

RI CCBHC
Program Year 1:
Impact Report

February 2026



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CCBHC Program: Utilization & Cost

Time Period: Oct 1, 2024 – Sept 30, 2025 (Demonstration Year 1, full year)
Data Source: MMIS & Ecosystem
Clients: Medicaid members only
Data Lag: Typically 2-3 months due to claims filing and processing timeline;
full adjudication in 6-12 months



Helping More Rhode Islanders Access Behavioral Healthcare



Attribution: Members Enrolled with a CCBHC

16,700
Cumulative # of distinct Medicaid members attributed to a CCBHC from Oct 2024 to Sept 2025

7%
increase in # of Medicaid members attributed to a CCBHC in Oct 2024 compared to Sept 2025

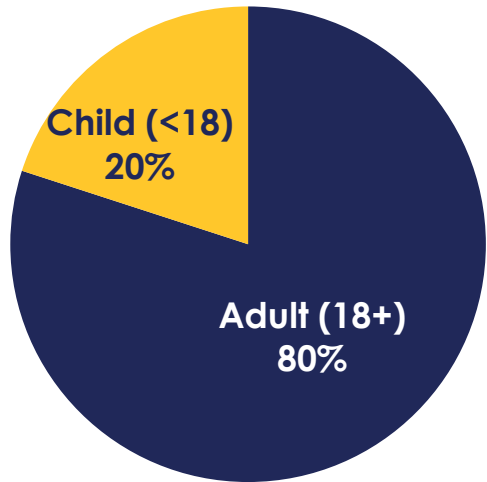
Standard Acuity: **35%**
High Acuity Adult: **57%**
High Acuity Child: **4%**
High Acuity SUD: **4%**
Snapshot of population breakdown in Sept 2025

70 - 80%
attributed Medicaid members visited a CCBHC in any given month

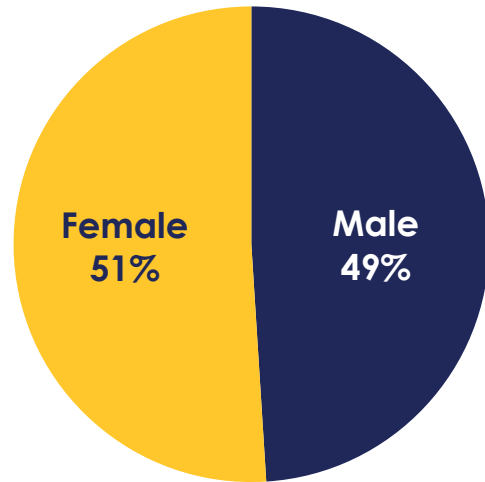
CCBHC Service Utilization: Demographic Trends

Utilization: Members with at least 1 CCBHC Visit in Program Year 1

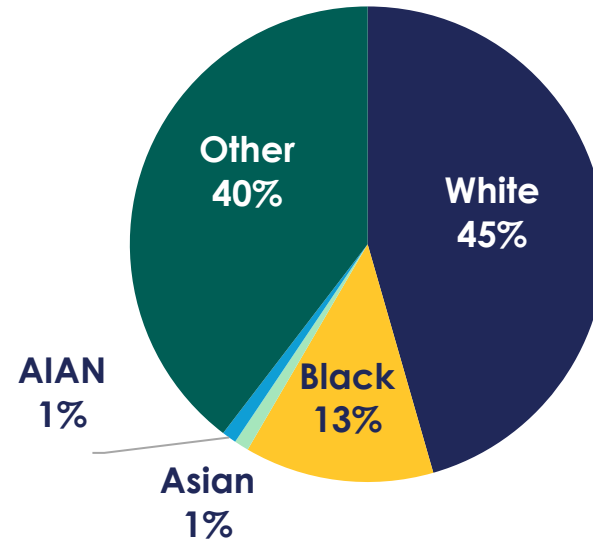
Age Group



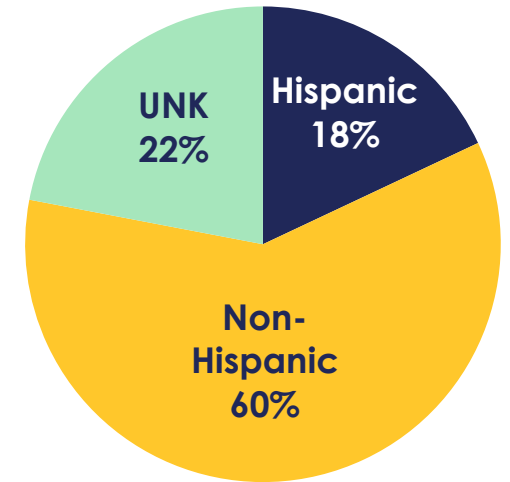
Gender



Race



Ethnicity

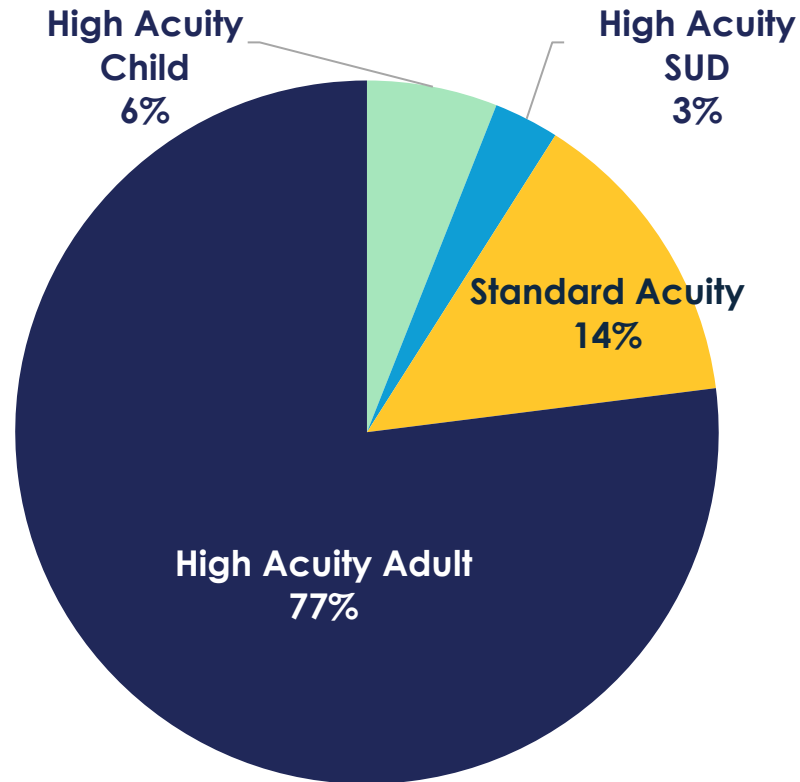


UNK: Unknown

AIAN: American Indian or Alaska Native

CCBHC Service Utilization: Volume and Cost

% of Medicaid Spend by CCBHC Population



\$127.2M

in Medicaid claims paid to CCBHCs¹

¹ The final paid amount for Program Year 1 is likely to rise, as additional claims from this period are fully processed and adjudicated.

Deep Dive: CCBHC Crisis Services

Time Period: Oct 1, 2024 – Sept 30, 2025 (Demonstration Year 1, full year)
Data Source: Mobile Crisis Report & MMIS
Clients: All payer
Data Lag: Typically 2 months due to data reporting and processing timeline; lag may be up to 3 months for MRSS given time duration in which stabilization services may be provided for.



Crisis Services: This data set reflects two types of crisis services: in-office crisis evaluations and mobile crisis responses.

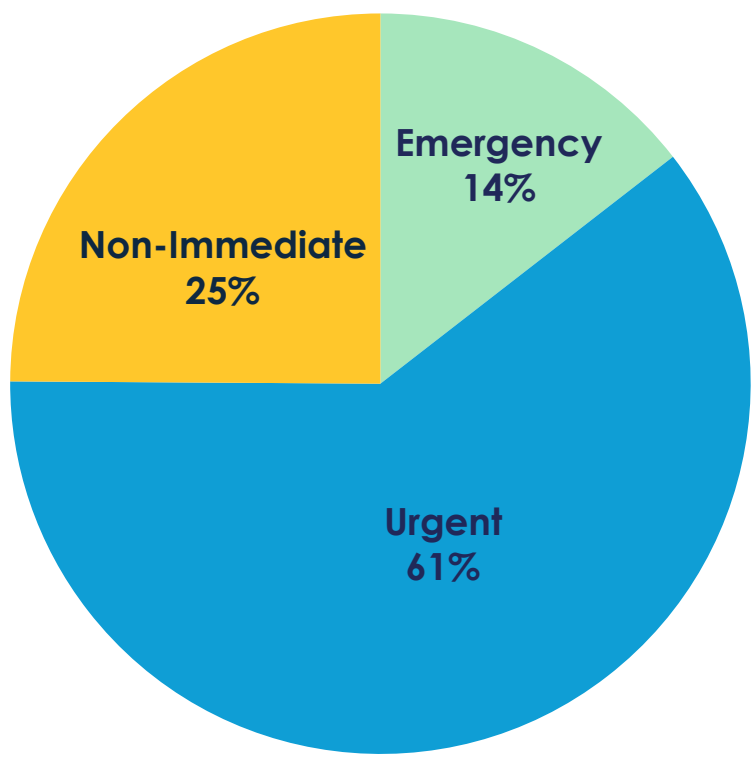
- A **crisis evaluation** is an assessment performed by professionals to gauge the severity of an individual's crisis and determine the appropriate level of care. This evaluation typically occurs in a healthcare setting, but these can also take place in other locations, such as a person's home, (during an intake or scheduled appointment) when staff may identify that the individual poses a risk to themselves or others.
- A **mobile crisis response** involves a team of professionals who directly respond to a crisis in the community, offering immediate support and de-escalation at the scene, either as requested by the individual in crisis or by a third-party caller.
- In summary, the key difference lies in the type of intervention (triage and subsequent actions) rather than the team performing the evaluation or response.



