

Behavioral Health System Review Technical Assistance Draft Summary Report

May 2021

DRAFT



HEALTH MANAGEMENT ASSOCIATES

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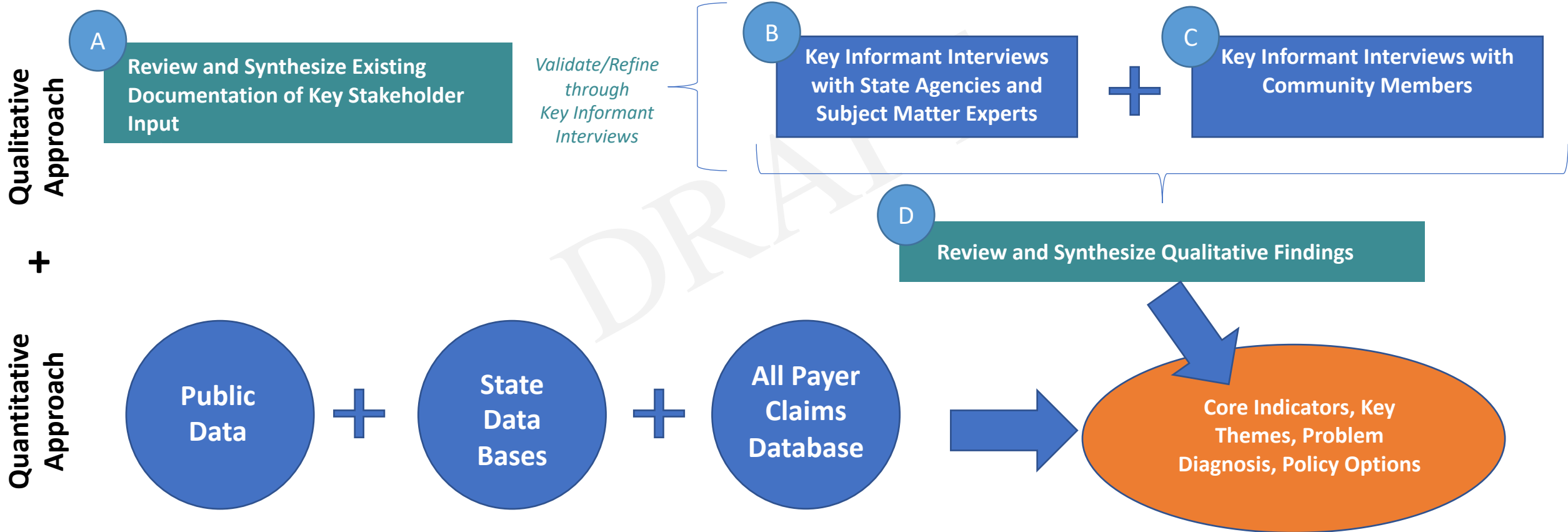
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Notes to Reader:

- 1) Greyed out sections are not included in this draft version.
- 2) Maroon boxes with notes on slides throughout describe additional detail anticipated for inclusion in the final draft

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.



Executive Summary

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. A history of systemic racism manifests itself in part through how RI's current behavioral health system does not meet the need of our community. 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.

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.

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 that encompass: accountability, payment, alignment 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 CCBHC (Certified Community Behavioral Health Clinic) 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.

“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	Yellow	Yellow	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	Red	Yellow	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	Red	Red	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	Yellow	Red	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	Yellow	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	Yellow	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	Yellow	Red	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

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Data suggests significant system concern, including outcomes are worse for RI than regional/national benchmarks, and outcomes are worse for non-white individuals
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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	Yellow	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	Red	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	Yellow	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	Red	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	Yellow	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	Yellow	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).

