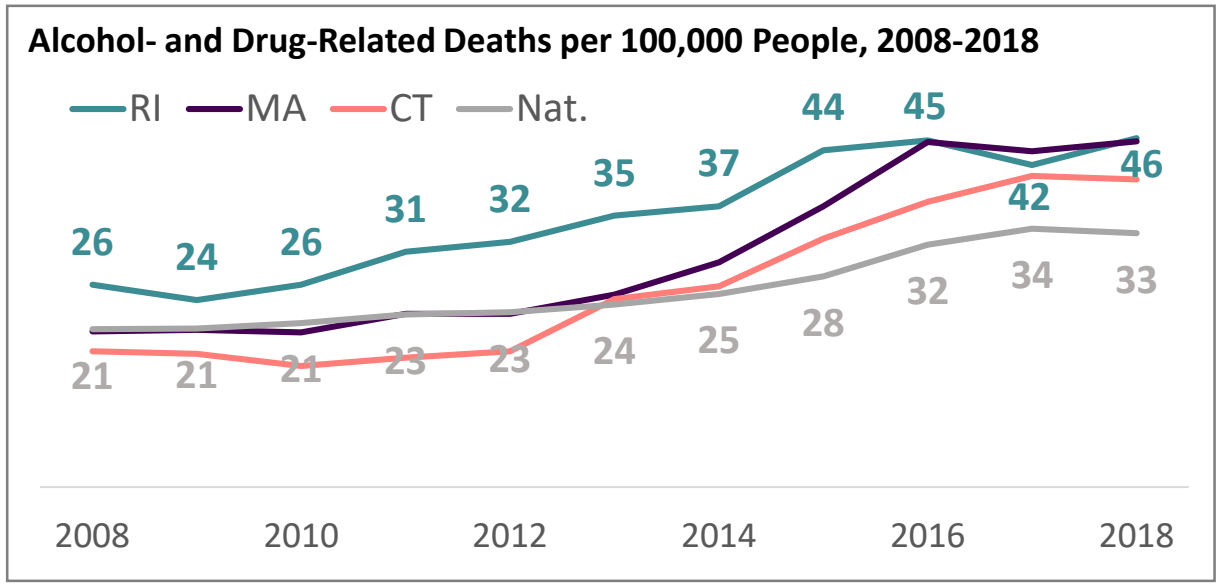






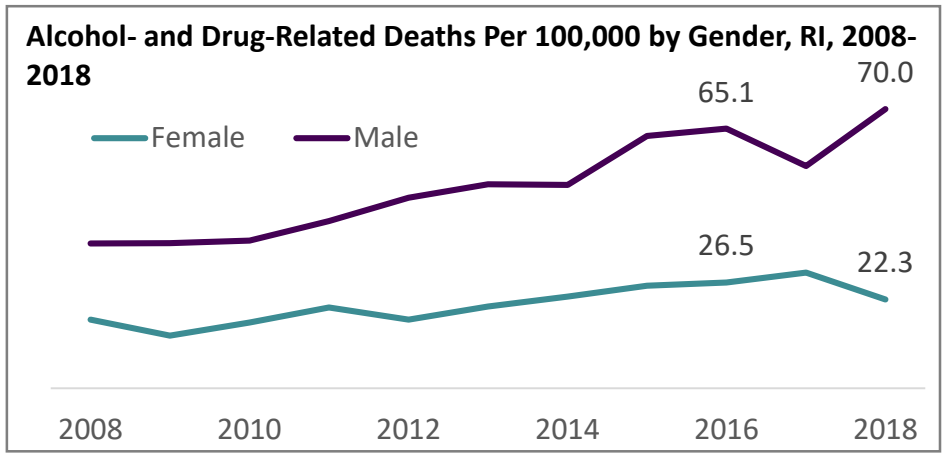
Source 1: State Health Facts, KFF, https://www.kff.org/other/state-indicator/opioid-overdose-deaths/
Source 2: Prevent Overdose RI, https://preventoverdoseri.org/overdose-deaths/, used only for RI data
Note: N superscript denotes that the data was normalized.

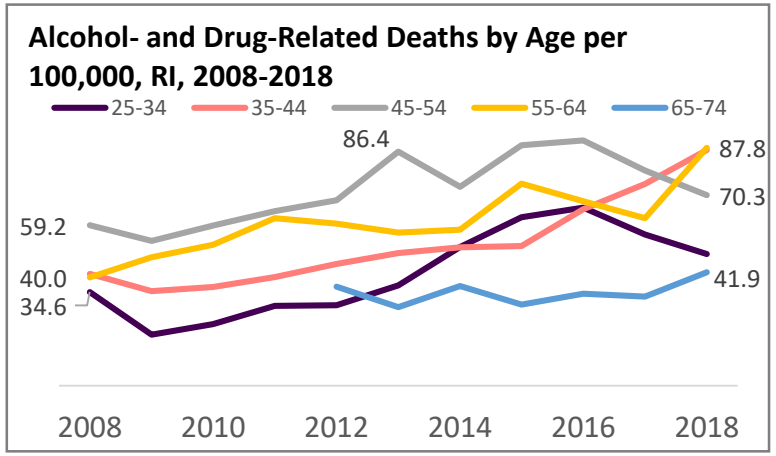
(5) The rate of alcohol- or drug-related deaths has increased 75% in Rhode Island in the past ten years and was 40% higher than the national average in 2018.

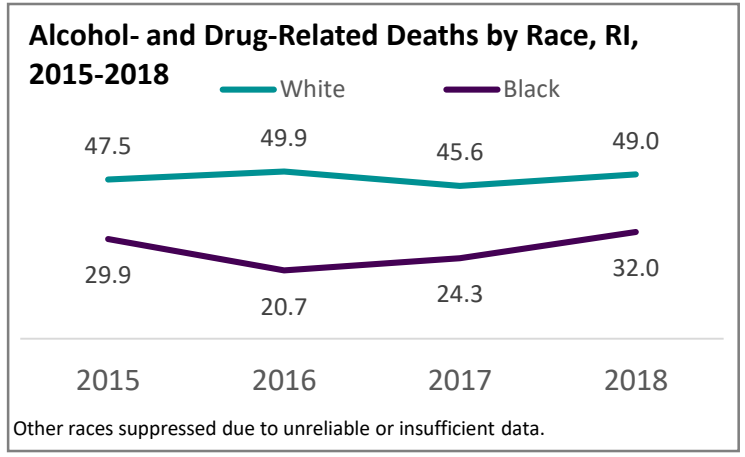


Key Takeaways

- The rate of alcohol- or drug-related deaths has increased 75% in Rhode Island in the past ten years and was 40% higher than the national average in 2018.
- Males die due to alcohol- or drug-related reasons at a rate 3x that of females.
- 35-64-year-olds have the highest rate of alcohol- or drug-related deaths.
- White individuals die due to alcohol- or drug-related reasons at a rate 1.5x that of black individuals.

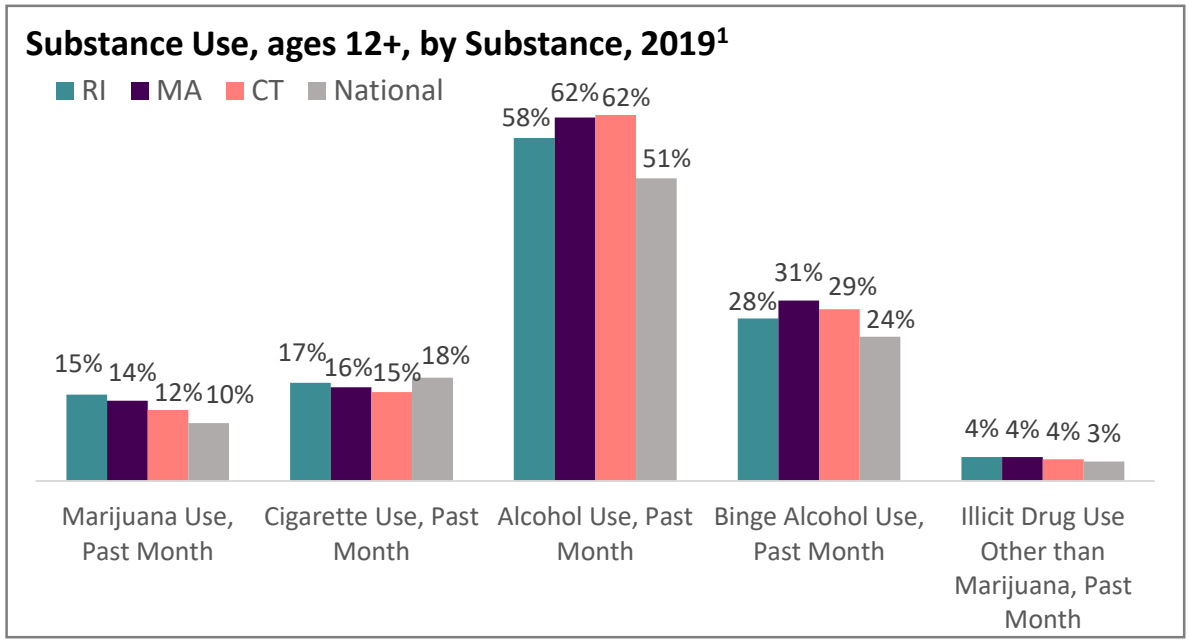






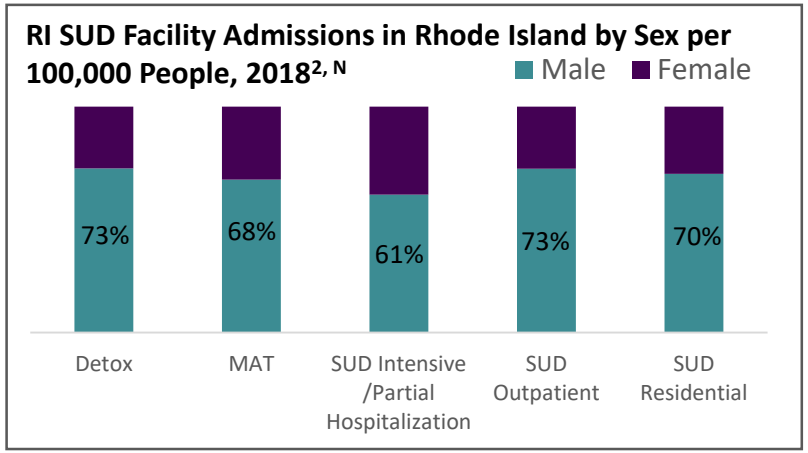
Source: Wide-ranging Online Data for Epidemiologic Research, CDC, https://wonder.cdc.gov/; data taken using Multiple Cause of Death (MCD) 1999-2018 data request
Note: Excludes drug-induced homicides.

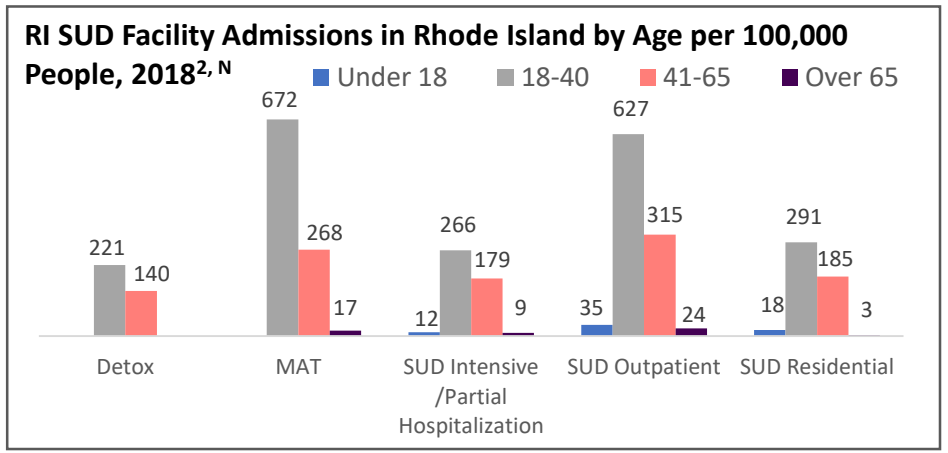
(6) RI has usage rates above the national average for all drugs surveyed except cigarette use. Recovery service utilization varies widely by age, sex, and race.

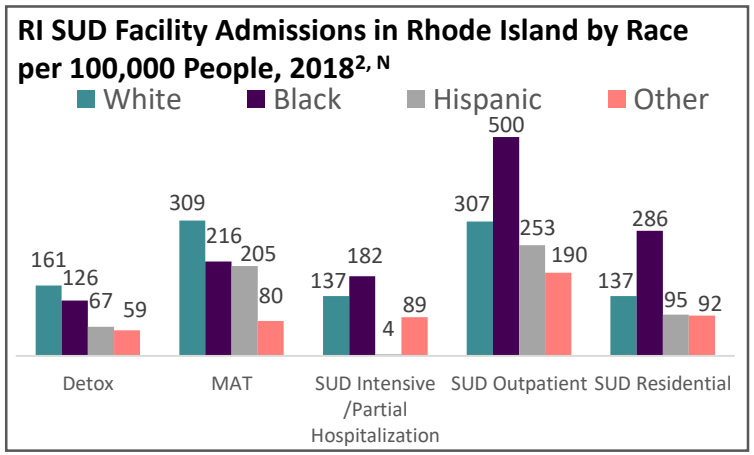


Key Takeaways:

- RI has higher rates of marijuana and cigarette use than neighboring states. RI also has rates above the national average for use of alcohol, binge use of alcohol, and other illicit drug use.
- Individuals who are admitted into an SUD treatment facility are majority male.
- Individuals aged 18-40 are the most represented age group in facility admissions. Children under the age of 18 are most likely to receive outpatient services.
- Black individuals receive outpatient services 1.6 times greater than white individuals; and twice as likely to receive residential services.







Source 1: National Survey on Drug Use and Health: Model-Based Prevalence Estimates, SAMHSA, https://pdas.samhsa.gov/saes/state;
Source 2: BHOLD data, BHDDH, as of December 2020
Note: N superscript denotes that the data was normalized (shown as per 100,000 population) using Census data.

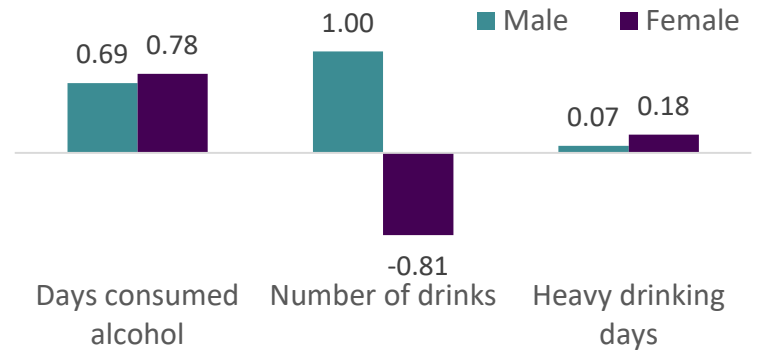
(7) Nationwide during the COVID pandemic, the number of days of "alcohol consumption over the past month" increased by nearly 1 day from 2019 to 2020.

Estimates of Increase in Alcohol Use in Past Month from June 2019 to June 2020

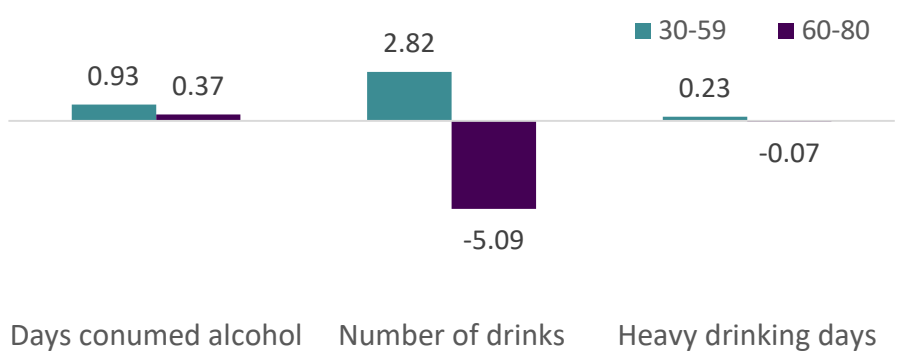
Key Takeaways:

- From a nationwide survey of 1,540 adults aged 30-80, the number of days of "alcohol consumption over the past month" increased by nearly 1 day from 2019 to 2020.
- Both males and females increased the days they consumed alcohol from 2019 to 2020, but males increased the number of drinks in the past month while females decreased that metric.
- Younger adults (30-59 years) had a greater increase in days consuming alcohol as well as number of drinks consumed than older adults. Adults over the age of 60 had 5 fewer per month in 2020 than 2019.
- Black and Hispanic individuals consumed 5.5 more drinks per month in 2020 than in 2019. White individuals had a small increase (0.66) in the number of days consuming alcohol.

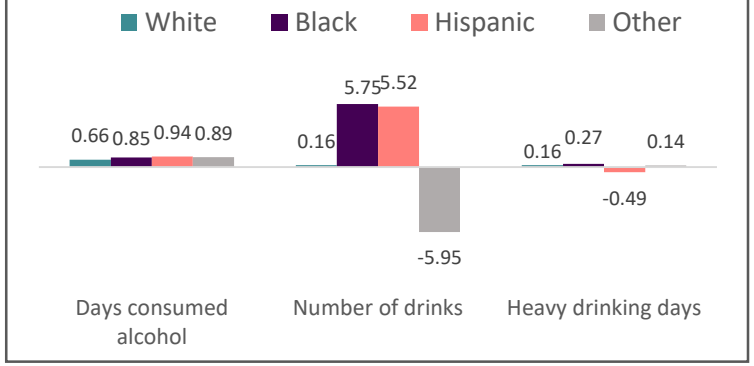
Estimates of Change in Alcohol Use in Past Month from June 2019 to June 2020 by Sex



Estimates of Change in Alcohol Use in Past Month from June 2019 to June 2020 by Age



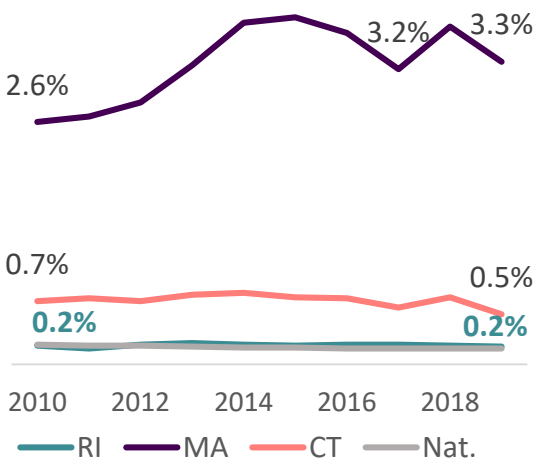
Estimates of Change in Alcohol Use in Past Month from June 2019 to June 2020 by Race



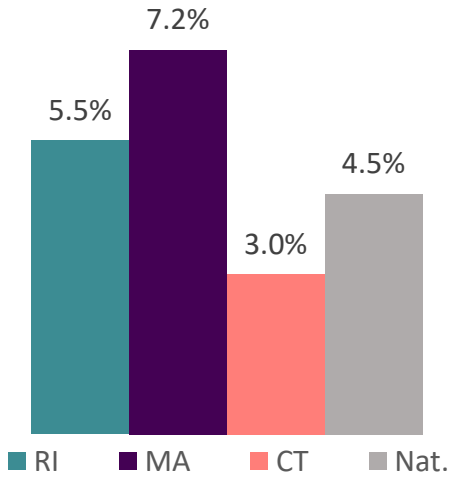
Source: JAMA Network Open, Changes in Adult Alcohol Use and Consequences During the COVID-19 Pandemic in the US
Note: Change was measured from baseline (April 29-June 9, 2019) to 2020 (May 28-June 16, 2020)
Note: Rhode Island specific data regarding alcohol assumption during COVID is not available.

(8) Rhode Island's homelessness rate of 0.2% is below both CT and MA and has been steady since 2010; MA has seen an overall increase in the same time period.

Percent of Population Experiencing Homelessness, 2010-2019[1,2]



Percent of Adult Mental Health Consumers who are Homeless, 2019[3]

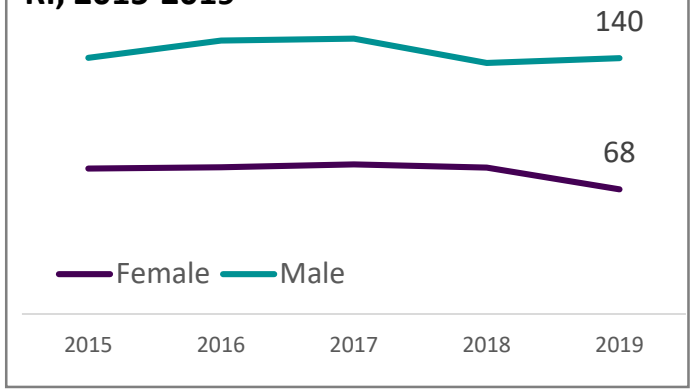


Key Takeaways:

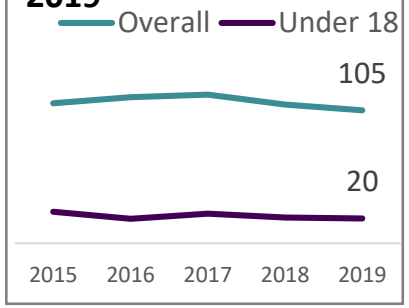
- Rhode Island's homelessness rate (0.2%) is below both CT and MA and has been steady since 2010; MA has seen an overall increase in the same time period.
- RI adult mental health consumers experience homelessness nearly 2x that of CT and slightly above the national average.
- Unsheltered homelessness, chronic homelessness, individual homelessness, and homelessness among veterans has increased since 2007.
- In 2019, males experienced homelessness at a rate 2x that of females.
- The number of homeless Rhode Islanders has remained steady since 2015. Homeless children make up 18-25% of all homeless individuals in RI.
- Black and Hispanic individuals experience homelessness at a significantly higher rate than whites. The rate of homeless individuals of other races has increased by 175% from 2015 to 2018.

Category[4]	% Change 2007-2019
Total	↓23%
Unsheltered	↑45%
Sheltered	↓26%
Chronic	↑31%
Family	↓55%
Individual	↑14%
Veteran	↑48%

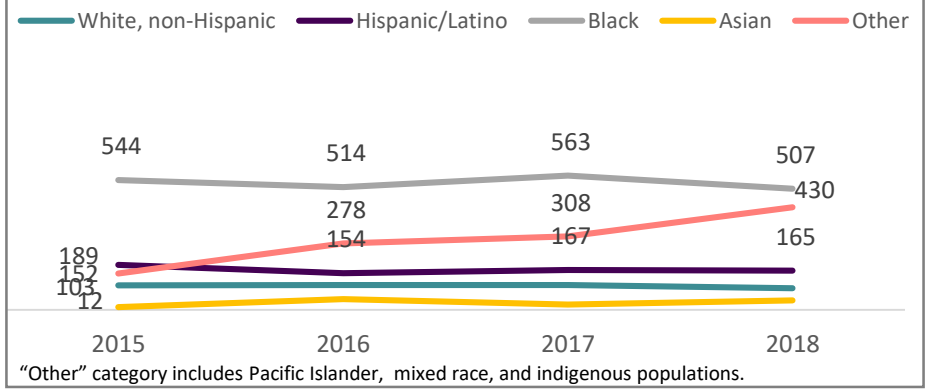
Homelessness by Sex per 100,000 People, RI, 2015-2019[1, N]



Homelessness in Rhode Island by Age per 100,000 People, 2007-2019[1, N]



Homelessness by Race per 100,000 People, Rhode Island, 2015-2019[1, N]

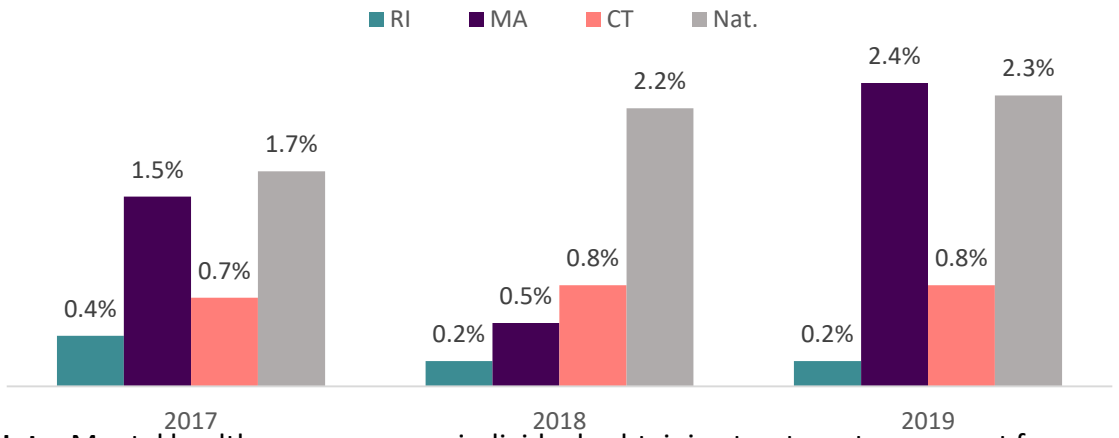


"Other" category includes Pacific Islander, mixed race, and indigenous populations.

Source 1: Annual Homeless Assessment Report, Dept. of Housing and Urban Development, https://www.hudexchange.info/homelessness-assistance/ahar/
Source 2: United States Interagency Council on Homelessness, https://www.usich.gov/homelessness-statistics
Source 3: 2019 Uniform Reporting System, SAMHSA, https://www.samhsa.gov/data/report/2019-uniform-reporting-system-urs-output-tables
Source 4: National Alliance to End Homelessness, https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness-dashboards/?State=Rhode%20Island
Note: N superscript denotes that the data was normalized.

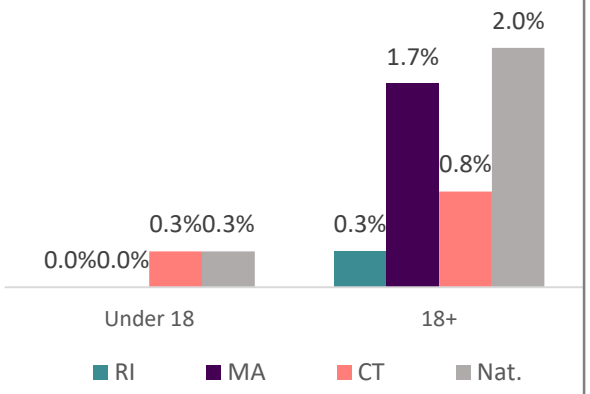
(9) Rhode Island has the smallest percentage of adult mental health consumers served in a jail/correctional setting amongst neighboring states and the national average.

Adult Mental Health Consumers Served in Jail/Correctional Facility by State, 2017-2019[1]

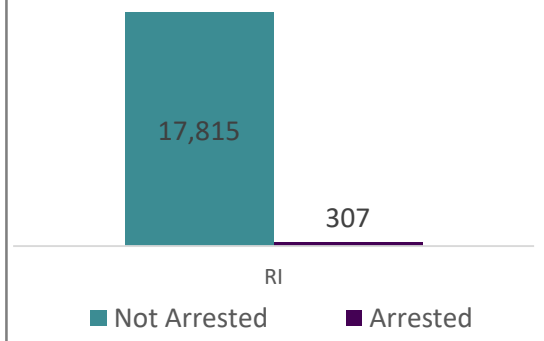


Note: Mental health consumers are individuals obtaining treatment or support for a mental health condition, as reported to SAMHSA by BHDDH.

Adult Mental Health Consumers Served in Jail/Correctional Facility by Age, 2019[1]



Criminal Profile of Adult Mental Health Consumers Receiving MH Service for at least 12 Months, 2019[2]



Key Takeaways:

- Rhode Island prison/correctional settings provide robust BH services, however, prison is not a therapeutic environment. Rhode Island has the smallest percentage of adult mental health consumers served in a jail/correctional setting amongst neighboring states and the national average.
- Despite these low rates, the correctional facilities in Rhode Island are the largest providers of behavioral health services in the state. Nonetheless, there are incarcerated people who are unable to access the services they need.
- Out of all adults served by state mental health services for at least 12 months, 2% had been arrested within the past year (7/2019-6/2020).

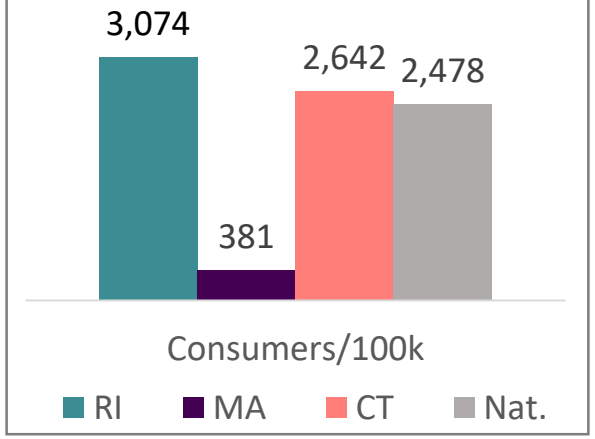
Qualitative Findings:

- Stakeholders confirmed robust BH offerings in prison/correctional settings, however, they expressed concern about the use of corrections as a treatment setting when more appropriate treatment alternatives outside of the criminal justice system are not available.
- Stakeholders expressed concern about the quality of mental health treatment in correctional settings. Quality concerns are exacerbated by workforce issues seen outside correctional settings (i.e., availability of professionals, professionals who are trauma-informed and/or culturally appropriate)
- Overall, stakeholders had positive feedback about MAT provided in correctional settings, including access and quality. However, individuals have difficulty locating available methadone treatment immediately upon release, which can result in relapse and reincarceration.
- People transitioning into the community post-release experience challenges maintaining treatment. In some cases, due to parole requirements and past offenses, certain appropriate residential treatment and step-down options are not available to individuals.

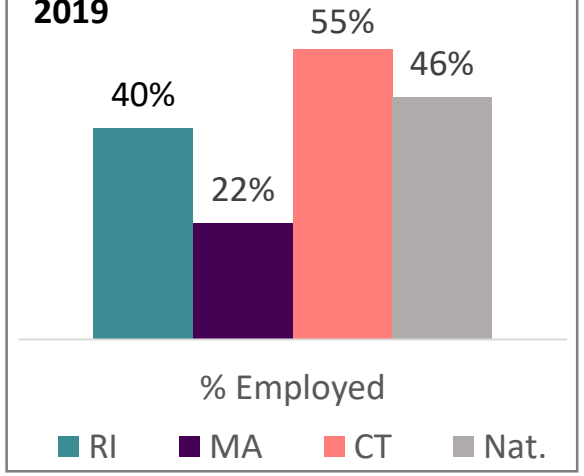
Source 1: 2017-2019 Uniform Reporting System, SAMHSA, https://www.samhsa.gov/data/report/2019-uniform-reporting-system-urs-output-tables
Source 2: ACI/RIDOC Data Pull, BHDDH, Dec 2020

(10) Adult mental health consumers are twice as likely to be employed in RI than in MA; however, RI's employment rate is still under the national average.

Adult Mental Health Consumers Served by Statewide Mental Health Agency per 100,000 People, 2019



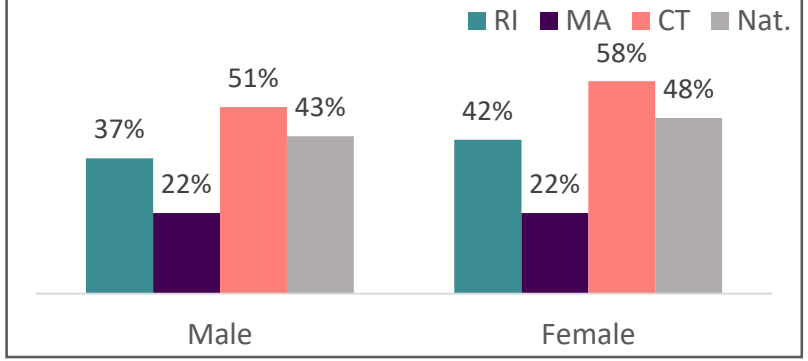
Adult Mental Health Consumers Served by Statewide Mental Health Agency who are Employed, 2019



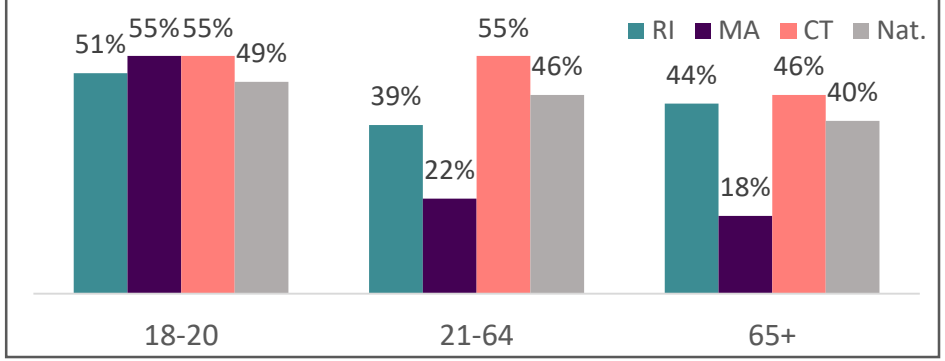
Key Takeaways:

- Adult mental health consumers are twice as likely to be employed in RI than in MA; however, RI's employment rate is still under the national average.
- More females than males receiving MH services are employed. This follows the trend in Connecticut and nationwide.
- 18-20-year-old MH consumers have a higher employment rate than older members of the population.
- Individuals with schizophrenia and other psychoses are nearly half as likely to be employed over those with no diagnosis, or with a diagnosis other than a mood disorder.

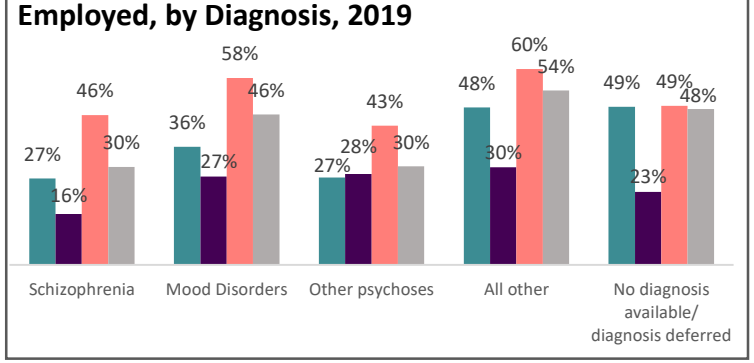
Adult Mental Health Consumers Served by Statewide Mental Health Agency who are Employed, by Sex, 2019



Adult Mental Health Consumers Served by Statewide Mental Health Agency who are Employed, by Age, 2019



Adult Mental Health Consumers Served by Statewide Mental Health Agency who are Employed, by Diagnosis, 2019

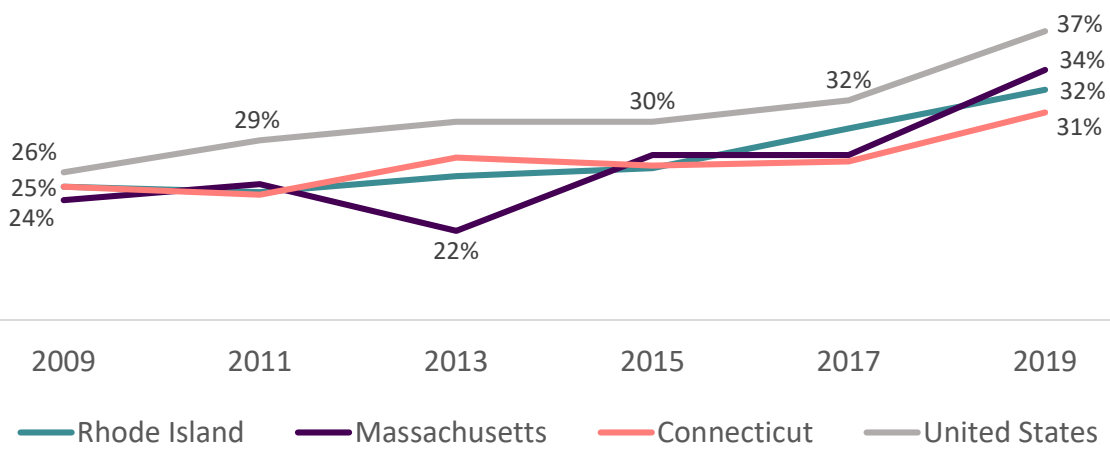


Source: 2019 Uniform Reporting System, SAMHSA, https://www.samhsa.gov/data/report/2019-uniform-reporting-system-urs-output-tables

Note: "Employed" describes a broad category of full- or part-time employment as well as supported employment. Mental health consumers are individuals obtaining treatment or support for a mental health condition, as reported to SAMHSA by BHDDH. URS data is only available for providers licensed by BHDDH.

(11) RI's rate of students feeling sad or hopeless for at least two weeks follows New England's trend and is just below the national average. This rate in RI has increased by 30% over the past decade.

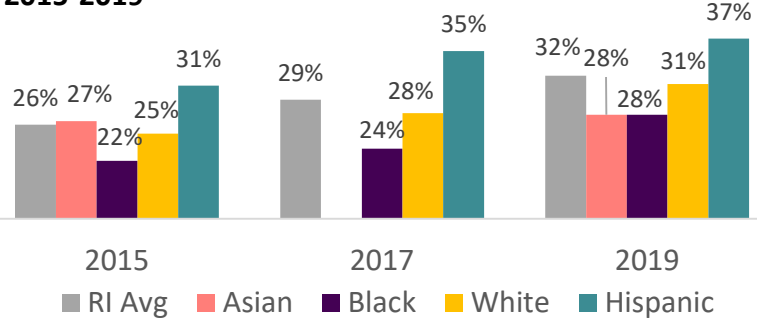
% of High Schoolers Who Felt Sad or Hopeless Almost Every Day for 2 or More Weeks in the Past Year, 2009-2019



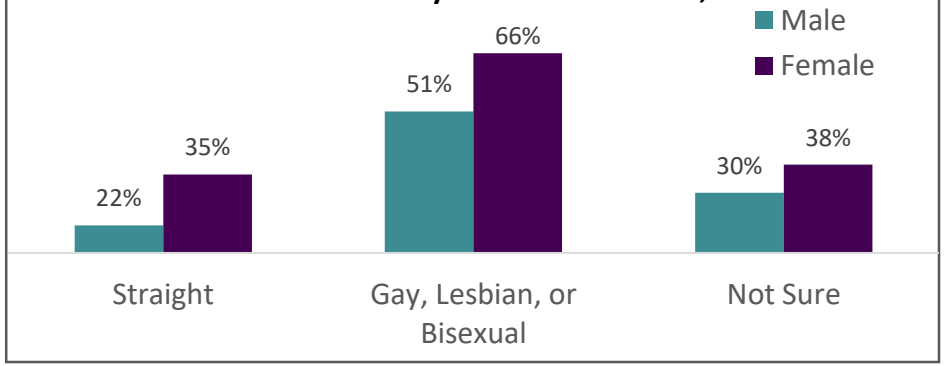
Key Takeaways:

- RI's rate of students feeling sad or hopeless for at least two weeks at a time follows the New England trend and is just below the national average. This rate in RI has increased by 30% over the past decade.
- Hispanic students report feeling sad or hopeless (37%) at higher rates than both students of other races and the state average (32%).
- >40% of females report feeling sad or hopeless everyday for 2 or more weeks in the past year, 1.7x that of their male peers.
- Lesbian, gay and bisexual students self-report higher rates of sadness and hopelessness than their straight peers; lesbian and bisexual women (66%) report higher rates than gay and bisexual men (51%).