Adult & Child Crisis Services: Overall Utilization



Volume and Type of Crisis Calls Received in Program Year 1 (n = 3,062)

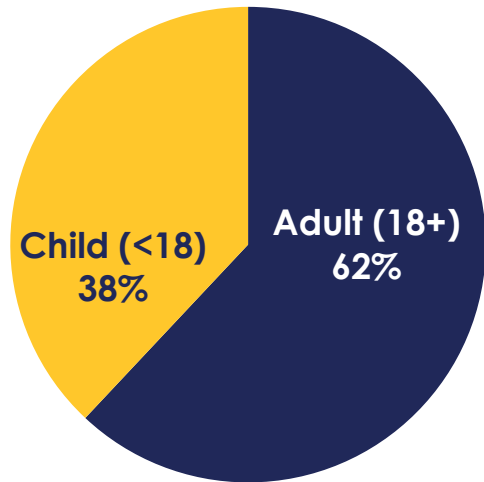


All crisis calls are evaluated and coded by the provider as follows, reflecting required response urgency:

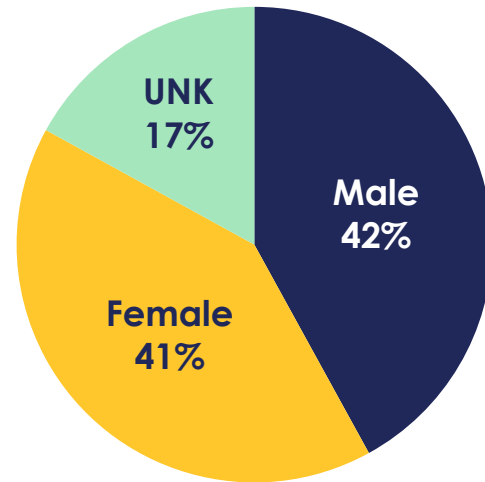
- **Emergency:** Engagement of law enforcement and/or EMS for hospital transport is required. Appropriate action must be taken immediately.
- **Urgent:** A BH crisis team should be deployed to the location of crisis within 1 hour, with telephonic support provided until in-person support arrives. An on-site response must be provided in no more than 3 hours.
- **Non-immediate:** A BH crisis team may be deployed to the location of the crisis at a time requested by the caller, with an expected response within 1 to 23 hours.
- **Non-applicable:** The deployment of a team to the client is not required; e.g., client is on-site at a CCBHC and can be clinically managed by staff who are currently with the client.

Adult & Child Crisis Services: Demographic Trends

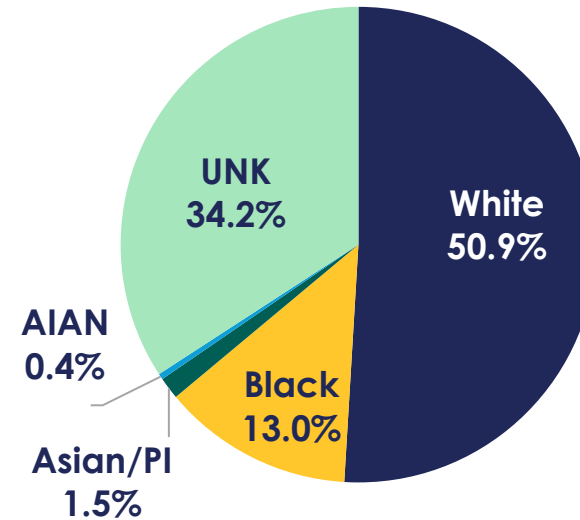
Age Group



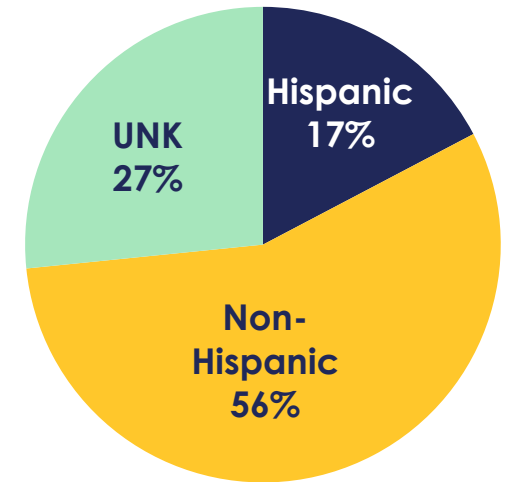
Gender



Race



Ethnicity

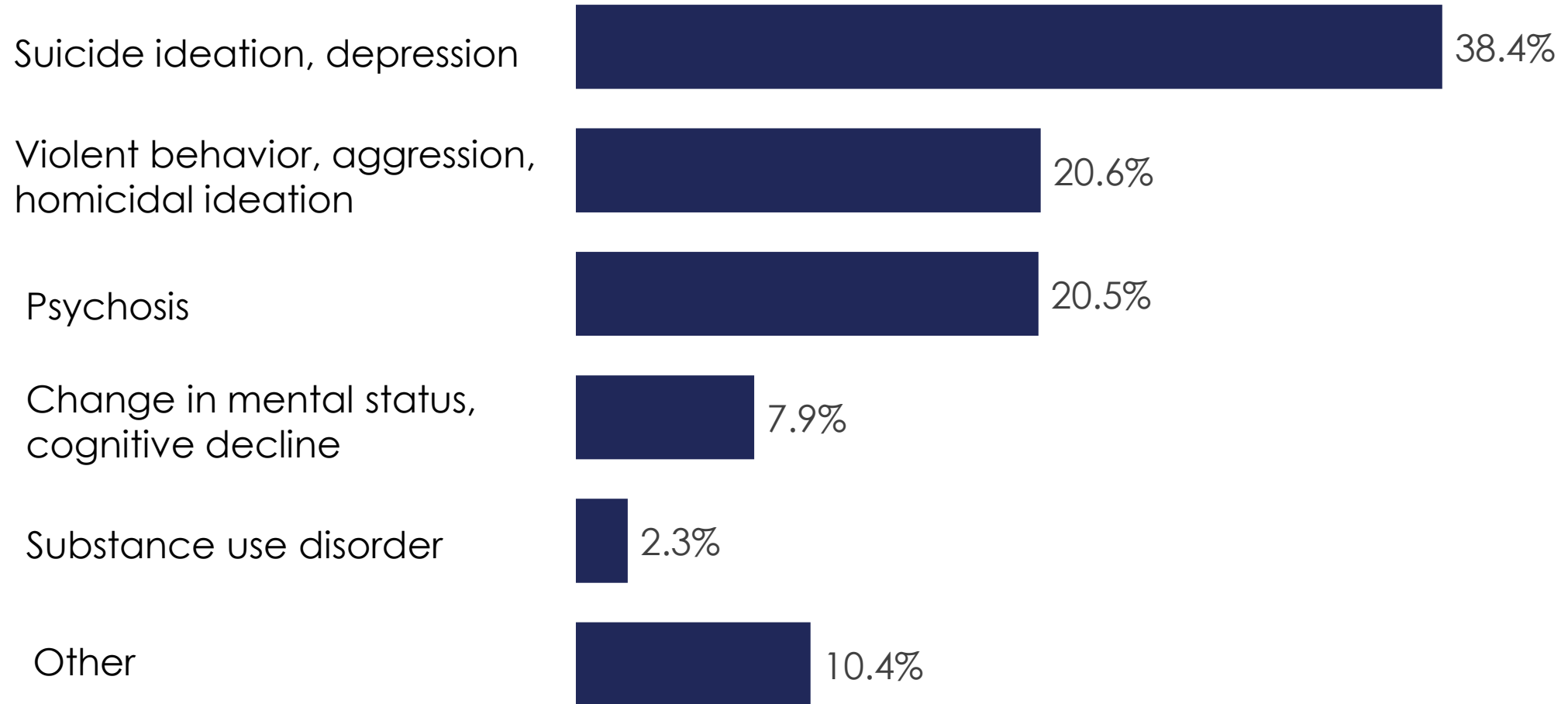


UNK: Unknown. The State is exploring analytic pathways to reduce the portion of unknown demographics.

AIAN: American Indian or Alaska Native

PI: Pacific Islander

Adult & Child Crisis Services: Primary Presenting Problem



Ensuring Delivery of the Right Care, at the Right Time



91%

of calls evaluated and coded as 'urgent' were responded to in under 1 hour

Federal requirement:
100% in under 3 hours

79%

of CCBHC crisis responses resulted in a successful diversion from arrest¹

More than 2/3

of CCBHC crisis calls were successfully resolved without requiring a transport to the hospital / emergency room²

¹'Diversion from arrest' is defined as follows: The individual was successfully diverted from law enforcement intervention; meaning that while the engagement of law enforcement was a realistic possibility at the scene, the situation was successfully de-escalated or managed by the CCBHC crisis provider on scene. This metric does not include any events in which an arrest or police action was unlikely due to the nature of the crisis or presenting client needs.

²Examples of alternative outcomes, other than hospitalization: i) The crisis was successfully resolved on-site; ii) The client was referred to an outpatient service; iii) The client was referred to a social service; iv) The client was referred to a follow-up with a current care provider; v) The client was transported to another treatment facility type, e.g. BHLINK.

Mobile Response & Stabilization Services (MRSS): Overview



Per federal requirements, all CCBHCs must provide 24/7 mobile crisis services. In Rhode Island, CCBHCs must provide children's mobile crisis services via the MRSS model.

849

total # of MRSS cases from Oct 2024 to Sept 2025

790

distinct clients served

22.5 days

Average MRSS case length¹

80%

of cases were successfully stabilized in the community and connected to ongoing BH care²

¹Includes initial crisis response plus duration of stabilization services that were provided per child based upon their demonstrated need (in alignment with the MRSS treatment model) prior to transition to ongoing outpatient BH care.

²Examples of other case outcomes: i) Child required a higher level of care, e.g. hospitalization and/or institutionalization; ii) Child was lost to follow-up, non-compliance, or moved out of State.

CCBHC Program: Federal Quality Measures

Time Period: Jan 1 – Sept 30, 2025 (Measurement Year 1, Q1-Q3 trending data only)

Data Source: Medicaid claims, provider electronic health record, and provider electronic scheduling and/or case management system

Clients: MCO-reported measures include performance for managed care Medicaid clients only; they do not currently include performance for fee-for-service (FFS) Medicaid clients. CCBHC-reported measures include performance for all clients, regardless of payer.

Data Lag: Typically 6 months due to data filing and processing timeline.



SAMHSA Measures: MCO-Reported



Quality Measure	Target ¹	Trending Performance ²
Follow-up After Hospitalization for Mental Illness within 30 Days: Age 18+	70.2%	75.8%
Follow-up After Hospitalization for Mental Illness within 30 Days: Age 6 to 17	77.5%	77.2%
Follow-Up after Emergency Department Visit for Mental Illness within 30 Days: Age 18+	NA	72.2%
Follow-Up after Emergency Department Visit for Mental Illness within 30 Days: Ages 6 to 17	NA	79.3%
Follow-Up after Emergency Department Visit for Substance Use within 30 Days: Age 18+	NA	64.1%
Follow-Up after Emergency Department Visit for Substance Use within 30 Days: Ages 6 to 17	NA	Minimum denominator not yet met
Initiation of SUD Treatment within 14 Days ³ : Age 18+	40.5%	51.0%
Engagement in SUD Treatment within 34 Days of Initiation ³ : Age 18+	14.8%	20.4%

¹ Threshold targets are only currently established for measures included within the CCBHC Quality Bonus Payment (QBP) program. The targets listed on this slide were set using the RI Medicaid MCO average for CY2022 as a baseline. All other measures on this slide must be reported by EOHHS to SAMHSA for monitoring purposes, but do not qualify for QBP payment. There are not formal established targets for these specific measures at this time. Program Year 1 data will be used to establish a baseline and targets for future program years.

² GREEN = Performance to-date meets threshold target. RED = Performance to-date does not meet threshold target. All CCBHCs have an additional quarter (3 months) to further improve their performance.

³ 'Initiation' refers to the percentage of individuals with a new SUD diagnosis who begin treatment within 14 days (this can include the initiation of inpatient or outpatient care, a telehealth visit, or medication assisted treatment). 'Engagement' refers to the percentage of individuals who initiated treatment and remain in ongoing treatment within 34 days of their first visit.

SAMHSA Measures: CCBHC-Reported



Quality Measure	Target ¹	Trending Performance ²
Average Time to Evaluation (Days) ³	10	6
Average Time to Clinical Services (Days) ³	10	15
Average Time to Crisis Services (Hours) ³	3	1
Screenings for Social Determinants of Health	NA	56.9%

¹ Threshold targets are only established for measures included within the CCBHC Quality Bonus Payment (QBP) program. The targets listed on this slide were set by SAMHSA. The other measure on this slide must be reported by EOHHS to SAMHSA for monitoring purposes but does not qualify for QBP payment. There is not a formal established target for this specific measure at this time. Program Year 1 data will be used to establish a baseline and targets for future program years.

² GREEN = Performance to-date meets threshold target. RED = Performance to-date does not meet threshold target. All CCBHCs have an additional quarter (3 months) to further improve their performance.

³ Per SAMHSA requirements, CCBHCs: i) must provide an initial evaluation or clinical service within 10 business days of initial request for support by a new client (or their guardian) for any 'routine' non-emergency or non-urgent need; ii) should provide an onsite, in-person response ideally within one hour, but in no longer than within 3 hours, to any request for crisis services that is evaluated to be of an 'emergency' or 'immediate' level of urgency.

CCBHC Program: Client Surveys

Time Period: Jan 1 – Dec 31, 2025 (Measurement Year 1, full year)

Data Source: Patient Experience of Care (PEC) survey; Youth and Family Experience of Care (Y/FEC) survey. Surveys are administered by the CCBHCs. Data is client-reported with surveys completed anonymously via REDCap.

Clients: All payer

Data Lag: None

Sample Size:

Survey	# Completed	Response Rate
PEC	4,729	71%
Y/FEC	949	89%



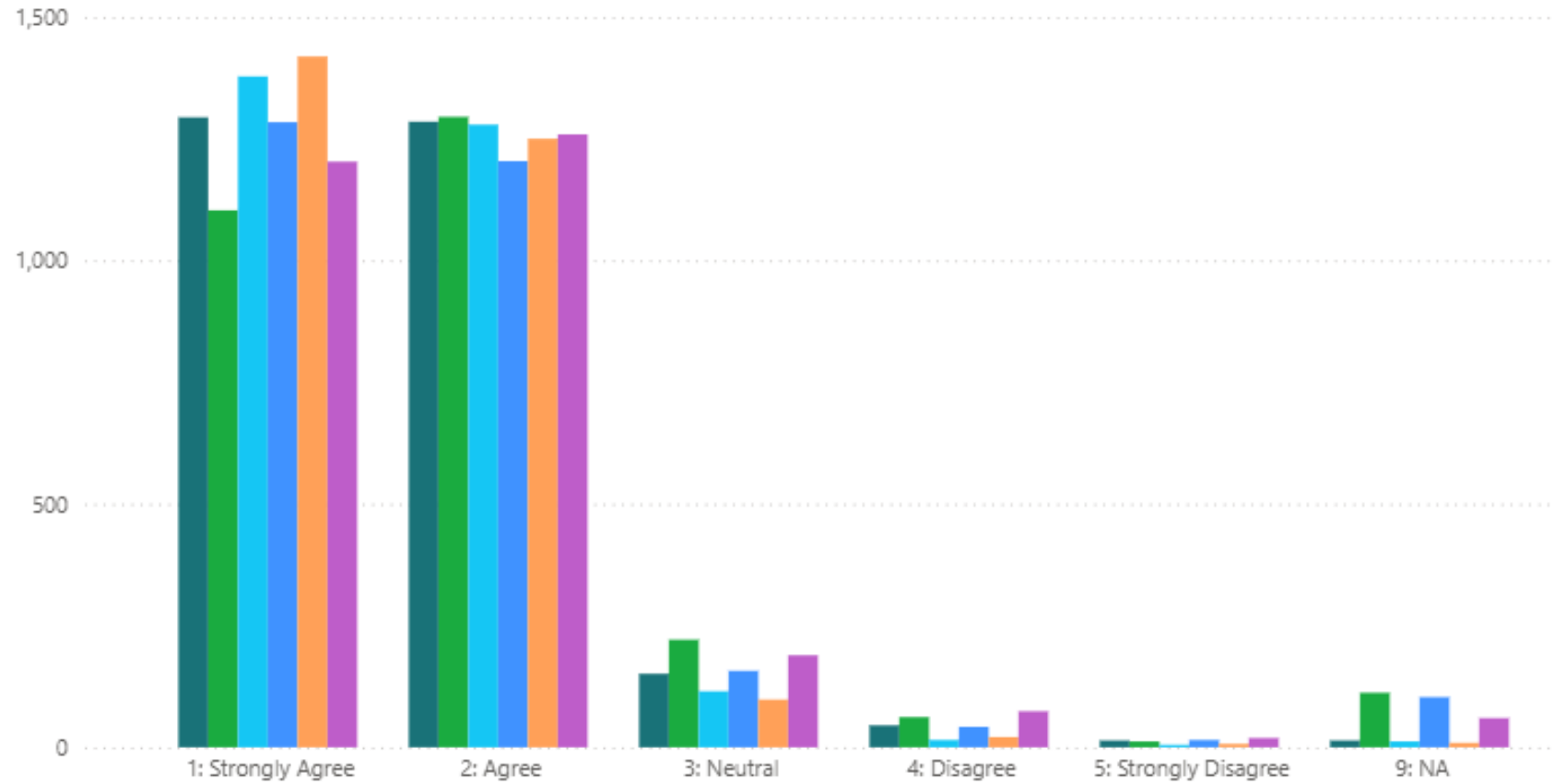
Adults: 91% Satisfied with Access to Services



Adult Question Response Count

Question

- I was able to get all the services I thought I needed.
- I was able to see a psychiatrist when I wanted to.
- Services were available at times that were good for me.
- Staff returned my call within 24 hours
- Staff were willing to see me as often as I felt was necessary.
- The location of services was convenient (parking, public transportation, dis...

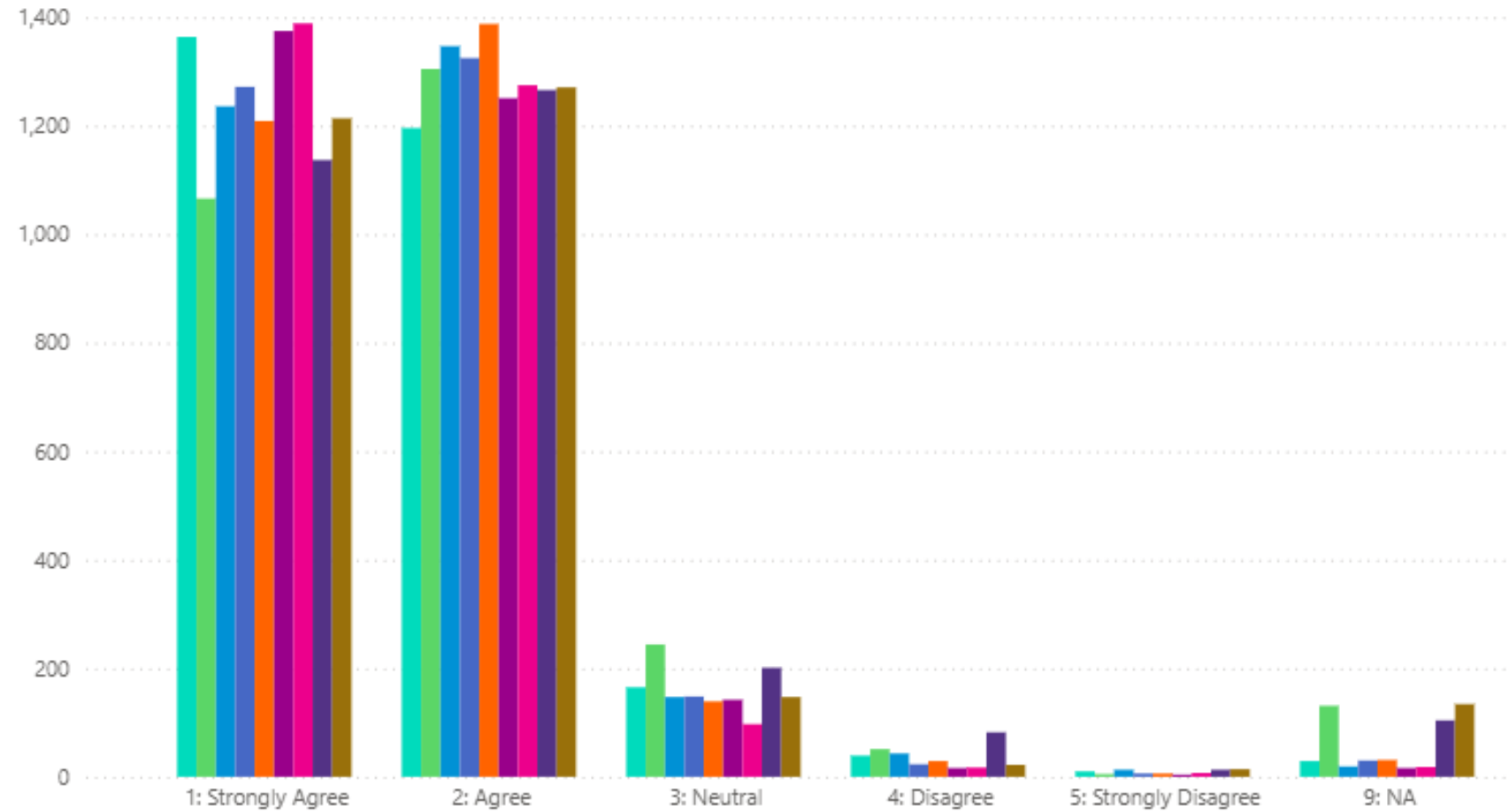


Adults: 91% Satisfied with Quality of Services

Adult Question Response Count

Question

- I felt free to complain.
- I was encouraged to use consumer-run programs (support groups, drop-i...
- I was given information about my rights.
- Staff encouraged me to take responsibility for how I live my life.
- Staff helped me obtain the information I needed so that I could take charg...
- Staff here believe that I can grow, change, and recover.
- Staff respected my wishes about who is and who is not to be given inform...
- Staff told me what side effects to watch out for.
- Staff were sensitive to my cultural background (race, religion, language, et...