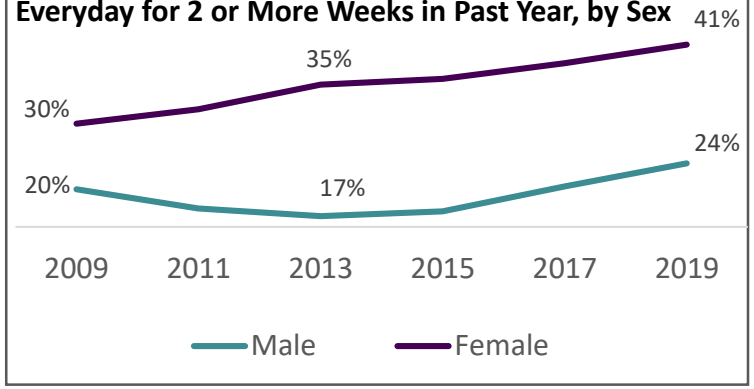
% of RI High Schoolers Who Felt Sad or Hopeless Everyday for 2 or More Weeks in the Past Year by Race, 2015-2019



% of RI High Schoolers Who Felt Sad or Hopeless Everyday for 2 or More Weeks in the Past Year by Sexual Orientation, 2019



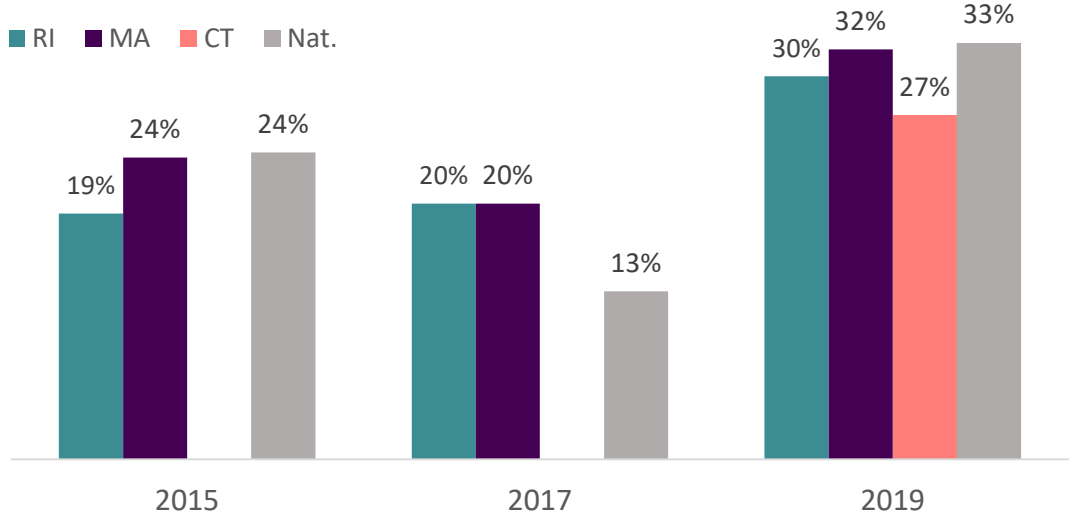
% of RI High Schoolers Who Felt Sad or Hopeless Everyday for 2 or More Weeks in Past Year, by Sex



Source: Youth Risk Behavior Surveillance System, CDC, https://nccd.cdc.gov/youthonline/App/Default.aspx

(12) The rate of high schoolers using electronic vapor products is increasing faster in Rhode Island than nationwide – 58% increase in RI since 2015 compared to a 38% increase nationwide.

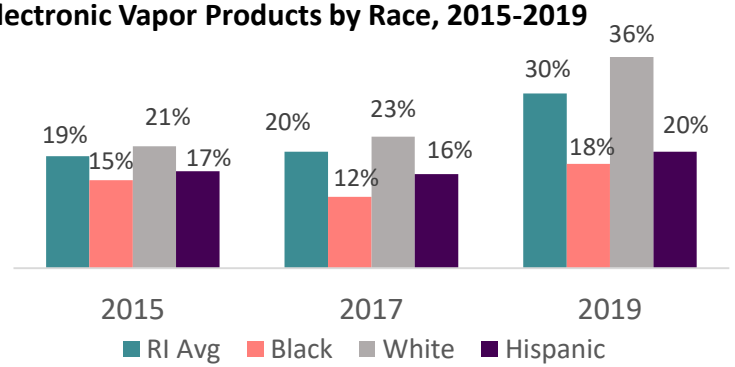
% of High Schoolers who Report Current Use (At least Once in Past 30 Days) of Electronic Vapor Products, 2015-2019



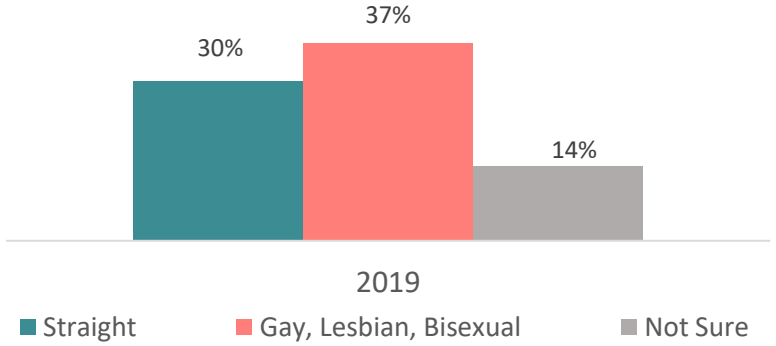
Key Takeaways:

- The percent of RI high schoolers who have reported use of electronic vapor products in the past month increased from 2015 (19%) to 2019 (30%).
- White students reported current use of electronic vapor products at the highest rate (36%) and use has increased among Black, white, and Hispanic students from 2015 to 2019.
- LGB students are 7% more likely to report current use of electronic vapor products compared to straight students.
- Students are more likely to report current electronic vapor product use as they advance through high school - 21% of 9th grade students report use while 42% of 12th grade students report use.

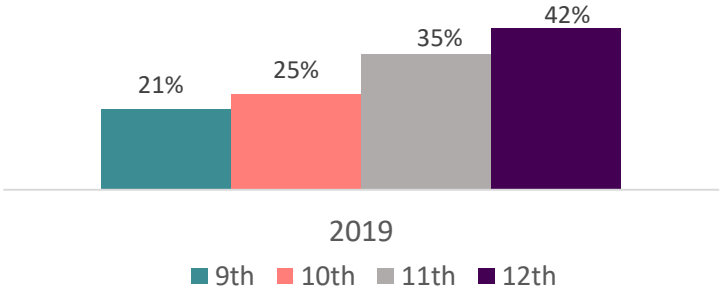
% of RI High Schoolers who Report Current Use of Electronic Vapor Products by Race, 2015-2019



% of RI High Schoolers who Report Current Use of Electronic Vapor Products by Sexual Orientation, 2019



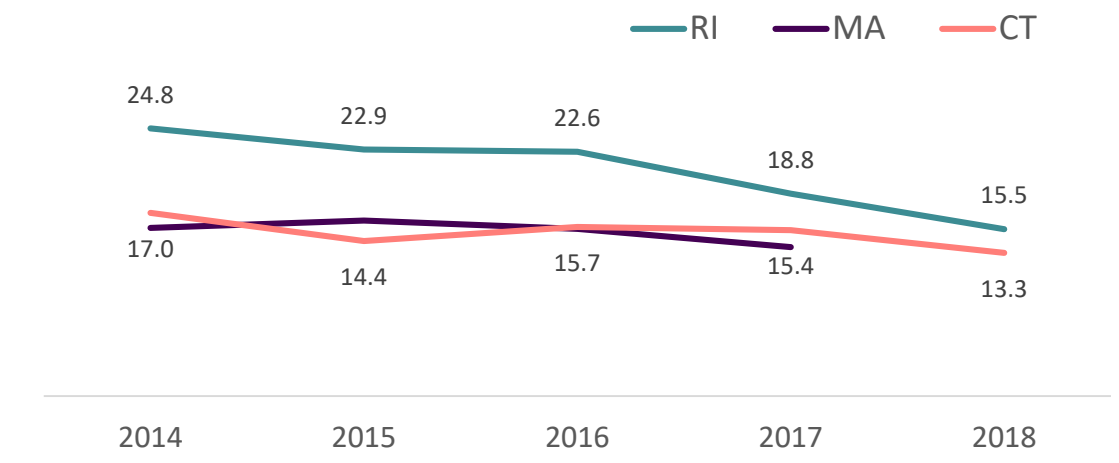
% of RI High Schoolers who Report Current Use of Electronic Vapor Products by Grade, 2019



Source: Youth Risk Behavior Surveillance System, CDC, https://nccd.cdc.gov/youthonline/App/Default.aspx

(13) Children in RI experiencing challenges are consistent with the region yet slightly worse than the national average.

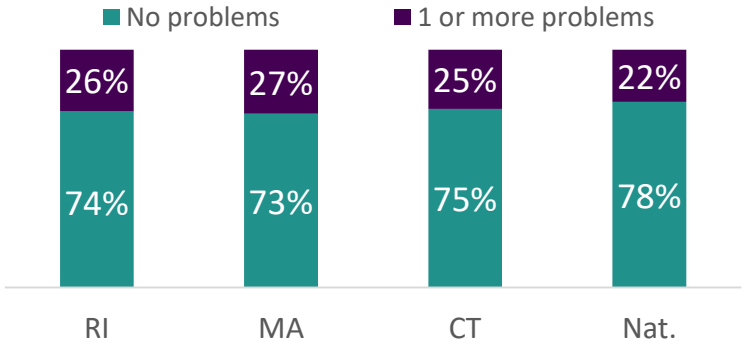
Number of Petitioned Juvenile Delinquency Court Cases per 1,000 Population, Ages 10-17, 2014-2018[1]



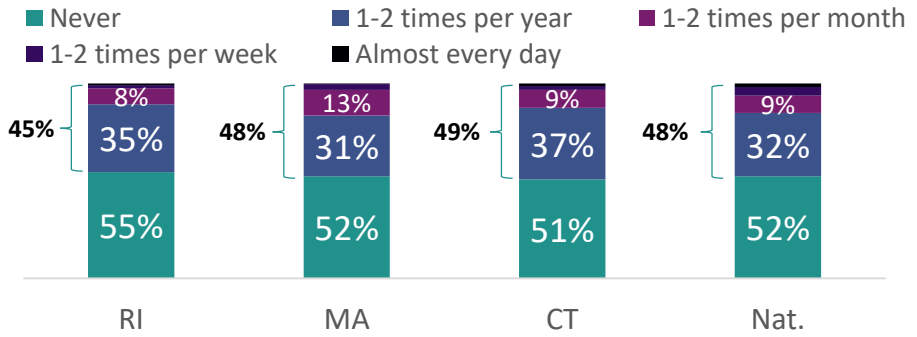
Key Takeaways:

- RI's rate of children with a mental, emotional, developmental, or behavioral problem is similar to the rate for MA and CT and is slightly worse than the national average.
- RI has a higher rate of juvenile delinquency cases per 1,000 amongst neighboring states; however, the RI rate has decreased by 40% since 2014.
- The percent of RI children who are bullied is better than neighboring states as well as the national average.
- RI has the lowest percentage of parents who say that their child lives in a safe neighborhood when compared to MA, CT, or nationwide.

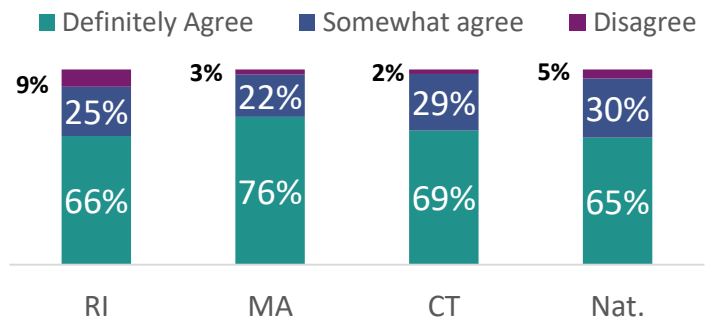
% of Children with a Mental, Emotional, Developmental, or Behavioral Problem, Age 3-17, 2018[2]



% of Children Who Have Been Bullied, Picked On, or Excluded by Other Children, Age 6-17, 2018[2]



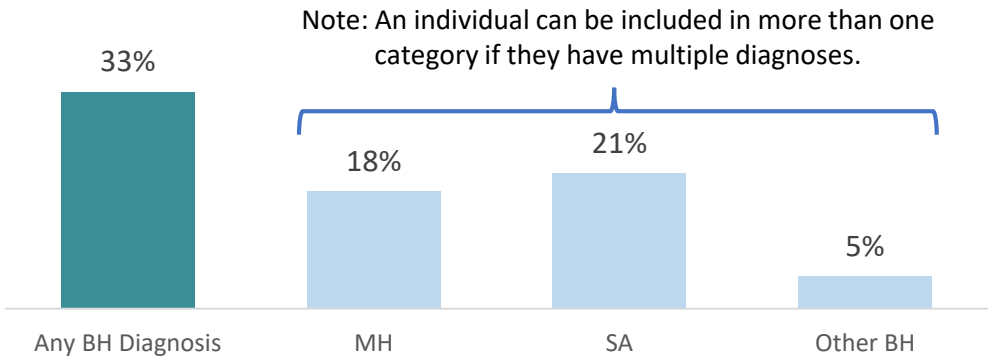
% of Parents Who Agree That Their Child Lives in a Safe Neighborhood, 2018[2]



Source 1: EZACO, Office of Juvenile Justice and Delinquency Prevention, https://www.ojjdp.gov/ojstatbb/ezaco/
Source: 2 National Survey of Children's Health, Child and Adolescent Health Measurement Initiative, https://www.childhealthdata.org/browse/survey

(14) 33% of ED visits in 2018 had a primary and/or secondary diagnosis related to behavioral health.

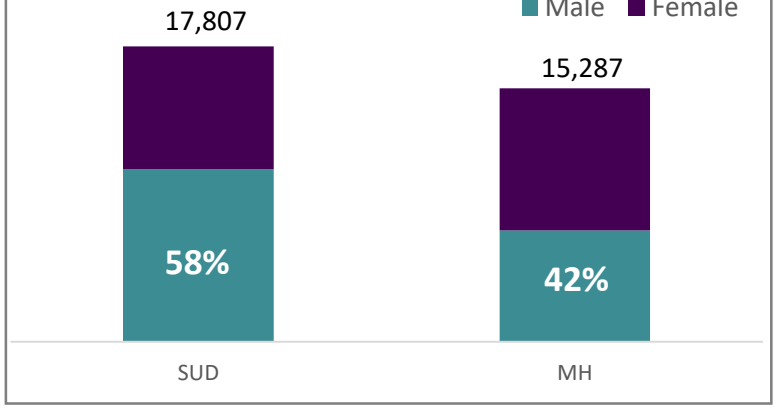
% of Behavioral Health Emergency Department Visits by Primary and Secondary Diagnoses, Rhode Island, 2018[1]



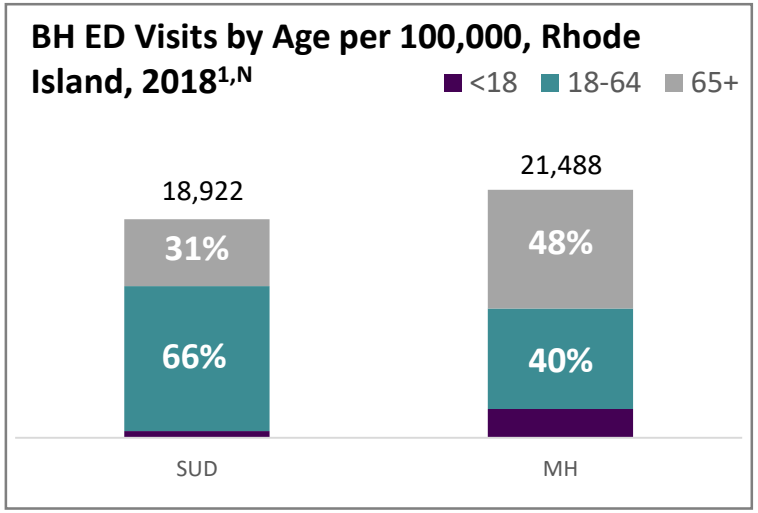
Key Takeaways:

- 33% of ED visits in 2018 had a primary and/or secondary diagnosis related to behavioral health.
- Substance use BH ED visits were majority male, while mental health visits were majority female.
- Substance use visits were overwhelmingly adult, while nearly 50% of MH ED visits were for individuals over 65. Adults over 65 only account for 17% of the Rhode Island population and are therefore significantly overrepresented in MH ED visits.
- SUD ED visits were equal across race, but white individuals visited the ED for MH issues 25% more than non-white individuals.

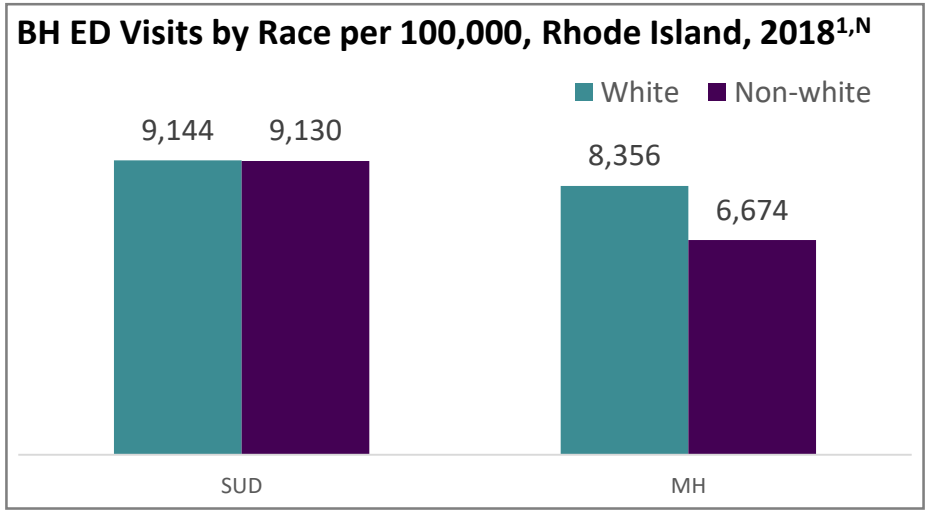
BH ED Visits by Gender per 100,000, Rhode Island, 2018[1,N]



BH ED Visits by Age per 100,000, Rhode Island, 2018[1,N]



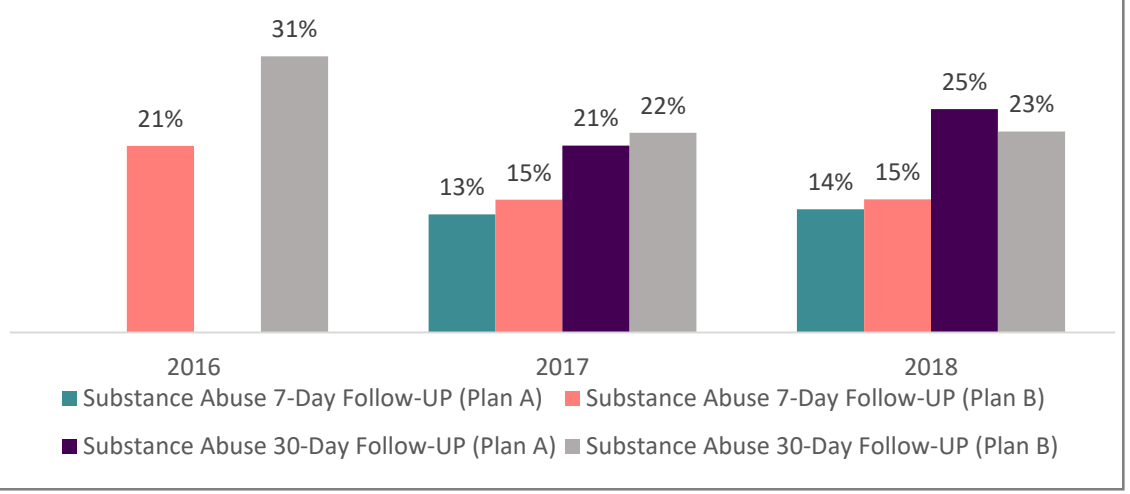
BH ED Visits by Race per 100,000, Rhode Island, 2018[1,N]



Source 1: Rhode Island Department of Health, Center for Health Data and Analysis, Hospital Discharge Data 2019
Source 2: US Census 2019, https://www.census.gov/quickfacts/fact/table/RI,US/AGE295219
Note: Categories are not mutually exclusive and patients may have more than one diagnoses. N superscript denotes that the data was normalized.

(15A) Less than a fourth of individuals follow-up within 30 days after an emergency department visit for SUD-related issues.

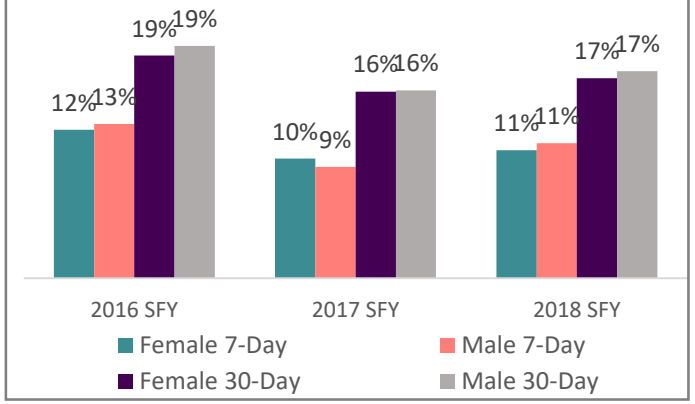
Post-Emergency Department Follow-Up Rates for Alcohol and Other Drug Abuse or Dependence, Rhode Island, 2016-2018[1]



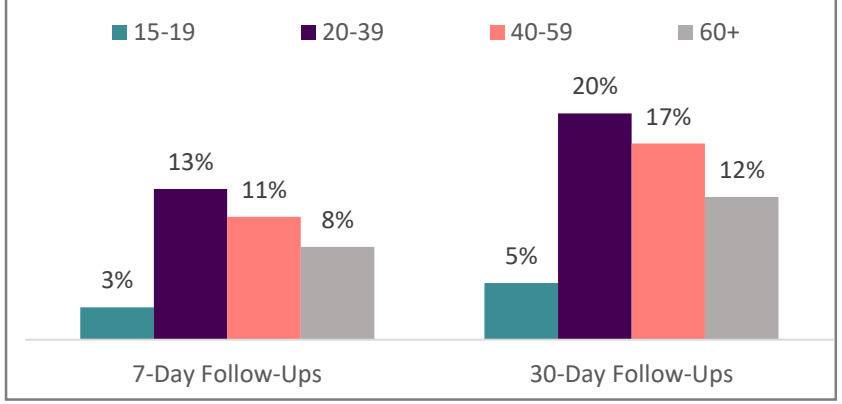
Key Takeaways:

- Less than a fourth of individuals follow-up within 30 days after an emergency department visit for SUD-related issues. Both plans have similar rates of follow-up in 2018 and 2019.
- The follow-up rates for SUD ED visits is consistent between males and females.
- 15-19-year-olds are significantly less likely to have a follow-up within 7 days and 30 days after a SUD ED visit compared to other age groups.
- Individuals on Medicare are more likely have a follow-up within 30 days after a SUD ED visit; individuals on Medicaid are less likely.

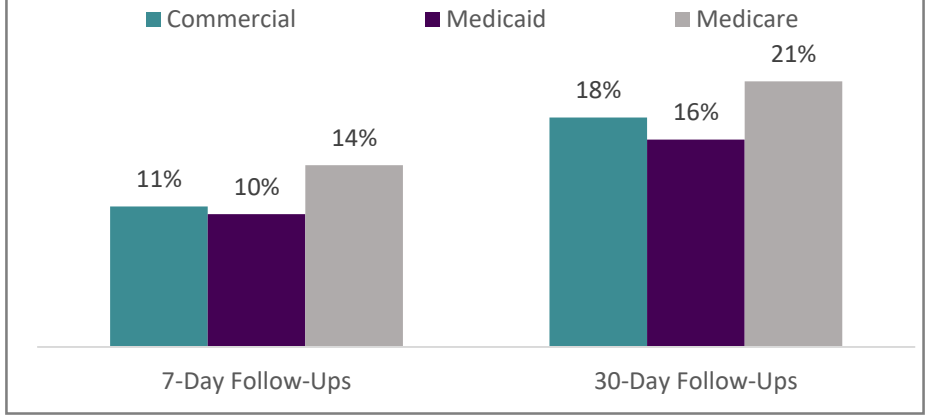
Post-Emergency Department Follow-Up Rates for Substance Abuse by Sex, RI, SFY 2018[2]



Post-Emergency Department Follow-Up Rates for Substance Abuse by Age, RI, SFY 2018[2]



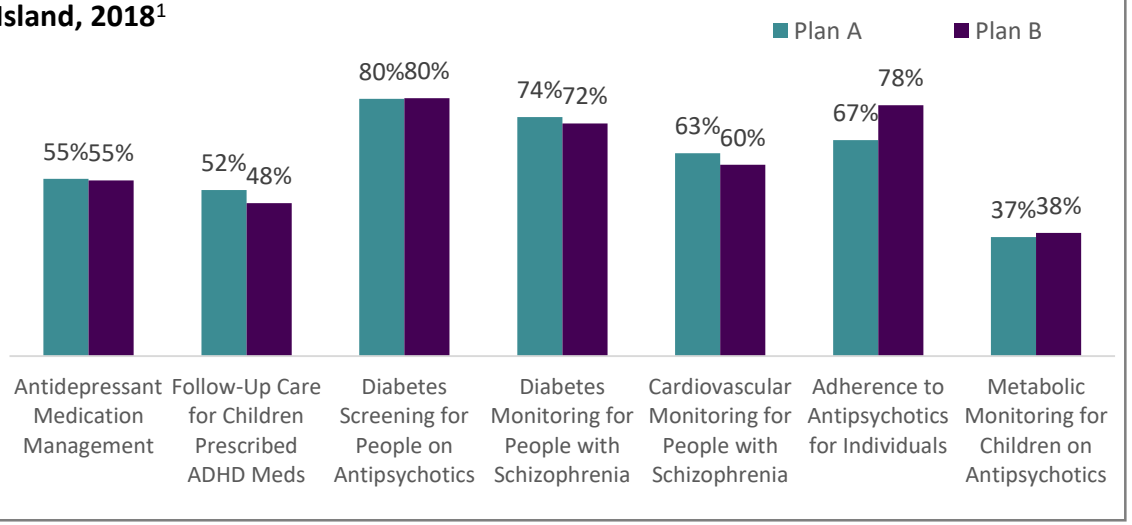
Post-Emergency Department Follow-Up Rates for Substance Abuse by Insurance, RI, SFY 2018[2]



Source 1: HEDIS Audit Data Pull 6/12/2019
Source 2: HealthFacts RI Public Records, Follow-up Rates after ED Visit, https://health.ri.gov/data/healthfactsri/
Note: Follow-up rates are determined through claims data submitted to the RI APCD.

(15B) Follow-up care for mental illness, as indicated by ED visits, for Medicaid members is significantly less likely than those of commercial- and Medicare-insured individuals.

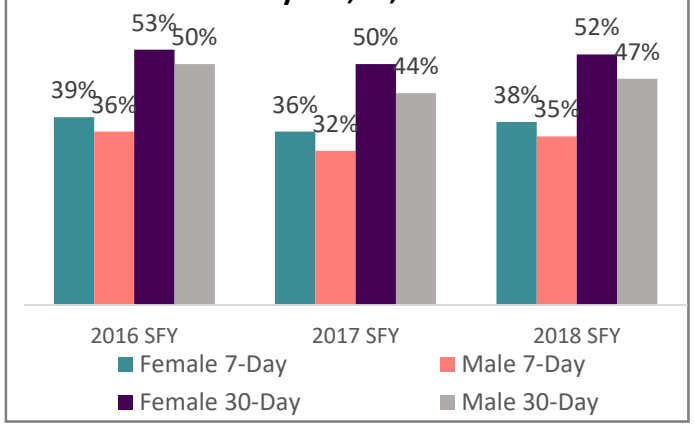
Mental Health Audit Measures for Commercially Available Health Plans, Rhode Island, 2018[1]



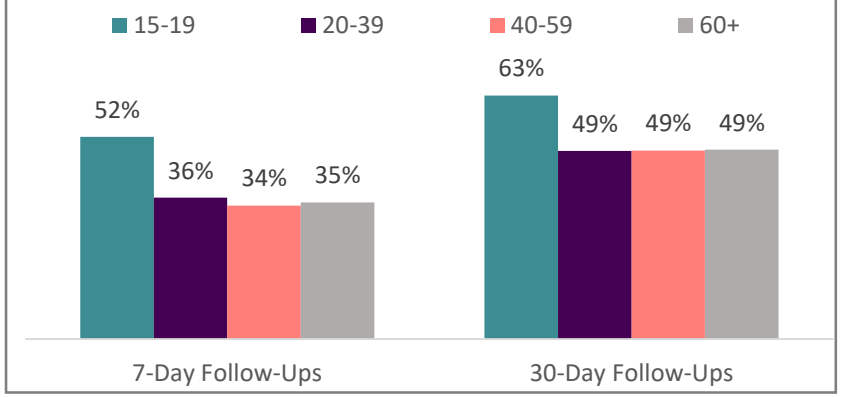
Key Takeaways:

- Follow-up care for mental illness, as indicated by ED visits, for Medicaid members is drastically less likely than those of commercial- and Medicare-insured individuals.
- The most followed HEDIS measure in 2018 was diabetes screening for individuals on antipsychotic medications. The least followed was metabolic monitoring for children on antipsychotics, at around 40%.
- The follow-up rates for MH ED visits is consistent between males and females.
- 15-19 year-olds are approximately 15% more likely to follow up after a MH ED visit after 30 days.

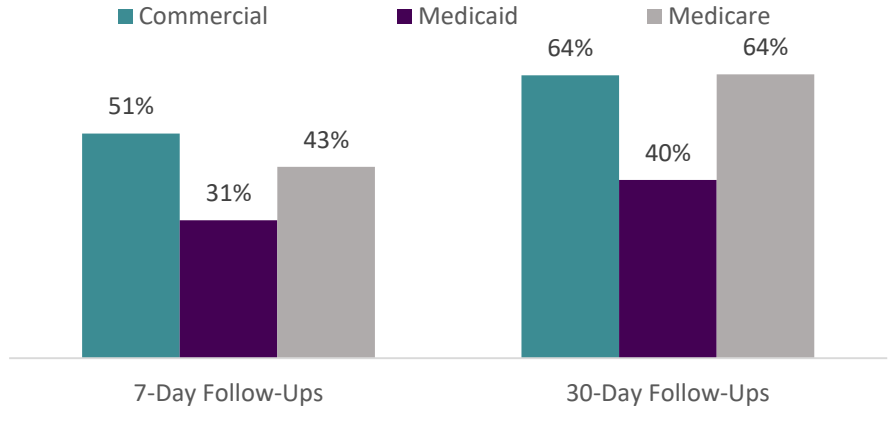
Post-Emergency Department Follow-Up Rates for Mental Illness by Sex, RI, 2016-2018[2]



Post-Emergency Department Follow-Up Rates for Mental Illness by Age, RI, SFY 2018[2]



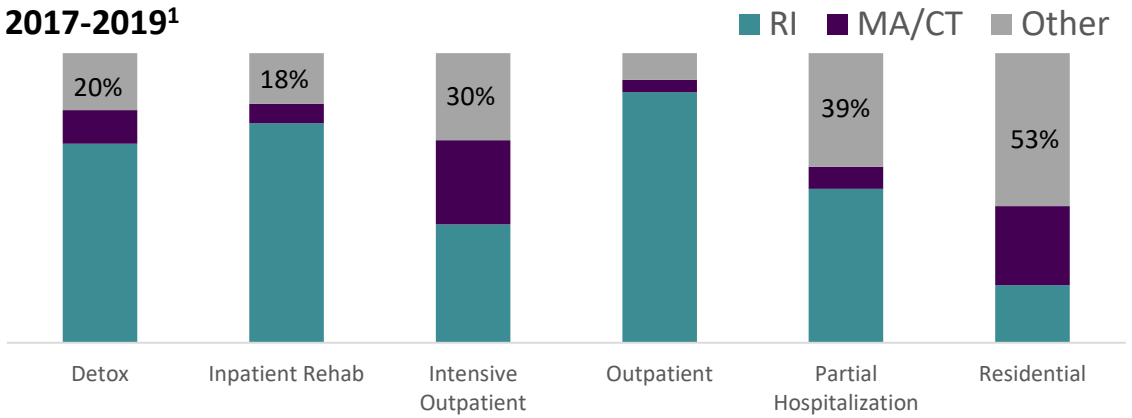
Post-Emergency Department Follow-Up Rates for Mental Illness by Insurance, RI, SFY 2018[2]



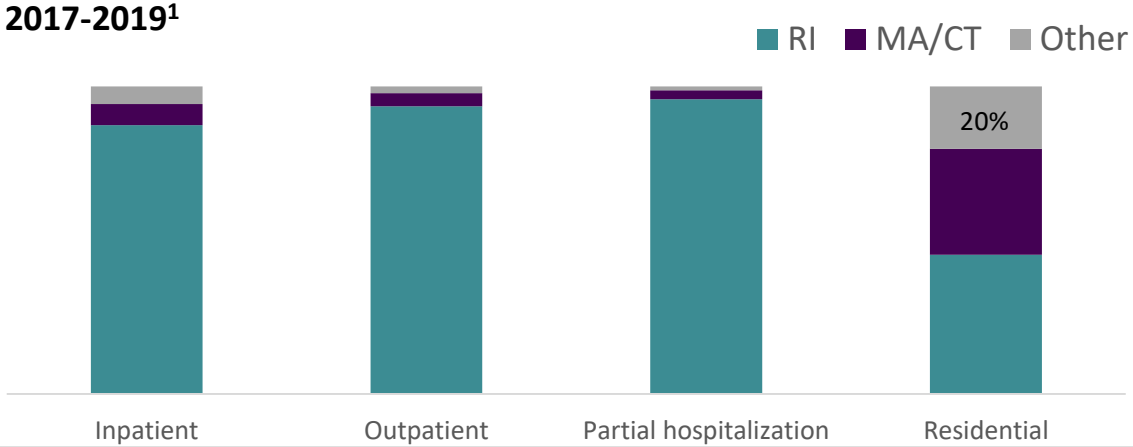
Source 1: HEDIS Audit Data Pull 6/12/2019
Source 2: HealthFacts RI Public Records, Follow-up Rates after ED Visit, https://health.ri.gov/data/healthfactsri/
Note: Follow-up rates are determined through claims data submitted to the RI APCD.

(16) Half of Rhode Islanders with commercial insurance or Medicare requiring substance use residential services obtain those services in a state other than RI, MA, or CT.

Distinct Users by Service Type for SUD Facilities by Location, RI APCD, 2017-2019[1]



Distinct Users by Service Type for MH Facilities by Location, RI APCD, 2017-2019[1]



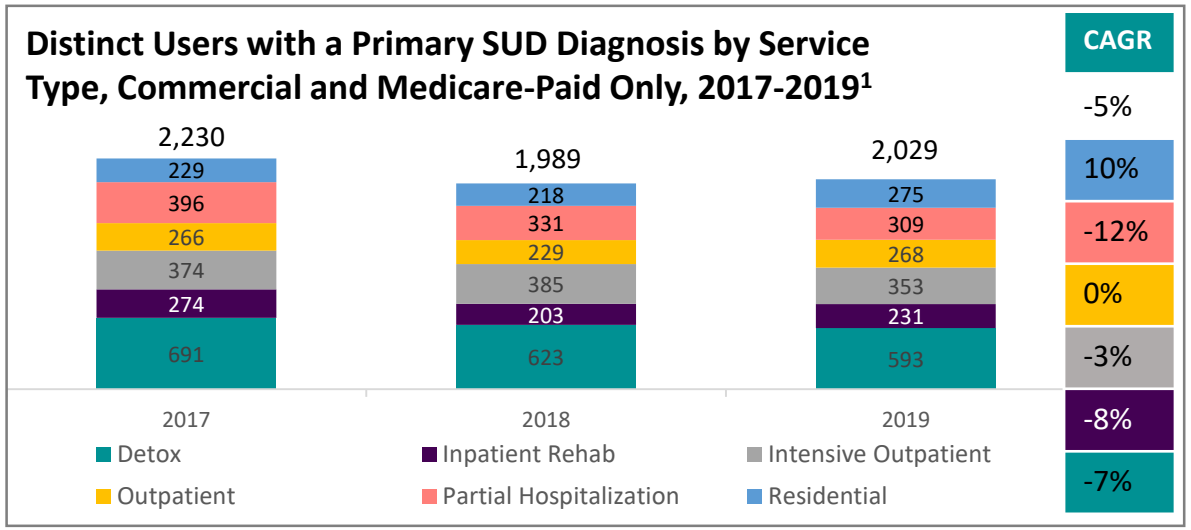
Key Takeaways:

- For substance use facilities, 53% of Rhode Island commercial- or Medicare-paid individuals obtain residential services in a state other than RI, MA, or CT. 39% of individuals utilizing partial hospitalization services also obtain that care in another state.
- For mental health facilities, 20% of Rhode Island commercial- or Medicare-paid individuals obtain residential care in a state other than RI, MA, or CT.

Service	Top Out-of-State Facilities
Residential (SUD)	9 Village Inn Road (MA), Greenhouse Treatment Center (TX)
Partial Hospitalization (SUD)	Greenhouse Treatment Center (TX), Green Mountain Treatment Center (NH)
Intensive Outpatient (SUD)	AdCare of Worcester (MA), Recovering Champions (MA)
Detox (SUD)	AdCare of Worcester (MA), SBH Haverhill (MA)
Residential (MH)	The McLean Hospital (MA), Northeast Behavioral Health (MA)

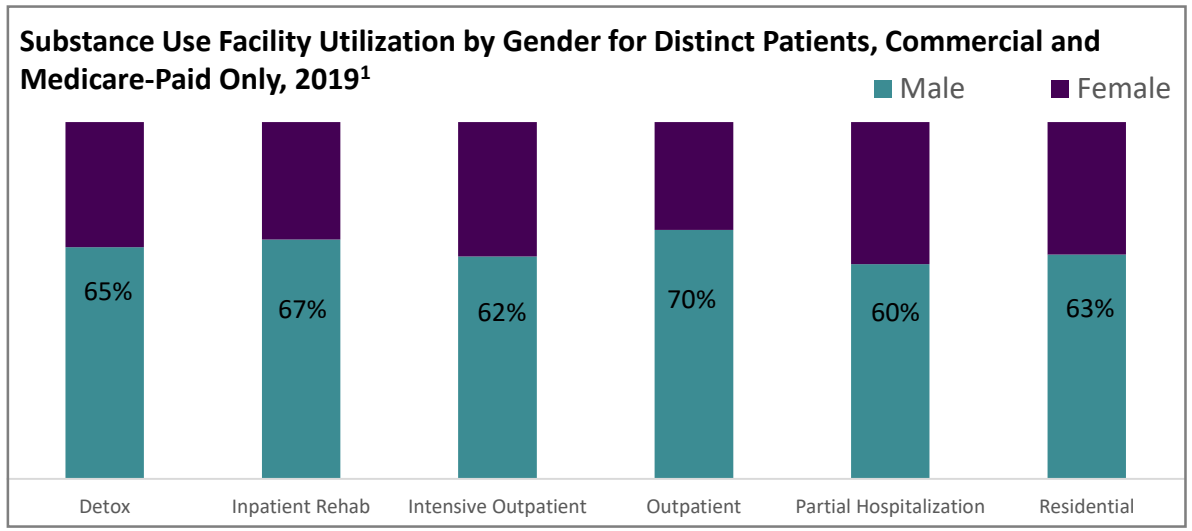
Source 1: RI APCD Data Pull, Freedman Healthcare, November 2020; only including commercial or Medicare-paid services. Substance use admissions has an average of 1,217 distinct patients per year, and mental health admissions has an average of 3,750 distinct patients per year.
Note: "Commercial" refers to fully-insured only. APCD Data excludes those insured by hospital confinement, disability income, accident-only claims, long-term care, Medicare supplement, limited benefit health insurance, specified disease indemnity, and other limited benefit policies. Data is also excluded from the following sources: commercial insurance plans with fewer than 3,000 covered lives in RI; dental insurance; federal programs including TRICARE, FEHBP< DVA, and the Indian Health Service; payments made out-of-pocket; and non-claims-related payments.