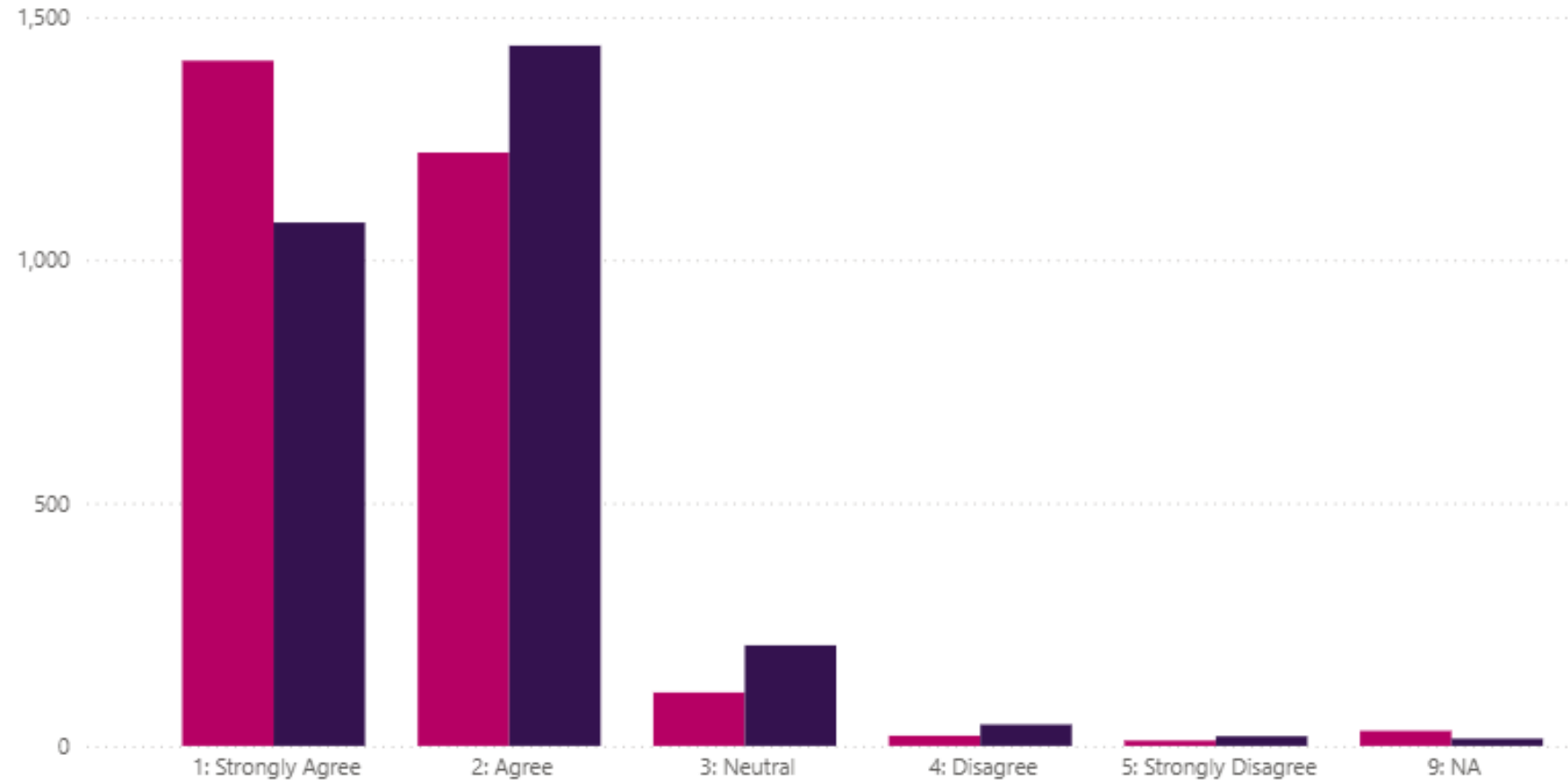
Adults: 92% Satisfied with Treatment Planning Process

Adult Question Response Count

Question

● I felt comfortable asking questions about my treatment and medication.

● I, not staff, decided my treatment goals.

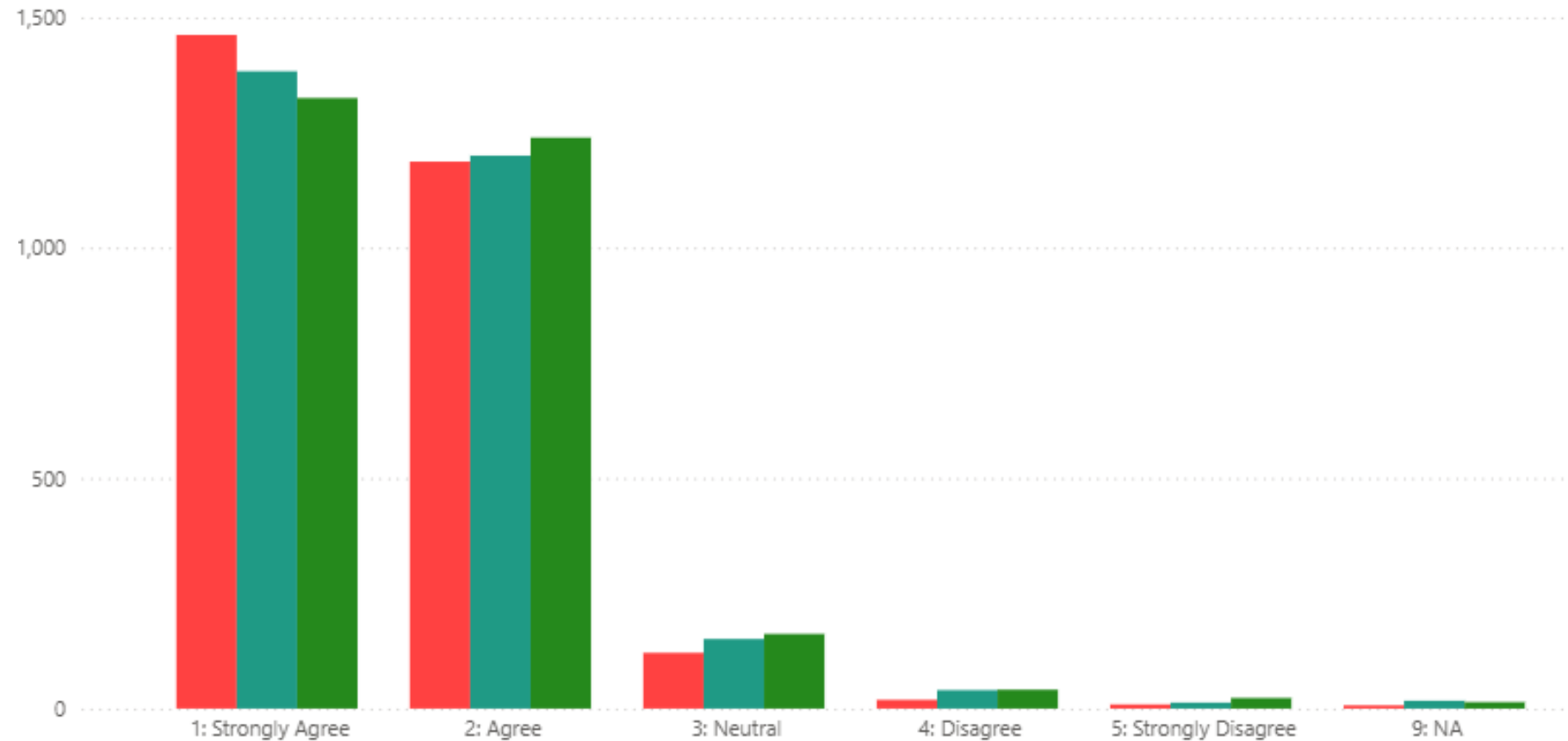


Adults: 93% with Strong Engagement in Services

Adult Question Response Count

Question

- I like the services that I received here.
- I would recommend this agency to a friend or family member.
- If I had other choices, I would still get services from this agency.