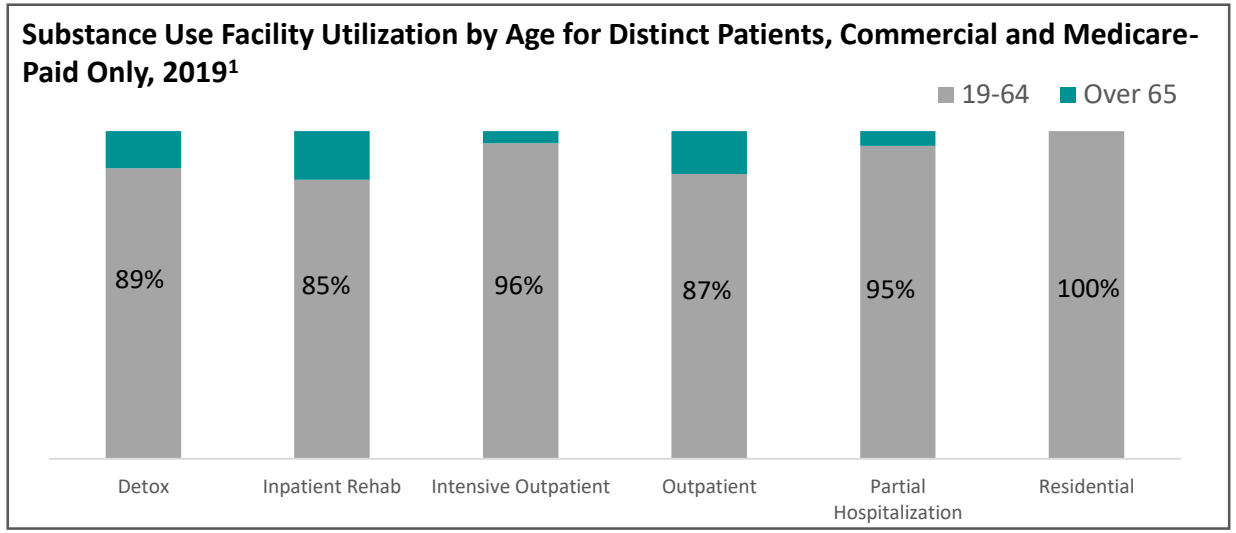
(17)Between 2017 and 2019, service utilization declined among commercial and Medicare patients with a primary SUD diagnosis. This has been driven by partial hospitalization services, which decreased 12% annually.



Key Takeaways:

- Between 2017 and 2019, there has been an average annual growth rate of -5% in utilization by individuals with a primary SUD diagnosis. This has been driven by partial hospitalization services, which decreased 12% annually.
- Males make up most SUD facility utilization in all categories.
- Individuals over 65 are mostly admitted to SUD facilities for detox services, inpatient rehab, or outpatient services.
- Butler Hospital, Prospect, and AdCare RI make up 80% of all distinct detox admissions across all payors from 2017-2019. Butler Hospital, The Providence Center, and Community Care Alliance make up 80% of all distinct outpatient utilization across all payors from 2017-2019.

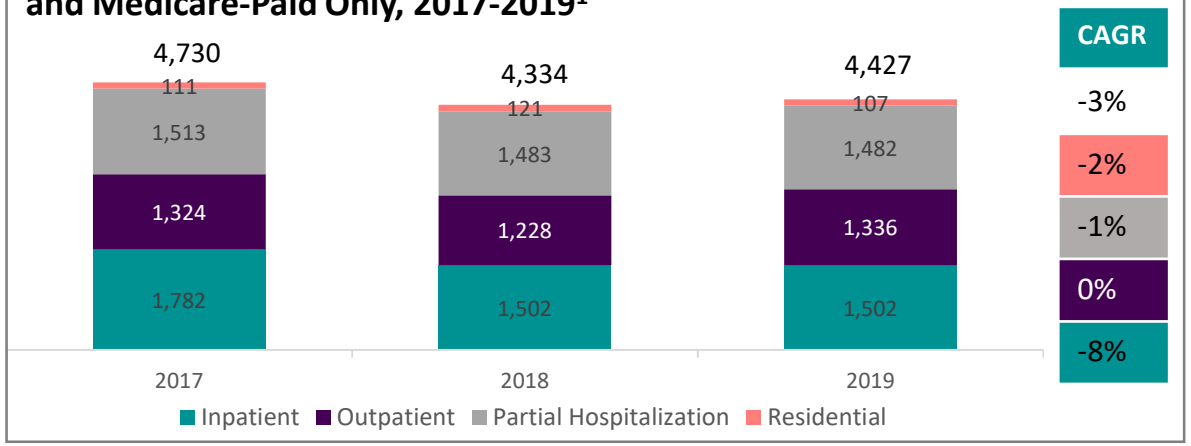




Source 1: RI APCD Data Pull, Freedman Healthcare, November 2020; only counting commercial or Medicare-paid services. Substance use admissions has an average of 1,217 distinct patients per year, and mental health admissions has an average of 3,750 distinct patients per year.
Note: Average annual growth rate determined by CAGR. "Commercial" refers to fully-insured only. APCD Data excludes those insured by hospital confinement, disability income, accident-only claims, long-term care, Medicare supplement, limited benefit health insurance, specified disease indemnity, and other limited benefit policies. Data is also excluded from the following sources: commercial insurance plans with fewer than 3,000 covered lives in RI; dental insurance; federal programs including TRICARE, FEHBP< DVA, and the Indian Health Service; payments made out-of-pocket; and non-claims-related payments. There is a set capacity and one contributor to the increase in intakes is decreased LOS due to limited authorizations from the MCOs.

(18) Between 2017 and 2019, service utilization declined among Commercial and Medicare enrolled individuals with a primary MH diagnosis. This has been driven by inpatient services, which decreased 8% annually.

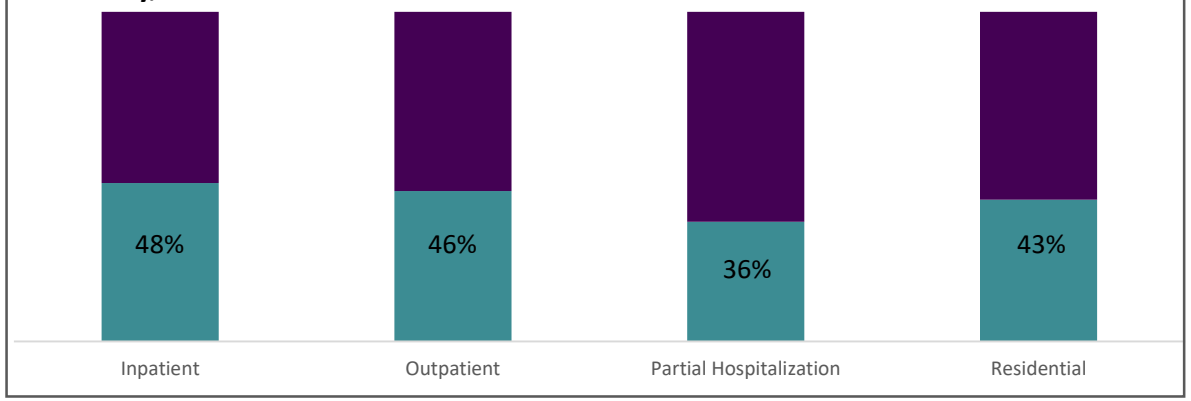
Distinct Users with a Primary MH Diagnosis by Service Type, Commercial and Medicare-Paid Only, 2017-2019[1]



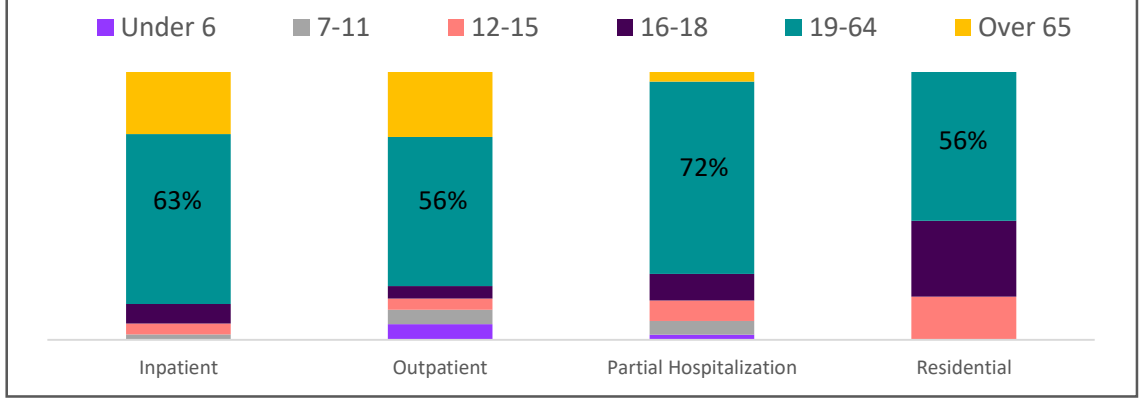
Key Takeaways:

- Between 2017 and 2019, there has been an average annual growth rate of -3% for individuals with a primary MH diagnosis. This has been driven by inpatient services, which decreased 8% annually.
- Partial hospitalization services have the greatest gender disparity at 64% female.
- Individuals over 65 mainly utilize inpatient or outpatient services.
- Butler Hospital, RI Hospital, and Prospect make up 73% of all distinct inpatient admissions across all payors from 2017-2019. Prospect, Bradley Hospital, and Gateway make up 50% of all residential admissions across all payors from 2017-2019.

Distinct Users with a Primary MH Diagnosis by Gender, Commercial and Medicare-Paid Only, 2019[1]



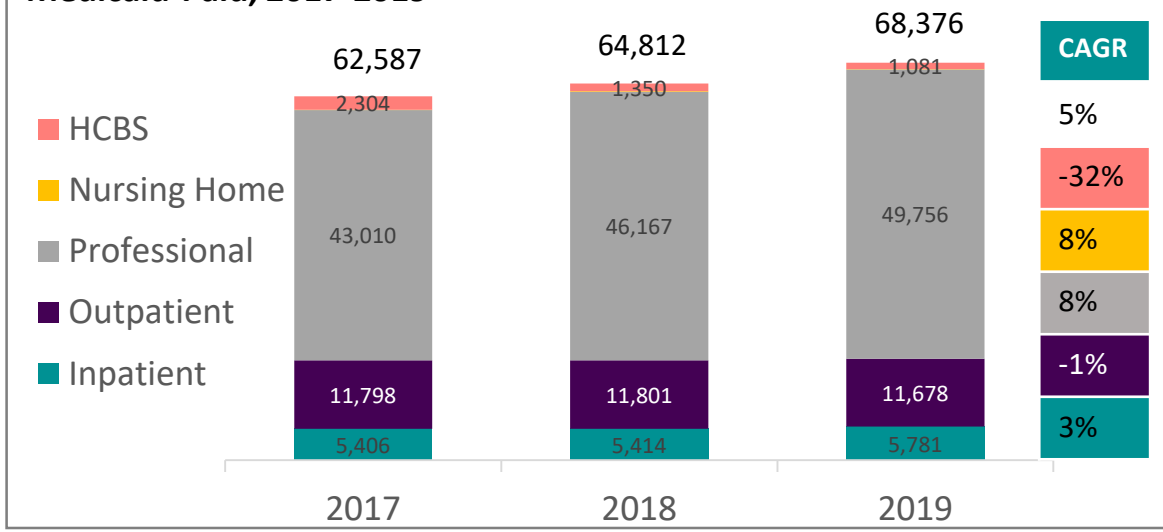
Distinct Users with a Primary MH Diagnosis by Age, Commercial and Medicare-Paid Only, 2019[1]



Source 1: RI APCD Data Pull, Freedman Healthcare, November 2020; only counting commercial or Medicare-paid services. Substance use admissions has an average of 1,217 distinct patients per year, and mental health admissions has an average of 3,750 distinct patients per year.
Note: Average annual growth rate determined by CAGR. "Commercial" refers to fully-insured only. APCD Data excludes those insured by hospital confinement, disability income, accident-only claims, long-term care, Medicare supplement, limited benefit health insurance, specified disease indemnity, and other limited benefit policies. Data is also excluded from the following sources: commercial insurance plans with fewer than 3,000 covered lives in RI; dental insurance; federal programs including TRICARE, FEHBP< DVA, and the Indian Health Service; payments made out-of-pocket; and non-claims-related payments.

(19) Among Medicaid members with a primary SUD diagnosis, utilization has grown an average of 5% per year from 2017 to 2019, driven by professional services which grew 8% annually.

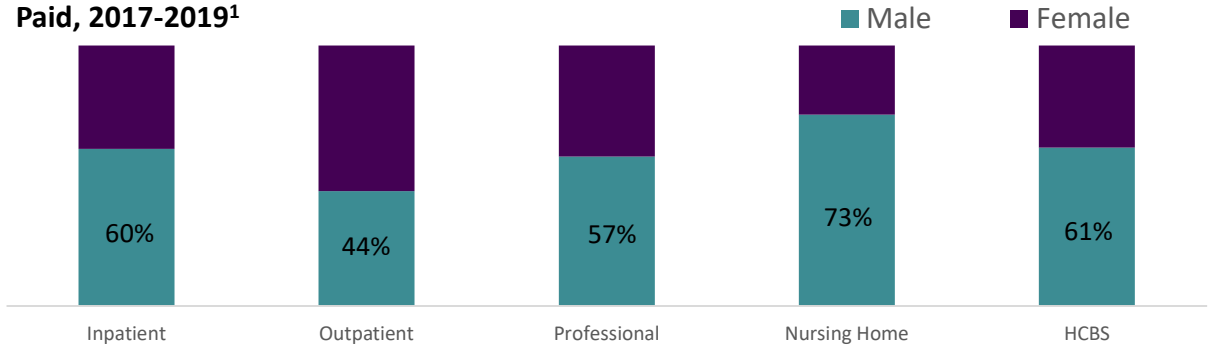
Facility Utilization for Distinct Patients with a Primary SUD Diagnosis, Medicaid-Paid, 2017-2019[1]



Key Takeaways:

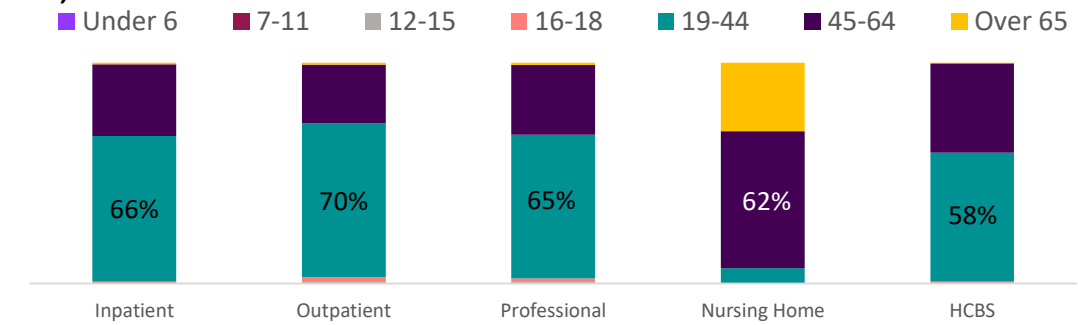
- Between 2017 and 2019, there has been an average annual growth rate of 5% per year in utilization, driven by professional services which grew 8% annually.
- Nursing home substance use services have the greatest gender disparity at 73% male.
- Substance use facility admissions are majority aged 19-44 except in nursing homes, where 62% of unique admissions are in the 45-64 age group.

Facility Utilization for Distinct Patients with a Primary SUD Diagnosis, Medicaid-Paid, 2017-2019[1]



Some data suppressed due to small sample size.

Facility Utilization for Distinct Patients with a Primary SUD Diagnosis, Medicaid-Paid, 2017-2019[1]

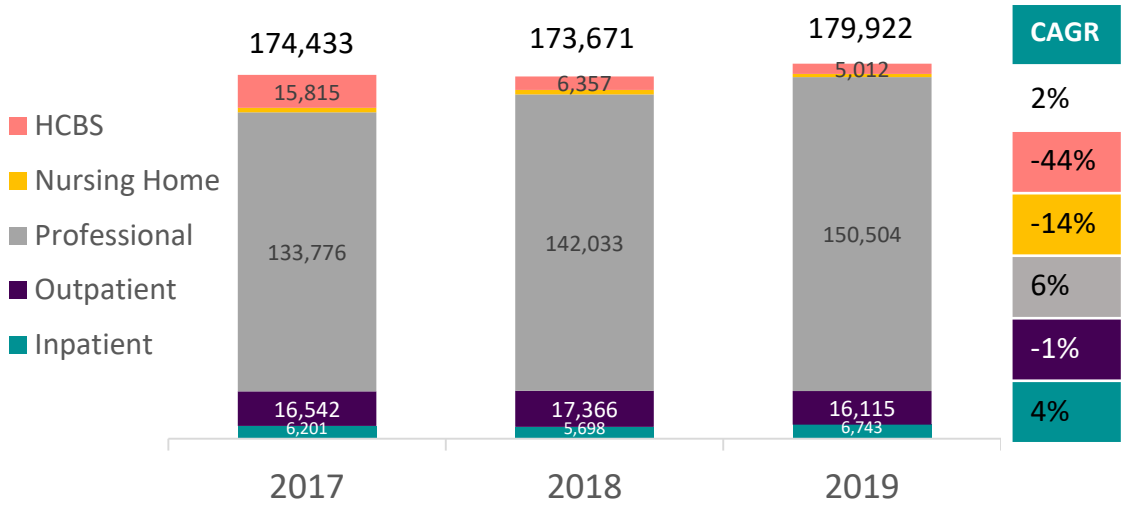


Some data suppressed due to small sample size.

Source 1: MMIS, Medicaid-Paid Services Only, November 2020.
Note: Average annual growth rate determined by CAGR. Nursing home claims includes Eleanor Slater and Tavares Claims as well as RICLASS group home claims. Professional services are determined by claim type and are services not included in inpatient/outpatient services nor provided in institutional settings.

(20) Among Medicaid members with a primary MH diagnosis, utilization grew an average 2% per year from 2017 to 2019, driven by professional services which grew 6% annually.

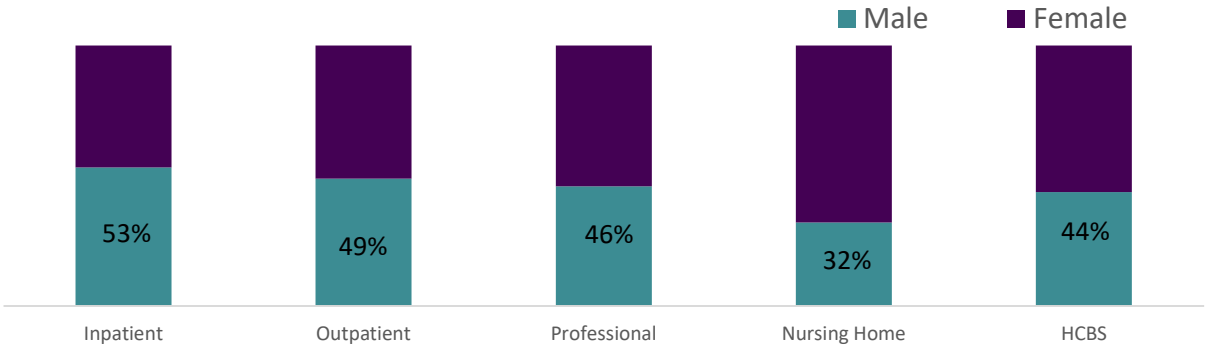
Facility Utilization for Distinct Patients with a Primary MH Diagnosis, Medicaid-Paid, 2017-2019[1]



Key Takeaways:

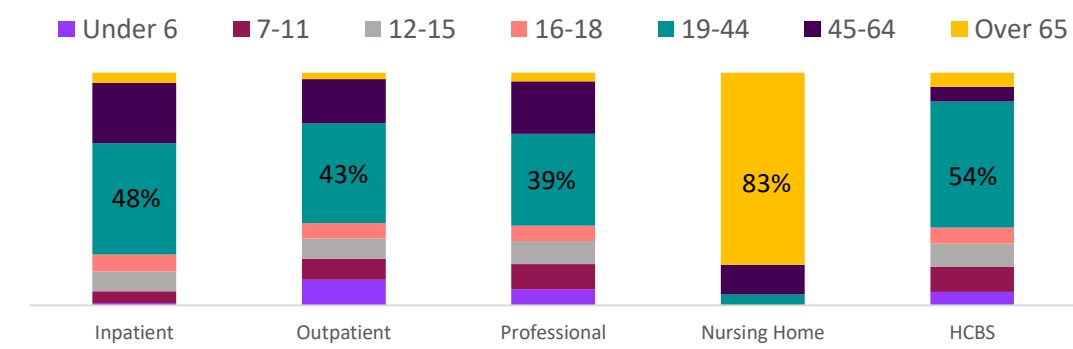
- Between 2017 and 2019, there has been an average annual growth rate of 2% per year in utilization, driven by professional services which grew 6% annually.
- Nursing home mental health services have the greatest gender disparity at 68% female.
- Mental health facility admissions are more age-neutral than substance use facility admissions, although most admissions are still in the 19-64 age range. Nursing home admissions are 83% over the age of 65.

Facility Utilization for Distinct Patients with a Primary MH Diagnosis, 2017-2019[1]



Some data suppressed due to small sample size.

Facility Utilization for Distinct Patients with a Primary MH Diagnosis, 2017-2019[1]



Some data suppressed due to small sample size.

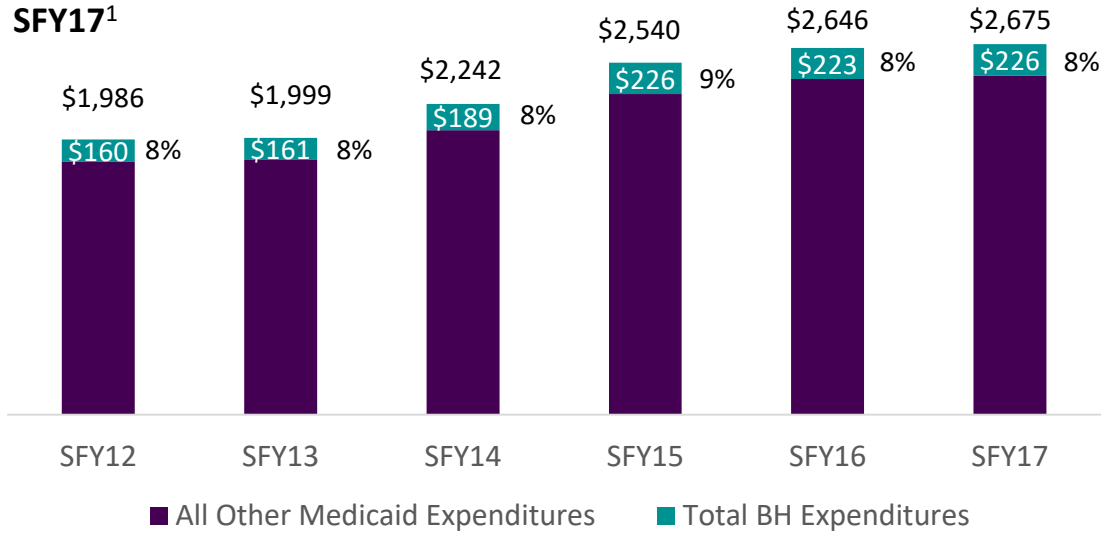
Source 1: MMIS, Medicaid-Paid Services Only, November 2020.
Note: Average annual growth rate determined by CAGR. Nursing home claims includes Eleanor Slater and Tavares Claims as well as RICLASS group home claims. Professional services are determined by claim type and are services not included in inpatient/outpatient services nor provided in institutional settings.

(21) Rhode Island Medicaid expenditures on behavioral health services have steadily shifted away from community-based services toward inpatient services, suggesting an opportunity to "rebalance" these expenditures toward lower cost, less restrictive community-based settings.

Key Takeaways:

- Between SFY 2012-2017, overall Medicaid expenditures increased from $1,986 M to $2,675 M, an annual average growth rate of 6%.
- Over this period behavioral health expenditures remained a consistent 8% share of total expenditures, increasing proportionally to total spend.

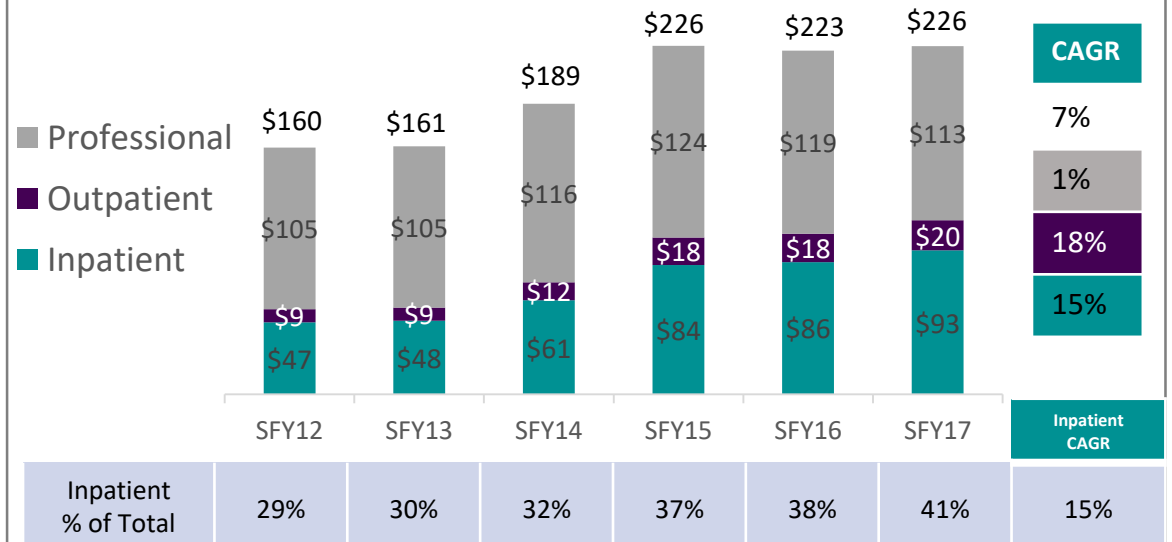
Total Medicaid Expenditures for Covered Services in Millions, RI, SFY12-SFY17[1]



Key Takeaways:

- Between SFY 2012-2017, Medicaid expenditures on behavioral health services increased from $160 Million to $226 Million, an average annual growth rate of 7%; these increases are largely driven by increases in inpatient expenditures.
- Medicaid expenditures on Behavioral Health services have been steadily shifting away from community-based services and toward inpatient services, as inpatient has increased from 29 to 41% of total expenditures – suggesting an opportunity to "rebalance" these expenditures toward lower cost, less restrictive community-based settings.

Medicaid BH Expenditure in Millions, RI, 2012-2017[1]

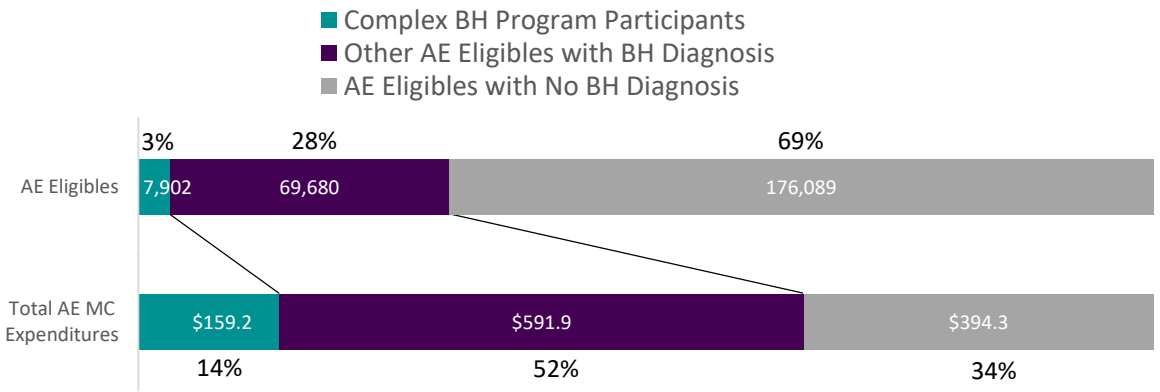


	SFY12	SFY13	SFY14	SFY15	SFY16	SFY17	Inpatient CAGR
Inpatient % of Total	29%	30%	32%	37%	38%	41%	15%

Source 1: Rhode Island Annual Medicaid Expenditure Report, page 31, SFY 2018, EOHHS. Includes Inpatient behavioral health, outpatient behavioral health, and professional BH behavioral health lines. Excludes HCBS, DD, NH/SNF/Hospice, Slater/Tav/Zam, and pharmacy lines.

(22) In Rhode Island Medicaid, 31% of Medicaid members eligible for the Accountable Entity (AE) program with BH diagnoses account for 66% of total AE Medicaid managed care expenditures.

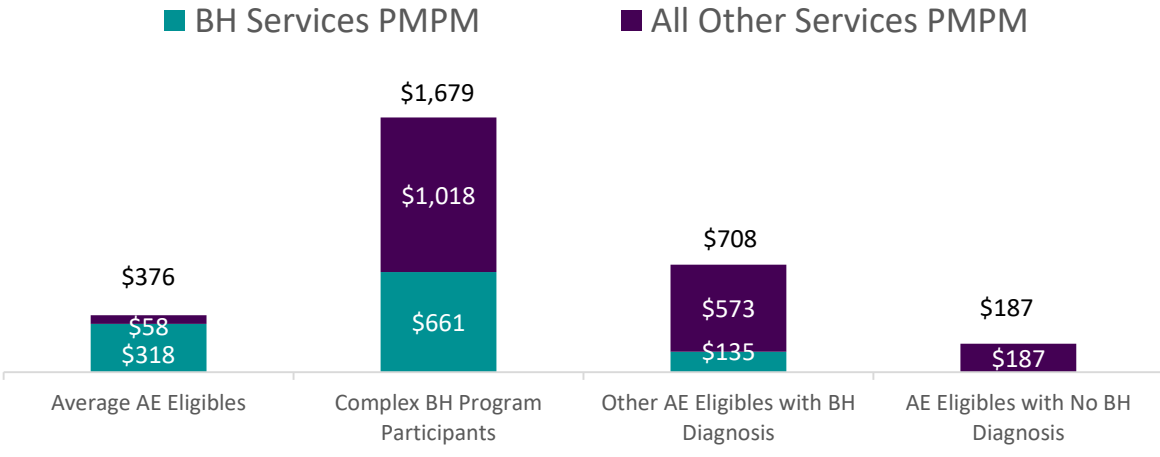
AE Eligibles and Total AE Managed Care Expenditures, RI, SFY 2018[1]



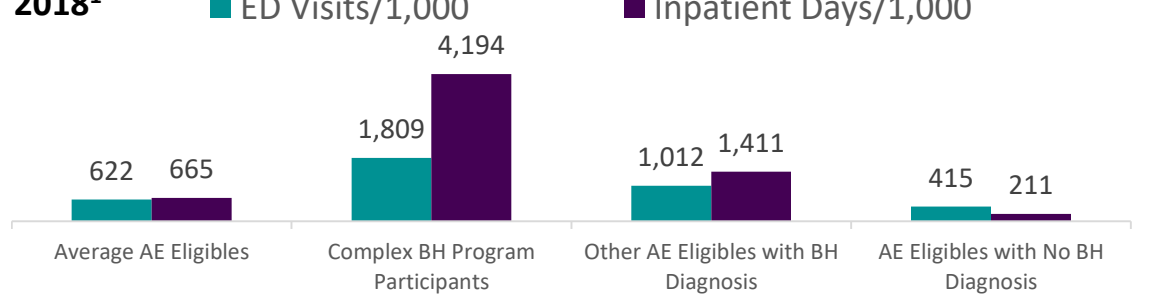
Key Takeaways:

- 31% of AE Eligibles with BH diagnoses account for 66% of total AE Medicaid managed care expenditures.
- Complex BH program participants have a PMPM that is 9x higher than individuals with no BH diagnosis.
- Compared to individuals with no BH diagnosis, complex BH program participants utilize the emergency department 4.4x as often and utilize inpatient services 19.9x as often.
- *Note: Due to data limitations, the AE eligible population is used as a proxy for the total Medicaid population.*

AE Eligible Managed Care Expenditure PMPM by BH User Type, SFY 2018[1]



Emergency Department and Inpatient Utilization by AE Eligibles, RI, SFY 2018[1]



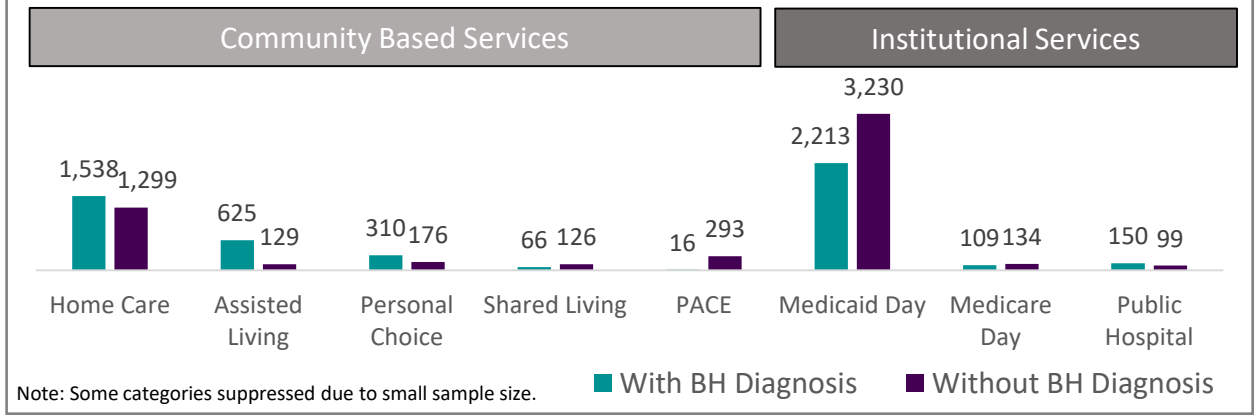
	Emergency Department	Inpatient
AE Complex BH Program Participants	4.4x	19.9x
Other AE Eligibles with BH diagnosis	2.4x	6.7x

Source 1: Accountable Entity Advisory Committee, EOHHS, Jan 2019 report

(23) Of those Medicaid LTSS eligible users with a BH diagnosis, about half receive institutional services, suggesting an opportunity to rebalance toward less restrictive, lower cost community-based settings.

Average Medicaid LTSS Eligibles per Month, 2018-2019

Eligible LTSS Members with a BH Diagnosis by Service, Average per Month, 2018-2019



Note: Some categories suppressed due to small sample size.

Key Takeaways:

- There are around 3,000 average Medicaid Long Term Services & Supports (LTSS) eligibles per month, across all services and populations.
- Half of these LTSS users have a BH diagnosis and of those individuals, half are in institutional settings, suggesting an opportunity to "rebalance" toward less restrictive, lower cost community-based settings.
- LTSS members with a BH diagnosis utilize home care services 20% more than individuals without a BH diagnosis. They are also nearly 5x as likely to be in assisted living compared to individuals without a BH diagnosis.

Note: "Community" LTSS members includes individuals in home care, assisted living, personal choice, group home, shared living, and PACE settings. "Institutional" LTSS members includes individuals in Medicaid day services, Medicare day services, and public hospital settings.

Averages based on monthly eligibility/utilization over the 18-month period, July 2018-December 2019. For Institutional LTSS, the average and confidence interval was calculated over the 12-month period of FY 2019 only to allow for a more significant lag in determinations/claims.

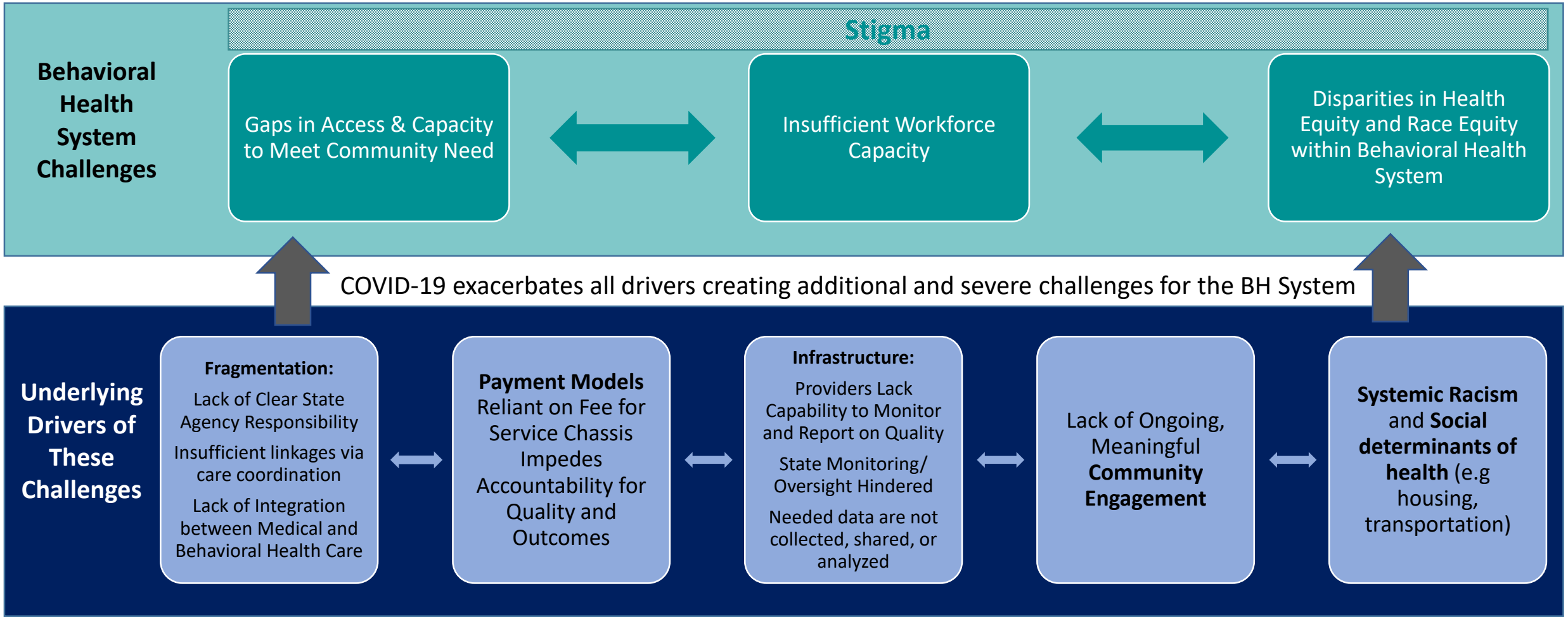
BH condition defined as member having a claim within the SFY with (a) a primary diagnosis between 'F01' and 'F69' or between 'F90' and 'F99' or between 'X710' and 'X838', or (b) from a state CMHO regulated by BHDDH, or (c) specific procedure codes for BH services.

Source: Summary of Potential Medicaid-Related PCOC Population in Rhode Island, MMIS, Community LTSS (July 1, 2018 – Dec 21, 2019), Institutional LTSS (July 1, 2018 – June 30, 2019)

Table of Contents

Summary of Key Findings

Key themes have emerged from quantitative and qualitative research include challenges in the current behavioral health system, and underlying drivers of those challenges. Any policy solutions must address the underlying drivers, otherwise the challenges will persist.



Gaps Between Supply and Demand

Significant gaps in the behavioral health system exist, as identified through both quantitative and qualitative analysis. The next three pages document gaps in:

- Rhode Island's continuum of care for mental health for adults and older adults.
- Rhode Island's continuum of care for substance use for adults and older adults
- Rhode Island's continuum of care for behavioral health for children.

Gap indicates that there was no evidence in our qualitative or quantitative analysis of the service existing in Rhode Island.
Shortage indicates that while some level of service exists it is not adequate to meet the need of Rhode Islanders with BH/SUD conditions.

Additional quantitative and qualitative detail for six specific gaps is provided on subsequent pages:

System Concern Due to Gaps:
1. **Access to children's behavioral heath services is significant challenge for RI families, and for RI providers trying to match treatment level need with available capacity.**
2. **Rhode Islanders often struggle to access residential and hospital levels of care for mental health and substance use.**
3. **Capacity and access to prescribers within behavioral health treatment services is mixed.**
4. **Crisis services are difficult to access.**
5. **Access to counseling and other professional services in the community is mixed.**
6. Access to prevention services is inconsistent and under-funded.

Qualitative feedback from the community also offered substantial detail on access challenges.

Rhode Island's Continuum of Care for Mental Health for Adults and Older Adults

	Gap (None)	Significant Shortage	Moderate Shortage	Slight Shortage	Evidence Source
Prevention		Universal BH Prevention Services			Qualitative
Clinical	Mobile Crisis Treatment				Qualitative/Quantitative
		Hospital Diversion			Qualitative/Quantitative
			Non-CMHC Outpatient Providers		Qualitative/Quantitative
			Intensive Outpatient Programs		Qualitative/Quantitative
			Dual Diagnosis Treatment		Qualitative
			Crisis/Emergency Care		Qualitative
			Inpatient Treatment		Qualitative/Quantitative
				Licensed Community Mental Health Centers	Qualitative/Quantitative
LTSS		State Sponsored Institutional Services			Qualitative/Quantitative
		Nursing Home			Qualitative
		Residential/Housing			Quantitative/Qualitative
			Home Care		Qualitative
Wrap-Around			Homeless Outreach		Qualitative

Rhode Island's Continuum of Care for Substance Use for Adults and Older Adults

	Gap (None)	Significant Shortage	Moderate Shortage	Slight Shortage	Evidence Source
Prevention		Indicated Prevention			Qualitative
Treatment	Mobile MAT				Qualitative/Quantitative
		Correctional SUD Transition Services	Detoxification		Qualitative
			Intensive Outpatient Services		Qualitative/Quantitative
			Low Intensity Residential		Qualitative/Quantitative
			High Intensity Residential		Qualitative/Quantitative
Recovery Supports		Recovery Housing			Qualitative
			Supported Employment		Qualitative

Rhode Island's Continuum of Care for Behavioral Health for Children

	Gap (None)	Significant Shortage	Moderate Shortage	Slight Shortage	Evidence Source
Prevention		All Universal, Indicated, and Targeted Prevention Programs			Qualitative
Mild, Moderate and Intensive	Community Step Down				Qualitative
	Transition Age Youth Services				Qualitative
		Home Based Therapeutic Services			Qualitative
			SUD Treatment		Qualitative/Quantitative
			Enhanced Outpatient Services		Qualitative/Quantitative
			Home and Community Based Services		Qualitative
			Mobile Crisis		Qualitative
Residential Services	Residential Treatment for Eating Disorders				Quantitative/Qualitative
		Residential Treatment for Adolescent Females			Quantitative/Qualitative
		Acute Residential Treatment			Quantitative
Acute Inpatient				Emergency Services	Qualitative

Problem Diagnosis: Services Assessed as More Adequate When Compared to Other Shortages Identified in the Continuum of Care

Adult Mental Health Services:

- Community Health Centers
- Primary Care Providers
- College Counseling Centers
- Treatment for people with TBI
- Correctional Mental Health
- IHH/ACT
- Psych Consult
- ACT
- Day Habilitation
- Club House
- Home and Community Based Services

This slide is not intended to convey that services listed are not in need of improvement or that individuals in RI do not experience challenges in accessing the services listed above. This list includes the comprehensive service array throughout the adult and children's continuum that were queried and assessed in addition to the services included in prior slides.

Adult Substance Use Disorder Services:

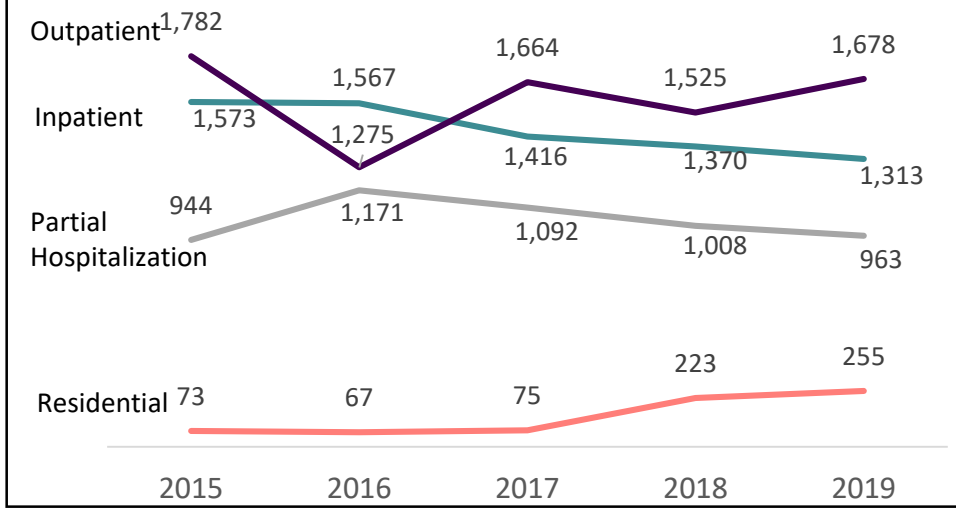
- Universal and Selective Prevention
- Early Intervention
- Crisis/Emergency Care
- Primary Care Providers
- Community Health Centers
- Outpatient Services
- Opioid Treatment Programs
- Correctional SUD Services
- Partial Hospitalization
- Medically Monitored Recovery
- Medically Managed Recovery
- Recovery Centers
- Case Management
- Peer Recovery Supports

Children's Behavioral Health Services:

- Non-Profit Human Service Agencies
- Community Action Programs
- Independent Providers or Small Group Providers
- School-based BH Services
- Early Intervention Programs
- Kids Connect
- PediPRN
- MomPRN
- Community Mental Health Centers (CMHCs)
- Partial Hospitalization Programs (PHP)
- Intensive Outpatient Programs (IOP)
- Family Care and Community Partnership (FCCP)
- Cedar
- DCYF Home-Based
- Alternative Education Programs
- KidsLink RI
- Applied Behavioral Health Analysis
- Personal Assistance Supports and Services
- Respite

Gap 1: Access to children's behavioral heath services is a significant challenge for RI families, and for RI providers trying to match treatment level need with available capacity.

Children Under Age 19 Treated at RI Psychiatric Hospitals, by Program, 2015-2019[1]



CAGR Values	
Outpatient:	-1.5%
Inpatient:	-4.4%
Partial Hospitalization:	0.5%
Residential:	36.7%

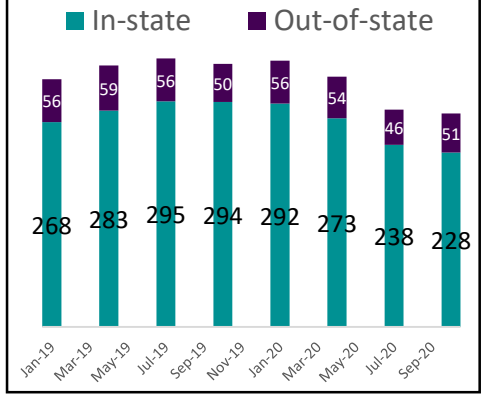
Key Takeaways

- Residential child psych services have seen a significant increase over the past year; a 2x increase in utilization from 2017 to 2019.
- Outpatient and inpatient services have been decreasing, while partial hospitalization has been relatively steady.
- Stakeholders report significant wait times for acute services and step-down services.
- Residential placements for children have been decreasing over the course of 2020.

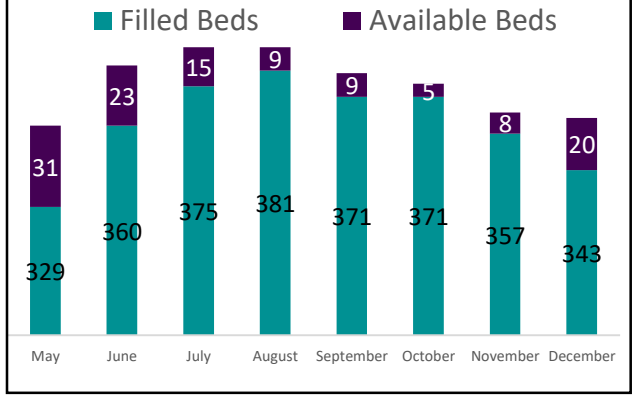
Qualitative Findings on Wait Times, Boarding and Transition Aged Youth:

- Stakeholders frequently cited long wait lists for beds at Bradley, noting that it was often at or near capacity, resulting in children "boarding" or "camping" in the emergency department, often teenagers.
- Many stakeholders attributed the lack of IP capacity and long wait lists to lack of available step-down services, resulting in longer IP stays. Youth can be stabilized in the hospital, but due to insufficient capacity for treatment in the community, youth often cycle back in and out of the hospital for BH care (see page 67 for more detail on mobile crisis opportunities)
- Stakeholders also expressed concerns about transition in age from the children's BH system to the adult BH system, noting that this transition is one of the most important transition periods in a child's life. Despite this importance, the transition is far from seamless and many children fall through the cracks when transitioning between the systems and changing from youth to adult services.

DCYF Residential Placements for Children, 2019-2020[3]



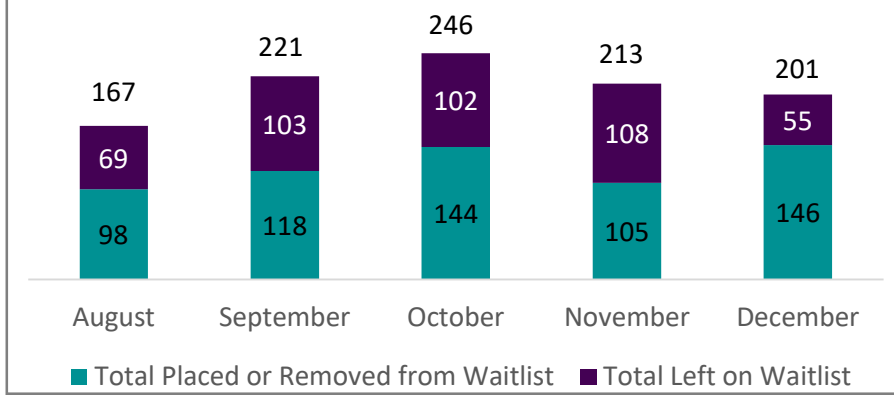
Average Available and Filled Beds for Children and Adolescents, RI, 2020[2]



Source 1: 2015-2019 Rhode Island KIDS COUNT Factbook / Health, http://www.rikidscount.org/Data-Publications/RI-Kids-Count-Factbook#821230-health
Source 2: BHOB Data Pull, Jan 2020, BHDDH; bed counts include BH – Adolescent, BH – Children, Hasbro 6-Green and CADD Unit
Source 3: DYCF Data Pull, Jan 2020

Gap 2: Rhode Islanders often struggle to access residential and hospital levels of care for mental health and substance use.

Total Individuals on SUD Residential Waitlist, 2020[3]

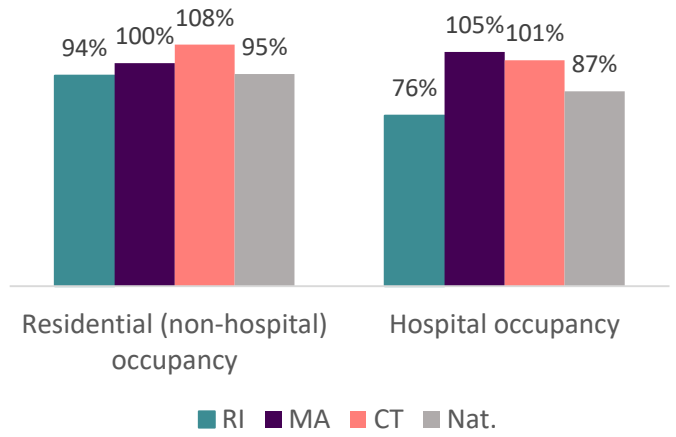


"We have a total lack of intensive/ED services in Rhode Island: the Hasbro ED is full of kids waiting for psych beds, waiting 24 hours for a bed. It is not ideal to have kids (in crisis) waiting for psych beds."
-- Community Stakeholder

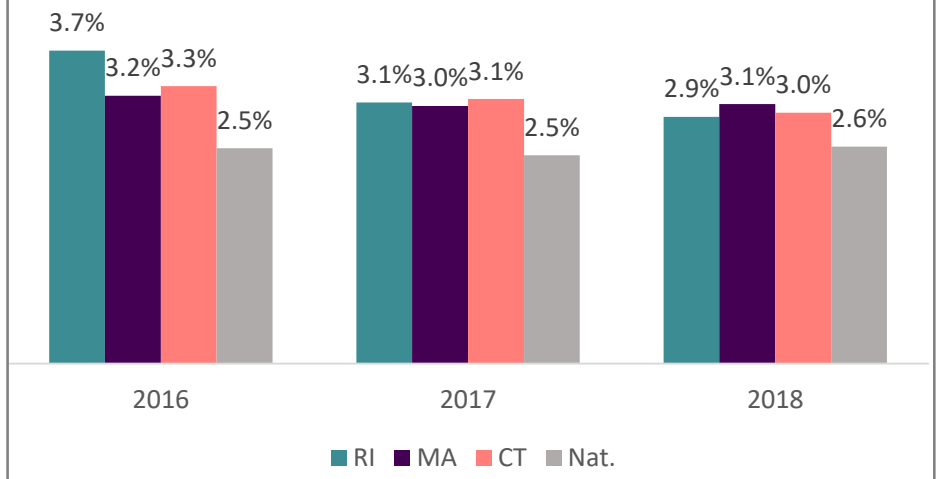
Key Takeaways

- Stakeholders report significant wait-times for inpatient & residential services, especially during the COVID crisis.
- In contrast to stakeholder feedback, Rhode Island's occupancy rate for hospital utilization in a SAMHSA sample in 2019 was 76%, while residential occupancy is 94%, both the lowest among regional and national benchmarks.
- Rhode Island has similar rates of unmet need for substance use disorders as neighboring states. New England does have slightly higher rates of unmet need than the national average.

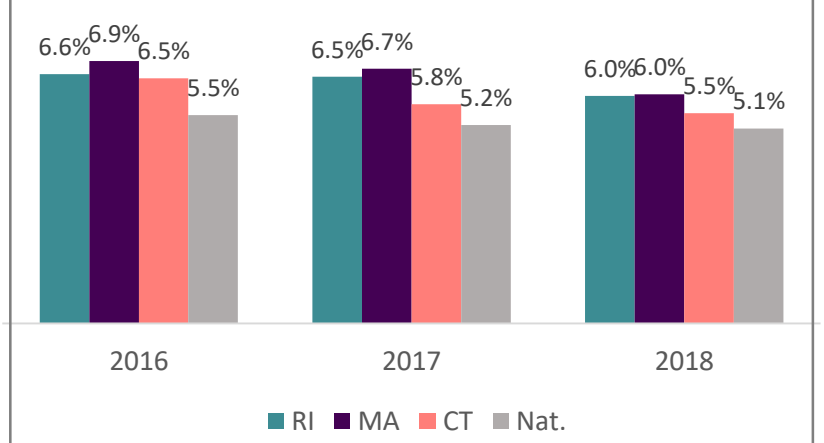
Occupancy Rate for Residential/Hospital Inpatient Services at SUD Treatment Facilities, March 29th 2019[2]



Needing But Not Receiving Treatment for Illicit Drug Use in the Past Year, 2016-2018[1]



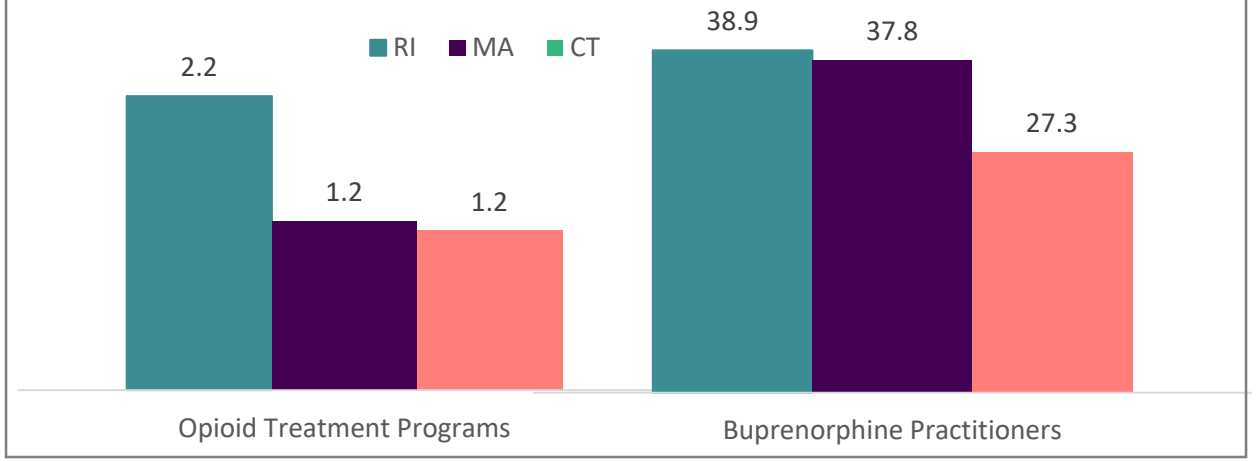
Needing But Not Receiving Treatment for Alcohol Use in the Past Year, 2016-2018[1]



Source 1: National Survey on Drug Use and Health: Model-Based Prevalence Estimates, SAMHSA, https://www.samhsa.gov/data/sites/default/files/reports/rpt23235/2k18SAEExcelTabs/NSDUHsaePercents2018.pdf, Tables 24/25
Source 2: https://wwwdasis.samhsa.gov/dasis2/nssats.htm, Table 6.19 **Notes:** Information is collected from facilities that provide substance abuse treatment. "Facility" may be program-level, clinic-level or multi-site respondent. Occupancy rates were calculated by dividing the number of clients by the number of designated beds. SUD clients may also occupy non-designated beds, so occupancy rates could be more than 100%.
Source 3: SUD Residential Waitlist Numbers data pull, BHDDH, January 2020

Gap 3: Capacity and access to prescribers within behavioral health treatment services is mixed.

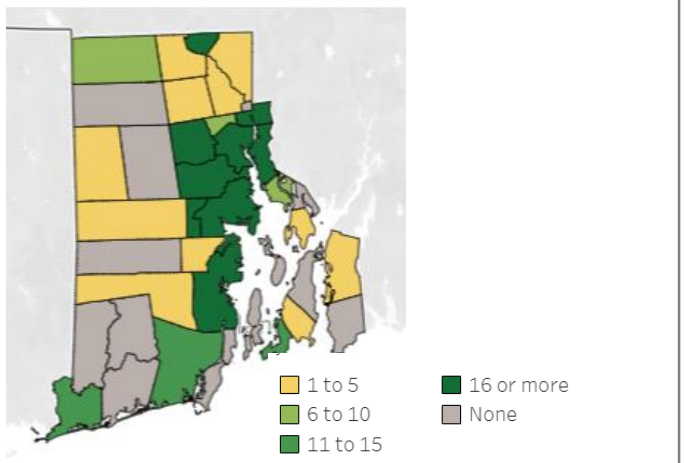
Number of OTPs and Buprenorphine Practitioners by State per 100,000 Population, 2020[N,2]



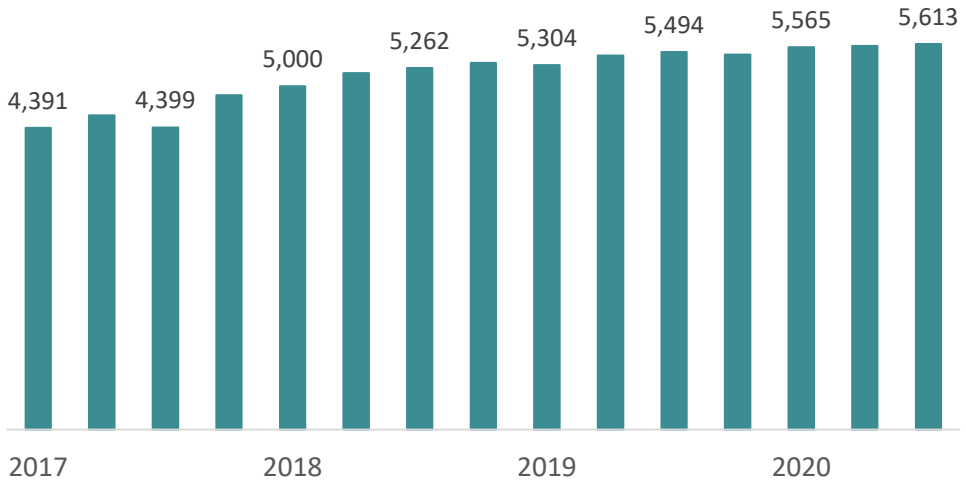
Key Takeaways

- RI has 1.5x the number of OTPs of MA and CT and nearly the same amount of buprenorphine practitioners as MA.
- The number of patients receiving buprenorphine has increased by 25% since 2017, despite number of providers increasing 200%.
- Rhode Islanders in Western RI and Bristol county likely need to travel to obtain access to MAT.
- Rhode Island has a higher number of psychiatrists per 100k population (23.5) than all other New England states except for Massachusetts (30.0). However, Rhode Island has the highest number of child and adolescent psychiatrists per 100k in the United States (8.1), excluding the District of Columbia[3].

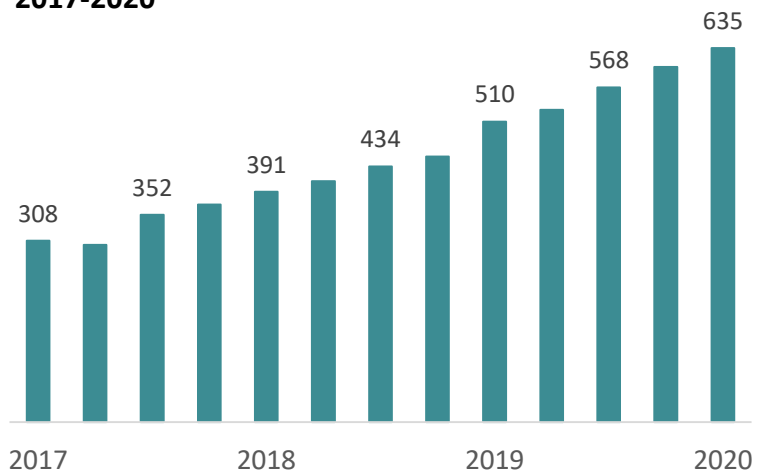
Waivered Providers Able to Prescribe Buprenorphine, Opioid Treatment Programs for Methadone. and Vivitrol Providers[1]



Number of Patients Actively Receiving Buprenorphine, 2017-2020[1]



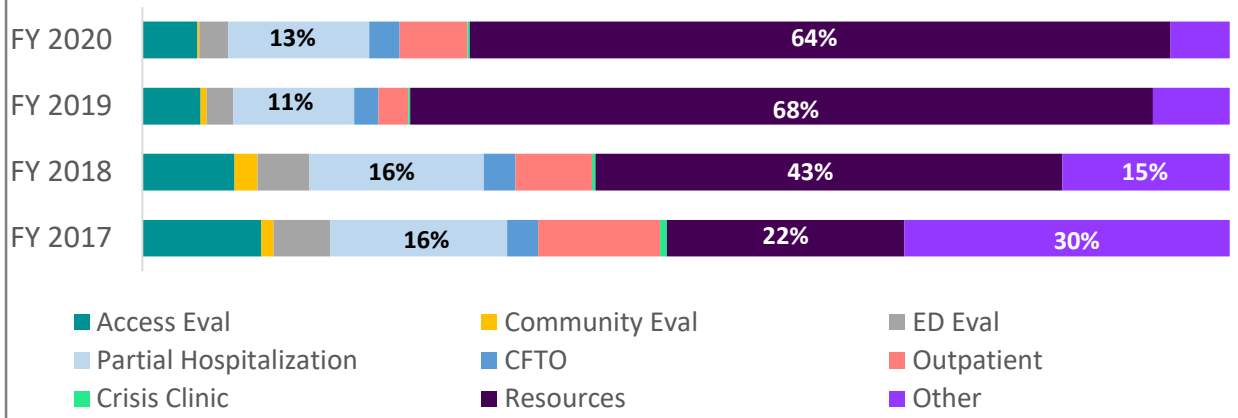
Number of Trained and DATA-Waivered Practitioners, 2017-2020[1]



Source 1: https://preventoverdoseri.org/medication-assisted-therapy/
Source 2: SAMHSA, https://dpt2.samhsa.gov/treatment/directory.aspx, https://www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator; US Census, 2019 Population Data
Source 3:"Estimating the Distribution of the U.S. Psychiatric Subspecialist Workforce", School of Public Health, University of Michigan, December 2018, https://www.behavioralhealthworkforce.org/wp-content/uploads/2019/02/Y3-FA2-P2-Psych-Sub_Full-Report-FINAL2.19.2019.pdf
Note: "N" superscript denotes that data was normalized based on US Census Population Data

Gap 4: Crisis services are difficult to access.

Outcomes of BHLink Crisis Calls, FY 2017- Aug 2020[1]



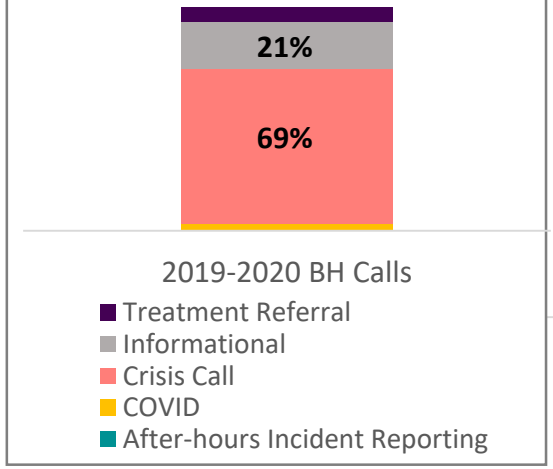
Key Takeaways

- Rhode Island providers are equipped to respond to crisis that occurs within a facility-setting. The percent of MH treatment facilities with a crisis team in RI is more than 2x MA and above the national average;
- However, resources are not well aligned to respond to crises that occurs in the community. 64% of individuals who call the BHLink crisis line are directed to resources, a 3x increase since 2017. However, Crisis Clinic referrals are comparatively very low. Stakeholders resoundingly called on the state to establish adequate access to mobile crisis assessment & treatment services.
- Rhode Island needs more wraparound services for families experiencing crisis at home or in the community.

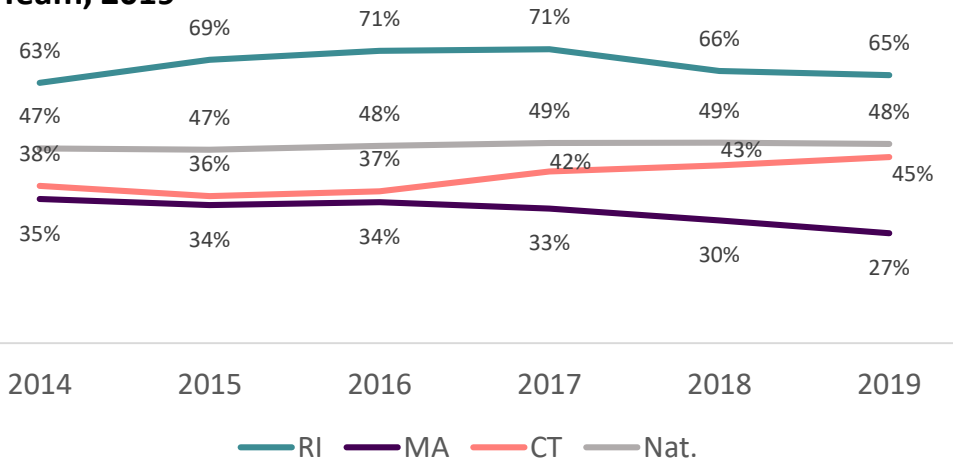
Qualitative Findings on Access to Mobile Crisis Treatment

- Stakeholders repeatedly acknowledged a lack of mobile treatment as a significant gap in the system.
- Many stakeholders, both from the community and from state agencies, repeated that Rhode Island does not have sufficient mobile crisis services for families experiencing acute BH needs.
- Stakeholders noted that other states have invested in mobile crisis units as a step-down approach to avoid hospitalizations, but that Rhode Island has not acted on this and has not build out such an intervention.

Number of Calls to BHLink by Reason for Call, 2019-2020[3]



% of MH Treatment Facilities that Employ a Crisis Intervention Team, 2019[2]



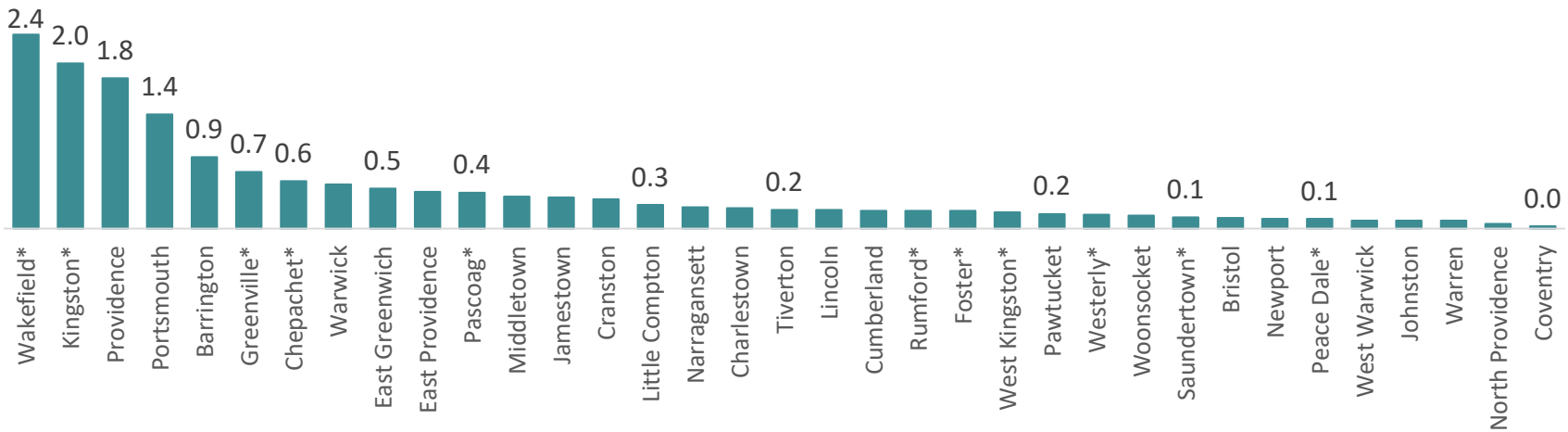
Source 1: BHLink and KidsLink data pull, RI DCYF, August 2020
Source 2: SAMHSA, NMHSS, https://wwwdasis.samhsa.gov/dasis2/nmhss.htm, Table 4.13
Source 3: BHLink data pull, January 2021

Gap 5: Access to counseling and other professional services in the community is mixed.

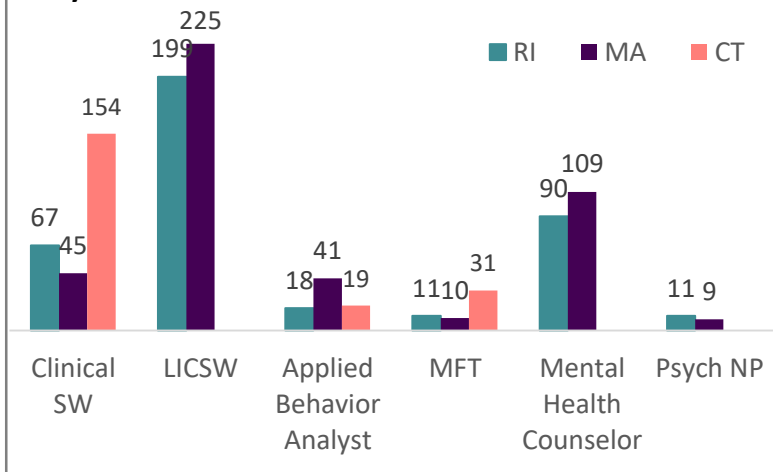
Key Takeaways

- 89% of RI cities & towns have fewer than one psychologist per 1,000 people. Wakefield, Kingston, and Providence have the highest number of psychologists per population in Rhode Island.
- RI has fewer licensed mental health counselors, social workers in healthcare and social workers in MH/SUD than regional peers.

Psychologists per 1,000 People by City, Rhode Island, 2020[1]



BH Health Professionals per 100,000 Population, May 2019[2]



Note: Only active licenses counted. Population data taken from 2019 census. * denotes that 2010 census data used due to lack of recent information.
Source 1: RIDOH, https://health.ri.gov/find/licensees/, US Census, https://www.census.gov/quickfacts/fact/table/US/PST045219
Source 2: https://health.ri.gov/lists/licensees/, https://elicensing.mass.gov/CitizenAccess/GeneralProperty/PropertyLookUp.aspx?isLicensee=Y, https://www.elicense.ct.gov/Lookup/GenerateRoster.aspx

Gap 6: Access to prevention services is inconsistent and under-funded.

Universal Prevention: Rhode Island needs more consistency and widespread access to universal prevention across all populations. Stakeholder feedback indicates that minority populations have less access to universal prevention services.
Selected Prevention: KidsLink improves referral to appropriate interventions, however, there is still concern about kids having sufficient access to prevention services based on Adverse Childhood Experiences (ACEs).
Indicated Prevention: Qualitative feedback indicates that there is discrepancy (driven by racial equity concerns) that impedes minors receiving quality prevention services. There is an over reliance on punitive and under reliance on preventive when issues are identified.

Qualitative Findings on Prevention:

- Rhode Island needs to do more work on prevention and behavioral health in school settings. RI schools are already overburdened (e.g. RI does not come close to national benchmarks for staff to student ratios) and the school system is already overtaxed.
- State agency stakeholders advocated for connecting schools with community-based BH services, as well as having dedicated BH staff integrated within schools to support students.
- Stakeholders also advocated to connect more prevention services to workplaces and colleges.
- Both community and state agency stakeholders noted that prevention services need to serve populations across the entire lifespan.

Key Takeaways

- Treatment capacity challenges could be driven by insufficient access to prevention.
- Prevention service access and capacity varies considerably by community and funding source.
- Schools and law enforcement must be part of the BH continuum of care to support prevention. Children of color are often targeted for BH intervention differently and are more apt to be referred by schools to law enforcement than to more appropriate treatment resources.
- Need improved data collection to monitor and scale needed prevention services in Rhode Island.

"Rhode Island's BH system is made up primarily of reactionary services — we are missing prevention. We need to be more proactive, with more pre-event services for people experiencing BH needs. It is better to prevent than to treat." -- Community Stakeholder

"Mental illness is preventable - but in RI we do not have a rich array of prevention services. We should look at behavioral health from birth to death - but in Rhode Island, we are lacking in prevention." -- State Agency Stakeholder

Source 1: https://preventoverdoseri.org/medication-assisted-therapy/
Source 2: SAMHSA, https://dpt2.samhsa.gov/treatment/directory.aspx, https://www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator; US Census, 2019 Population Data
Note: "N" superscript denotes that data was normalized based on US Census Population Data

Challenges: Gaps in Access and Coverage

- Insufficient Medicaid benefits and prior-authorization requirements create barriers to care (i.e. need for appropriate length of stays without administrative barriers/benefit limits)
- **Coverage and insurance challenges**:
  - Non-citizens, non-Medicaid, uninsured forced to access ED for crisis services
  - Several cash-only providers; even with insurance, many people face high out-of-pocket costs
  - Seniors facing lack of access as many providers do not accept Medicare
  - Utilization review requirements (i.e., prior authorization) make BH access more challenging
  - Mental Health parity issues associated with private insurance, which lead to difficulties accessing needed services and supports they need.
- A punitive approach to patient compliance can result in less access for the most complex patients
  - If a patient has poor compliance with appointments (i.e. miss 3 appointments), patient will get dropped by the provider. System does not meet people where they are and has unrealistic expectations of complex patients who may also have unmet SDOH needs
- Need for improved communication regarding how to access all available BH services directly in communities in need
- Need mobile assessment, treatment, and crisis intervention services in the community
- **Schools** and **law enforcement** must be part of the BH continuum of care
- Courts in RI must be educated and provided options for crisis diversion that avoids unnecessary, prolonged incarceration

"It is very striking how our systems are not set up for people who have any instability in their lives. If someone is homeless or struggling with SUD and is trying to see a psychiatrist and misses appointments, the provider "breaks up" with you because they cannot bill. This becomes a big access problem – there is a lack of flexibility in our BH system."
--Community Stakeholder

"We have built a system that keeps people out."
-- Community Stakeholder

"Who you trust and who you can see is predicated on who takes your insurance."
-- Community Stakeholder

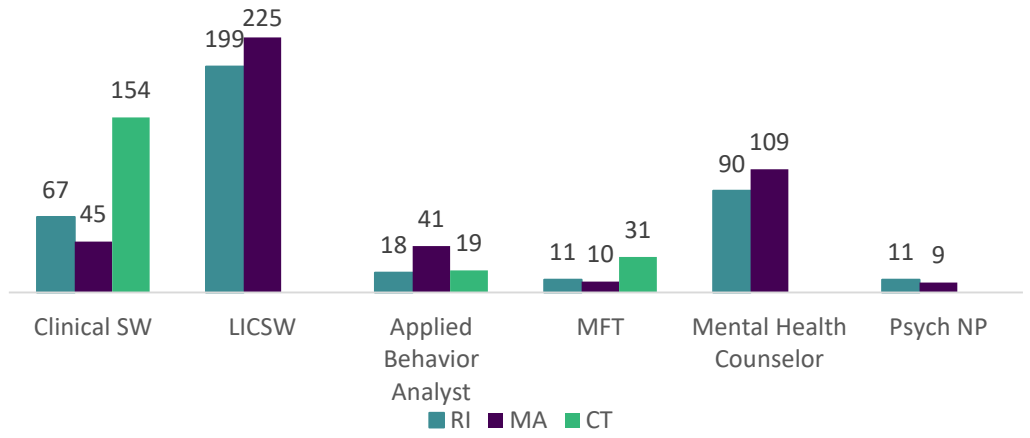
Challenges: Insufficient Workforce Capacity

- Rhode Island faces many challenges with workforce recruitment and retention, which is driven in part by low wages and insufficient reimbursement. There are high turnover rates among BH providers, and providers may opt to go into private practice/accept cash-only payments or move to bordering states with higher reimbursement options. Workforce shortages have led to a lack of capacity to meet BH need.
- There are a lack of qualified specialty providers (particularly for community-based services for children and geriatric providers, and in assisted living)
- Rhode Island has a **shortage of linguistically and culturally competent providers**; Black, Asian, and Latinx providers are underrepresented. Rhode Island needs a diverse workforce representative of the communities they serve.
- Need **trauma-informed care**. Layers of stigma persist associated with having and seeking care for a BH diagnosis in various cultures and communities.
- Need more opportunity for **nontraditional workforce** to serve communities with inequitable access (reimbursement for CHWs, peers, street outreach, reexamine credential/educational requirements to enter BH workforce at Medicaid reimbursable level)
- **Peers/People with Lived Experience**: peer recovery coaches have been well-utilized in SUD, but stakeholders report compensation for coaches is insufficient. More clinical/staff supervision and support for peers is needed.
- Need to invest in the **workforce pipeline**: create more pathways to certification, offer support for students in training, provide mentorship/professional development, especially for students of color
  - Prescriptive licensing standards create barriers that can lead people to opt out of the workforce
  - Licensing exam is only offered in English and is biased toward native English speakers, which is a barrier to increasing workforce diversity
- Neighboring states have invested in workforce (e.g. CT has a cost of living increase, MA is actively recruiting Black/Latinx workforce), creating a competitive disadvantage for Rhode Island providers

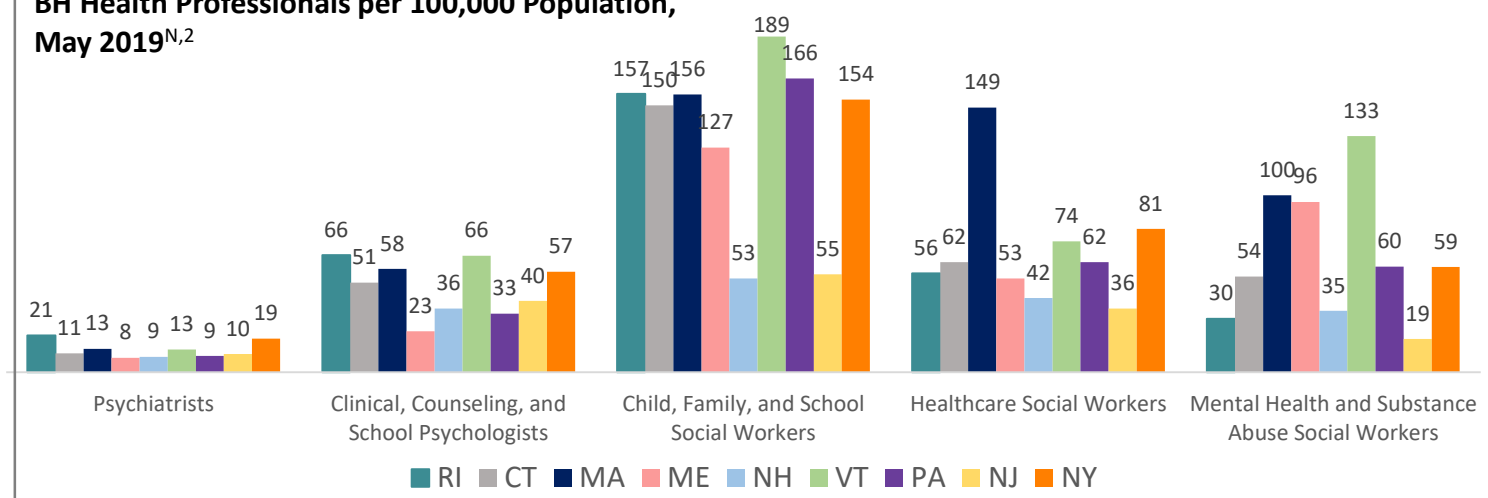
"Sometimes you are the only behavioral health provider at your practice who is bilingual and bicultural. You get siloed, you get burned out, and eventually you may leave for private practice, because of the pay."
– Community Stakeholder,
on the challenges faced by providers in the community

Challenges: Insufficient Workforce Capacity

BH Health Professionals per 100,000 Population, May 2019[3]



BH Health Professionals per 100,000 Population, May 2019[N,2]



Key Takeaways

- While Rhode Island has the highest number of psychiatrists and clinical, counseling, & school psychologists per 100,000 among regional peers, feedback indicates that there are significant shortages of children's psychiatrists and that there are communities that lack equitable access to qualified BH professionals.
- Rhode Island's rate of child, family, and school social workers is on par with regional peers, though lower than VT and PA.
- Rhode Island's rates of healthcare social workers and mental health & substance use social workers are among the lowest compared to regional peers.
- Even before COVID HRSA was projecting a nationwide BH practitioner shortage of between 27,000 and 250,000 FTE by 2025
- This access data does not consider these additional important barriers:
  1. Professionals that do not accept insurance
  2. Professionals only offering limited hours
  3. Professionals who are in training, and therefore offer more limited services
  4. The number of professionals in training that choose to relocate to neighboring states at the conclusion of their training.