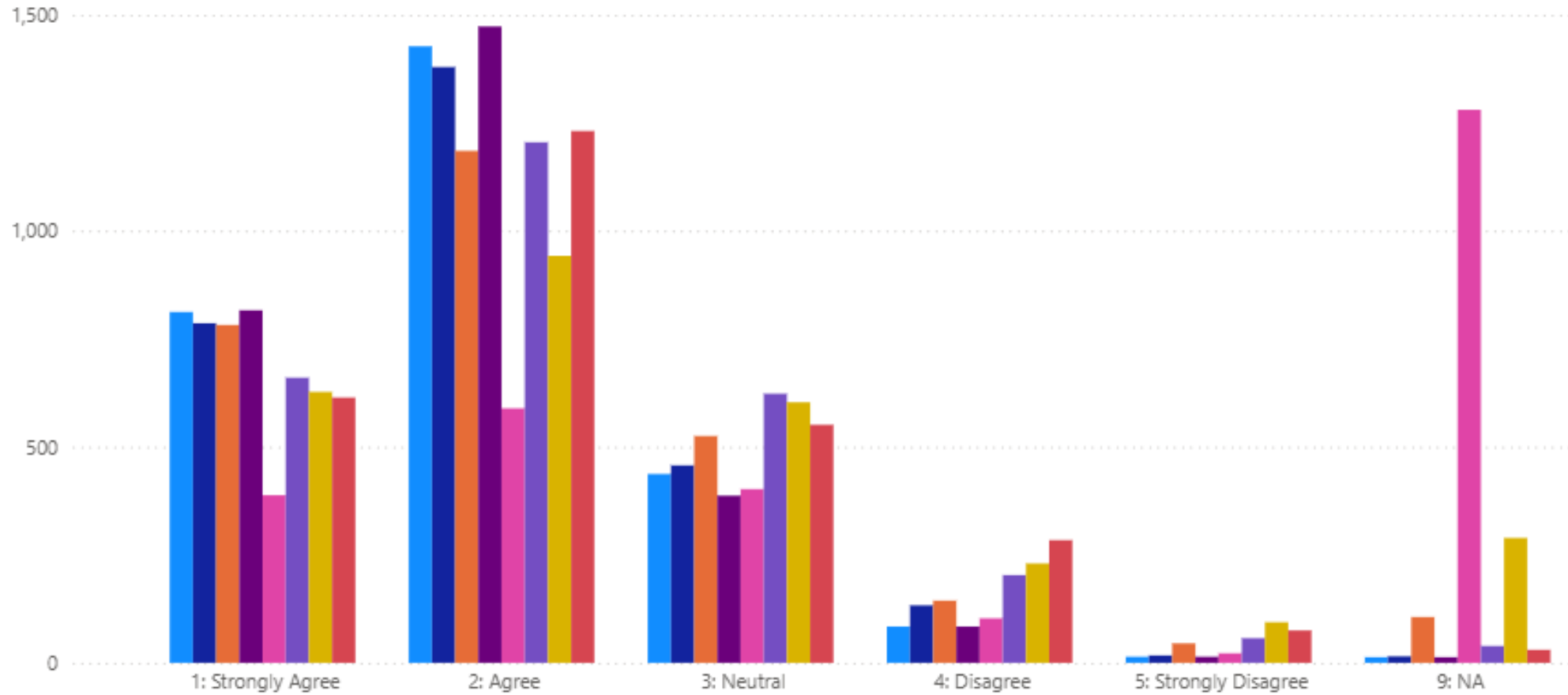


Adults: 67% with Improved Outcomes Due to Services

Adult Question Response Count

Question

- I am better able to control my life.
- I am better able to deal with crisis.
- I am getting along better with my family.
- I deal more effectively with my daily problems.
- I do better in school and/or work.
- I do better in social situations.
- My housing situation has improved.
- My symptoms are not bothering me as much.



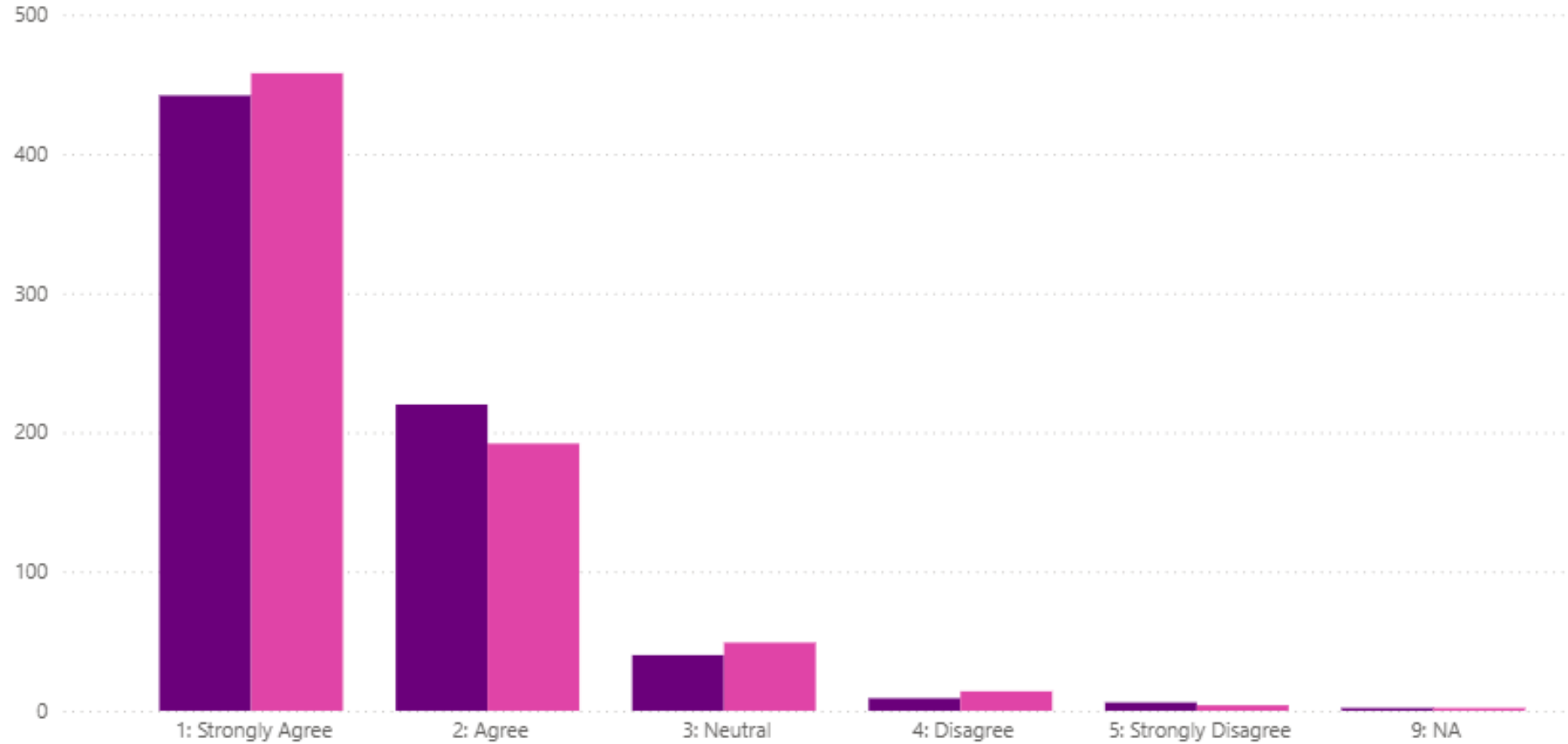
Children & Families: 91% Satisfied with Access to Services



Caregiver Question Response Count

Question

- Services were available at times that were convenient for us.
- The location of services was convenient for us.



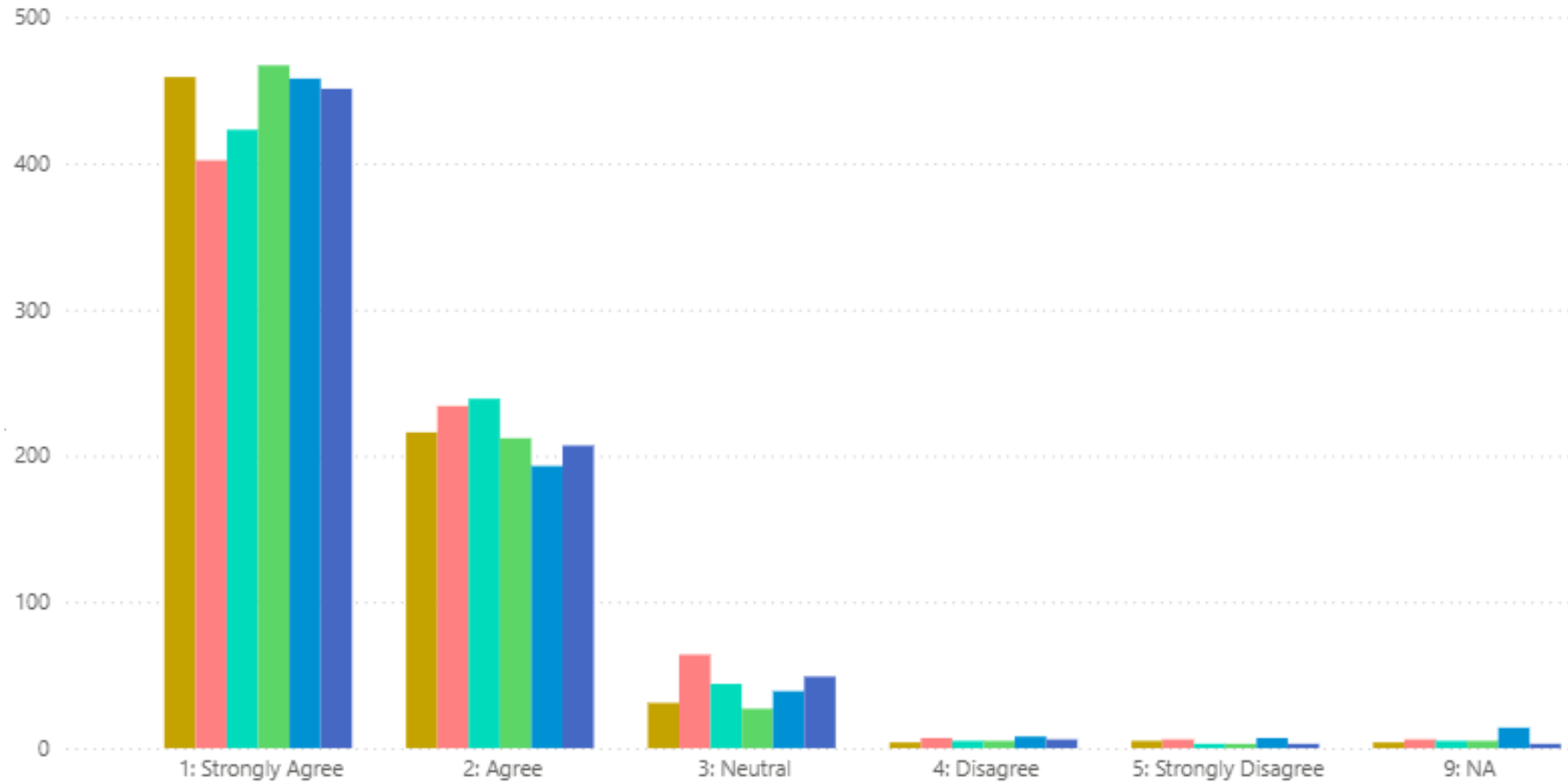
Children & Families: 92% Satisfied with Quality of Services



Caregiver Question Response Count

Question

- I felt my child had someone to talk to when he/she was troubled.
- My family got as much help as we needed for my child.
- My family got the help we wanted for my child.
- Overall, I am satisfied with the services my child received.
- The people helping my child stuck with us no matter what.
- The services my child and/or family received were right for us.