Note: Only active licenses counted. Population data taken from 2019 census. * denotes that 2010 census data used due to lack of recent information.
Source 2: https://www.bls.gov/oes/tables.htm
Source 3: https://health.ri.gov/lists/licensees/, https://elicensing.mass.gov/CitizenAccess/GeneralProperty/PropertyLookUp.aspx?isLicensee=Y, https://www.elicense.ct.gov/Lookup/GenerateRoster.aspx

Challenges: Disparities in Health Equity and Race Equity

- All systems need to be **grounded in health and racial equity** and should be **person-centered and trauma-informed**.
- **Need more culturally competent care:**
  - Disparities in access and outcomes exist – the continuum of care was not designed for disenfranchised communities, including BIPoC, LGBTQ+, and refugee/immigrant populations
  - People seek care from people they trust (and may not seek care from traditional providers if they perceive a lack of trust/understanding of their lived experience). Providers need to do more to build trust, especially within diverse and disenfranchised communities.
  - Lack of cultural competency in BH system and school system can lead to children being mis-diagnosed with behavioral challenges, when the problem is in fact tied to social drivers of health
  - Intersectional challenges (i.e. the intersection of a person's gender, sex, race/ethnicity, sexual orientation, disability) need to be acknowledged and addressed
- **Current data collection is insufficient** to capture full range of inequity in the BH system; more demographic data needs to be collected to inform BH policies
- **Disparities by Race/Ethnicity:** Very few Black, Latinx, and Asian providers are able to serve these Rhode Island communities; a need for more bilingual and bicultural services.
- **Disparities by Age**: both older adults and youth lack access to quality care; aging populations may not always be aware of available services; no services for LGBTQ+ seniors
- **Disparities by LGBTQ+:** Community does not feel welcome in all care settings. BH system has insufficient capacity to serve the trans community; Thundermist is highlighted as a success story in serving the trans population
- **Disparities by Geography:** Stakeholders frequently cited transportation as a challenge in accessing care, especially for communities outside the Providence metro area.

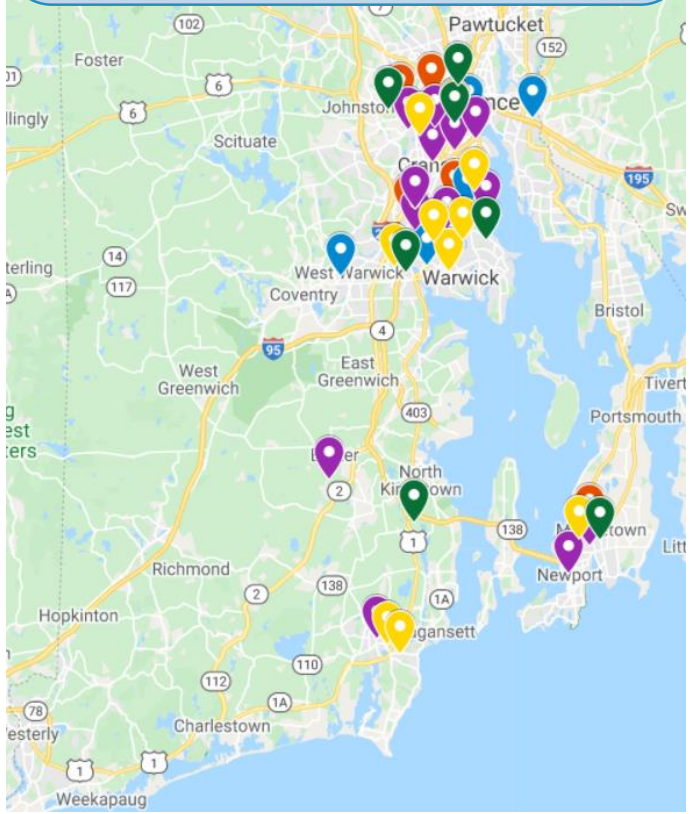
"The BH treatment system would have more opportunity for success if we addressed systemic racism."
– Community Stakeholder

"The behavioral health continuum in Rhode Island is set up to address people who are of the white majority."
– Community Stakeholder

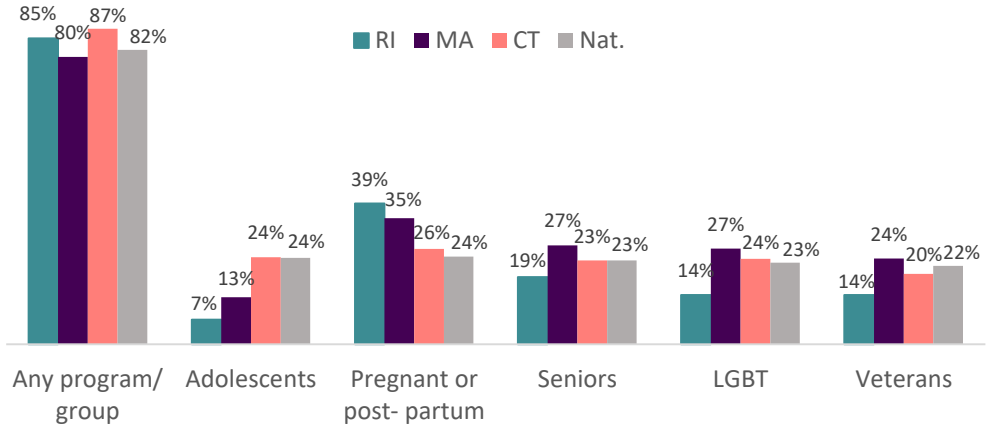
"Race-based care needs to be seriously considered, funded, and supported. There need to be mental health professionals of color who can understand the experiences of the community."
-- Community Stakeholder

Rhode Island has lower rates of specialized SUD programs both regionally and nationally for seniors, LGBT, veteran, and adolescent populations.

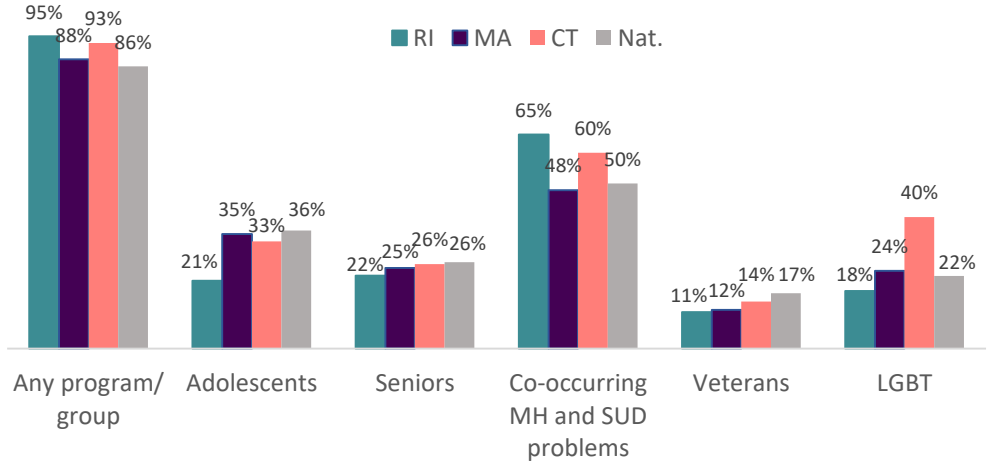
Total: 22 SUD facilities
Red: LGBT programs (5)
Blue: Adolescent programs (5)
Purple: Pregnant/post-partum programs (14)
Yellow: Senior/older adult programs (10)
Green: Veteran programs (7)
Note: Facilities with multiple specialties shown as two separate markers



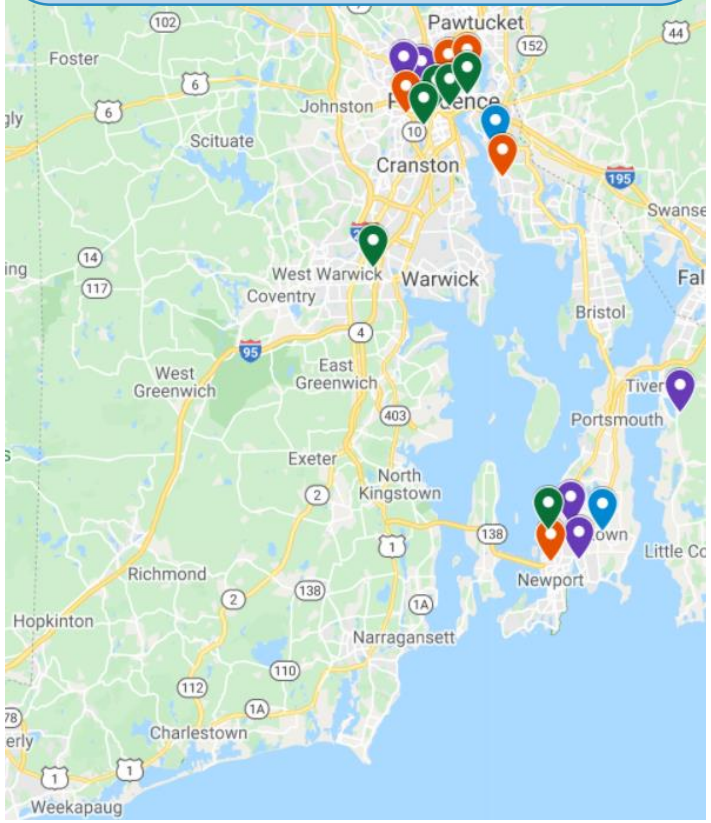
% of SUD Facilities Offering Special Programs for Specific Client Types, 2019



% of MH Facilities Offering Special Programs for Specific Client Types, 2019



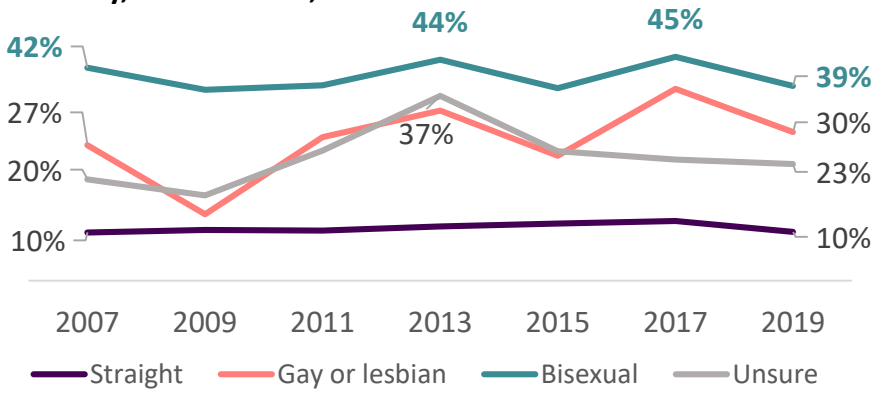
Total: 12 MH facilities
Red: LGBT programs (5)
Blue: Adolescent programs (2)
Purple: Senior/older adult programs (5)
Green: Veteran programs (6)
Note: Facilities with multiple specialties shown as two separate markers



Notes: Information is collected from facilities that provide mental health treatment. "Facility" may be program-level, clinic-level or multi-site respondent.
Source: https://wwwdasis.samhsa.gov/dasis2/nmhss.htm, Table 4.11a and 4.11b; https://findtreatment.samhsa.gov/locator

Major behavioral health disparities are present in Rhode Island across many metrics and demographics.

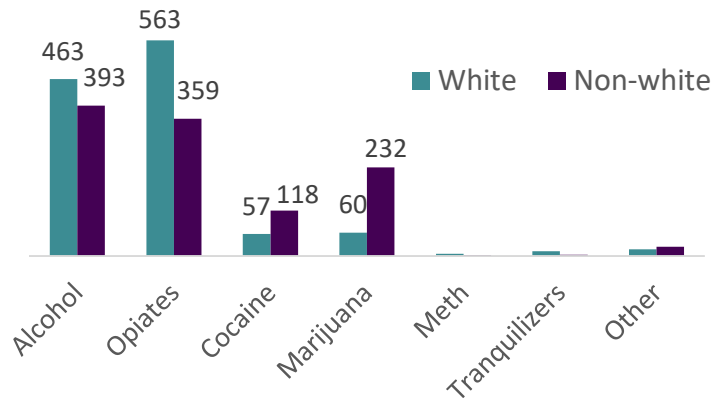
% of High Schoolers who Considered Suicide in the Past Year by Sexuality, Rhode Island, 2007-2019[1]



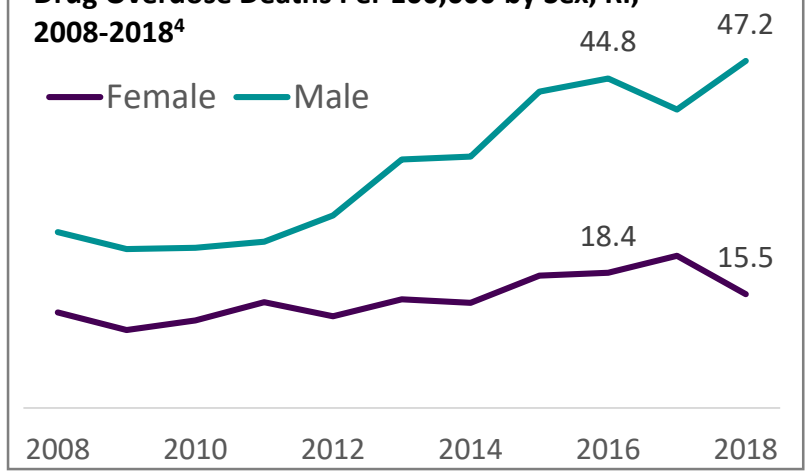
Key Takeaways:

- 40% of bisexual students seriously considered suicide in the past year; 4x the rate of straight students.
- Whites are admitted to SUD facilities at a higher rate for alcohol and opiate usage than non-white individuals; non-white individuals are admitted for marijuana nearly 4x the rate of white individuals.
- Males have a higher rate of overdose in 2018; 3x that of females.
- Black and Hispanic individuals experience homelessness at a significantly higher rate than whites. The rate of homeless individuals of other races increased by 175% from 2015 to 2018.

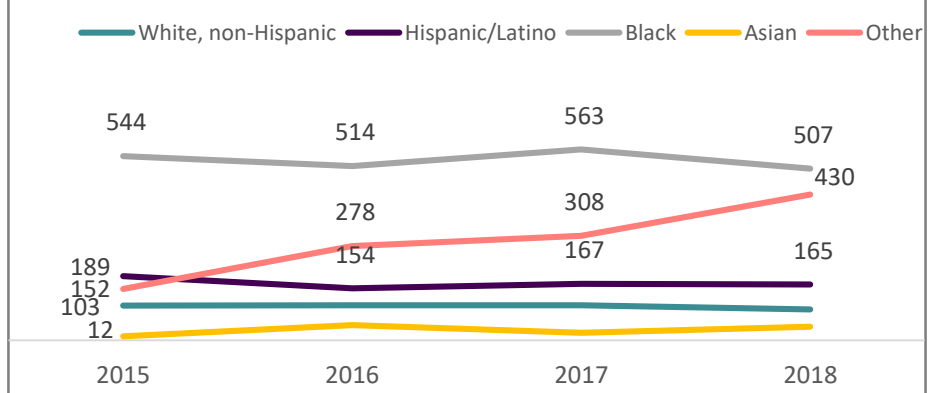
RI SUD Facility Admissions in Rhode Island by Race per 100,000 People, 2015[3, N]



Drug Overdose Deaths Per 100,000 by Sex, RI, 2008-2018[4]



Homelessness by Race per 100,000 People, Rhode Island, 2015-2019[2, N]



"Other" category includes Pacific Islander, mixed race, and indigenous populations.

Source 1: Youth Risk Behavior Surveillance System, CDC, https://nccd.cdc.gov/youthonline/App/Default.aspx
Source 2: Annual Homeless Assessment Report, Dept. of Housing and Urban Development, https://www.hudexchange.info/homelessness-assistance/ahar/
Source 3: Most recent available data is 2015. Treatment Episode Data Set, SAMHSA https://www.samhsa.gov/data/sites/default/files/2015%20TEDS_State%20Admissions.pdf, Table 3.37a
Source 4: Wide-ranging Online Data for Epidemiologic Research, CDC, https://wonder.cdc.gov/; data taken using Multiple Cause of Death (MCD) 1999-2018 data request
Note: N superscript denotes that the data was normalized.

Challenges: Bias, Fear, and Discrimination

- Across all other underlying drivers is the added complication of bias, fear, and discrimination in the system when an individual is diagnosed with a mental health and/or SUD condition
- It is well documented that bias is a significant factor that negatively affects both access and willingness to receive necessary BH treatment. [1]
- Through our stakeholder interview process, we received feedback that this can affect Rhode Islanders in several ways:
    - **Social:** structural in society and creates barrier for persons with mental health or behavioral disorders. Causes unequal access to treatment services or the creation of policies that disproportionately and differently affect the population. Social issues can also cause disparities in access to basic services and needs, such as housing.
    - **Self-Driven:** internalized shame as a result of having a BH diagnosis. Individuals may fear being labeled that will trigger discrimination in society. Leads to embarrassment, isolation, or anger. Can influence an individual to feel guilty and inadequate about his or her condition.
    - **Health Professional Bias:** health professionals may develop their own biases from their upbringing or even from burnout in their own working roles, particularly when working with individuals who have severe and persistent mental illnesses. Health professionals may not provide adequate intervention, early detection, or community referral options for individuals with mental or behavioral disorders because of their own biases and personal histories. Similarly, some organizations restrict access to services due to stigma surrounding SUD diagnosis limiting access, options, and adequate treatment.

"There is a lot of stigma around behavioral health. In some cultures, there is taboo associated with mental health [which] is a big barrier."
– Community Stakeholder

"To reduce stigma, we need to treat people in clinically appropriate settings."
– State Agency Stakeholder

"An important first step we need to take is to decrease stigma associated with seeking for behavioral health."
– State Agency Stakeholder

[1]https://www.psychiatry.org/patients-families/stigma-and-discrimination
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3248273/

Underlying Drivers: Fragmentation

- **Rhode Island's behavioral health system is highly fragmented due to the involvement of many state agencies in behavioral health.** Stakeholders expressed a need for greater clarity of roles and better coordination between BHDDH, DYCF, Medicaid, and RIDOH in behavioral health. BH funding is not always coordinated or streamlined - community organizations/providers may have contracts with multiple different state agencies. Additionally, Rhode Island would benefit from greater coordination of SDoH interventions in conjunction with BH programs and services.
- **Rhode Island has a lack of clear state agency responsibility; stakeholders called for defining an accountable agency for BH coordination and management,** with roles clearly defined for Managed Care, Accountable Entities, and CMHCs, as well as other organizations involved in behavioral health care.
- Stakeholders described **licensing requirements and regulations as overly burdensome with opportunity to streamline** and condense. Requirements are disproportionate to funding, and licensing requirements beyond those needed to ensure health outcomes may create barriers that contribute to a lack of diversity in the workforce.
- **A lack of Integration between Medical and Behavioral Health Care remains.** Prior work has been done in this area, though has not been as successful as hoped.
  - Lack of IT infrastructure for communicating and sharing medical records poses a challenge to successful BH/Medical Integration
  - More pilot programs should integrate medical care into behavioral health settings, vs. solely focusing on integrating BH care into primary care settings.

"Our fragmented administrative structure leads to fragmented care coordination. Having lots of entities involved in behavioral health care is the genesis of the problem."
-- State Agency Stakeholder

"There are lots of cooks in the kitchen, but no chefs."
– Community Stakeholder,
in reference to multiple state agencies involved in behavioral health oversight

Underlying Drivers: Fragmentation

INSUFFICIENT LINKAGES VIA CARE COORDINATION

- **Care coordination is often overlapping and duplicated,** which can be both ineffective and confusing for clients
- **Need to create more pathways to BH care, including linkages between existing programs and programs that provide alternatives to high cost, high acuity settings:**
  - Need single point of access/no wrong door access for individuals seeking BH services (i.e., leverage KidsLink, BHLink)
    - **BH Link** is widely viewed as a success, but there is a need for additional locations to ensure access for all communities
    - Repeated stakeholder feedback about BH Link emphasized "East Providence is not where communities most in need are situated"
  - Need more wraparound supports (including intensive in-home services) for families and adults post-crisis or in support of a new community placement
- People are **unclear about how to navigate the system** and where to seek BH care
  - Need a coordinated point of entry to clearly communicate available programs and services
  - Need better education and communication for the community about available services

> "A lot of people fall through the cracks because …the providers they are connected to are unwilling to meet them where they are in their life, at that moment."
> --Community Stakeholder

TRANSITIONS OF CARE

- Need better connections to care/discharge planning/**warm hand offs** when individuals are released/discharged into the community from inpatient, corrections, or residential treatment
- **Need improved transitions of care** for young adults aging out of children's services
- Need more diversion programs for EDs, residential care, and corrections
- Need for improved health IT to facilitate care coordination and transitions of care

> "Kids can potentially have eight different care plans – one from school, one from their PCP, one from their counselor, etc. There's too much overlapping care coordination and this is hard for parents and families to manage"
> -- Community Stakeholder

Underlying Drivers: Payment Models

Payment models are reliant on the fee-for-service chassis, which impedes accountability for quality and outcomes.

- Reimbursement is widely considered by stakeholders as insufficient to cover the cost of care; the long length of time to receive reimbursement is also a challenge for providers.
- There is a high administrative burden on providers associated with billing and contracting with multiple state agencies and payers.
- **Payment models and funding should be invested in evidence-based sustainable models and support areas of greatest need.** Stakeholders are looking to Rhode Island to invest in promising pilots/demonstration phases.
- Stakeholders consistently echoed concern that the state should define **an accountable provider for BH coordination and management, with roles clearly defined.** Incentives for the accountable providers should be tied to specific quality metrics and outcomes, and the state should conduct routine oversight of providers and MCOs to ensure desired quality and outcomes.
- Stakeholders identified an opportunity for the state to incent demographic data collection/data on health disparities through all contracts.
- Stakeholders generally expressed favorable support for implementing a **Certified Community Behavioral Health Clinic (CCBHC) model** (with prospective payment systems) statewide that could serve as a potential catalyst for payment reform, consolidation, and standardization amongst BH providers.
- **Payment models need flexibility**: expand reimbursable services and allow billing for services that support lower-cost care
    - Providers expressed the need for flexible funding to address individual-based needs. Providers also expressed the need for recognition of/payment for work done in non-traditional settings and by non-traditional providers (i.e. street outreach, housing organizations providing BH services, BH services provided by peers and CHWs).

> "Any future payment reform should be tied to evidence-based outcomes. Current financial incentives are not aligned with performance outcomes. We need to better harness data to inform payment and system changes."
> -- Managed Care Stakeholder

> "Rhode Island needs to ease the glide path for providers delivering integrated care. Rhode Island comparatively provides lower reimbursement for integrated/collaborative care, which does not enable or support the mechanisms to do it correctly."
> -- Managed Care Stakeholder

Underlying Drivers: Insufficient Infrastructure

- **Need to modernize and invest in BH infrastructure**
  - Stakeholders consistently identified the need for modern, safe BH facilities (in parity with medical service providers) to better serve and attract individuals to BH services for treatment
  - SUD treatment centers are old buildings in need of repairs and upgrades. The sub-standard infrastructure can send the message to clients receiving treatment that they are not worthy.
  - Many BH buildings are state-owned; stakeholder expressed concern regarding regular building maintenance. Providers have expressed interest in purchasing state-owned buildings in order to invest in them and upgrade facilities. Committees have previously analyzed how to improve state structures, but have faced challenges due to changes in leadership, COVID, and lack of funding needed for large capital investments.

> "Our SUD treatment centers need an upgrade – they are old buildings with holes in the rugs. If you are getting treatment there, you might wonder, are you not worthy? Why doesn't the treatment center look like a hospital or doctor's office setting?"
> – State Agency Stakeholder

- **Need to invest in IT infrastructure to improve data collection and data sharing between behavioral health and medical providers**
  - Prior investments made in improving IT for medical providers – BH providers need see similar investments
- **Investments in IT infrastructure will improve data collection and allow for measurement-based care.**
  - Improved IT infrastructure will allow for improved oversight, quality management, and rate-setting
- **Telehealth has been extremely beneficial during COVID.** Stakeholders expressed a desire to maintain regulatory flexibilities as a way of maintaining and assuring these access points after the pandemic.
- **No sufficient centralized mechanism exists to facilitate community referrals.**

> "We need to first capture sufficient data to understand disparities before we can address those disparities."
> – State Agency Stakeholder

Underlying Drivers: Lack of Community Engagement

- The Rhode Island community members engaged in this study may be more inclusive than stakeholders who have participated in past work. Community member perspectives included those from faith leaders and leaders of community organizations. Community members are committed to working with state leaders to advance meaningful opportunities that address behavioral health system challenges
- Community stakeholders expressed frustration at being left out of decision-making processes; for effective BH system reform, community members and leaders must be engaged and be decisionmakers in the planning and implementation of BH models

> "There's a need for more connection between the ground level and the state level."
> – Community Stakeholder

- Need for a "marriage" between community stakeholders and decisionmakers on an ongoing basis to inform priorities and policies
- Stakeholders expressed a desire for the state to pursue policies that **directly fund local communities** to integrate and collaborate with BH providers. Communities of color and the providers who serve them seek equitable funding for SDoH/BH programs
- Provision of care, especially social supports, need grounding in **local community resources** and **coordinated/facilitated through HEZs/AEs/local CBOs**
- Need to prioritize and invest in culturally competent services that engage existing community-based leaders and organizations in structured **ongoing partnerships**
- Large agencies have historically received a majority of BH funding and in turn, **smaller agencies with deeper roots in specific communities may not receive adequate funding.** Trickle down funding models through upstream providers may fail to ensure that necessary resources reach the right communities and organizations.
- Ongoing stigma associated with having a behavioral health need and seeking treatment for it contributes to the lack of engagement from many communities

> "If you give the community-based organizations direct funds, they can build something for their community."
> – Community Stakeholder

> "Community members need to have a voice and a connection [to the behavioral health system] to ensure that it is set up to serve these communities. The community needs to be embraced – there needs to be a marriage between the system and the communities it serves."
> -- Community Stakeholder

Underlying Drivers: Social Determinants of Health

- **SDOH is deeply tied to BH.** Social determinants of health are intricately connected to behavioral health outcomes and should be considered when planning, funding, and implementing BH interventions.
- **Prevention is better than treatment.** Addressing underlying social causes of mental illness/SUD first is preferrable to treating BH conditions in a medical model.
- Social determinant of health needs often contribute to people cycling in and out of care. BH programs and services must create linkages to SDOH interventions, including access to education, employment, housing, and food
- **Housing**: There is a dearth of affordable housing stock in Rhode Island. Homelessness in RI is increasing dramatically in the wake of COVID-19.
- **Transportation:** Getting to/from appointments can be a challenge for Rhode Islanders who do not have a car, live far from available services, or who must navigate a disjointed public transportation system.
- **Employment** needs to be addressed in parallel with BH to stabilize individuals and families. Families who lack flexible employment may struggle to access BH care/keep appointments.
- Lack of cultural competency in BH system and school system can lead to children being mis-diagnosed with behavioral challenges, when in fact the problem is tied to social drivers of health
- **SDOH and socioeconomic interventions should be viewed on par with other medical and behavioral health treatments for safety-net populations**

"Any work we are doing now does not matter if housing and employment aren't in play. Both need to be part of the approach to behavioral health, otherwise care is delivered in a vacuum."
-- State Agency Stakeholder

"There are issues of privilege in the behavioral health system. You have to live in a certain zip code to get access -- or you have to be in a crisis."
--Community Stakeholder

COVID-19 exacerbates all drivers creating additional and severe challenges for the BH System

Category	Rhode Island	National
Mental Health	In October 2020, 22% of Rhode Islanders reported needing mental health care (counseling or therapy), but not receiving it[1]. In 2020, the number of calls to Kids Link RI, a 24-hour emergency mental health and behavioral referral network, increased 22% compared to the previous year[2].	More than one-third of all American adults have reported symptoms consistent with an anxiety or depressive disorder since May 2020, an increase from one-tenth in January 2020[1]. In a June 2020 survey by the CDC, one-tenth of all adult respondents considered suicide in the past 30 days. This rate is 50% higher for minority groups, double for essential workers, and triple for self-reported unpaid adult caretakers[3]. In November 2020, only 34% of Americans reported their mental health as "excellent", a 9 point decline from 2019[7].
Substance Use	In Rhode Island, drug overdoses have increased by 25%, from 308 in 2019 to 384 in 2020[6]. July 2020 had the highest number of fatal overdoses in the state since tracking began in 2014[5]. Fatal overdoses affected individuals across the age spectrum, from 17-76, however, individuals between the ages of 45 and 54 suffered the greatest increase of burden[4].	More than 35 states have also seen an increase in overdoses[6]. Analysis from the Commonwealth estimates that 2020's total overdose deaths could have exceeded 90,000 — compared to 70,630 in 2019. This would represent the largest single-year percentage increase in overdoses in the past two decades[4].
Behavioral Health		93% of behavioral health organizations have reduced operations during the COVID-19 pandemic and 30% of patients have been turned away. 83% of all BH organizations do not have personal protective equipment to last 2 months (as of September 2020)[8]. As of June 2020, 83% of LGBTQI community centers projected a deficit in 2020 without a PPP loan. 67% hired staff within 60 days (as of June 2020)[11].
Homelessness	Rhode Island experienced a 4.6% increase in homelessness from 2019 to 2020. 9.8% of homeless individuals were unsheltered in 2020 compared to 6.7% in 2019[12]. In order to promote social distancing, the number of available year-round beds dropped from 486 to 325[9].	From 2019-2020, the total number of homeless individuals increased in the US by 2.2%. The total sheltered population decreased by 0.6%, while the unsheltered population increased by 7.0%[12].

Source 1: KFF, Mental Health in Rhode Island, https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/rhode-island/#-mental-distress-during-the-covid-19-pandemic-
Source 2: Providence Journal, "How COVID-19 affected children in this year's Kids Count Factbook" https://www.providencejournal.com/story/news/education/2021/05/10/how-covid-19-affected-children-years-kids-count-factbook/4986050001/
Source 3: CDC, Morbidity and Mortality Weekly Report, https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm
Source 4: Commonwealth, The Spike in Drug Overdose Deaths During the COVID-19 Pandemic and Policy Options to Move Forward, https://www.commonwealthfund.org/blog/2021/spike-drug-overdose-deaths-during-covid-19-pandemic-and-policy-options-move-forward
Source 5: RI's Task Force on Overdose Prevention and Intervention, Report to Governor, https://preventoverdoseri.org/wp-content/uploads/2021/04/April2021TF-Master-PowerPoint-Final1.pdf
Source 6: Boston Globe, "Another pandemic fallout: Deaths from accidental drug overdoses are soaring in Rhode Island", https://www.bostonglobe.com/2020/08/05/metro/another-pandemic-fallout-deaths-accidental-drug-overdoses-are-soaring-rhode-island/
Source 7: WHDH, "Fatal drug overdose deaths in Rhode Island are on the rise", https://whdh.com/news/fatal-drug-overdose-deaths-in-rhode-island-are-on-the-rise/
Source 8: SAMHSA, Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) Update: Behavioral Health Issues and COVID-19
Source 9: Providence Journal, "Advocates for homeless see disaster in RI as COVID, cold weather collide", https://www.providencejournal.com/story/news/local/2020/11/06/advocates-homeless-fear-disaster-ri-covid-winter/6159177002/
Source 10: Gallup, "Americans' Mental Health Ratings Sink to New Low", https://news.gallup.com/poll/327311/americans-mental-health-ratings-sink-new-low.aspx
Source 11: MAP, "Understanding the Impact of COVID-19 on the LGBTQI Movement", https://www.lgbtmap.org/2020-covid-impact-report
Source 12: HUD, "The 2020 Annual Homeless Assessment Report (AHAR) to Congress ", https://www.huduser.gov/portal/sites/default/files/pdf/2020-AHAR-Part-1.pdf

Impact of COVID on Behavioral Health System from Stakeholder Engagement

Participants in the key informant interviews shared comments and observations in the following areas related to the impact of the pandemic on Rhode Island's behavioral health system:

1. Impact on Mental Health and Substance Use Disorder Conditions
2. Impact on Social Determinants of Health, including Safety, Violence, and Isolation
3. Impact on Behavioral Health Workforce, Services, and Infrastructure
4. Impact on Behavioral Health Telehealth Services
5. Impact on Financing and Reimbursement for Behavioral Health Providers
6. Emerging Best Practices

1. Impact on Mental Health Conditions and Substance Use Disorders

- BH system is seeing a greater need for services
- Concerns about increasing alcohol use
- BH system seeing greater need for overdose services.
- Concerns that there are less in-person social supports that are note easily replicated in telehealth.
- New BH needs are emerging due to the psychological impact of the pandemic, including conditions such as anxiety, depression, and trauma
- Positive feedback on the State's response for people on MAT

2. Impact on Social Determinants of Health, including Safety, Violence, and Isolation

- Need for social supports has intensified, especially the need for housing. (Limited inventory pre-pandemic coupled with increasing rate of homeless.)
- Concerns about increasing domestic violence and sexual violence incidents.
- Concerns over the possibility of increased interpersonal violence and suicide due to isolation, particularly for youths.
- For LGBTQ+, many are forced to stay in unsafe domestic situations without access to services.
- For seniors, social isolation is a large concern. Limited access to technology and visitor restriction policies. Greater need for respite services for families during COVID.

3. Impact on BH Workforce, Services, and Infrastructure

- Gaps in prevention services for older adults – more visible with increasing BH needs.
- Need for peers to be considered essential workers.
- Concerns about gaps between KidsLink and CMHC suicide prevention work.
- Committees tasked with improving BH infrastructure/ facilities have had difficulty advancing their work.
- Nursing homes need more BH capacity.
- Increased merger activity amongst hospitals and BH providers, in part, due to net financial impact of pandemic.
- New BH needs for frontline workers – anxiety, depression, and trauma.

4. Impact on BH Telehealth Services

- Telehealth coverage beneficial. Strong desire for continued reimbursement and flexibility post-pandemic.
- Beneficial for home methadone management; reduces stigma of being on MAT.
- Better engagement and more kept appointments; reduced barriers to care.
- Positive impact on disparities; expands access to people who previously did not access services. Many LGBTQ+ youth and people facile with technology are now accessing services virtually.
- Barriers for individuals who lack internet or mobile connectivity
- Limitation for home-based therapy. Telehealth not as effective as in-person; family coaches providing parenting and resilience courses to reach families in need.

5. Impact on Financing and Reimbursement for BH Providers

- COVID has exacerbated financial challenges for BH providers. A recent example is the court-appointed master for Phoenix House[1].
- Concerns about BH provider organizations closing or reducing capacity due to financial constraints.
- Detox and SUD residential providers have been hit hard financially.
- Some BH agencies received PPP funds - given short term stability, however, loans are not sustainable funding streams.
- Telehealth has been helpful in mitigating financial issues for some BH providers – there is evidence suggesting that telehealth billing has helped sustain certain BH providers.

[1]https://www.providencejournal.com/story/news/courts/2021/01/10/phoenix-house-remain-fully-operational-as-it-works-to-right-its-financial-woes/6616456002/

Impact of COVID on Behavioral Health System from Stakeholder Engagement

6. Emerging Best Practices

- During COVID, DCYF has opened services to non-DCYF and non-Medicaid enrolled kids expanding access and supports to more families.
- Hospitals were able to create flex units during COVID. For example, a research unit was converted to an inpatient unit in anticipation of a surge in patients. The flexibility was helpful and improved patient flow and throughput. Would like to see/have funded a similar flex approach as a mechanism to flex up/increase bed capacity when needed beyond COVID pandemic, particularly for youths who are boarded in EDs with BH conditions.
- KidsLink is utilizing the UniteUs platform to refer children to community supports. This platform is currently funded through a COVID grant provided by SAMHSA. Currently in review to see if the system creates tangible benefit to determine longer term funding.
- Since COVID, there has been greater use of KidsLink triage line.
- During COVID, the State utilized community centers for testing and PR campaigns about mask wearing. Community suggestion to use this approach to create better awareness for BH services in BIPOC communities.

Table of Contents

A. Themes of National Best Practices

Models and programs detailed below touch upon these collective themes, which are indicative of best practice and innovation in the BH and SUD treatment space. Models and programs:

1. Establish networks of BH providers with the capacity to operate as a system of care:
   - Promote closed loop referral to ensure completion of planned follow-up
   - Support the development of a data governance and data capture, analysis, and sharing strategy with providers
   - Establish outcome and quality metric expectations for various populations
   - Tie accountability to payment (Value Based Payment readiness)
2. Address behavioral health access concerns via technology and/or workforce extenders
3. Adopt a consistent care model that sets standards across payers and providers
4. Inclusion of communities of color, ethnic minorities, and other disenfranchised groups to adapt BH models for local and cultural needs
5. Address fragmentation in state oversight of BH services

A: Inventory of Models, Best Practices Included in this Report

National Model

Section 5:
- Trauma Informed Systems of Care
- Measurement Based Care
- Statewide Screening Assessments and LOC Standards for SUD

Additional Models in Appendix:
- *Integrated Care and Psychiatric Collaborative Care Model (CoCM)*
- *Interventions for SUD in Emergency Departments*
- *Practice Coaching for MAT*
- *BH Workforce Extenders*

State Model

Section 5:
- Certified Community Behavioral Health Organizations– Missouri
- Behavioral Health Integrated Practice Associations (IPAs)
- Pathways Community Hub – Ohio
- Centralized State Agency Oversight – Arizona and Colorado

Additional Models in Appendix:
- *Integrated Managed Care and Integrated Care Network –Washington*
- *Behavioral Health Community Partners – Massachusetts*
- *Center of Treatment Innovation- New York*

Specialty Models

Additional Models in Appendix:
- *Intensive Care Coordination for Youth – Massachusetts*
- *Crisis Stabilization for Youth – Massachusetts*
- *Healthy IDEAS – Connecticut, Massachusetts, New York*
- *PEARLS – New York, Illinois*
- *BRITE - Florida*
- *Mobile Outreach for Seniors – California, New York*
- *Community Reentry from Corrections for Individuals with BH*

Accountable Entities

Additional Models in Appendix:
- *Coordinated Care Organizations – Oregon*
- *Regional Accountable Entities – Colorado*
- *Accountable Communities of Health – Washington*

Other Models Identified by Stakeholders

- *Housing First*
- *Wrap Around Services – Milwaukee*
- *Social Worker Licensure Exemption – Texas*
- *System of Care for Children – New Jersey*
- *One Family One Plan – San Francisco*
- *Hub and Spoke Model - Vermont*

Behavioral Health Integrated Practice Associations (IPAs) –New York's Behavioral Health Care Collaboratives *(Government as Catalyst)*

Program/Model Description	Behavioral Health Care Collaboratives (BHCCSs) is a New York State program financing collaboratives of BH and SUD providers to form networks. It is expected that collaboratives partner with medical providers, community-based organizations, and payers to identify a cohesive behavioral health delivery strategy for the region assigned. Almost all BHCCs have formed IPAs and are now pursuing individual sustainability strategies. One of the chief deliverables for the BHCC program is to create VBP readiness for BH providers.
Target Population	 Specific population determined by BHCC focus. There are adult and youth focused BHCCs and at least one family focused BHCC.
Service Category(ies)	Licensed Medicaid MH and SUD services; workforce development, shared services, data management, contracting support, quality management and assurance
Regulatory Levers/State Authorities	New York's 1115 DSRIP Waiver
Payment Model	For initial start up, each BHCC was awarded funds from the DSRIP Waiver based on Medicaid attribution associated with the services delivered by their BH licensed agency members. BHCCs/IPAs must identify sustainability funding (through MCO contracts, grants, and/or service agreements with members) to fund operations moving forward.
Key Themes Addressed	☒ Gaps in Service Continuum ☒ System Integration ☒ Care Coordination/Management ☒ Training/Workforce ☐ Health Disparities/Equity ☒ Rate/Payment Models ☒ Accountability
Relevance to Rhode Island	BH IPAs and networks have proven to be an important model in providing infrastructure and support for BH providers engaging with MC. BH IPAs are at varying stages of maturity and development. IPAs provide important infrastructure to support governance, quality oversight & management, and financial management across multiple organizations.

Certified Community Behavioral Health Organizations Added to SPA - Missouri

Program/Model Description	MO was selected as an original CCBHC demonstration state. Due to promising results statewide, the State decided to pursue a permanent model to replace the demonstration under it's State Plan with CMS. In 2019, MO received CMS approval to add CCBHCOs services and its rate methodology to its Medicaid CCBHC program. Services became effective July 1, 2019.
Target Population	 ☒ Adult/Gen Pop ☒ Youth ☒ Family ☒ Seniors ☐ Corrections
Service Category(ies)	CCBHCs, under SAMSHA requirements, must provide crisis mental health services; screening, assessment and diagnosis; patient-centered treatment planning; outpatient mental health and substance use services; primary care screening and monitoring; targeted case management; psychiatric rehabilitation services: peer support, counseling and family support services; and services for veterans.
Regulatory Levers/State Authorities	Services added permanently under SPA
Payment Model	State has established a prospective payment system (PPS) rate for each CCBHO; behavioral health is managed both by FFS and Managed Care based on the enrollment status of the individual.
Key Themes Addressed	☒ Gaps in Service Continuum ☒ Care Coordination/Management ☒ Rate/Payment Models ☒ System Integration ☒ Training/Workforce ☒ Accountability ☐ Health Disparities/Equity
Relevance to Rhode Island	CCBHCs are useful for promoting provider readiness to engage in VBP. Many skills providers need to succeed in CCBHC are similar to skills needed to thrive in VBP (i.e., measurement-based care, collaborative agreements with mutual accountability, detailed financial analysis skills, integration). In addition, CCBHC can be used to incent consolidation in the provider system. The comprehensive nature of CCBHC requires the organized delivery of services. By offering a differential payment structure for comprehensive care, the State can incent consolidation of the provider system.

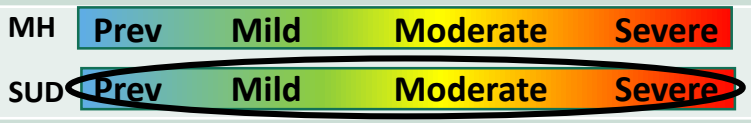
Measurement Based Care - (National)

Program/Model Description	MBC is the systematic administration of a symptom rating scales and use of the results to drive clinical decision making at the level of the individual patient. MBC gives the clinical team specific data that allows them to identify a) if a patient is getting better, b) how close they are to target goals, and c) if they are getting worse. MBC incorporates two elements: the systematic administration of validated measurement tools for specific health condition and developing a registry to track data and respond to the results by adjusting care or increasing outreach as indicated by scores
Target Population	MH Prev Mild Moderate Severe SUD Prev Mild Moderate Severe ☒ Adult/Gen Pop ☒ Youth ☒ Family ☒ Seniors ☒ Corrections
Service Category(ies)	All categories of service; standardized assessment tools vary based on category of illness/service. X
Regulatory Levers/State Authorities	Several states have adopted MBC as a core component of VBP structures.
Payment Model	N/A
Key Themes Addressed	☐ Gaps in Service Continuum ☐ System Integration ☒ Care Coordination/Management ☐ Training/Workforce ☐ Health Disparities/Equity ☐ Rate/Payment Models ☒ Accountability
Relevance to Rhode Island	Adopting MBC is an important mechanism for driving additional accountability for providers and ensuring correct resource allocation to step up and down individuals appropriately who are engaged in MH and SUD treatment. MBC maximizes the value of the existing treatment capacity, enabling improved access without increased cost.

Trauma Informed Systems of Care - (National)

Program/Model Description	Refers to an organizational structure and treatment framework that understands, recognizes and responds to the effects of all types of trauma in order to ensure physical, psychological and emotional safety for consumers and providers. Organizations adopting TIC adapt care principles that are aimed to provide support services in a way that are accessible and appropriate to those who may have experienced trauma.
Target Population	MH Prev Mild Moderate Severe SUD Prev Mild Moderate Severe ☒ Adult/Gen Pop ☒ Youth ☒ Family ☒ Seniors ☒ Corrections
Service Category(ies)	SAMHSA recommends that when organizations and systems create a trauma-informed environment that ten implementation domains be considered: governance & leadership; policy; physical environment; engagement & involvement; cross-sector collaboration; screening; assessment; treatment services; training and workforce development; progress monitoring & quality assurance; financing; and evaluation.
Regulatory Levers/State Authorities	N/A
Payment Model	N/A
Key Themes Addressed	☐ Gaps in Service Continuum ☐ System Integration ☐ Care Coordination/Management ☐ Training/Workforce ☒ Health Disparities/Equity ☐ Rate/Payment Models ☐ Accountability
Relevance to Rhode Island	As the State seeks to improve its system of care for individuals with BH conditions and address health disparities and equity it is critical that systems of care are designed to address trauma, including the multi-generational trauma found in black and brown communities.

Statewide Screening Assessments and LOC Standards for SUD - Emerging Best Practice (National)

Program/Model Description	Require use of validated screening, assessment, and level of care tools; creates a common language and avoids duplication. Allows consistent confirmation of SUD and severity. NM-ASSIST is validated in multiple settings, in 30+ languages. Gives severity (mid, moderate, severe) using validated norms. Considerable benefit to use of computerized evaluations (inter-rater reliability much higher). Data can be used to evaluate population characteristics.
Target Population	 ☒ Adult/Gen Pop ☒ Youth ☐ Family ☐ Seniors ☐ Corrections
Service Category(ies)	N/A
Regulatory Levers/State Authorities	N/A
Payment Model	N/A
Key Themes Addressed	☐ Gaps in Service Continuum ☒ System Integration ☒ Care Coordination/Management ☐ Training/Workforce ☐ Health Disparities/Equity ☐ Rate/Payment Models ☒ Accountability
Relevance to Rhode Island	National research has shown use of standardized assessments and level of care criteria is inconsistent. Significant benefit if community can agree on one tool.

Pathways Community Hub – Ohio (National)

Program/Model Description	A Community Pathways HUB is a single point of access for healthcare partners to refer people to CBOs for SDoH interventions. The HUB shares administrative functions across its network. The CBOs identify "pathways" addressing SDoHs dependent on the target population. The HUB coordinate CBOs; trains and assigns CHWs; shares metrics and quality management; identifies gaps related to SDoH; provides centralized collective planning; and centralized contracting infrastructure.
Target Population	 Dependent on Hub design and established pathways.
Service Category(ies)	Neutral forum/facilitator; grand & contract management; service development & implementation; manage outcomes & payment; facilitate care coordinators and advisory committees; link between Medicaid Managed Care and Care Coordination Agencies; workforce development; and evaluation and quality assurance.
Regulatory Levers/State Authorities	N/A; Active HUBs in Ohio, Michigan, Washington, Oregon, Texas, New Mexico, Wisconsin, Minnesota. Developing HUBs in Pennsylvania, New York, North Carolina, South Carolina, Connecticut, and Virginia.
Payment Model	Blended and braided funding from multiple sources, including: milestone payment funding models; stipends hire CHWs and care coordinators; grant funding for seed dollars or subsidy for uninsured clients; and Medicaid MC and health system contracts.
Key Themes Addressed	☒ Gaps in Service Continuum ☐ System Integration ☒ Care Coordination/Management ☒ Training/Workforce ☒ Health Disparities/Equity ☐ Rate/Payment Models ☐ Accountability
Relevance to Rhode Island	HUBs have served as important vehicle for helping CBOs organize and contract for critical SDoH services that feed Medicaid outcomes. HUBs enable CBOs to integrate with the healthcare delivery system and alleviate stress in the contracting process for MCOs and Health Systems seeking a network of services for their Medicaid and uninsured population.

Centralized State Agency Oversight – Arizona and Colorado

Program/Model Description	Several states have recognized the challenges associated with fragmented state oversight of BH and related Medicaid services (MH, SUD, Children's services, social services, etc.) to ensure efficient and aligned functioning regarding services, payment, data, and policy. Arizona and Colorado are currently involved in planning and endeavoring a reorganization of BH oversight. These states found that disparate accountability among State agencies results in fragmented efforts, dual "systems of care" and ultimately significant disparities in individual experience. Colorado is socializing a new behavioral health authority that contracts with regional community coordination entities (CCE) to streamline care for consumers and families and bringing funding for non-Medicaid BH dollars into a State authority. The process also creates a statewide consumer and stakeholder advisory board. Arizona is implementing a revised framework that centralizes oversight for physical, behavioral, children's rehabilitative services (if applicable), and long-term care services, where appropriate.
Key Themes Addressed	☐ Gaps in Service Continuum ☐ System Integration ☐ Care Coordination/Management ☐ Training/Workforce ☐ Health Disparities/Equity ☐ Rate/Payment Models ☒ Accountability
Relevance to Rhode Island	In Stakeholder interviews and in state agency discussions, we have heard concerns about fragmentation in BH and related services oversight and potential opportunities to further maximize funding and efficiencies in a reimagined central oversight structure, working alongside Managed Care.

Other Models Identified By Stakeholders

Program	Location	Description
Housing First	National	Housing First is a homeless assistance approach that prioritizes providing permanent housing to people experiencing homelessness, thus ending their homelessness and serving as a platform from which they can pursue personal goals and improve their quality of life. This approach is guided by the belief that people need necessities like food and a place to live before attending to anything less critical, such as getting a job, budgeting properly, or attending to substance use issues. Permanent supportive housing (PSH) is targeted to individuals and families with chronic illnesses, disabilities, mental health issues, or substance use disorders who have experienced long-term or repeated homelessness. It provides long-term rental assistance and supportive services.
Wrap Around Services	Milwaukee	Wraparound Milwaukee is a unique system of care for children with serious emotional, behavioral, and mental health needs and their families. It utilizes a WRAPAROUND philosophy and approach which focus on strength-based, individualized care. Combined with a unique organizational structure, Wraparound Milwaukee delivers a comprehensive and flexible array of services to youth and their families. Wraparound Milwaukee has been in existence since 1995. It was developed out of a 6-year, $15 million federal grant that Milwaukee County received from the Center for Mental Health Services in Washington, D.C. Milwaukee County was one of the first ten such sites funded throughout the country. The intent of the federal grants was to foster the development of more comprehensive, community-based care for children with serious emotional needs and their families. Wraparound Milwaukee was designed to reduce the use of institutional-based care such as residential treatment centers and inpatient psychiatric hospitals while providing more services in the community and in the child's home. The federal government also stressed more family inclusion in treatment programs along with collaboration among child welfare education, juvenile justice and mental health in the delivery of services.
Social Worker Licensure Exam Exemption	Texas	The Alternative Method of Examining Competency (AMEC) was created in response to the Texas Professional Social Work Act to assist individuals who, while unable to achieve a passing score on the national examination, have demonstrated the knowledge, skills and abilities to become professionally licensed social workers in Texas. Our AMEC Supervision is offered for those in our Alternative Method of Examining Competency (AMEC) program. AMEC supervisors provides one on one support and mentorship in assisting those in our AMEC program further develop their knowledge and skills as a professionally licensed social work.
Reaching Recovery	Denver	Measurement-based solution to promote recovery developed by the Mental Health Center of Denver. The outcome tools consist of a set of clinical measures for adult individuals with mental illness that promotes engagement and progression towards recovery. The tools help providers assess and measure a person's recovery progress. The tools are used for Joint Commission outcome requirements.

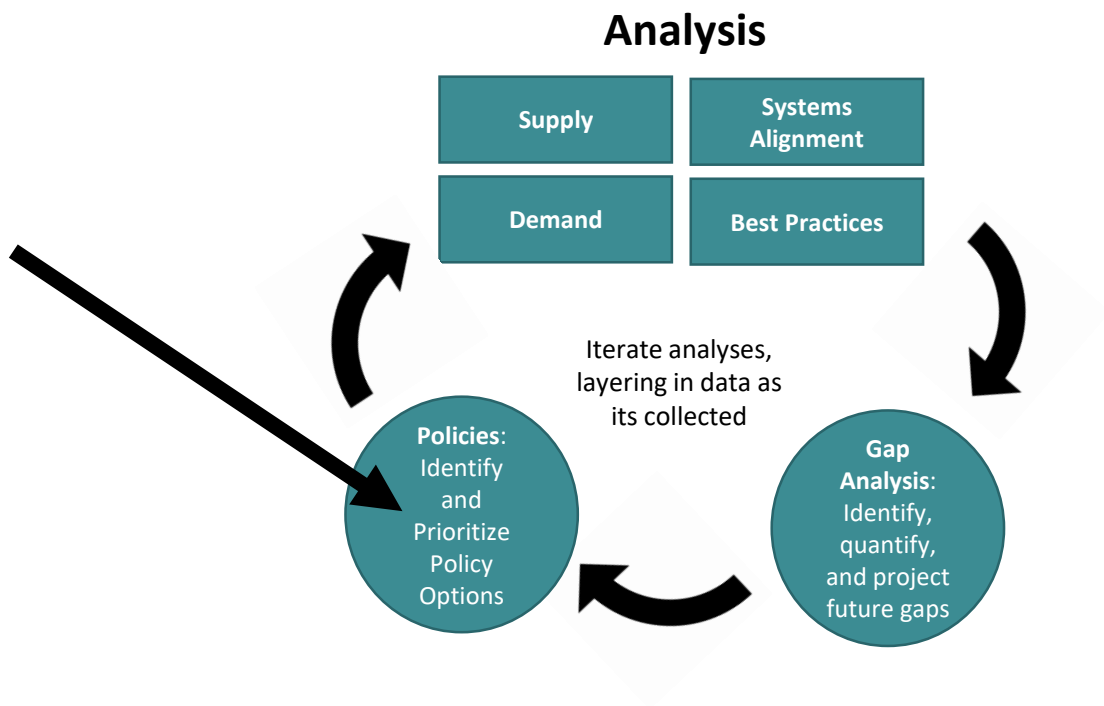
Other Models Identified By Stakeholders

Program	Location	Description
System of Care for Children	New Jersey	The New Jersey Children's System of Care (CSOC) is a division with the New Jersey Department of Children and Families (DCF). The foundational philosophy of all System of Care partners is the Wraparound/Child Family Team. The Wraparound approach is used to provide voluntary services to youth ages 5-21 with mental, emotional, behavioral, developmental, intellectual, and substance abuse challenges and their families at no cost to families regardless of income and insurance status. There are key partners in the Children's System of Care available in each county throughout the State. Most fundamental to the Children's System of Care (CSOC) is its emphasis on the family or caregiver as playing a central role in the health and well being of children. CSOC involves families throughout the planning and any service delivery process in order to create a system that values and promotes the advice and recommendations of the family, a system that is friendly to families and one which provides them the tools and support needed to create successful life experiences for their children with emotional, behavioral, developmental, intellectual, and substance abuse needs. CSOC partners are committed to providing free, voluntary services in a family driven, community-based environment.
One Family One Plan	San Francisco	The San Francisco Dependency Drug Court Prevention And Family Recovery program builds on local efforts to expand access to children's therapeutic and developmental services by creating an Integrated Care Management model that is highly coordinated, inter-generational in scope, and functions under the rubric of "One Family/One Plan." DDC will develop an attachment-based system that assumes families have experienced significant trauma and fragmentation.
Hub and Spoke Model	Vermont	Vermont implemented the Care Alliance for Opioid Addiction, an innovative Hub & Spoke system of medication-assisted treatment (MAT) for people who are addicted to opioids. The primary goal of MAT is to reduce illicit opioid use. Since the introduction of this system of care in 2014, access to treatment has expanded, and new clinical and supportive services not typically included in MAT have been added. treatment. Vermont's hub-and-spoke system has been implemented state-wide and well-received by providers and patients alike. Adoption of this model has been associated with substantial increases in the state's OUD treatment capacity, with Vermont now having the highest capacity for treating OUD in the United States with 10.56 people in treatment per 1000. There has been a 64% increase in physicians waivered to prescribe buprenorphine, a 50% increase in patients served per waivered physician, and a robust bidirectional transfer of patients between hubs and spokes based upon clinical need.

B. Why Principles of Prioritization?

Several solutions and policy options emerge from the research to address the challenges described throughout this report. Some are large scale systemic changes, and others are smaller "quick wins". Most will require investment either through direct funding or human resource commitment to implement.

Principles of Prioritization serve as a 'yardstick' to hold up against potential policy proposals and solutions to determine both a feasible suite of policy options AND prioritize which ones advance first to the implementation phase.



B. Principles To Drive and Prioritize Solutions

1. **Service delivery should align with community need, grounded in health equity and racial equity:** All systems over the full lifespan should be person-centered and trauma-informed. Providers should meet people where they are and be accessible to all. Access should be streamlined, people should be clear about their options for where to receive care, and people should be able to get their needs met through one comprehensive service from the provider of their choice. Data should be shared across service providers to maximize treatment outcomes while protecting confidentiality. Prioritize pathways of care over episodes of care, integrated across medical and behavioral health care services.

2. **Solutions should actively address systemic racism** as an underlying driver of challenges that manifest with the behavioral health system today.

3. **Prevention is better than treatment. Recovery is possible for everyone.** Investments in prevention are a priority. All services should be part of a recovery-oriented system of care.

4. **Invest in sustainable solutions**, including housing, workforce extenders and data capture, analysis, and sharing infrastructure.

5. **Payment:** Payment should drive to outcomes and access to the right care at the right time. Payment and outcomes should be tied together. Payments should be sufficient to sustain workforce, ensure access to services, and make certain practitioners can practice at the top of their license.

6. **Accountability**: For every person with a BH condition, there should be one provider accountable and one state agency accountable for outcomes, while engaging sister agencies to collaborate as appropriate.

7. **Regulatory Oversight:** Right-size regulatory requirements to ensure regulations tie to meaningful client outcomes and accountability. If a current regulation doesn't directly tie to outcomes or accountability, phase it out. Shift from process to outcome management.

8. **Leverage the existing foundation:** Establish infrastructure efficiently by building on Rhode Island's starting point in a manner consistent with RI's size and scale. Any services created to fill the gaps in existing care continuum should be created in the context of a strategic plan for a full continuum of care.

9. **Standardization:** Screening should be universal and frequent; assessments should be standardized utilizing specific tools. Assessment results should track to equitable referrals for services across the continuum of care (risk stratification). Consistent quality measures should be selected and reported by all providers and tied to payment.

B. Methodology for Policy Identification and Prioritization

1. **Identify Policy Options** – Leveraged best practices from other states to identify policy options that would address one or more of the system challenges identified through the qualitative and quantitative analysis
2. **"Rhode Island-ize" Policy Options** – Adapted policy options from other states and national models to determine how best to apply them to Rhode Island's unique characteristics and starting point.
3. **Scored Each Policy Against Alignment with Problems Diagnosed (Key Themes)** – Assessed each policy against each of the 9 identified principles, scoring as "full alignment" (2), "partial alignment" (1) or "no alignment" (0). Aggregated scores for each policy across principles, and ranked ordered.
4. **Scored Each Policy Against Alignment with Principles** – Assessed each policy against each of the 9 identified principles, scoring as "full alignment" (2), "partial alignment" (1) or "no alignment" (0). Aggregated scores for each policy across principles, and ranked ordered.
5. **Documented Policy Alignment by Population** – for each policy option, confirmed if it would address youth, adults, and/or older adults for mental health, as well as the same three population segments for substance use
6. **Documented High-Level Feasibility Components –** qualitatively assessed: statutory, regulatory, and/or contractual lever? Funding source other than general revenue? Which payer(s) are impacted? Stakeholder support documented from interviews? Speed to implementation? Current RI initiatives upon which the policy would build on? Other state(s) that have implemented the policy option? Provider infrastructure investment required?

Themes/Problem Addressed:
- Gaps/Access
- Workforce
- Health Equity
- Fragmentation
- Payment Models
- Infrastructure
- Community Engagement
- Systemic Racism
- Social Determinants

Principles Addressed:
- Detailed on prior slide

Populations Served:
MH: Youth
MH: Adults
MH: Older Adults
SUD: Youth
SUD: Adults
SUD: Older Adults

Feasibility:
Policy Levers
Funding Source
Payers Impacted
Community Support
State Leadership Support
Speed to Implementation
Leveraging RI Initiatives
Other State Examples
Infrastructure Required

C. Policy Proposals Arising from Stakeholder Engagement, Ranked by Percent Alignment with Principles and Problem Addressed (Themes)

Policy Proposals	Align w/Principles	Align w/Themes
Implement statewide CCBHC model	94%	83%
Payment for outcomes	94%	83%
Centralized state agency oversight	94%	61%
Update AE attribution model	89%	72%
Train ED prescribers & full care team to start buprenorphine administration in ED, including cultural competency training for addiction treatment in ED.	89%	94%
Care coordinator Complement to KIDSLink, for those without adequate family support structure -- wraparound support for youth under 21 w/SUD diagnosis	89%	83%
Enact new statute/rules for community reentry from corrections to ensure that there's a warm handoff to intensive BH services at the time of release (e.g. weekend support).	83%	94%
Expand school-based behavioral health services.	83%	89%
5-year plan that includes outcomes paid at combination of aggregate performance and performance based on specific demographic stratifications (race, gender, language, etc)	83%	83%
Support eligibility redetermination/ maintenance of Medicaid for community re-entry from corrections to smooth transition of access to services upon release.	83%	83%
Add Intensive Community-Based Treatment to State Medicaid Plan	83%	83%
Integrate Step up and Step Down service into managed care contract and create capacity within community providers.	83%	78%
Ensure 24/7/365 access to MAT, particularly for community reentry from corrections	78%	72%
Targeted case management program built into Medicaid benefit for re-entry from corrections.	78%	94%
Peer CM in ED with Motivational Interview training connects person who came in for OD with CM	78%	94%
Establish mobile program specific to MAT as part of a broader mobile treatment solution to support SUD mgmt.	78%	94%
Expand capacity of Family Care Community Partnership	78%	83%
Workforce investments, including loan forgiveness, support for higher clinical degrees commensurate with longer organizational tenure, and licensure exams in Spanish.	78%	83%
Expand access to children uninvolved with DCYF to DCYF's in-home BH services	78%	78%
Procure infrastructure development for BH providers, including EHR, data warehouse, business intelligence, closed loop referral, population health management/predictive analytics software.	78%	72%
Procure and implement single point of access with 24/7/365 availability to screen, triage and initiate referrals to appropriate services and supports.	78%	72%
Development of 24/7 emergency services through a Mobile Response and Stabilization Services (MRSS) model to be implemented statewide	72%	94%
Establish a rate enhancement that incents providers to establish and maintain specialized programs for LGBTQ, veterans and other special populations.	72%	94%
Establish community paramedicine program to engage EMS and police in post-discharge visits for patients discharged from ED for SUD	72%	94%
Establish Data Use Agreements between DOC and providers to support care management/hand offs at reentry.	72%	83%
Procure in-state capacity for adolescent females with acute behavioral health conditions.	72%	83%
Standardized screening tool to drive assignment of level of care implemented at all SUD access sites	72%	72%
Establish a consumer affairs office for behavioral health and corresponding community advisory board, to create permanence in community engagement in BH.	72%	72%
Procure and implement eReferral/CM system to support data collection, quality reporting, and interoperability.	72%	67%
Create metrics and hold providers accountable for trauma informed care	67%	83%
Hold provider organizations accountable for hiring people with lived experience in the communities they serve	67%	78%
(A) Contract req't for AEs to push down ADT feeds to providers & (B) Include HIE for BH & ADT feeds to BH within affordability std for HIE investment	67%	67%
(A) State sells building to CMHCs & (B) Look for federal funding options to support upgrades	67%	67%
Include SDOH in RA for both MCOs and Aes	56%	89%

C. Policy Proposals Arising from Stakeholder Engagement, Cataloguing Population Served and/or Impacted

Policy Proposals	Population Served					
	MH-Y	MH-A	MH-O	SUD-Y	SUD-A	SUD-O
Add CCBHC program to RI SPA	Y	Y	Y	Y	Y	Y
Payment for outcomes	Y	Y	Y	Y	Y	Y
Centralized state agency oversight	Y	Y	Y	Y	Y	Y
Update AE attribution model	Y	Y	Y	Y	Y	Y
Train ED prescribers & full care team to start buprenorphine administration in ED, including cultural competency training for addiction treatment in ED.	N	N	N	Y	Y	Y
Care coordinator Complement to KIDSLink, for those without adequate family support structure -- wraparound support for youth under 21 w/SUD diagnosis	Y	N	N	Y	N	N
Enact new statute/rules for community reentry from corrections to ensure that there's a warm handoff to intensive BH services at the time of release (e.g. weekend support).	N	Y	Y	N	Y	Y
Expand school-based behavioral health services.	Y	N	N	Y	N	N
5-year plan that includes outcomes paid at combination of aggregate performance and performance based on specific demographic stratifications (race, gender, language, etc)	Y	Y	Y	Y	Y	Y
Support eligibility redetermination/ maintenance of Medicaid for community re-entry from corrections to smooth transition of access to services upon release.	N	Y	Y	N	Y	Y
Add Intensive Community-Based Treatment to State Medicaid Plan	Y	N	N	Y	N	N
Integrate Step up and Step Down service into managed care contract and create capacity within community providers.	Y	N	N	Y	N	N
Ensure 24/7/365 access to MAT, particularly for community reentry from corrections	N	N	N	N	Y	Y
Targeted case mgmt program built into Medicaid benefit for re-entry from corrections.	N	Y	Y	N	Y	Y
Peer CM in ED with Motivational Interview training connects person who came in for OD with CM	N	N	N	Y	Y	Y
Establish "black car" program specific to MAT as part of a broader mobile treatment solution to support SUD mgmt.	N	N	N	N	Y	Y
Expand capacity of FCCP	Y	N	N	Y	N	N
Workforce investments, including loan forgiveness, support for higher clinical degrees commensurate with longer organizational tenure, and licensure exams in Spanish.	Y	Y	Y	Y	Y	Y
Expand access to children uninvolved with DCYF to DCYF's in-home BH services	Y	N	N	Y	N	N
Procure infrastructure development for BH providers, including EHR, data warehouse, business intelligence, closed loop referral, population health management/predictive analytics software.	Y	Y	Y	Y	Y	Y
Procure and implement single point of access with 24/7/365 availability to screen, triage and initiate referrals to appropriate services and supports.	Y	N	N	Y	N	N
Development of 24/7 emergency services through a Mobile Response and Stabilization Services (MRSS) model to be implemented statewide	Y	Y	Y	Y	Y	Y
Establish a rate enhancement that incents providers to establish and maintain specialized programs for LGBTQ, veterans and other special populations.	N	N	N	Y	Y	Y
Establish community paramedicine program to engage EMS and police in post-discharge visits for patients discharged from ED for SUD	N	N	N	Y	Y	Y
Establish Data Use Agreements between DOC and providers to support care management/hand offs at reentry.	N	Y	Y	N	Y	Y
Procure in-state capacity for adolescent females with acute behavioral health conditions.	N	N	N	N	Y	Y
Standardized screening tool to drive assignment of level of care implemented at all SUD access sites	N	N	N	Y	Y	Y
Establish a consumer affairs office for behavioral health and corresponding community advisory board, to create permanence in community engagement in BH.	Y	Y	Y	Y	Y	Y
Procure and implement eReferral/CM system to support data collection, quality reporting, and interoperability.	Y	Y	Y	Y	Y	Y
Create metrics and hold providers accountable for trauma informed care	Y	Y	Y	Y	Y	Y
Hold provider organizations accountable for hiring people with lived experience in the communities they serve	Y	Y	Y	Y	Y	Y
(A) Contract req't for AEs to push down ADT feeds to providers & (B) Include HIE for BH & ADT feeds to BH within affordability std for HIE investment	Y	Y	Y	Y	Y	Y
(A) State sells building to CMHCs & (B) Look for federal funding options to support upgrades	Y	Y	Y	Y	Y	Y
Include SDOH in RA for both MCOs and Aes	Y	Y	Y	Y	Y	Y

C. Policy Proposals Arising from Stakeholder Engagement, Feasibility Analysis For top 5 policy options (by Principles)

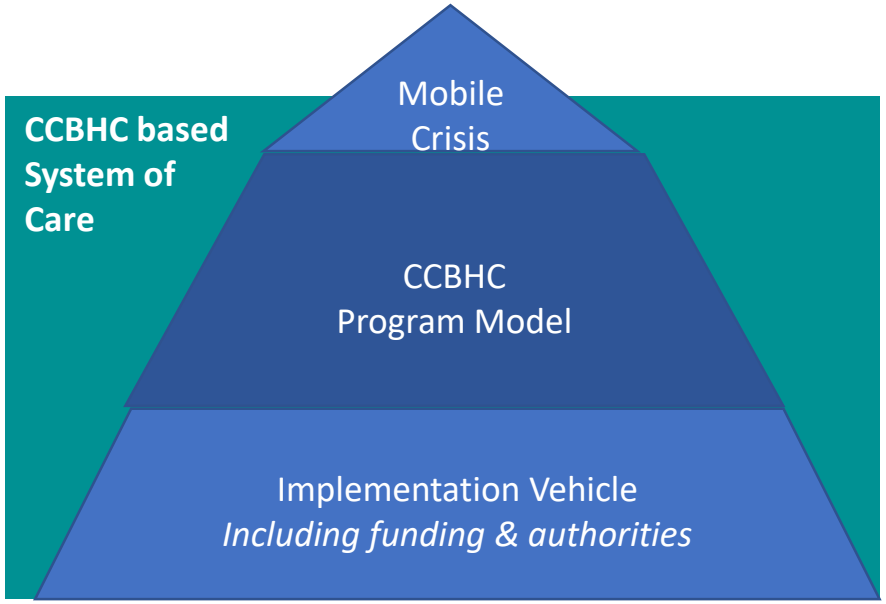
	Policy Option	Statutory, Regulatory or Contractual Lever?	Funding Source other than Budget Initiative/GR?	Which Payer(s) are impacted? Medicaid, Commercial, or all?	Community Support?	State Leadership Support?	Speed to Implementation?	What current RI initiatives would this build from?	What other state(s) have implemented this approach?	Provider Infrastructure Investment Required to Implement?
1	Statewide CCBHC Program	Contractual (+Regulatory)	SAMHSA CCBHC Funding; State Plan Amendment	Medicaid	Mixed	Mixed	12-24 months	Managed Care	Missouri, Texas, National	Y
2	Payment for outcomes	Contractual	Contractual outcome metrics	Medicaid	Y	Y	12-24 months	Accountable Entities; Managed Care	National Best Practice	Y
3	Update AE attribution model	Contractual	1115 DSRIP Waiver	Medicaid			12-24 months	Accountable Entities; Managed Care	Massachusetts	
4	Individuals can begin getting buprenorphine in ED (harm reduction approach)	Regulatory	SAMHSA SOR Grant	All	Y	N/A	6 months	MAT programming	National Best Practice	
5	Complement to KIDSLink, for those without adequate family support structure -- wraparound support for youth under 21 w/SUD diag	Contractual	Contracted ACO service	Medicaid	Y	Y	12 months	KIDSLink	Massachusetts	Y

Detail of Two Synergistic Policies

To address problems diagnosed through gap analysis with policy solutions that most closely align with the state's principles, team recommends further exploring the following policies via implementation plan development. **These policies are not necessarily stand-alone independent options, but rather mutually reinforcing to address RI's challenges in BH system**:

1. Design a Single Statewide Mobile Mental Health Crisis System as central part of CCBHC

- Prioritize critical capacity gap identified in Task 1 AND Enable the efficient implementation of CCBHC.
- Reduce need to transport individuals in crisis to inpatient settings of care.
- Integrate the implementation plan with existing efforts to reform the children's mental health system and other BHDDH initiatives in this area.



2. Program Model Design for CCBHC

Develop a state-specific program model design for a statewide RI CCBHC program.

- RI-specific program model designed to provide comprehensive mental health and substance use disorder services to vulnerable individuals throughout the life cycle.
- Plan will incorporate an approach to payment for outcomes for CCBHC participants.
- Include base requirements (to the extent applicable) and any mods/ additions determined necessary to address RI's unique needs.
- Include programmatic design - required staffing, governance, care coordination, integration elements.

Supporting Implementation Vehicle – Funding and Authorities

Determine the best policy vehicle(s) for implementation and associated funding mechanisms.

- Include options for leveraging federal support/participation and approaches to state financing.
- Plan for multiple funding streams and implementation approaches, including both short and long-term financing options and phased implementation model.
- Include specific agency grants, congressional appropriations, state plan amendment, waiver options, and demonstration programs. Explore requirements and timing for various funding options.
- Will explore funding for upfront & ongoing CCBHC support for state, plan, and provider partners, including infrastructure investments.

D. Improvements Identified in Stakeholder Interviews

Several opportunities were identified by stakeholders and should be considered by Rhode Island government as ways of improving access and quality of BH services.

Regulatory Flexibilities:

- Several stakeholders indicated that regulations and licensure requirements outsize the funding/payment tied to BH services in Rhode Island and recommended a "rightsizing" effort to ensure the field of BH remains attractive and viable in the State.
- Corrections settings leverage transitional care units (TCUs) to assist in the stepdown of individuals who are experiencing acute mental illness. Providers outside the correctional setting recognized the benefit of having this flexibility to ensure appropriate, supported treatment for individuals with acute BH conditions. Flexibilities granted as a result of the pandemic support the use of flex units. Many stakeholders would like to see these flexibilities made permanent and the implementation of TCUs to assist in BH management.
- Relatedly, facilities would like to leverage and expand the ability to "switch" bed capacity based on surge demand for certain services (particularly recommended in a children's context).
- Additionally, many stakeholders indicated they would like to see allowances and flexibilities provided during the COVID-19 pandemic, including telehealth reimbursement, made permanent.

Licensing/Workforce:

- Licensing reciprocity, particularly with neighboring states such as Massachusetts and Connecticut, was identified as a way of providing workforce flexibility.
- Recommendation that the Rhode Island Social Worker licensing exam should be offered in languages other than English.
- Rhode Island needs to identify more places for training/mentoring that are accepting/friendly to non-white providers with different lived experience.
- Student Loan repayment for particular needs in BH (bachelor's level counselors, LPNs) that are currently excluded from repayment programs and the easing of requirements of existing student loan repayment programs.

Emergency Services and Correctional Recommendations:

- To ensure better transitions of care, there should be flexibility in setting the release date from correctional/residential settings to ensure linkage to care can be made before Friday-Sunday.
- To support meaningful community diversion, the state should develop reimbursement for ambulances when hospital is not destination.

KidsLink:

- There is a need for more education and training to gain buy-in and endorsement of KidsLink to ensure referrals meaningful in terms of hand off for service.
- Need to extend KidsLink triage functionality to additional communities.
- KidsLink needs additional interpreter services for non-English speakers.
- There are gaps between KidsLink and suicide prevention work at CMHCs (and other program offerings)
- There was feedback about the possible expansion of KidsLink/BH Link to more communities in RI. In addition, stakeholders felt there was important infrastructure in both KidsLink and BH Link on which to build for needed programming, such as mobile crisis intervention.

Consumer Engagement:

- BHDDH should create a Consumer Affairs Office to improve consumer engagement and address concerns from consumers interacting with RI's BH system

D. COVID-19 Policy Recommendations

Several states have explored BH policy changes as a result of the COVID-19 pandemic to address equity and access challenges aggravated in the current system of care.

Ongoing Continued Access to Telehealth

- Make permanent telehealth reimbursement opportunities and service definition flexibilities created in response to COVID-19.

Caring for Caregivers

- Explore a variety of solutions to address burnout, including, workplace surveys to assess stressors and monitor impact on workforce, regulatory flexibility to support workload redistribution strategies and administrative simplification, and ensuring access to mental health support for caregivers.

Safe Reopening Strategies

- Develop protocols to reopen services safely. There are concerns that vital BH and SUD services must resume to treat individuals who are at-risk without treatment or lack access to telehealth/telepsychiatry options.
- Reopening strategies should address capacity limits for in-person office staffing and visitors, staffing ratios, remote work options for administrative personnel, sanitation/cleaning strategies, and vaccination strategies for high-risk populations.

Vaccine Distribution to High Need, Vulnerable Populations

- People with serious mental illness are at increased risk of being infected by COVID-19 and have higher subsequent rates of hospitalization, morbidity, and mortality. Running vaccination clinics parallel to mental health services can increase vaccination rates by up to 25%[1].

Broadband Internet Access

- Prioritize expanding internet access to homeless shelters and low-income housing to assure equitable access to vital internet-based resources during COVID-19 quarantine/isolation.