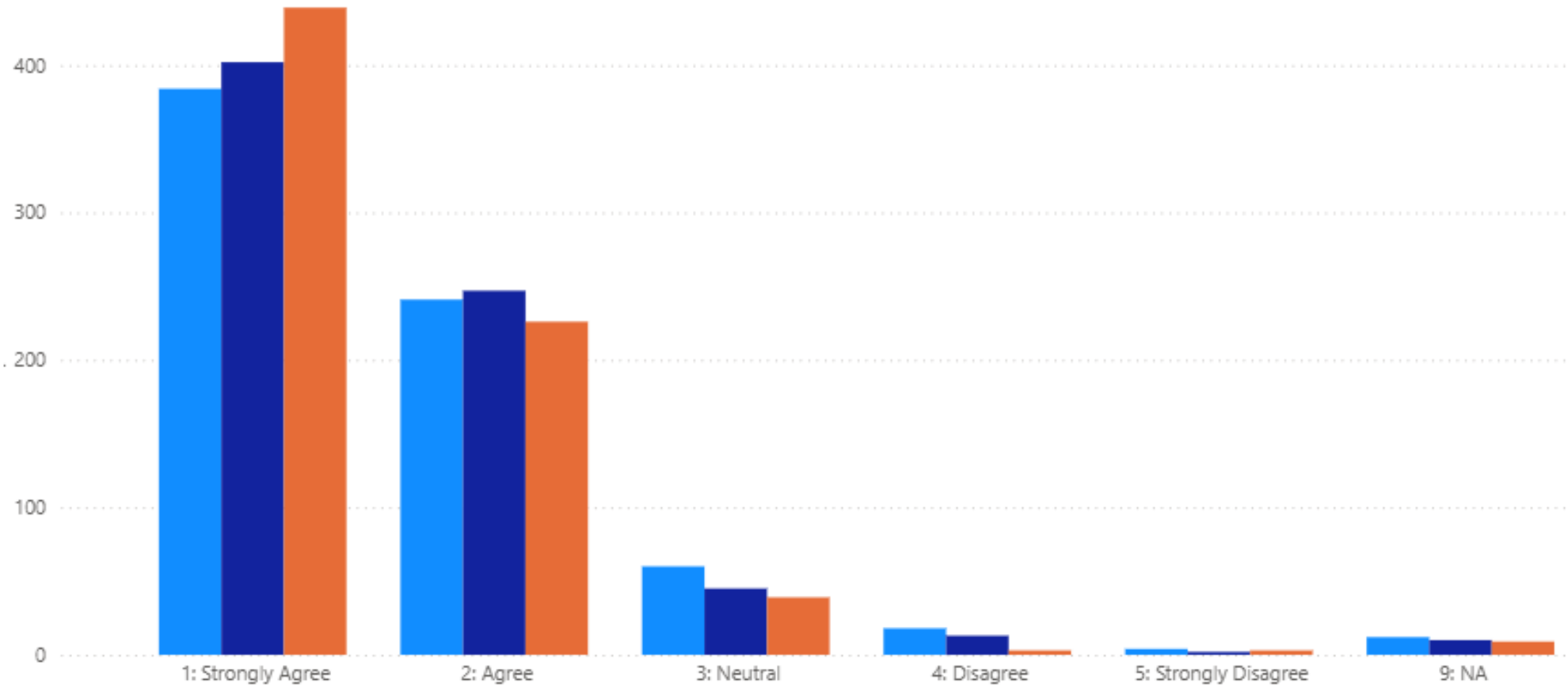
Children & Families: 90% Satisfied with Treatment Planning Process



Caregiver Question Response Count

Question

- I helped to choose my child's services.
- I helped to choose my child's treatment goals.
- I participated in my child's treatment.



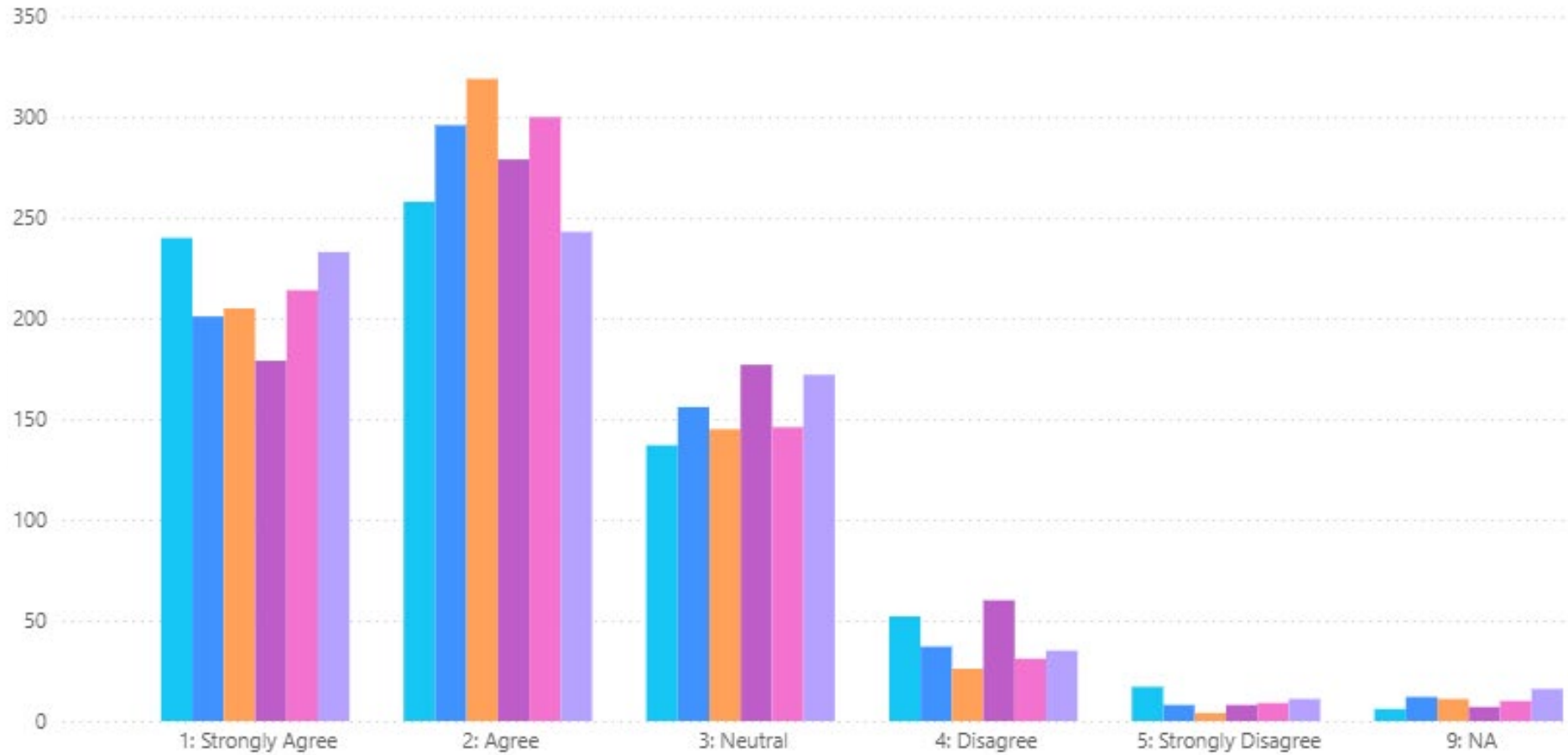
Children & Families: 70% with Improved Outcomes Due to Services



Caregiver Question Response Count

Question

- I am satisfied with our family life right now.
- My child gets along better with family members.
- My child gets along better with friends and other people.
- My child is better able to cope when things go wrong.
- My child is better at handling daily life.
- My child is doing better in school and/or work.



Building Strong Partnerships Across the State's BH Care Continuum



DCO Partnerships in Program Year 1



CCBHCs may partner with a Designated Collaborating Organization (DCO) to deliver any of the core services. DCOs enable CCBHCs to extend their service capacity. The CCBHC maintains clinical responsibility for all services.

CCBHC	DCOs & Services Provided
Community Care Alliance (CCA)	<ul style="list-style-type: none"> • Tides Family Services: Children's mobile response and stabilization services (MRSS)
Family Service of Rhode Island (FSRI)	<ul style="list-style-type: none"> • TPC: Assertive Community Treatment (ACT) – high and lower intensity; Adult mobile crisis • VICTA: Substance use disorder (SUD) services
Gateway Healthcare (GHI) - Johnson	<ul style="list-style-type: none"> • FSRI: MRSS • VICTA: SUD services
GHI - Pawtucket	<ul style="list-style-type: none"> • FSRI: MRSS
GHI – Washington County	<ul style="list-style-type: none"> • Child & Family Services: Family functional therapy (FFT) • Tides: MRSS • Wood River Health: SUD services; Primary care health screenings
Newport Mental Health (NMH)	<ul style="list-style-type: none"> • None
The Providence Center (TPC)	<ul style="list-style-type: none"> • Butler Hospital: SUD services • FSRI: MRSS
Thrive Behavioral Health (TBH)	<ul style="list-style-type: none"> • CODAC: SUD services • Tides: MRSS

Care Coordination Partnerships in Program Year 1



CCBHCs must develop a range of care coordination partnerships to ensure their clients' health and social service support needs are met. Ideal partners are those that offer complementary services to the CCBHCs'. These agreements ensure smooth referrals and well-coordinated care (where/when needed).

State Required Partnerships	Examples of Additional Partnerships Established by CCBHCs At-Will
<ul style="list-style-type: none"> • Service area <ul style="list-style-type: none"> ○ Hospital/emergency department ○ Urgent care ○ Primary care providers ○ Police and/or emergency medical services (EMS) ○ Family Care community Partnership (FCCP) providers • Hospitals <ul style="list-style-type: none"> ○ Butler ○ Bradley ○ Hasbro Children's • Federally Qualified Health Centers (FQHCs) • Accountable Entities (AE) • Veterans Administration (VA) • RI Department of Corrections (DOC) • Opioid Treatment Provider (OTP/Methadone) • BH Link • 988 	<ul style="list-style-type: none"> • Community-based organizations working with specific populations across the State, e.g. <ul style="list-style-type: none"> ○ Seven Hills, proAbility, The Autism Project: Supports of individuals with intellectual and development disabilities (I/DD) ○ Sojourner House, House of Hope, Crossroads, Pawtucket Housing Authority: Supports for individuals with SSI/SSDI benefit application and service navigation needs, and home stabilization service needs ○ Progreso Latino: Supports for Rhode Island's Latino and immigrant communities ○ Center for Southeast Asians: Supports for Rhode Island's southeast Asian and immigrant communities ○ Project Weber/RENEW: Supports for Rhode Island's LGBTQ+ community, people of color, immigrants, people in recovery, and people experiencing housing insecurity and homelessness

How Rhode Island is Leading the Way: Innovative Provider-led Initiatives



Enhanced Children's Behavioral Health Services



Rhode Island's CCBHCs take the charge to provide 'age-appropriate' care to heart. Below are some of the exemplary care models used by **Family Service of Rhode Island (FSRI)** and **The Providence Center (TPC)** to ensure children and their families receive high quality supports. These models are grounded in evidence-based practices (EBP) and take the unique needs of children into consideration:

- **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT):** TF-CBT is an EBP for children and youth experiencing traumatic stress. In addition to offering this service directly to clients, FSRI also offers TF-CBT training to staff at other CCBHCs free-of-charge to expand service access across the State. To date, 22 clinicians have completed this training!
- **Parent-Child Interaction Therapy (PCIT):** This EBP targets children ages 2-7 years with challenging behaviors. It focuses on strengthening caregiver-child relationships and teaching trauma-informed strategies via live coaching – a therapist guides the caregiver in real-time through a one-way mirror. To-date, over 83 children and families have received this support, resulting in improved child behavior and caregiver skills.
- **Early Child Institute (ECI):** TPC's ECI supports young children with behavioral, emotional, and social challenges prepare for school and improves their functioning within early education settings.
 - The **Intensive Outpatient Program** (for children ages 3-5 years) offers therapeutic preschool-level support.
 - The **Partial Hospital Program** (for children ages 5-8 years) offers day-based intensive treatment to address challenges that interfere with success in school. This includes therapeutic classrooms, psychiatric evaluation and medication management, group/family/individual therapy, crisis support, case management, caregiver support, and school/daycare consultation.

Tailored Supports for ADSM, Veterans, and their Families



All of Rhode Island’s CCBHCs work closely with the State’s **Office of Veterans Services (OVS)** to ensure that active-duty service members (ADSM), veterans, and their families are well supported and receive culturally-competent behavioral healthcare. In RI, CCBHCs must:

- Screen all clients for current or past military service;
- Have an identified ‘Veteran’s Coordinator’ to help ADSM, veterans, and their families connect with potential military benefits, and to coordinate care with other veteran’s agencies (e.g., the Veterans Health Administration), community supports, and activities.

Stories from the Field:

- “Our CCBHCs are transforming the way we care for service members, Veterans, and their families. These clinics are breaking down barriers by bringing innovative, accessible mental health solutions directly into the communities where our Veterans live, work, and raise their families. With dedicated CCBHC coordinators deployed statewide, we’re meeting Veterans where they are — not where the system expects them to be. I’m proud to see Rhode Island leading the charge in a model that’s not just working — it’s being embraced and expanded across the nation.” (**Kasim Yarn, Director of RI OVS**)
- “As a Veteran Service Coordinator, I’ve had the opportunity to travel through the State and meet with many different organizations. I started to see windows of opportunity and growth potential across partnerships and community engagements. RI has come a long way in a very short time in terms of Veteran Services, and I am happy to be in a position that is able to make an impact on something I’m passionate about. As a veteran myself, it is easy to connect with other veterans. It is great to have the creative freedom to keep building new programs and bringing other organizations together for the betterment of Veterans.” (**Patrick Lachey, Veteran Services Coordinator at Thrive Behavioral Health**)

Meeting People Where They Are in the Community



In 2025, **Gateway Healthcare – Pawtucket** began a focused partnership with the **Pawtucket Housing Authority (PHA)** to increase community access to behavioral health services and supports.

Staff from Gateway regularly visit PHA's sites where they:

- Conduct proactive outreach to residents to build trust and educate them about CCBHC service;
- Provide consultation and training to PHA staff to help them better understand and support residents with their behavioral health needs. This includes building staff capacity through the provision of training on suicide prevention, trauma-informed care, and de-escalation, as well as helping staff to navigate available resources along the State's behavioral healthcare continuum; and
- Provide direct clinical services when appropriate.

In addition, Gateway has embedded a clinician at Kennedy Manor (PHA's largest public housing development, which focuses on the provision of shelter and supports for the elderly and individuals with disabilities). In three months, the clinician has:

- Coordinated and led ten outreach group events; and
- Helped six residents to access and meaningfully engage in CCBHC services.

Ensuring Continuity of Care Post Hospitalization



Rhode Island's CCBHCs partner closely with hospitals. In RI, CCBHCs are required to execute Care Coordination Agreements with all major hospitals in the State, as well as local hospitals within their service area. This ensures strong care coordination across providers, smooth transitions-of-care with warm handoffs, and the assurance of continued care for a client in their home and community immediately post hospital discharge.

Building upon years of partnership serving the Providence community together, **The Providence Center (TPC)** and **Butler Hospital** (which specializes in psychiatric and SUD inpatient care) took their relationship one step further by entering into a Designated Collaborating Organization (DCO) contract. This collaboration has resulted in:

- Faster linkages to outpatient and peer support services for individuals discharging from Butler Hospital;
- Improved continuity of care for individuals at risk of relapse; and
- Enhanced communication between the Butler's hospital team and TPC's community-based multidisciplinary teams.

Stories from the Field:

- "Our partnership with Butler has significantly reduced gaps in care following discharge. Individuals are now connected to peer support and outpatient services more quickly, which has improved engagement and supported more stable recovery outcomes."
(SUD Intensive Outpatient Program Manager)
- "One Butler client who previously cycled between emergency care and short inpatient stays was connected to peer support at TPC within 24 hours of discharge. The immediate engagement and warm handoff helped stabilize the client's recovery, avoid readmission, and re-establish consistent outpatient treatment."

Partnering with First Responders to Meet BH Needs



Community Care Alliance (CCA) and **Newport Mental Health (NMH)** are two CCBHCs that demonstrate the impactful role clinics can play in coordinating, leading, or supporting responses to crises in the community.

Examples of how CCA and NMH meaningfully and effectively collaborate with **local law enforcement, fire departments, emergency medical services, and other first responders** include provision of:

- An embedded clinician or an on-call clinician to 'ride along' with police, or to meet them on-scene upon request (e.g., when the crisis involves an identified behavioral health need);
- De-escalation and behavioral health supports on-scene at the time of the crisis;
- Trauma-informed care and behavioral health supports post crisis for the directly afflicted individual, their family, the community, and/or involved first responders; and
- The coordination of 'Situation Table' meetings, inclusive of first responders, schools, FQHC, community-based organizations, and others to regularly review crisis cases within the community to: i) Ensure the provision of well-coordinated clinical and wrap-around supports for all impacted; and ii) Identify opportunities for improvement, e.g., steps that can be taken to prevent similar crises in the future, or steps that can be taken to ensure a more effective and efficient response in the future.

These thoughtful and intentional collaborations have resulted in:

- Many successful diversions from arrest and hospitalization;
- A stronger safety net within the community; and
- Better behavioral supports for the community and first responders.

Partnering with Schools to Meet BH Needs



In addition to providing vital supports to the State's first responders, Rhode Island's CCBHCs provide critical behavioral health supports for students, staff, and families via their partnerships with local schools. For example:

- **Community Care Alliance (CCA)** and **Community College of Rhode Island (CCRI)**: Like many schools across the nation, CCRI faces funding and staffing challenges which has made it difficult for them to ensure all students' behavioral health needs are met. With only two counselors available to support over 50,000 students located across four main campuses and two satellites, CCRI was excited about the launch of CCBHCs across the State and the expansive array of services they provide from psychiatry to assistance with housing and food insecurity – challenges which some students struggle with at home, and which impact school attendance and their ability to educationally thrive. CCRI approached CCA for a partnership and the rest is history! CCA warmly welcomes referrals from CCRI, is happy to provide supports to CCRI's students, staff, and their respective families, and is proud of the role they play in expanding access to care within the community they serve. In addition, CCA has helped CCRI to directly connect with other CCBHCs throughout the State to ensure everyone is able to receive the services they need regardless of which campus they're affiliated with, or where they live.
- **Family Service of Rhode Island (FSRI)** and **Providence Public Schools (PPS)**: To assist with behavioral health resource shortages within the PPS, FSRI has leverage the CCBHC funding model to embed clinicians within 10 schools. These clinicians provide timely, on-site supports for students, their families, and school staff. Their co-location within these schools has helped to overcome many traditional barriers to care such as scheduling and transportation challenges, or family circumstances. In addition, FSRI has an established partnership with 7 other schools, which they regularly receive referrals from.

Enhanced Primary Care and BH Care Integration



Rhode Island's CCBHCs have pursued and engaged in meaningful partnerships with primary care providers in their service area to ensure truly integrated medical and behavioral health care for their clients. Below are two specific examples from **Gateway Healthcare**

– Washington County:

- Collaboration with **Wood River Health (WRH)**: As a Federally Qualified Health Center (FQHC) and Patient-Centered Medical Home (PCMH), Wood River is a trusted and critical service provider in Washington County, dedicated to providing high quality and affordable services for all residents regardless of their ability to pay. Gateway and WRH have established a wonderful partnership that's grounded in a shared mission to serve all via a 'whole-person' approach and in their offering of complementary services. Gateway has conducted targeted outreach efforts to WRH clients. Visiting staff facilitate warm handoffs and provide crisis supports on-site at WRH's Hope Valley office. This has helped to reduce transportation barriers to care (a challenge in this rural part of the State) and created a pathway to client engagement and retention in CCBHC services. Gateway currently conducts an average of three new intakes per week.
- Collaboration with **Block Island Medical Center (BIMC)**: The remote nature and seasonal economy of Block Island presents unique behavioral health stressors for its permanent residents. BIMC is a federal rural health clinic that provides critical primary, urgent, and emergency care for the island. Gateway and BIMC have expanded and strengthened their partnership over the past year based on the community's needs. Early on, Gateway provided visiting staff to offer on-site behavioral health crisis services and clinical evaluations. Gateway now provides on-site and telehealth outreach services, clinical supports for SUD, therapy services, and wraparound supports for individuals with high-acuity mental health needs. The provision of on-site care at BIMC has helped to increase access to high-quality evidence-based behavioral health services for a historically under-served population, reduce geographic barriers to care, support culturally-responsive practices, and enable better coordinated care across providers.