[1]https://www.providencejournal.com/story/news/courts/2021/01/10/phoenix-house-remain-fully-operational-as-it-works-to-right-its-financial-woes/616456002/

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Implementation Plan Outline

Each implementation plan will include:

I. Statement of Need/Identified Gap: Connect the initiative to the needs of Rhode Islanders

- Document the problems diagnoses that will be addressed through the implementation plan, including gaps in the continuum of care and challenges moving between levels of care that were identified by the earlier phase of work
- Determine the critical elements of the initiative that impact the identified gaps and challenges

II. Establishing/Generating Needed Stakeholder Buy-In:

Develop a plan for **community stakeholder** buy-in.

- Consumers
- Families
- Providers
- Insurers
- AEs
- Advocates

Develop a plan for engaging needed **government partners**.

- CMS
- HHS
- SAMHSA
- Governor's Office
- Municipalities

III. Program Model Considerations: Develop plan for program model that **addresses problems diagnosed & aligns with principles documented** by this project, including:

- Prioritizes issues of health equity and leverages capacity of CBOs to address the social drivers of health
- Coordinates and integrates care
- Reduces utilization of high-cost services, e.g. inpatient and nursing home levels of care
- Incents providers to improve the quality and accessibility of the care they offer
- Improves screening and assessment
- Enables providers to attract and retain a high-quality workforce

IV. Operational Model Considerations: Identify operational considerations include:

- Impacted business models managed care/fee for service, Duals/non duals, and programs – children/families, adults with disabilities, expansion
- Contractual changes needed to support this initiative
- Critical systems changes needed
- Critical business processes, staffing, reports impacted by this program

Implementation Plan Outline (continued)

V. Authorities – Determine what authorities are necessary to implement the initiative, and what vehicles are available to expedite implementation.

- Conduct federal authority analysis (SPA vs. Waiver)
- Conduct state authority analysis (legislation vs. regulation vs. agency-directed)
- Determine appropriate Medicaid authority and benefit structure
- Identify potential alignment with federal financing opportunities

VI. Payment Model – Identify the outcomes the payment model is endeavoring to produce and the provider behaviors we are trying to incent.

- Determine appropriate payment mechanism(s) and funding source(s), including Medicaid and multi-payer levers as applicable
- Identify outcome benchmarks to drive performance improvement
- Develop a payment model strategy that supports sustainable long-term financing

VII. Leveraging Existing RI Programs/Projects – Determine the way in which the proposed initiative fits with other system transformation initiatives already under way in Rhode Island.

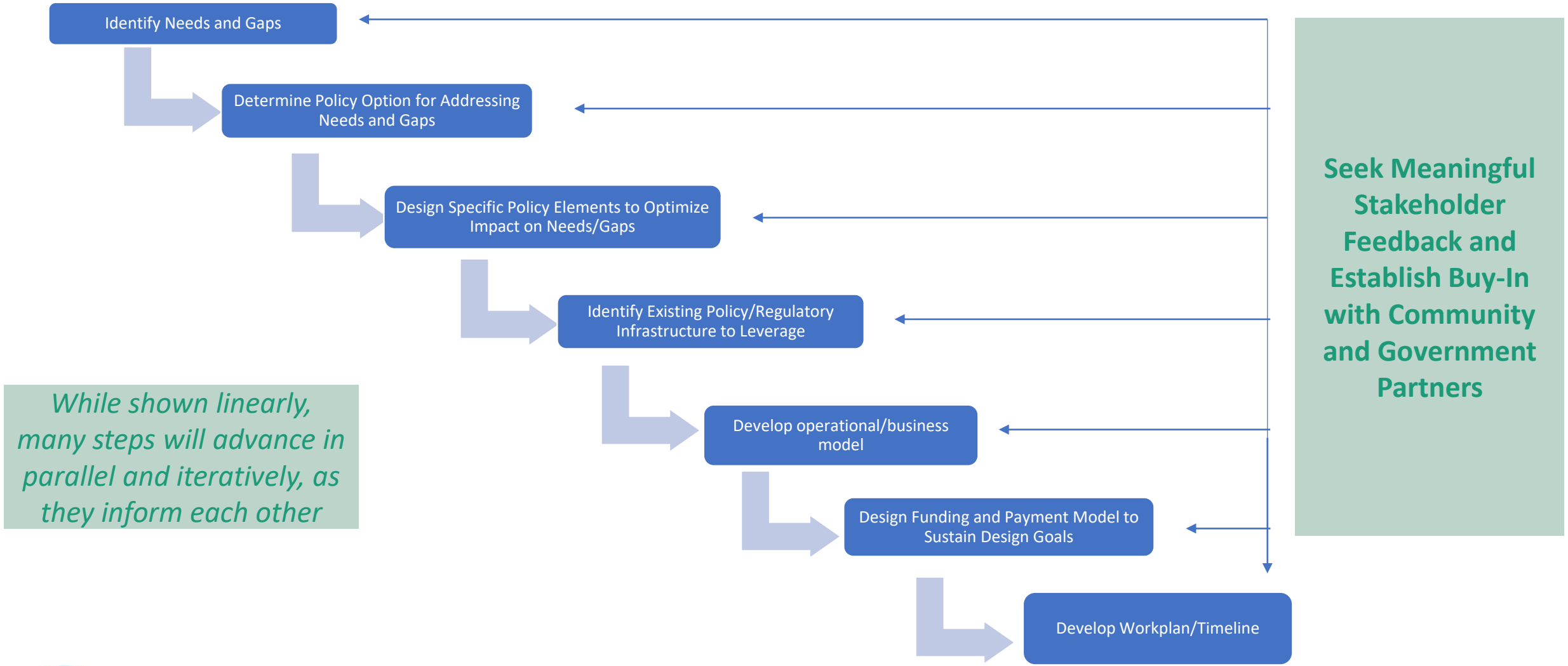
- Analyze relevant programs and projects that need to be accounted for/included in program implementation
- Identify synergies/efficiencies with Accountable Entities, BH reform initiatives, and existing infrastructure

VIII. Workplan/Timeline– Develop a workplan that will enable Rhode Island to implement the initiative in a timely manner.

Determine:

- Milestones and deliverables
- Accountable agencies
- Critical deadlines

Approach to Implementation Plans



CCBHC Implementation Plans: Key Elements

Priority Policy Option 1:
State-specific model design for a Statewide RI CCBHC

I. Statement of Need: Identified Gap
- Why CCBHC
- National Evidence
- Other State Action

II. CCBHC Program Model Considerations
- Approach to Development
- National Program Model Overview (Starting Point)
- Rhode Island Specific Model Considerations

III. CCBHC Operational Model Considerations
- Participants
- Administrative oversight
- Data and Metrics
- Performance Specifications

IV. Leveraging Existing RI Programs/Projects
- Starting Point: Current CCBHCs, CMHOs, and AEs
- Additional RI Programs/Projects
- Current Medicaid Covered Services

V. Generating Community Stakeholder Buy-In
- Approach to Stakeholder Input
- Key Participants and Activities

VI. Authorities
- Two Options: SPA, 1115 Waiver
- Other State Approaches
- Process & Timeline

VIIa. Payment Model: Case Studies
- State Defined CCBHCS Payment Model - Texas
- Federal PPS Model

VIIb. Payment Model: Rhode Island Options
- Payment Model Goals and Principles
- Three model options, considerations & assessment

VIII. Potential Federal Sources of Revenue

IX. Workplan/Timeline

Appendix:
- **CCBHC Program Model**
  - Service Requirements Detail
  - Organizational Requirements Detail
- **Other State CCBHC Implementation Case Studies**

Mobile Crisis Implementation Plans: Key Elements

Priority Policy Option 2:
State-specific model design for a Statewide RI Mobile Crisis System

I. Statement of Need: Identified Gap
- Why Mobile Crisis Services
- National Evidence
- Other State Action

II. Mobile Crisis Services Program Model Considerations (*Slides 10-14)*
- Approach to Development
- National Program Model Overview (Starting Point)
- Rhode Island Specific Model Considerations

III. Mobile Crisis Services Operational Model Considerations *(Slides 15-17)*
- Participants
- Administrative oversight
- Data and Metrics
- Performance Specifications

IV. Leveraging Existing RI Programs/Projects *(Slides 18-19)*
- Starting Point: Current Mobile Crisis Services , CMHOs, and AEs
- Additional RI Programs/Projects
- Current Medicaid Covered Services

V. Generating Community Stakeholder Buy-In (*Slides 20)*
- Approach to Stakeholder Input
- Key Participants and Activities

VI. Authorities *(Slides 21-22)*
- Two Options: SPA, 1115 Waiver
- Other State Approaches
- Process & Timeline

VIIa. Payment Model: Case Studies *(Slides 23-26)*
- State Defined Mobile Crisis Services Payment Model - Texas
- Federal PPS Model

VIIb. Payment Model: Rhode Island Options *(Slides 27-29)*
- Payment Model Goals and Principles
- Three model options, considerations & assessment

VIII. Potential Federal Sources of Revenue (*Slides 30)*

IX. Workplan/Timeline *(slide 31-33)*

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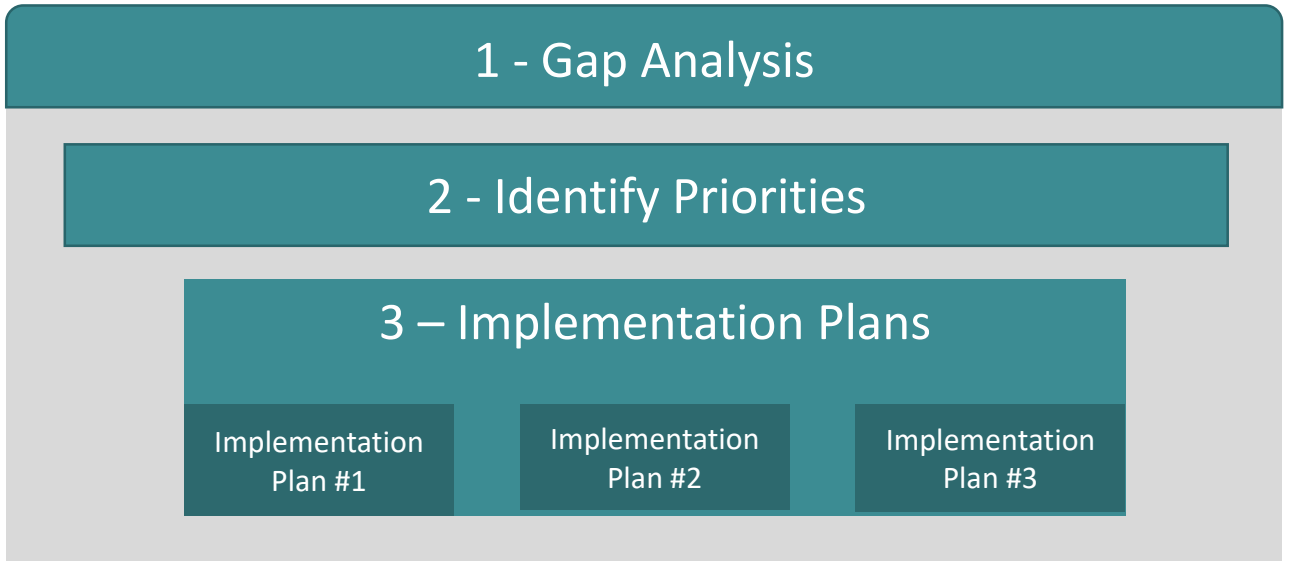
Behavioral Health System Review - Goals

- EOHHS, on behalf of an interagency team with representation from BHDDH, RIDOH, OHIC, DCYF, DHS, RIDE, DOC, OHA, and VETS, engaged a partnership of Faulkner Consulting Group and Health Management Associates to assess gaps in the BH system, identify policy and implementation priorities, and establish implementation plans for those priorities.
- All project efforts and deliverables will be grounded in Rhode Island's starting point, including but not limited to workgroup recommendations from RI's Executive Order on Behavioral Health and findings from the State Innovation Model.



Interagency Partnership Approach

	Steering Committee	Subject Matter Experts	Working Group
Composition	Health Cabinet (Agency Directors)	BHPH Planning Team	Marti (EOHHS), Charlotte (EOHHS), Marjorie (Medicaid), Ryan (BHDDH), Kari (Medicaid), Susan L (DCYF), James (DOH), Marea (OHIC), and FCG|HMA team members
Role	- Key input, decisions and direction on project - Final feedback on deliverables	- Provides agency subject matter expertise - Provides input on materials, deliverables, direction needed prior to advancing to Health Cabinet	- Provide real-time input on working draft project deliverables - Project management of deliverables and tasks - Advance materials to BHPH team for input
Frequency	Bi-Monthly to Quarterly	Monthly	Weekly

Participating as Subject matter Experts:

Agency	Name
BHDDH	Corinna Roy Richard Sabo Linda Mahoney Linda Barovier Olivia King Lisa Gargano Ryan Erickson
EOHHS	Amy Katzen Rick Brooks Marti Rosenberg Charlotte Kreger

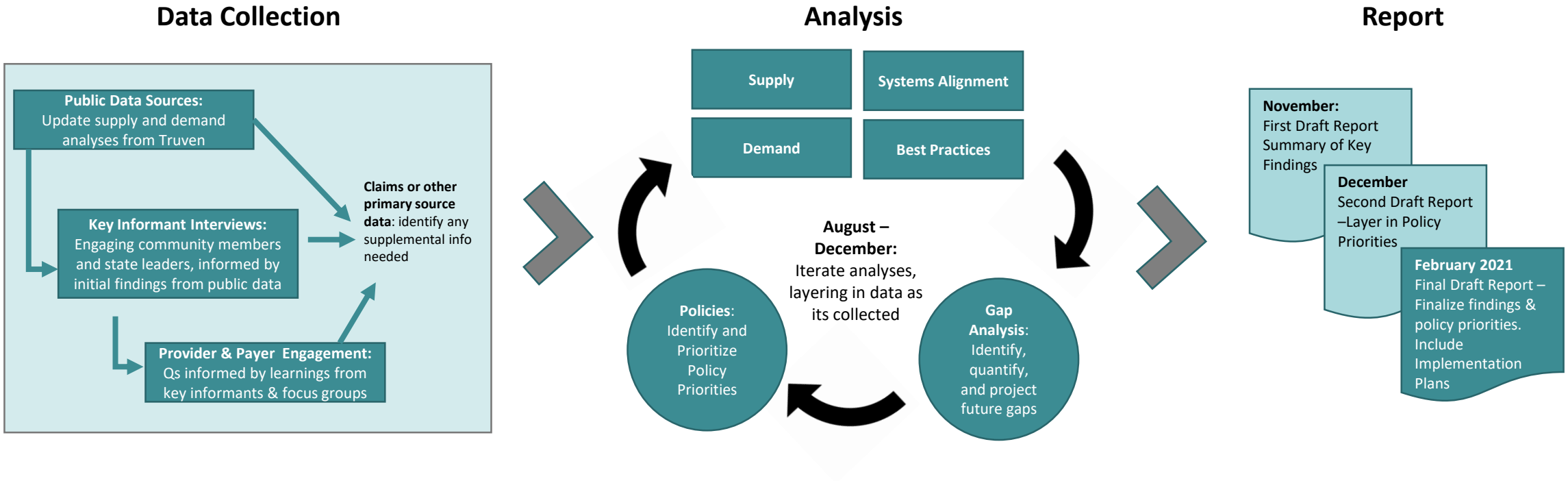
Agency	Name
RIDOH	Jenn Koziol Tracy Jackson Carol Hall-Walker Blythe Berger James Rajotte
OHIC	Marea Tumber
DOC	Kathleen Kelly
OHA	Michelle Szylin Mary Ladd
VETS	Matthew Golderese

Agency	Name
EOHHS/ Medicaid	Deborah Morales Libby Bunzli Jason Lyon Chantele Rotolo Kari Kusler Marjorie Delille
DCYF	Chris Strnad Peter Slom Stephanie Terry Susan Lindberg
DHS	Maria Cimini
RIDE	Rosemary Reilly-Chammat

Analytic Plan & Report: Sequencing & Rationale

Principles:

- *Use primary data collection ONLY for data not available from public data sources.*
- *Iterate on gaps, policy options and priorities as data is collected and integrated into analysis*
- *Integrate results of analysis, policy recommendations, and implementation plan into comprehensive final report*

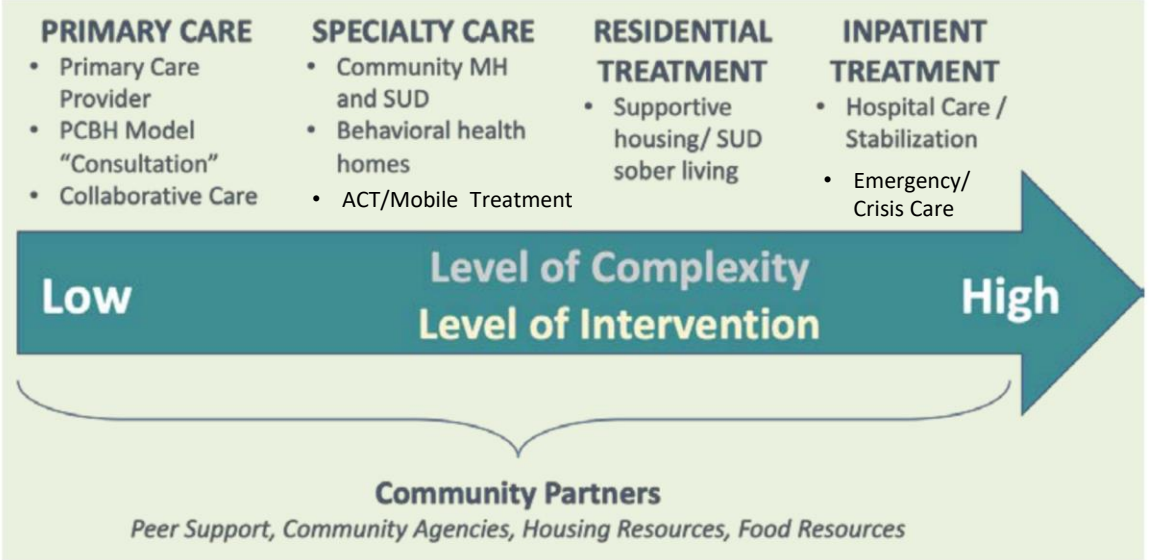


Considerations Woven Through Analysis and Report

Considerations woven throughout ALL sections of the report:

- **Race Equity**: Focus on health disparities that arise from systemic racism
- **Health Equity:** Assess health disparities for populations including race/ethnicity, language, age, gender, gender identity, and sexual orientation. Incorporate standards for Culturally and Linguistically Appropriate Services (CLAS) in review.
- **Special populations:** special attention to specific population subgroups: populations with SPMI/SMI, people with chronic substance use disorders, age-based distinctions (children, seniors), race/ethnicity, LGBTQ+, and other subgroups as applicable.
- **Recent Rhode Island Innovations**: include programs implemented through SIM, BH Link, and Medicaid AE program
- **Multi-payer**: Considering demand and supply of services regardless of the payer, with special attention to Medicaid-specific populations and services where appropriate
- **COVID-19**: Anticipate substantial impacts on both demand and supply, including but not limited to seclusion, isolation, trauma
- **Role of Primary Care:** Assess community capacity for SUD inclusive of PCPs with MAT certification
- **Integration of BH & Medical Care:** consider how primary care could be integrated into BH care within BH provider settings

Continuum of Care Considered:



Source: http://www.breecollaborative.org

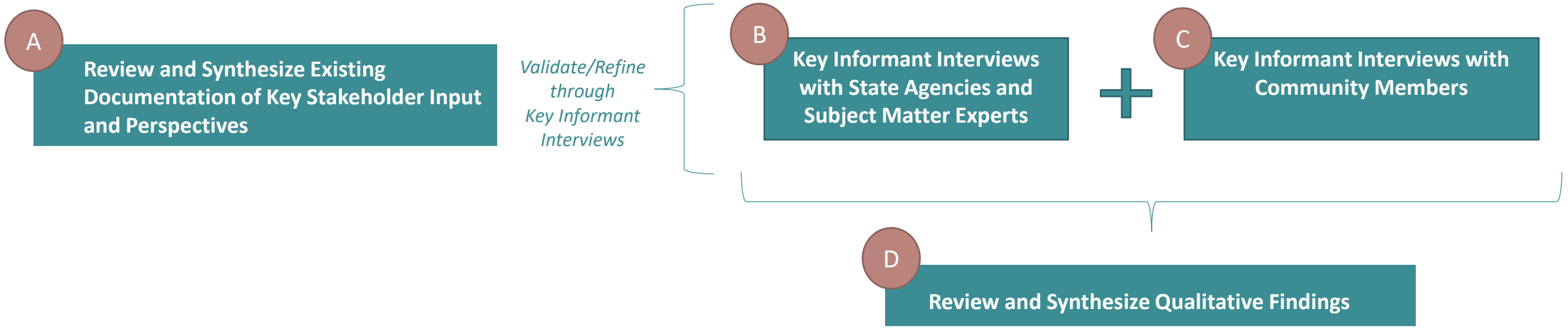
Quantitative Analysis: Methods

1) **Public Data:** The project team searched publicly available data sources for core indicator, supply and demand metrics. In particular, the project team focused on datasets that illustrated Rhode Island's relative position regionally and nationally on key metrics, and aimed to find datasets that included demographic information such that results could be stratified by age, sex, race/ethnicity, sexual orientation, and payer whenever available.

2) **Supplemental Data Requests:**
   a) **State Data Bases:** The interagency project team reviewed initial findings public data and identified gaps in information that could be filled in via data collected by the state. The team defined data requests for relevant agencies
   b) **Utilization data from Rhode Island payers:** The team worked with OHIC to request mental illness and substance use facility utilization claims data from Blue Cross Blue Shield of Rhode Island, United Health Care, Tufts Health Plan, and Neighborhood Health Plan. In addition, the team partnered with Rhode Island's APCD team to request utilization data to support Medicare and Medicaid fee-for-service claims. (Note: APCD did not have complete data for relevant diagnoses and demographic stratification to support all payer utilization data sourced from the APCD).
   c) **Supplement data from Rhode Island providers:** In select situations where results needed further explanation or contextualization, or where data points were missing, the team prepared limited data requests of Rhode Island providers.

Qualitative Research Process

Approach: The team informed key themes and findings through a mixed methods approach, including qualitative work engaging stakeholders from both state agencies and the community, as well as a quantitative assessment of the gaps between supply and demand in Rhode Island's behavioral health system.



Key Informant Interviews and Qualitative Analysis: The interagency project team identified participants for key informant interviews. EOHHS made email introductions to prospective interviewees requesting participation and FCG scheduled and coordinated interviews. FCG and HMA conducted group interviews using two interview guides: one for state agencies and subject matter experts, and one for community stakeholders. The team recorded all interviews and took detailed notes. The team analyzed the qualitative data from the interviews to ensure that all findings were adequately captured. The team used a framework-based approach to synthesize the data: first, coding data by *a priori* themes – those previously identified from past stakeholder input – as well as by *de novo* themes – those that emerged as new findings.

Key Informant Interview Participants

In order to ensure the most complete picture of our behavioral health system, we recruited interview participants from a broad range of organizations.

State Interviews:

BHDDH: Kathryn Power
EOHHS/RIDOH: Ana Novais
RIDE: Rosemary Reilly-Chammat
BHDDH: Michelle Brophy
Governor's Office: Dacia Read/Katja Hamler
Medicaid: Ben Shaffer
Medicaid: Chantele Rotolo/Jason Lyon
DCYF: Kevin Aucoin/Susan Lindberg/ Christopher Strnad
SAMSHA Regional Office: Tom Coderre
DOC: Dr. Clark/Kathleen Kelly/Caitlin Bouchard

Community Group Interviews:

Community Leaders
Peer Recovery
Housing/Homeless Community
Seniors/Older Adults
Advocates
Youth Services
LGBTQ+ Community
Faith Communities
Crisis & Referral Sources
Previously Incarcerated Community
Colleges
Emergency Department

Payers:

Blue Cross Blue Shield Rhode Island
United Health Care
Tufts Health Plan
Neighborhood Health Plan

Providers:

Safety Net Providers (CHCs)
SUMHLC and CMHC/SUD/OTP Providers
Hospitals
Care Transformation Collaborative

Key Informant Interview Participants

Community stakeholder organizations that participated in key informant interviews are listed below:

- Higher Ground International
- African Alliance
- Refugee Dream Center
- Center for Southeast Asians
- West End Community Center
- Council on LTSS
- Anchor
- Parent Support Network RI
- Recovery Friendly Workplace
- Recovery Coaches/RI Cares
- RI Coalition for the Homeless
- House of Hope
- Amos House
- West Elmwood Housing Development Corp
- HousingWorks RI
- KidsLink
- Bradley Hospital
- TIDES
- RI Coalition for Children and Families
- Brown University
- BH Link
- 211/United Way
- Lifespan Community Health Institute
- RICADV
- RI EMS
- Center for Health and Justice Transformation
- King's Cathedral
- King's Tabernacle
- RI Minster's Alliance
- Muslim Community
- Youth Pride
- SAGE
- Thundermist Health Center
- National LCBTQ Cancer Network
- NAMI
- MHARI
- Mental Health Advocate
- RI Psychological Association
- RIC Social Work Department
- Latinx Mental Health Professionals
- SUMHLC
- East Bay Community Action Program
- CODAC
- Newport Mental Health
- Horizon Healthcare Partners
- VICTA
- Gateway Healthcare
- Galilee Mission
- Providence Center
- Community Care Alliance
- Wood River Health Services
- Tri County Community Action Agency
- Providence CHC
- East Bay CAP
- RI Health Center Association
- Rhode Island Parent Information Network

Best Practices and Evidence Based Models Research Process

Approach:
The project team conducted research on best practices and innovative models impacting BH, SUD, and related specialty services from across the country. We targeted those models with specific alignment and applicability to Rhode Island based on quantitative and qualitative analysis, to date, plus our knowledge of existing program models and the regulatory landscape.

The report includes for each model: a program/model description; the intended target population; the included service category or categories; applicable regulatory levers or state authorities used to implement the program/model; key stakeholder themes addressed; and relevance to Rhode Island.

Additional background and detail are available on each model contained in this report.

The intention is for this list to evolve and become more targeted as our research develops and will grow to include additional models that may be applicable as our collective analysis matures. ***A list of potential additional models captured during our qualitative research phase is included in Section 4 of this draft report.***

As we progress through this project, this research is intended to help facilitate a discussion amongst the project team members and stakeholders to refine the list to those models with most relevance and applicability to our future implementation plans.

Methodology for Policy Identification and Prioritization

1. **Identify Policy Options** – Leveraged best practices from other states to identify policy options that would address one or more of the system challenges identified through the qualitative and quantitative analysis
2. **"Rhode Island-ize" Policy Options** – Adapted policy options from other states and national models to determine how best to apply them to Rhode Island's unique characteristics and starting point.
3. **Scored Each Policy Against Alignment with Problems Diagnosed (Key Themes)** – Assessed each policy against each of the 9 identified principles, scoring as "full alignment" (2), "partial alignment" (1) or "no alignment" (0). Aggregated scores for each policy across principles, and ranked ordered.
4. **Scored Each Policy Against Alignment with Principles** – Assessed each policy against each of the 9 identified principles, scoring as "full alignment" (2), "partial alignment" (1) or "no alignment" (0). Aggregated scores for each policy across principles, and ranked ordered.
5. **Documented Policy Alignment by Population** – for each policy option, confirmed if it would address youth, adults, and/or older adults for mental health, as well as the same three population segments for substance use
6. **Documented High-Level Feasibility Components –** qualitatively assessed: statutory, regulatory, and/or contractual lever? Funding source other than general revenue? Which payer(s) are impacted? Stakeholder support documented from interviews? Speed to implementation? Current RI initiatives upon which the policy would build on? Other state(s) that have implemented the policy option? Provider infrastructure investment required?

Themes/Problem Addressed:
- Gaps/Access
- Workforce
- Health Equity
- Fragmentation
- Payment Models
- Infrastructure
- Community Engagement
- Systemic Racism
- Social Determinants

Principles Addressed:
- Detailed on prior slide

Populations Served:
MH: Youth
MH: Adults
MH: Older Adults
SUD: Youth
SUD: Adults
SUD: Older Adults

Feasibility:
Policy Levers
Funding Source
Payers Impacted
Community Support
State Leadership Support
Speed to Implementation
Leveraging RI Initiatives
Other State Examples
Infrastructure Required

DRAFT Methodology - Implementation Plan Outline

Develop detailed implementation plans for up to three priority initiatives. Each implementation plan will include:

I. Statement of Need/Identified Gap: **Connect the initiative to the needs of Rhode Islanders**

- Document the problems diagnoses that will be addressed through the implementation plan, including gaps in the continuum of care and challenges moving between levels of care that were identified by the earlier phase of work
- Determine the critical elements of the initiative that impact the identified gaps and challenges

II. Establishing/Generating Needed Stakeholder Buy-In:

Develop a plan for **community stakeholder** buy-in.

- Consumers
- Families
- Providers
- Insurers
- AEs
- Advocates

Develop a plan for engaging needed **government partners**.

- CMS
- HHS
- SAMHSA
- Governor's Office
- Municipalities

III. Program Model Considerations: Develop plan for program model that **addresses problems diagnosed & aligns with principles documented** by this project, including:

- Prioritizes issues of health equity and leverages capacity of CBOs to address the social drivers of health
- Coordinates and integrates care
- Reduces utilization of high-cost services, e.g. inpatient and nursing home levels of care
- Incents providers to improve the quality and accessibility of the care they offer
- Improves screening and assessment
- Enables providers to attract and retain a high-quality workforce

IV. Operational Model Considerations: **Identify operational considerations** include:

- Impacted business models managed care/fee for service, Duals/non duals, and programs – children/families, adults with disabilities, expansion
- Contractual changes needed to support this initiative
- Critical systems changes needed
- Critical business processes, staffing, reports impacted by this program

DRAFT Methodology - Implementation Plan Outline (cont.)

V. Authorities – Determine what authorities are necessary to implement the initiative, and what vehicles are available to expedite implementation.

- Conduct federal authority analysis (SPA vs. Waiver)
- Conduct state authority analysis (legislation vs. regulation vs. agency-directed)
- Determine appropriate Medicaid authority and benefit structure
- Identify potential alignment with federal financing opportunities

VI. Payment Model – Identify the outcomes the payment model is endeavoring to produce and the provider behaviors we are trying to incent.

- Determine appropriate payment mechanism(s) and funding source(s), including Medicaid and multi-payer levers as applicable
- Identify outcome benchmarks to drive performance improvement
- Develop a payment model strategy that supports sustainable long-term financing

VII. Leveraging Existing RI Programs/Projects – Determine the way in which the proposed initiative fits with other system transformation initiatives already under way in Rhode Island.

- Analyze relevant programs and projects that need to be accounted for/included in program implementation
- Identify synergies/efficiencies with Accountable Entities, BH reform initiatives, and existing infrastructure

VIII. Workplan/Timeline– Develop a workplan that will enable Rhode Island to implement the initiative in a timely manner.

Determine:

- Milestones and deliverables
- Accountable agencies
- Critical deadlines

Table of Contents

A. Core Indicators – Sources and Data Availability

Category	Dashboards	Reg & Nat. Benchmarks	Gender	Race	Age	LGBTQ+	Insurance	Source
Suicide Rate	(1) Suicide Deaths/100k	✓	✓	✓	✓	TBD	TBD	SHADAC; CDC
	(2) % with suicidal ideation	✓	✓ (<18)	✓ (<18)	✓	✓ (<18)	TBD	NSDUH/CDC
Overdose death Rate	(3) Drug overdose death rate/100k	✓	✓	✓	✓	TBD	TBD	KFF
	(4) overdose deaths due to opioids/100k	✓	✓	✓	✓	TBD	TBD	KFF
	(5) Alcohol or Drug-related deaths/100k	✓	✓	✓	✓	TBD	TBD	CDC
Rates of Substance Use	(6) Substance Use Rates	✓ **(except facility use)**	✓	✓	✓	TBD	TBD	NSDUH – BRFSS; TEDS
	(7) COVID-19 Impact on Alcohol Usage	TBD	✓	✓	✓	TBD	TBD	JAMA
Homelessness Rates	(8) % homeless rate by state; Point-in-time count of homeless individuals; Percent of Adult Mental Health Consumers who are Homeless	✓	✓	✓	✓ (< 18)	✓ (2015+)	TBD	HUD; USICH

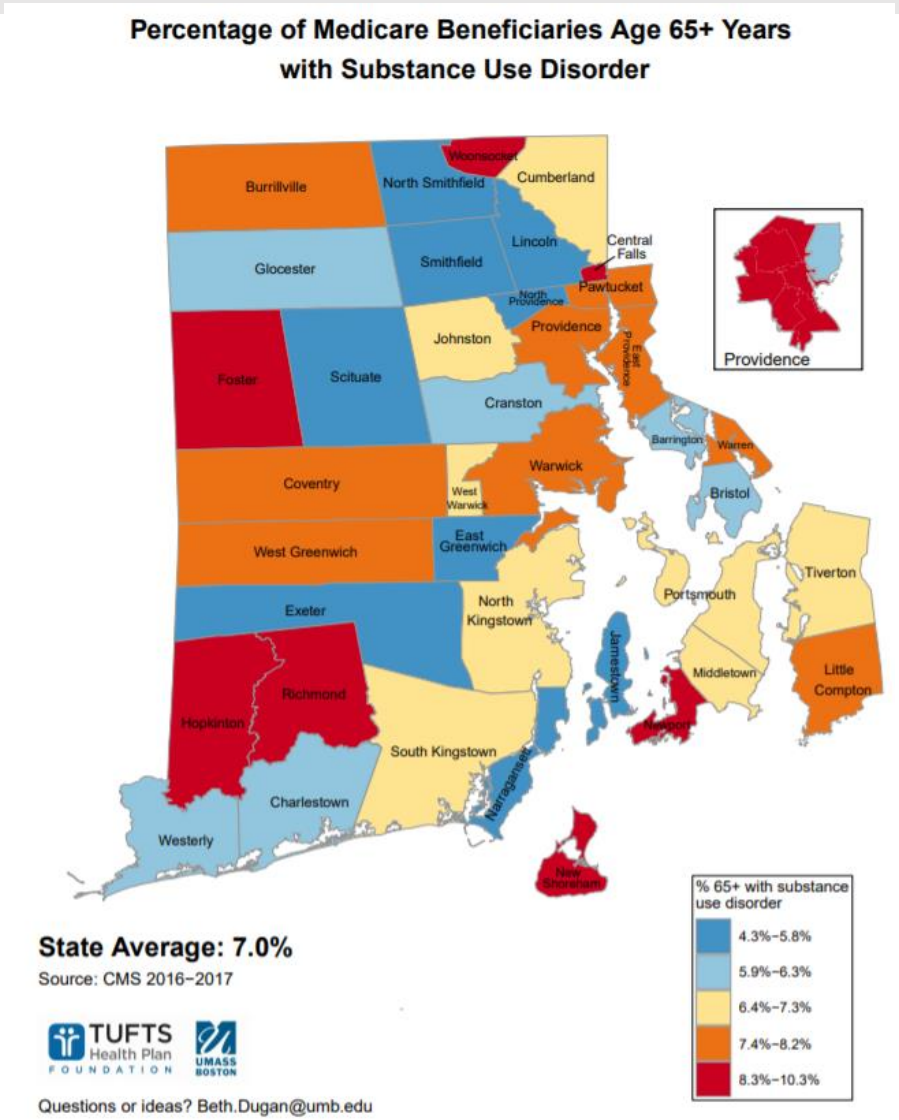
A. Core Indicators – Sources and Data Availability (Cont'd)

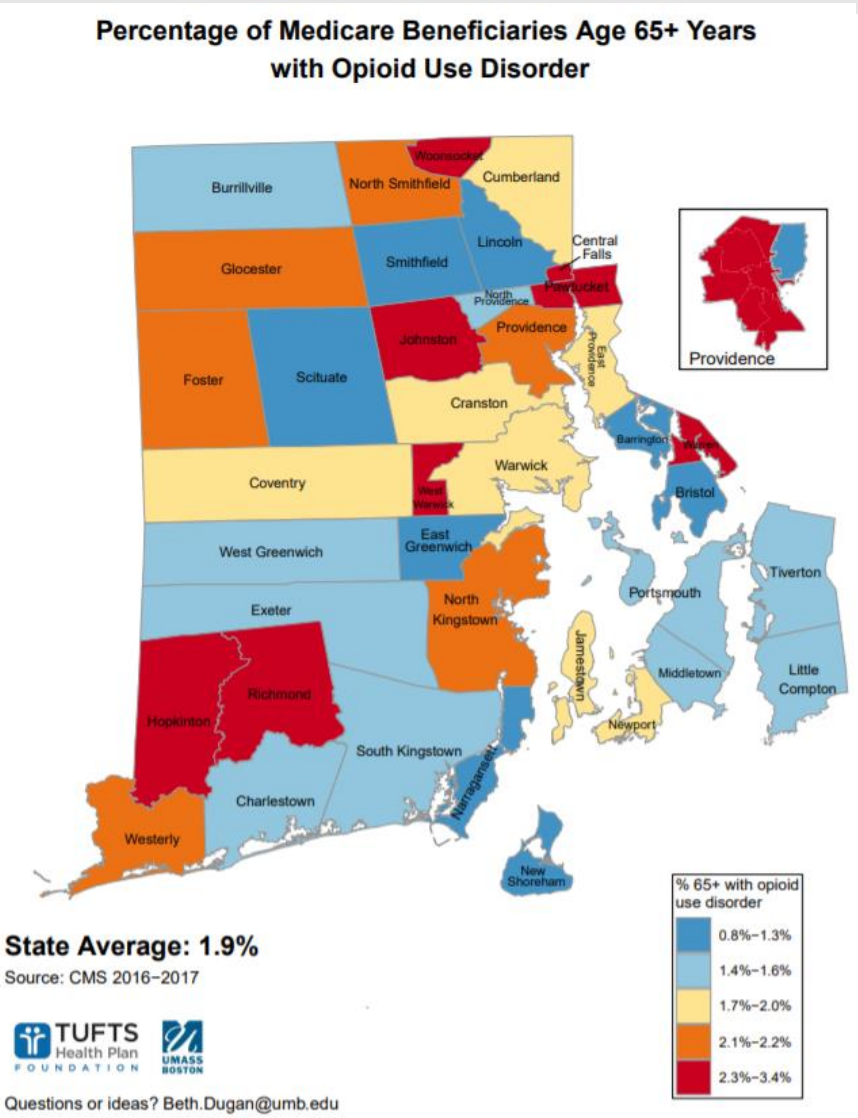
Category	Dashboards	Reg & Nat. Benchmarks	Gender	Race	Age	LGBTQ+	Insurance	Source
BH Utilization of ED	(9) #/% of ED utilization for MH Diagnosis; #/% of ED utilization for SUD diagnosis	TBD	✓	✓	✓	TBD	✓	DOH (hospital discharge DB)
	(10A & B) 7 & 30-day post-ED visit follow-up rates for pts with SUD and MH	TBD	✓	TBD	✓	TBD	✓	DOH
Incarceration Care	(11) Living Situation of Mental Health Consumers	✓	TBD	TBD	TBD	TBD	TBD	*TBD*
Employment in recovery/ post-treatment	(12) MH Employment	✓	✓	TBD	✓	TBD	TBD	URS
Children-specific measures	(13) % of High Schoolers Who Felt Sad or Hopeless almost Every Day for 2 or More Weeks in the Past Year	✓	✓	✓	✓	✓	TBD	CDC
	(14) % of high schoolers who used e-vape products at least once in the past 30 days	✓	✓	✓	✓	TBD	TBD	CDC
	(15) MH indicators for youth and adolescents	✓	TBD	TBD	✓	TBD	TBD	NSCH
Health system costs	(16) SUD/MH Utilization by Location	✓	TBD	TBD	TBD	TBD	✓	RI APCD
	(17) SUD Service Utilization (Commercial/Medicare)	TBD	✓	TBD	✓	TBD	✓	RI APCD
	(18) MH Service Utilization (Commercial/Medicare)	TBD	✓	TBD	✓	TBD	✓	RI APCD
	(19) SUD Utilization (Medicaid)	TBD	✓	TBD	✓	TBD	✓	MMIS
	(20) MH Utilization (Medicaid)	TBD	✓	TBD	✓	TBD	✓	MMIS
	(21) MH/SUD Expenditure	TBD	TBD	TBD	TBD	TBD	✓	MMIS
	(22) Total BH Expenditure	TBD	TBD	TBD	TBD	TBD	✓	EOHHS
	(23) BH AE Expenditure	TBD	TBD	TBD	TBD	TBD	✓	EOHHS
	(24) BH and the LTSS Population	TBD	TBD	TBD	TBD	TBD	✓	MMIS