Culturally Competent Community Outreach and Care



Core priorities of the CCBHC model include: i) expansion of behavioral healthcare access, especially for historically marginalized populations; and ii) provision of culturally competent care for all. To this end, **Gateway – Johnston** and its other certified clinic sites (**Pawtucket** and **Washington County**) have thoughtfully formed strategic partnerships with the following well-established and trusted community-based organizations to support client outreach, education, meaningful engagement in CCBHC services where clinically appropriate, and culturally-responsive and linguistically appropriate care:

- **Progreso Latino (PL):** Is a social service agency that supports the Latino and immigrant community in Rhode Island through the provision of adult education, early childhood and senior services, health and wellness supports, workforce development, domestic violence prevention services, and emergency food relief.
- **Center for Southeast Asians (CSEA):** Provides direct supports to the Southeast Asian and immigrant community in Rhode Island through the provision of case management services, job training, transitional housing, victim assistance services, and linguistic translational services.
- **Project Weber/RENEW (PWR):** Is an organization that provides peer supports to individuals with a substance use disorder, who may be experiencing homelessness or housing insecurity, and/or identify as transexual, gender non-conforming, or non-binary.

In addition to the establishment of a strong care coordination partnership, Gateway also offers direct clinical support to each of these organization via: i) Full-time clinicians embedded at PL and PWR who conduct individual and group outreach services, psychoeducation presentations, counseling for individuals with standard acuity mental health needs, and intakes into Gateway services; and iii) Supports for the clinical services provided by CSEA's social worker.

Enhanced Integrated Mental Health and SUD Supports



The CCBHC model is designed to ensure access to coordinated comprehensive behavioral healthcare, recognizing the common co-occurrence of mental health and substance use disorders (SUD). **Newport Mental Health (NMH)** is advancing the standard of care for Rhode Islanders with a high acuity level of need through its adoption of the Integrated Dual Disorder Treatment (IDDT) model.

- The IDDT model is strength-based, evidence-informed, and tailored to support individuals with co-occurring conditions. It can be informally described as Assertive Community Treatment (ACT) with a SUD focus. It emphasizes shared decision-making and long-term skill building, allowing individuals to define their own recovery goals while receiving integrated services from a designated, multidisciplinary team.
- For NMH's clients, IDDT has helped to reduce substance use and relapse rates, psychiatric symptom severity, hospitalization rates, crisis episodes, incarceration, and homelessness; and to improve treatment engagement, medication adherence, independent living skills, and overall quality of life. NMH data shows that clients engaged in IDDT have a significantly higher rate of treatment retention and medication adherence compared to those enrolled in traditional outpatient programs.

Stories from the Field:

- “One client, previously experiencing frequent hospitalizations and homelessness, engaged with the IDDT team and, through coordinated case management and stage-wise interventions, achieved stable housing, reduced substance use, and reconnected with family. The multidisciplinary team's assertive outreach and motivational interventions were key to his success. This story exemplifies how the IDDT model's holistic, evidence-based approach fosters long-term recovery and community integration. We see people not only stabilize but thrive. (**Madisson Catanzaro, Program Manager**)

Integration of Lived Experience into the BH Care Model



The CCBHC program integrates individuals with lived experience into the BH service delivery model by requiring peer supports. Peer services are an integral part of **The Providence Center (TPC)**. The following centers operated by TPC, with supplemental funding, ensure that all individuals who walk through their doors are quickly connected with peer support:

OASIS Drop-in Center: Is a peer-run, safe, supportive space for adults managing mental health and SUD challenges.

- "This is a place where I can express frustration and feel empowered instead of hopeless. It revived my spirit through art, music, and connection."

Jim Gillen Teen Center: Provides teens in recovery with an environment that celebrates, and helps facilitate recovery through dynamic programming, shared lived experience, and peer support.

- "A client shared that after graduating high school they struggled with trauma and substance use. After being connected to the Teen Center, they found a welcoming community and consistent support. Over the course of a year, they were able to rebuild personal stability and discover a renewed purpose. They describe the Teen Center as a "sanctuary" where they learned they were not alone, developed healthier perspectives and broke generational cycles. They continue to rely on the center as a foundation for ongoing growth and healing."

Anchor Recovery Community Center: Is run by individuals with lived experience dedicated to providing addiction recovery supports.

- "One of our members achieved a full year of continuous recovery and transitioned from a recovery residence into independent housing. They continued volunteering, demonstrating reliability, compassion, and leadership. Their story reflects how peer-driven spaces and supports help individuals rebuild stability and purpose."

How Rhode Island is Leading the Way: Innovative State-led Initiatives



Ongoing Investment in Building Provider Capacity



Rhode Island implemented the federal CCBHC model to transform and enhance how behavioral health services are delivered statewide, with the goals of: i) ensuring coordinated and comprehensive outpatient supports for all Rhode Islanders; and ii) increasing access to timely quality services for everyone. This is no small task! To ensure a successful implementation and ongoing quality improvement, the State has and continues to invest thoughtfully to build provider capacity. For example:

- **CCBHC Infrastructure Grant Program:** Prior to program launch, the State issued approximately \$25M in grant funding, leveraging American Rescue Plan Act (ARPA) dollars to help local organizations interested in pursuing the CCBHC or DCO path to build capacity and work toward meeting the rigorous program standards and requirements. Grants were awarded through a competitive process to 22 organizations. Many have since successfully become CCBHCs, DCOs, or care coordination partners.
- **Evidence-Based Practice (EBP) Trainings:** Post program launch, the State continues to sponsor EBP trainings for CCBHC staff using braided funding. Over the past year, the State invested over \$50K to support trainings in: Assertive Community Treatment (ACT); Individual Placement and Supports (IPS); Cognitive Behavioral Therapy (CBT); Dialectical Behavioral Therapy (DBT); Zero Suicide; and Seven Challenges.
- **Learning Collaborative:** The State also convenes a monthly roundtable, establishing a rich environment for relationship building, cross-training, and collective troubleshooting across the CCBHCs, DCOs, and other providers in the State's BH care continuum. Recent topics include: 'Navigating RI's Intellectual and Development Disabilities (I/DD) Services', 'Best Practices in Primary Care Screening and Monitoring', and 'Real-Time Consultations and Supports for Pregnant and Post-Partum Mothers with BH Concerns'.

Statewide BH Crisis System Planning



CCBHCs are a critical component of Rhode Island's behavioral healthcare continuum. One core CCBHC requirement is the provision of 24/7 mobile crisis services for both adults and children. This has greatly helped to ensure statewide access to this vital support.

The State is presently engaged in statewide planning efforts to ensure: i) A 'no wrong' door approach to all BH services; ii) Warm referrals and handoffs-of-care between providers to ensure a smooth transition of each client from immediate crisis response, to stabilization, to ongoing BH supportive services; and iii) A streamlined and efficient BH mobile crisis system that strategically leverages the unique strengths of each provider along the care continuum. This planning work continues in earnest. To date, the State has done the following to support system alignment:

- Make **Mobile Response and Stabilization Services (MRSS)** the required children and youth mobile crisis response service delivery model for CCBHCs to ensure statewide access to this effective treatment modality; and
- Require all CCBHCs to establish care coordination agreements with **988** and **BHLink** to ensure appropriate data-sharing and seamless referrals among all entities, optimizing rather than supplanting existing statewide BH crisis resources. The three entities currently meet for monthly roundtables to ensure a meaningful partnership, collectively troubleshoot emergent challenges, and strategize for the future.

Promoting a 'Whole Person' Approach to BH Care



The CCBHC model advances a holistic and 'whole person' approach to behavioral healthcare, recognizing the critical ways that clinical and non-clinical factors (e.g. housing) can impact an individual's health and wellbeing. When basic daily needs are unmet – they can become stressors that contribute to substance use, exacerbate underlying mental health conditions, and stand in the way of meaningful disease management and recovery.

While the federal standards require CCBHCs to inquire about individuals' housing status and needs as part of the screening and care planning process, Rhode Island has issued the following additional guidance in alignment with local identified needs and supports.

CCBHCs:

- Must execute a care coordination agreement with an agency that provides Home Stabilization services to ensure that all clients in need of the service can access it.
- Must coordinate with the **RI Continuum of Care** collaborative and take referrals for eligible individuals in need of Home Stabilization services within their designated service area.
- Are encouraged to partner with their **local housing authorities** to conduct outreach and engagement services, and to provide critical access to behavioral healthcare services. Some of our CCBHCs have opted to provide co-located staff at the housing authorities in their service area to provide immediate assessments!

Destigmatizing Substance Use Disorders (SUD)



Rhode Island is committed to building a safe, respectful, supportive, and stigma-free environment statewide to assist individuals in recovery. In alignment with this State priority and goal, RI's CCBHCs are required to become State certified:

- **Peer Based Recovery Support Services (PBRSS) providers:** This ensures all CCBHCs have Certified Peer Recovery Specialists on staff to offer assistance to those in recovery and their loved ones. Peers offer critical supports drawing on their lived experience – they're able to offer a unique level of understanding, perspective, and set of disease management skills and strategies rooted in their personal experiences struggling with and successfully managing a SUD. Peer support services offer individuals healthy living skills, as well as individual and group supports, education, empowerment, and connection; and
- **Recovery Friendly Workplaces (RFW):** The State supports employers in creating workplaces where individuals affected by a SUD can succeed without stigma. RFWs strengthen the workforce, improve safety, and build cultures where all employees feel valued and supported. To support this endeavor, the State offers: employer guidance to build supportive and inclusive workplace policies; training opportunities for supervisors, HR teams, and staff; sample practices and toolkits to promote staff wellness; and resources for staff seeking supports or accommodations. By securing this designation, CCBHCs commit to supporting SUD recovery among their clients and their staff!