B. Supply Measures – Sources and Data Availability

Category	(page #) Measures	Yearly benchmks?	Gender	Age	LGBTQ+	Geo?	Source
MAT	(65) # of OTPs and Buprenorphine Practitioners/100k	TBD	TBD	TBD	TBD	✓	SAMHSA
	(65) # of Patients Receiving Buprenorphine (65) # of DATA-Waivered Practitioners	✓	TBD	TBD	TBD	TBD	PreventOverdoseRI
Children's Continuum	(63) Children Under 19 Treated at RI Psychiatric Hospitals (63) DCYF Residential Placements for Children (63) Average Available and Filled Beds for Children and Adolescent	✓	TBD	TBD	TBD	TBD	KidsCount; Lifespan & CNE ann. reports; DCYF; BHOB
Partial Hosp/IOP	(74) % SUD and MH facilities that offer programs for special groups	✓	✓	✓	✓	TBD	SAMHSA
Inpatient TX	(64) Occupancy Rate for Residential/IP Services at SUD Facilities (20) Bed counts for SUD, MH, and MHPRR Facilities	TBD	TBD	TBD	TBD	✓	SAMHSA, RIBHOpenBeds, BHDDH, Treatment Advocacy Center
Residential	(64) Individuals on SUD Residential Waitlist	TBD	TBD	TBD	TBD	✓	BDHHD
Crisis	(66) % of MH Facilities that Employ a Crisis Team (66) Outcomes of BHLink Crisis Calls (66) # of Calls to BHLink by Reason for Call	✓	TBD	TBD	TBD	✓	SAMHSA; DCYF
General OP	(22/67/71) BH providers/100k People (67) Psychologists/1k People by City, RI	TBD	TBD	TBD	TBD	✓	HRSA workforce, BLS,
	(21) % of MH Facilities that are CMHCs	TBD	N/A	N/A	N/A	✓	SAHMHSA

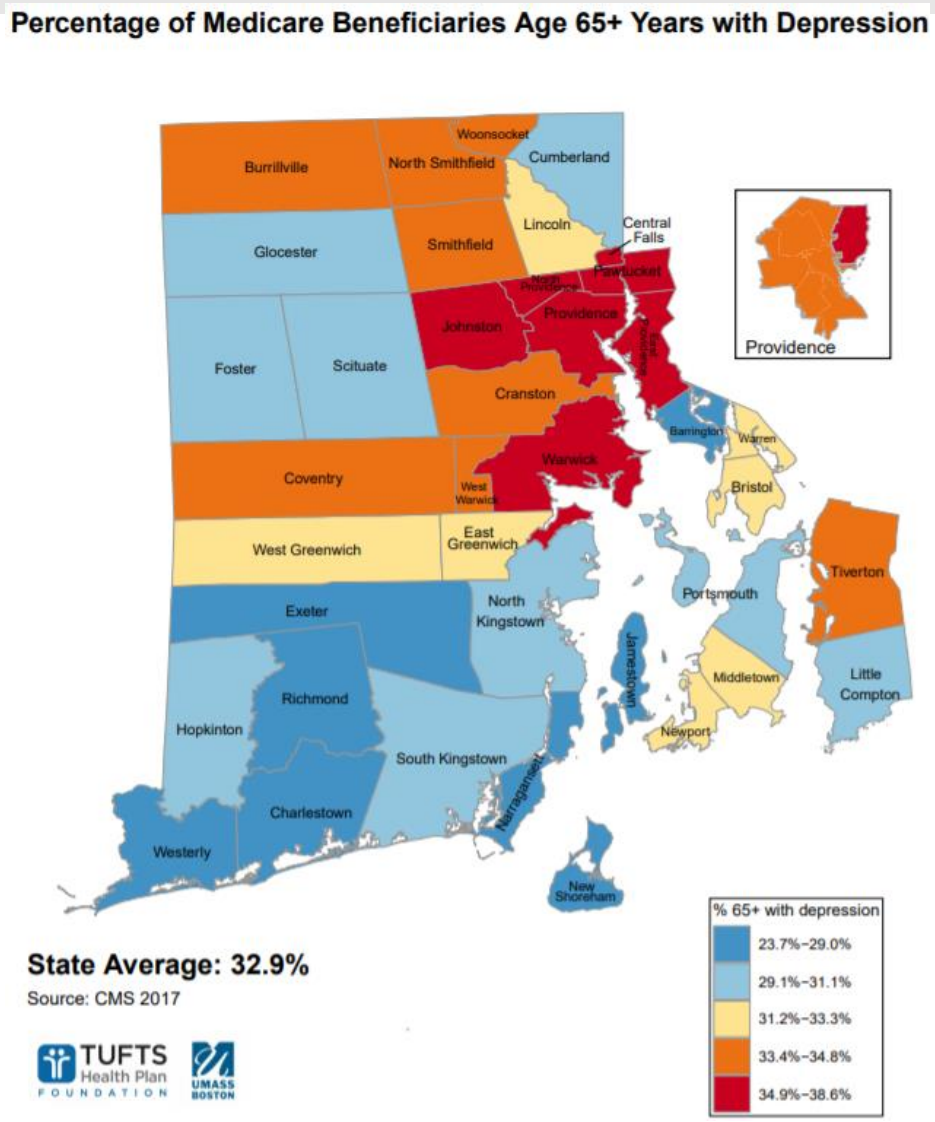
Older Adult Population

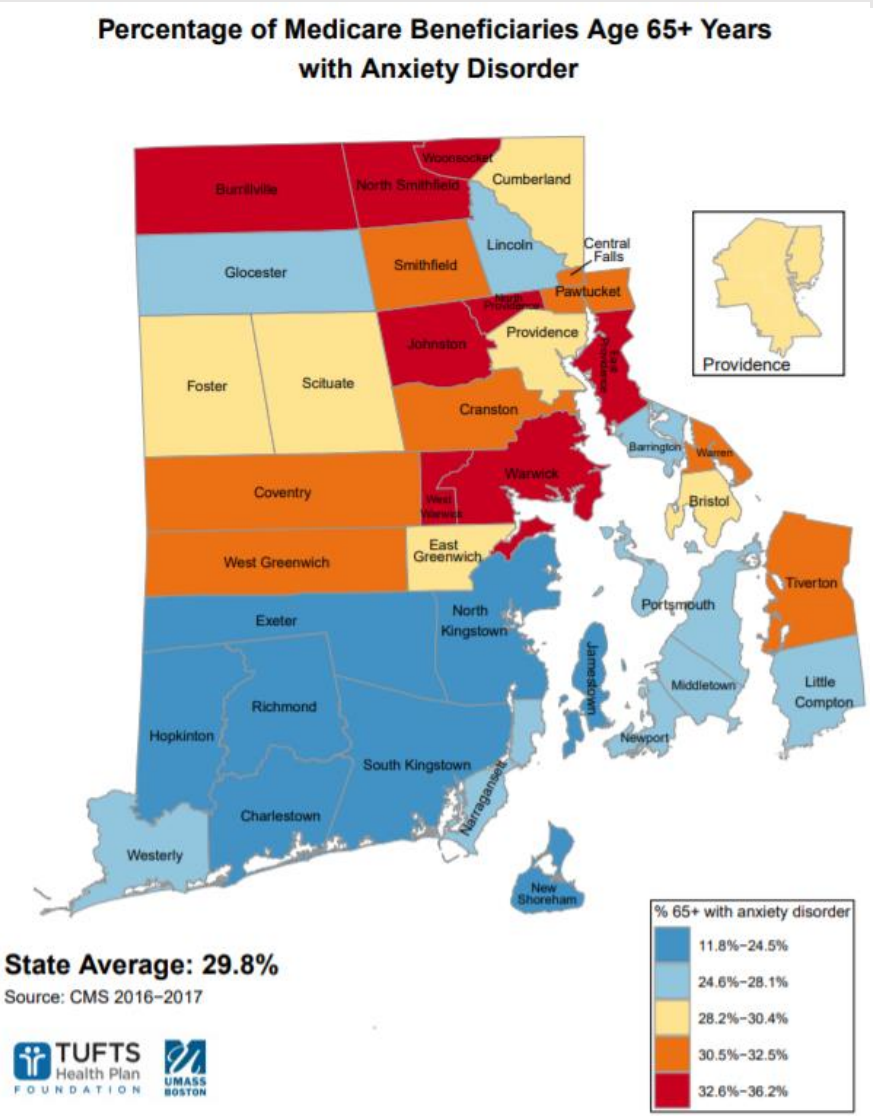




Source: Tufts Health Plan Foundation, 2020 Rhode Island Healthy Aging Data Report, https://healthyagingdatareports.org/rhode-island-healthy-aging-data-report/
Note: Data sourced from the 2016-2017 Master Beneficiary Summary File – A/B/C/D/Other, CMS Chronic Condition Data Warehouse.

Older Adult Population





Source: Tufts Health Plan Foundation, 2020 Rhode Island Healthy Aging Data Report, https://healthyagingdatareports.org/rhode-island-healthy-aging-data-report/
Note: The percentage of Medicare beneficiaries 65 years or older in 2016 who ever met the claims-based criteria indicating listed condition since 1999. These criteria are having at least one inpatient, skilled nursing facility, home health, outpatient or Part B Medicare claim with appropriate diagnosis codes during a 1-year period.

B. Inventory of Models Included in this Report

National Model

Section 5:
- Trauma Informed Systems of Care
- Measurement Based Care
- Statewide Screening Assessments and LOC Standards for SUD

Additional Models in Appendix:
- *Integrated Care and Psychiatric Collaborative Care Model (CoCM)*
- *Interventions for SUD in Emergency Departments*
- *Practice Coaching for MAT*
- *BH Workforce Extenders*

State Model

Section 5:
- Certified Community Behavioral Health Organizations– Missouri
- Behavioral Health Integrated Practice Associations (IPAs)
- Pathways Community Hub – Ohio
- Centralized State Agency Oversight – Arizona and Colorado

Additional Models in Appendix:
- *Integrated Managed Care and Integrated Care Network –Washington*
- *Behavioral Health Community Partners – Massachusetts*
- *Center of Treatment Innovation- New York*

Specialty Models

Additional Models in Appendix:
- *Intensive Care Coordination for Youth – Massachusetts*
- *Crisis Stabilization for Youth – Massachusetts*
- *Healthy IDEAS – Connecticut, Massachusetts, New York*
- *PEARLS – New York, Illinois*
- *BRITE - Florida*
- *Mobile Outreach for Seniors – California, New York*
- *Community Reentry from Corrections for Individuals with BH*

Accountable Entities

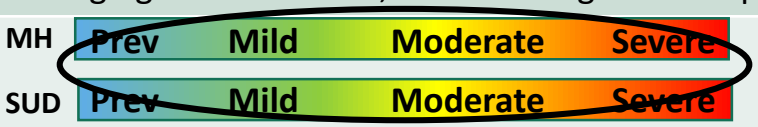
Additional Models in Appendix:
- *Coordinated Care Organizations – Oregon*
- *Regional Accountable Entities – Colorado*
- *Accountable Communities of Health – Washington*

Other Models Identified by Stakeholders

- *Housing First*
- *Wrap Around Services – Milwaukee*
- *Social Worker Licensure Exemption – Texas*
- *System of Care for Children – New Jersey*
- *One Family One Plan – San Francisco*
- *Hub and Spoke Model - Vermont*

State MH and SUD Programs

Integrated Managed Care (IMC) and Integrated Care Network (KCICN) – King County, Washington

Program/Model Description	Partnership between King County's Behavioral Health and Substance Use Division (BHRD) and provider agencies serving Medicaid. BHRD runs the State's BH-Accountable Service Organization, which provides crisis services and manages all State, federal, and locally funded BH services. The partnership eliminates the need for individual BH provider agencies to manage five different sets of MCO contractual requirements and provides economies of scale for managing authorizations, credentialing and IT support.
Target Population	 ☒ Adult/Gen Pop ☒ Youth ☐ Family ☒ Seniors ☐ Corrections
Service Category(ies)	Outpatient BH, MH & SUD Residential, Health Home Care Coordination, Wraparound, ACT, Adult & Children's Crisis, Detox, Prevention, Block Grant Services, Crisis Diversion, Mental Illness and Drug Dependency Programs, Supported Employment, and Education/Workforce Development
Regulatory Levers/State Authorities	State legislation directed the Health Care Authority to integrate delivery and purchasing of medical and behavioral healthcare for Medicaid statewide by 2020. King County opted to be an adopter of integrated managed care (IMC) by January 2019 and received incentive funding to do so.
Payment Model	KCICN receives a capitated payment from IMC, which in turn is typically contracted downstream with providers on a FFS basis with the goal of glide pathing to P4P/Shared Savings based on specific provider readiness. The ACH in Washington supports projects through incentive dollars for reaching metric targets, IT improvements, and transition to VBP. The State's waiver supports selected services for older adults and additional supportive housing and supportive employment services.
Key Themes Addressed	☐ Gaps in Service Continuum ☒ System Integration ☒ Care Coordination/Management ☐ Training/Workforce ☐ Health Disparities/Equity ☒ Rate/Payment Models ☒ Accountability
Relevance to Rhode Island	Provider agencies in Washington were experiencing similar pain points as RI provider agencies due to the shift away from cost-based reimbursement and the administrative lift of contracting with Medicaid MC entities. KCICN has alleviated that burden by absorbing major administrative costs, while leveraging the unique credibility of the county to encourage MCOs to come to the table

Behavioral Health Community Partners (BHCP)- Massachusetts

Program/Model Description	Launched in 2018 as a key component of MA's delivery system reform efforts, BHCP is designed to support and coordinate BH services across the continuum of care for individuals with SMI and/or SUD. BHCPs serve Medicaid ACO and MCO enrolled members 21 and older. Community-based entities support Medicaid members in navigating BH and LTSS services and improve continuity and quality of care. Substantially based on HH concepts.
Target Population	MH: Prev Mild Moderate **Severe** SUD: Prev Mild Moderate **Severe** ☒ Adult/Gen Pop ☐ Youth ☐ Family ☐ Seniors ☐ Corrections
Service Category(ies)	BH CPs perform comprehensive care coordination and care management, including outreach and engagement; comprehensive assessment and ongoing person-centered treatment planning; care coordination and care management across services including medical, behavioral health, long-term services and supports, and other state agency services; support for transitions of care; medication reconciliation support; health and wellness coaching; connection to social services and community resource.
Regulatory Levers/State Authorities	1115 DSRIP waiver initiative; waiver began SFY2018 and runs five years through 2023.
Payment Model	DSRIP funded. CPs (inclusive of BHCPs and LTSS CPs) and Community Service Agencies (CSAs) received 30% ($547 million) and of that $547 million, approximately $539 million will be invested in CPs.
Key Themes Addressed	☐ Gaps in Service Continuum ☒ Care Coordination/Management ☐ Rate/Payment Models ☐ System Integration ☐ Training/Workforce ☐ Accountability ☐ Health Disparities/Equity
Relevance to Rhode Island	BHCPs have been effective in linking services in the community as a way of avoiding hospitalization/crisis intervention. The partnerships are staffed by both clinicians and paraprofessionals, including peers, recovery coaches, and community health workers who can intervene successfully prior to an exacerbation of illness. Also serves as an important linkage between the ACO/MCO and the workforce in the community, under an organized system of management to avoid duplication of care coordination/management.

Center of Treatment Innovation (COTI) - New York

Program/Model Description	COTI are SUD-treatment certified providers focused on engaging people in treatment through mobile clinic services bringing treatment staff into un/underserved areas; expanding tele-practice sites; and enhancing peer outreach and engagement within the community.
Target Population	MH: Prev Mild Moderate Severe SUD: Prev Mild Moderate Severe ☒ Adult/Gen Pop ☐ Youth ☐ Family ☐ Seniors ☒ Corrections
Service Category(ies)	Mobile evaluations for SUD; referral to appropriate level of care for SUD treatment; individual counseling sessions; MAT; telehealth MAT; care management services; transportation support; insurance enrollment; peer specialist linkage and support services; navigation through criminal justice system; and advocacy.
Regulatory Levers/State Authorities	Federal grant supporting State appropriation in NYS budget; State identified awardees through application
Payment Model	State Targeted Response to the Opioid Crisis Grant
Key Themes Addressed	☒ Gaps in Service Continuum ☐ System Integration ☐ Care Coordination/Management ☒ Training/Workforce ☒ Health Disparities/Equity ☐ Rate/Payment Models ☐ Accountability
Relevance to Rhode Island	COTIs have proven especially useful for people outside urban areas who experience difficulty getting to treatment, detox, MAT, etc. COTIs have targeted their efforts in emergency shelters and respite programs to bridge services for the homeless community. COTIs facilitate linkages with services targeting SDoH in 'pre-admission' model, including SNAP and Medicaid enrollment. Program also enables ongoing contact – if there is no bed available, COTI allows consumers to be picked up once a bed becomes available. Model relies heavily on peer supporters trained in Motivational Interviewing in order to encourage consumers to engage in treatment.

Behavioral Health Integrated Practice Associations (IPAs) –Illinois' Health Practice Alliance and Florida's Next Gen Model for Health Plan Behavioral Health Services *(Payer as Catalyst)*

Program/Model Description	Centene in Illinois and Florida have promoted a model to created a shared-ownership IPA. The model adopts principles and performs function if Integrated Health Home and creates a single contracting point for BH providers, statewide.
Target Population	MH Prev Mild Moderate Severe SUD Prev Mild Moderate Severe ☒ Adult/Gen Pop ☐ Youth ☐ Family ☐ Seniors ☐ Corrections
Service Category(ies)	IHH services, workforce development, shared services, data management, contracting support, quality management and assurance
Regulatory Levers/State Authorities	N/A
Payment Model	IPA is shared ownership (50/50) between providers and Centene. IPA receives capitated rate.
Key Themes Addressed	☒ Gaps in Service Continuum ☒ System Integration ☒ Care Coordination/Management ☒ Training/Workforce ☐ Health Disparities/Equity ☒ Rate/Payment Models ☒ Accountability
Relevance to Rhode Island	Same as prior slide. Clear benefit of payer sponsored IPA is a direct path to payment/reimbursement for IPA structure.

National Models

Integrated Care and Psychiatric Collaborative Care Model (CoCM) - (National)

Program/Model Description	Operationalizes the principles of the chronic care model to improve access to evidence based mental health treatments for primary care patients. In 2002, one of the earliest significant trials of CoCM, known as IMPACT, demonstrated that the model doubles the effectiveness of the treatment of depression in elderly adults. The trials showed that the model works in both rural and urban settings and across multiple payers, including Medicaid. It adds two BH members to a primary team to provide treatment in tandem with the PCP. The model leverages validated screening tools, standardized care and follow-up
Target Population	MH: Prev / Mild / Moderate / Severe SUD: Prev / Mild / Moderate / Severe ☒ Adult/Gen Pop ☒ Youth ☐ Family ☒ Seniors ☐ Corrections
Service Category(ies)	PCP services; targeted to individuals with a range of common diagnoses: depression, anxiety, PTSD, ADHD, and SUD
Regulatory Levers/State Authorities	CMS introduced a CoCM billing code for both Medicaid and Medicare; States have to "turn on" Collaborative Care codes in their billing system to enable CoCM
Payment Model	Providers bill a CPT code to generate a monthly management fee to reimburse for team member's time and activities. Studies published suggests an ROI of $6.50 for every dollar spent for adults in multi-payer populations with diabetes and depression
Key Themes Addressed	☐ Gaps in Service Continuum ☒ System Integration ☐ Care Coordination/Management ☐ Training/Workforce ☐ Health Disparities/Equity ☒ Rate/Payment Models ☐ Accountability
Relevance to Rhode Island	From research, it appears RI has comparatively low rates for CoCM, which may be inhibiting statewide adoption.

Interventions for SUD in Emergency Departments – Emerging Best Practice (National)

Program/Model Description	Large number individuals with SUD interface with ED. Integration of recovery coaches in the ED can provide immediate intervention for assessment, support, and service navigation. Buprenorphine administration can start in the ED after overdose or during withdrawal. Program also allows for rapid intervention after OD using a team of peer and professionals (paramedic, nurse, police) to conduct follow-up visit after OD to offer harm reduction and warm hand off to treatment, if interested.
Target Population	MH: Prev Mild Moderate Severe SUD: Prev Mild **Moderate** Severe ☒ Adult/Gen Pop ☐ Youth ☐ Family ☐ Seniors ☐ Corrections
Service Category(ies)	ED SUD services and community interventions
Regulatory Levers/State Authorities	N/A
Payment Model	N/A
Key Themes Addressed	☒ Gaps in Service Continuum ☐ Care Coordination/Management ☐ Rate/Payment Models ☐ System Integration ☐ Training/Workforce ☐ Accountability ☐ Health Disparities/Equity
Relevance to Rhode Island	

Practice Coaching to Increase MAT - (National)

Program/Model Description	There has been a significant increase in providers obtaining X waivers to prescribe buprenorphine, however, experience shows the greatest hurdle is putting systems in place to start prescribing and having support to begin. Opportunity to increase capacity for primary care, especially FQHCs, to provide MAT: initiation for mild to moderate; continuation of meds started in ED: continuation of med started in specialty units to increase capacity in higher intensity (step down).
Target Population	MH Prev Mild Moderate Severe SUD Prev Mild Moderate Severe ☒ Adult/Gen Pop ☐ Youth ☐ Family ☐ Seniors ☐ Corrections
Service Category(ies)	MAT
Regulatory Levers/State Authorities	N/A
Payment Model	N/A
Key Themes Addressed	☒ Gaps in Service Continuum ☐ System Integration ☐ Care Coordination/Management ☐ Training/Workforce ☐ Health Disparities/Equity ☐ Rate/Payment Models ☐ Accountability
Relevance to Rhode Island	675 providers in RI have an X waiver to prescribe buprenorphine. Since 2016, the number of waivered providers has increased greater than 200%, buprenorphine Rx are only up 25%.

Workforce Extenders to Meet Growing BH Needs - (National)

Program/Model Description	States and programs have been forced to seek out creative approaches to extending BH workforce to meet growing demand and address professional shortages. One model of a workforce extender is the licensure and/or approval of a professional/paraprofessional workforce, including CHWs, navigators, and peers. This can also include redeploying existing healthcare workforce to address gaps in the system, including OT, paramedics, etc. Another important strategy to extend the workforce that has been in the forefront due to COVID-19 is the utilization of telehealth and virtual care in the BH field. Most states relaxed stringent regulatory requirements and use of telehealth and telepsychiatry has grown dramatically as a result, with promising results. There are also a growing number of technologies and applications geared to extending BH and SUD services directly. (i.e., PeerRx, ACHESS, and Dynamicare Health)
Target Population	 ☐ Adult/Gen Pop ☐ Youth ☐ Family ☐ Seniors ☐ Corrections
Regulatory Levers/State Authorities	May be necessary to modify regulation to acknowledge new professional categories, adjust scope of practice, and facilitate telehealth and telepsychiatry.
Key Themes Addressed	☒ Gaps in Service Continuum ☐ System Integration ☒ Care Coordination/Management ☒ Training/Workforce ☒ Health Disparities/Equity ☐ Rate/Payment Models ☐ Accountability
Relevance to Rhode Island	Important vehicle for bringing services to areas with inequitable access, including those facing barriers to care.

State Specialty MH and SUD Programs

Youth, Seniors, and Corrections

Intensive Care Coordination (ICC) for Youth 0-21 - Massachusetts

Program/Model Description	Targeted case management and care coordination through wraparound care planning for youths under age 21 who have been diagnosed with SED. Care coordinator works with the youth, family/caregiver, supports, providers, school, state agencies, and others who play a key role in the youth's life. The care coordinator identifies the individual care planning team to address the youth's needs and support the goals identified by the youth and family/caregiver.
Target Population	MH: Prev / Mild / Moderate / **Severe** SUD: Prev / Mild / Moderate / Severe ☐ Adult/Gen Pop ☒ Youth ☐ Family ☐ Seniors ☐ Corrections
Service Category(ies)	Family Support and training; in-home behavioral services; in-home therapy; therapeutic monitoring; and mobile crisis intervention
Regulatory Levers/State Authorities	
Payment Model	Contracts with ACOs/MCOs
Key Themes Addressed	☒ Gaps in Service Continuum ☐ System Integration ☒ Care Coordination/Management ☐ Training/Workforce ☒ Health Disparities/Equity ☐ Rate/Payment Models ☒ Accountability
Relevance to Rhode Island	ICC facilitates care planning and coordination of services. Care planning is driven by the needs of the youth through a wraparound planning process consistent with systems of care philosophy. The program provides mobile crisis assessment, intervention, stabilization and care coordination. Mobilizes to the home or other site where the youth is located 24/7/365.

Crisis Stabilization for Youth (CBAT) - Massachusetts

Program/Model Description	Voluntary service for youth up to age 18 having serious BH crisis with serious BH disorders requiring 24/7 staff secure treatment setting. The primary function is to provide short term crisis stabilization, therapeutic intervention and specialized programming in a staff secure environment with a high degree of supervision and structure, with the goal of supporting the rapid and successful transition of the child/adolescent back to the community. Youths may be admitted to this program directly from the community or as a transition from inpatient services.
Target Population	MH: Prev Mild Moderate **Severe** SUD: Prev Mild Moderate Severe ☐ Adult/Gen Pop ☒ Youth ☒ Family ☐ Seniors ☐ Corrections
Service Category(ies)	Psychiatric assessment and treatment; pharmacological assessment, monitoring and treatment; nursing; individual, group, and family therapy; care coordination; family consultation; and discharge planning.
Regulatory Levers/State Authorities	
Payment Model	Contracts with ACOs/MCOs
Key Themes Addressed	☒ Gaps in Service Continuum ☐ System Integration ☒ Care Coordination/Management ☐ Training/Workforce ☐ Health Disparities/Equity ☐ Rate/Payment Models ☐ Accountability
Relevance to Rhode Island	The CBAT program has proven to be an expeditious way to step down youths in crisis with the support and supervision needed while not relying on traditional inpatient placement. The benefit is avoiding long term inpatient placement by deploying a rapid crisis team to assist the youth and the family or to step down from inpatient services with appropriate supports and discharge planning in place.

Healthy IDEAS – Connecticut, Massachusetts, New York (National)

Program/Model Description	Healthy IDEAS (Identifying Depression & Empowering Activities for Seniors) is a service delivery model designed to detect and manage depressive symptoms among at-risk older adults and their caregivers through existing community-based management services. The pilot study and large-scale demonstration was conducted in Houston, Texas, as part of a community-academic partnership managed by Care for Elders in collaboration with Baylor College of Medicine. Agencies providing case management services to older adults embed the Healthy IDEAS core components into their delivery of services.
Target Population	MH Prev Mild Moderate Severe SUD Prev Mild Moderate Severe ☐ Adult/Gen Pop ☐ Youth ☐ Family ☒ Seniors ☐ Corrections
Service Category(ies)	The model extends the reach of current community-based aging services by integrating depression awareness and self-management interventions into existing case-management programs.
Regulatory Levers/State Authorities	N/A
Payment Model	N/A
Key Themes Addressed	☒ Gaps in Service Continuum ☐ System Integration ☒ Care Coordination/Management ☒ Training/Workforce ☐ Health Disparities/Equity ☐ Rate/Payment Models ☐ Accountability
Relevance to Rhode Island	The program is delivered by non-mental health professionals, such as case managers, social workers, and care coordinators, who employ short-term, focused intervention to support better management of depressive symptoms and increased engagement in meaningful activities. Healthy IDEAS engages local mental health experts (coaches) to provide back-up and support for staff.

PEARLS – New York, Illinois (National)

Program/Model Description	The Program to Encourage Active, Rewarding Lives (PEARLS) is a national evidence-based program for late-life depression. PEARLS brings high quality mental health care into community-based settings that reach vulnerable older adults. Developed in the late 1990s through a partnership between Seattle and King county Aging and Disability Services and University of Washington health Promotion Research Center (HPRC).
Target Population	MH: Prev / Mild / Moderate / Severe SUD: Prev / Mild / Moderate / Severe ☐ Adult/Gen Pop ☐ Youth ☐ Family ☒ Seniors ☐ Corrections
Service Category(ies)	Geared toward individuals being served through the home- and community-based services (HCBS) program. PEARLS is a brief, home-based program that leverages social service and community-based organizations to administer problem-solving treatment, social and physical activation, and potential recommendations to patient's physicians regarding antidepressant medications.
Regulatory Levers/State Authorities	N/A
Payment Model	HCBS program
Key Themes Addressed	☒ Gaps in Service Continuum ☒ System Integration ☐ Care Coordination/Management ☐ Training/Workforce ☐ Health Disparities/Equity ☐ Rate/Payment Models ☐ Accountability
Relevance to Rhode Island	

BRITE – Florida (2006-2011)

Program/Model Description	Brief Intervention and Treatment for Elders (BRITE) was a program developed in Florida which served individuals 55 years and older to identify non-dependent substance use or prescription medication issues and to provide effective service strategies prior to their need for more extensive or specialized substance abuse treatment. demonstrating statistically significant reductions in use of alcohol, medications, and illicit drugs, as well as reduced symptoms of depression.
Target Population	MH Prev Mild Moderate Severe SUD Prev Mild Moderate Severe ☐ Adult/Gen Pop ☐ Youth ☐ Family ☒ Seniors ☐ Corrections
Service Category(ies)	SBIRT; Provider agencies offered in-home screenings and services, focusing on brief intervention for alcohol, illicit substances, and prescription and over-the-counter medications.
Regulatory Levers/State Authorities	Demonstration program
Payment Model	The SAMHSA/CSAT grant award was built on the success of a three-year pilot project from 2004-2007 funded by the Florida Department of Children and Families Substance Abuse Program Office (DCF/SAPO) and conducted in four Florida counties.
Key Themes Addressed	☒ Gaps in Service Continuum ☐ Care Coordination/Management ☐ Rate/Payment Models ☒ System Integration ☐ Training/Workforce ☐ Accountability ☐ Health Disparities/Equity
Relevance to Rhode Island	

Mobile Outreach Programs for Seniors – California and New York

Program/Model Description	Multiple models being funded in California and New York. All share in the goal of bringing mobile geriatric BH teams and support services to older adults. Provides brief voluntary BH services with the aim of resolving immediate BH needs. Can be directed toward seniors who may be unable to access services due to impaired mobility, frailty, or other limitations. Programs reduce isolation and the decline that can accompany untreated BH and unaddressed aging issues.
Target Population	MH: Prev Mild **Moderate** Severe SUD: Prev Mild **Moderate** Severe ☐ Adult/Gen Pop ☐ Youth ☐ Family ☒ Seniors ☐ Corrections
Service Category(ies)	Mobile interventions
Regulatory Levers/State Authorities	State grant funded projects: Geriatric Assessment and Response Team (CA), Geriatric Evaluation Networks Encompassing Services Intervention Support (CA), Family Services of Westchester (NY), Flushing Hospital (NY)
Payment Model	Grant funding
Key Themes Addressed	☒ Gaps in Service Continuum ☐ System Integration ☐ Care Coordination/Management ☐ Training/Workforce ☒ Health Disparities/Equity ☐ Rate/Payment Models ☐ Accountability
Relevance to Rhode Island	

Community Re-Entry from Corrections for Individuals with Behavioral Health Need – New York and National

Program/Model Description	Significant opportunity exists for re-entry coordination, especially individuals with Opioid Use Disorder or Medication Assisted Treatment, as well as individuals with SMI. Best practices include: - Specific contract language for prioritization of re-entering prisoners with BH needs - Data use agreements between state departments for the coordination and monitoring of care - Development of specific targeted case management benefit focused on re-enter prisoners with chronic health/BH needs SPA - Contractually required in-reach by Medicaid health plans to coordinate benefits and follow up care for enrollees planning for re-entry - Maintaining Medicaid eligibility for incarcerated individuals
Target Population	MH Prev Mild Moderate Severe SUD Prev Mild Moderate Severe ☐ Adult/Gen Pop ☐ Youth ☐ Family ☐ Seniors ☒ Corrections
Service Category(ies)	Varies based on model
Regulatory Levers/State Authorities	SPA, MCO contract amendment, DUA
Payment Model	Varies based on model
Key Themes Addressed	☒ Gaps in Service Continuum ☒ System Integration ☒ Care Coordination/Management ☐ Training/Workforce ☐ Health Disparities/Equity ☐ Rate/Payment Models ☐ Accountability
Relevance to Rhode Island	Given RI's extensive experience with MAT and combined jail and prison system, there may be potential benefit from the best practice examples for both jails and prisons.

Accountable Entities/BH Authorities

National Accountable Entities (AE's) and their Relevance to RI AE's

- This section explores how RI can potentially leverage best practices from other national accountable entities for its own Accountable Entity program
- Some themes from other accountable entities that are consistent with the goals for RI's AE program regarding BH are:
  - Better integration of medical and behavioral health to support complex or chronic needs
  - Improvement in health equity to address SDoH and BH through a reimagined primary care foundation with interdisciplinary capacity

Coordinated Care Organizations (CCOs) - Oregon

Program/Model Description	A **CCO** is a unique network of all types of care providers (physical health care, addictions and mental health care and dental care providers) accountable for managing the health care coverage under the Oregon Health Plan (Medicaid). CCOs focus on prevention and managing chronic conditions.
Governance	Can be single provider or network of providers. Consumers must sit on governance.
Interaction with Managed Care	CCOs serve in place of MCOs
Specific BH Initiatives	BH integration is a core goal of CCO 2.0. CCO's must identify how they will achieve a BH integration strategy (no prescribed integration model is identified). 2021 incentive metrics include: depression screening and follow-up for adolescents and adults; mental/physical/oral health screening for children in DHS custody; initiation and engagement of alcohol or other drug abuse/dependent treatment.
Regulatory Levers/State Authorities	State Plan Amendment (authority established via legislation)
Payment Model	CCOs manage local and regional distribution of healthcare for the state's population under a global budget with the opportunity for shared savings based on attainment of quality metrics.

Regional Accountable Entities (RAEs) - Colorado

Program/Model Description	RAEs were established as part of Colorado's Accountable Care Collaborative (ACC), aimed at controlling cost and improving health through integrating primary care and BH. RAEs are responsible for building networks of providers, monitoring data and coordinating members' physical and BH care. Replaced Regional Care Collaboration Organizations (RCCOs) and Behavioral Health Organizations (BHOs).
Governance	Comprised of different coalitions and networks: two provider-based organizations (one FQHC led and one CMHC led) serve as RAEs. Providers have varying degrees of ownership in RAEs.
Interaction with Managed Care	Serve in place of MC, however, national managed care companies have a bigger presence in RAEs than they did in Phase 1. A national managed care company plays a role in each RAE, except one.
Specific BH Initiatives	Preliminary data show the service penetration rates for the RAEs among all members are slightly by statistically significantly higher than they were under the BHO model. The Governor's Behavioral Health Task Force recently commissioned a BH needs assessment that found disparate accountability among State agencies had resulted in fragmented efforts and "dual system of care" which has in part driven disparities in individual experience.
Regulatory Levers/State Authorities	1915(b) Waiver Proposal
Payment Model	The State's Medicaid program pays the RAE a capitated rate to arrange BH services for all Medicaid enrolles. The state government, not the RAE's reimburse physical health directly. RAEs also receive a PMPM to build incentive models for medical providers.

Accountable Communities of Health (ACH) - Washington

Program/Model Description	Established under the waiver as independent multi-sector collaborative organizations. There are nine ACHs serving multi-county service areas. Two ACH's serve single counties – King and Pierce.
Governance	Include local public health, multiple health system partners (hospitals, primary care and behavioral health providers, Medicaid managed care plans, and community health centers), CBOs, Tribes, and consumers or community members. Many governing bodies also include representatives from education, oral health, housing, first responders, long-term care, employers, local government, philanthropy, and coalitions that work on equity.
Interaction with Managed Care	Support provider readiness and transition to integrated MC model
Specific BH Initiatives	A mandatory project is implementing bi-directional integration of physical and behavioral health through care transformation. Strategies and projects vary across ACHs but generally including supporting BH integration, building care coordination infrastructure, promoting practice transformation, developing systems for regional data sharing, building the capacity of providers and organizations to transform, and contributing to transformation-related policy change.
Regulatory Levers/State Authorities	Began under SIM and evolved to State Medicaid Transformation Project funded under 1115 waiver
Payment Model	The State's waiver provided up to $1.1 billion for regional health system transformation projects that benefit Medicaid consumers ("up to" because a significant portion of funding is performance-based).

Best Practices from Rhode Island's AE's

- Integrated Healthcare Partners (IHP) is working with URI DataSpark to execute a gap analysis assessment for mental health and substance use services rendered to their patients. IHP can currently see where patients live and where they receive primary care and behavioral health care. By integrating claims data to gain a comprehensive view of its population, IHP expects to be able draw conclusions related to access adequacy by geography. A later phase of the project will focus on where patients live an receive social services.
- Coastal Medical has implemented universal screenings across all practices to assess and identify needs around depression, anxiety, and social determinants of health, and is currently implementing SUD screening. Regular reporting around screenings and the associated needs are reviewed and acted upon in a variety of ways. Care management and behavioral health teams conduct outreach and make referrals to both internal and external resources, and established interdisciplinary care conferences also provide a forum for surfacing these issues
- Providence Community Health Centers has redesigned and implemented complex care protocols to manage the highest-cost and highest-risk patients. This includes integrating primary care, behavioral health, nurse case management, and clinical pharmacy services.
- Integra has launched an Integrated Behavioral Health pilot program in select pediatric and adult practices.
- Prospect Health Services is working to integrate behavioral health/ substance use disorder expertise into all aspects of its AE program, including through expanding integrated behavioral health in primary care; expanding tele-health consulting, and incorporating behavioral health into its care management program through the regular participation of behavioral health leadership in High Intensity Care Management rounds
- Blackstone Valley Community Health Center added a more experienced psychiatric nurse practitioner in a clinical leadership role to strengthen the behavioral health component of care teams while offering frontline expertise to the AE governance team.

C. Glossary of Acronyms

Acronym	Meaning	Explanation
MH	Mental health	
SUD	Substance use disorder	
BH	Behavioral health	
SDoH	Social determinant of health	The social, physical, and economical environments that promote good health.
AE	Accountable Entity	A provider organization which is accountable for Medicaid healthcare outcomes for its population
LTSS	Long-Term Services and Support	May encompass care provided at home, in the community, or in facilities to help assist individuals with needs and activities of daily living (like eating, bathing, etc.)
IHH	Integrated Health Home	Specialized programs created to address the needs of individuals with severe mental illnesses and are responsible for ensuring integration of healthcare.
ACT	Assertive Community Treatment	
MAT	Medication Assisted Treatment	The use of medication (along with counseling and other therapies) to help treat substance use disorders.
CMHO/CMHC	Community Mental Health Center/Organization	A private, nonprofit licenses health center that provides behavioral health services.
HEDIS	Healthcare Effectiveness Data and Information Set	Used to measure the quality of health plans to see how well they give service and care to individuals.
MMIS	Medicaid Management Information System	Online system designed to support state-wide Medicaid Assistance benefits.
APCD	All-Payer Claims Databases	State databases that include claims, eligibility, and provider files from private and public payers.
DATA Waiver	Drug Addiction Treatment Act	Waiver that allows physicians to treat opioid dependency with narcotics like buprenorphine

Questions?

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