“Health of RI’s Behavioral Health System”: Core Indicators of Capacity & Cost

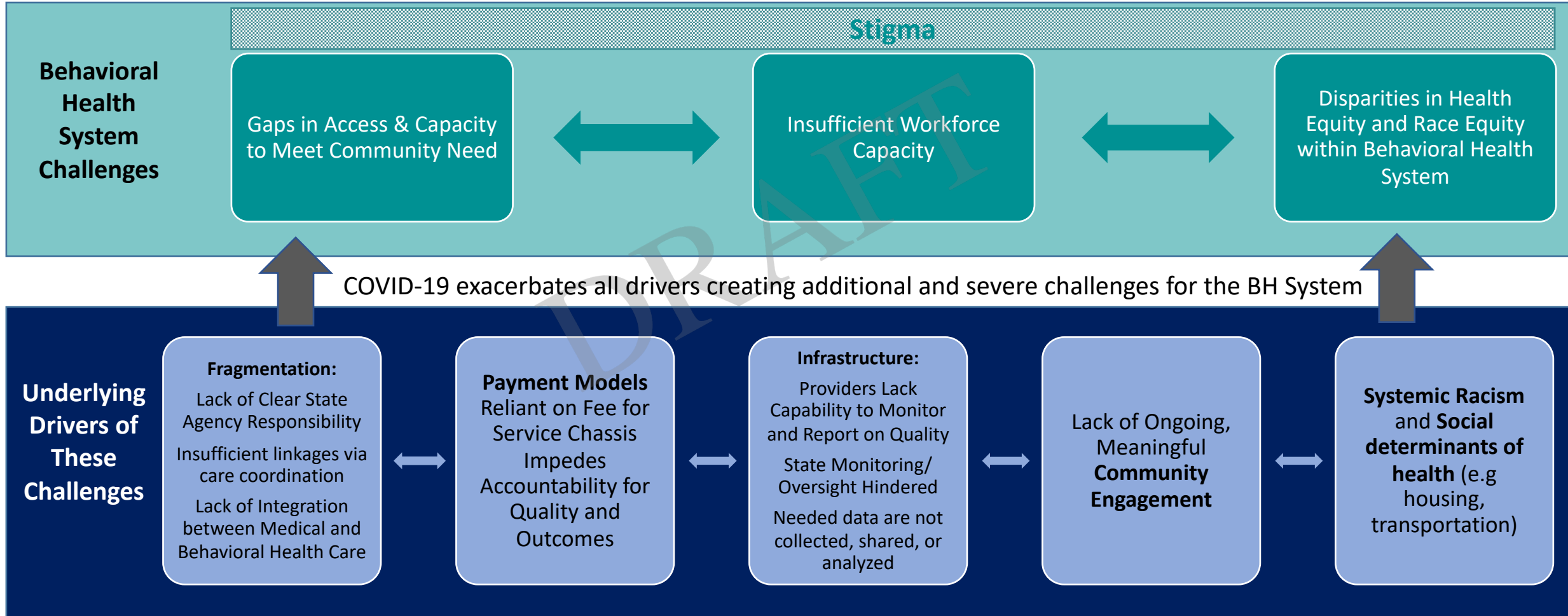
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Data does not suggest system concern; ideal state for indicator is achieved.

Core Indicators	Status Overall	*Race Equity Outcomes	Key Findings
Medicaid Expenditures for BH Services	Yellow	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	Red	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	Yellow	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	Yellow	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.

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 svcs.

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 be 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.

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.

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*

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*

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*

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)

- **FCCPs:** 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.

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
- **PCMH-Kids:** extend primary care transformation to children
- **Culturally and Linguistically Appropriate BH Services:** workforce development/job training, train in BH
- **Behavioral Health Workforce Development Project:** improve BH provider capacity, recruit/onboard new staff, create a pipeline for a more diverse BH workforce

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 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 CCBHC (Certified Community Behavioral Health Clinic) 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

Goals Addressed by CCBCH Model

- Expanded access to assessment, treatment, and referral
- Consistent application of evidence-based trauma informed care
- Focus on equity issues
- Coverage throughout the state for all ages
- Focus on community-based intervention
- Maximize federal support in the form of matching funds or other revenue opportunities.
- Coordination for all communities accessing the BH system, including the I/DD community



CCBHC Service Delivery Model

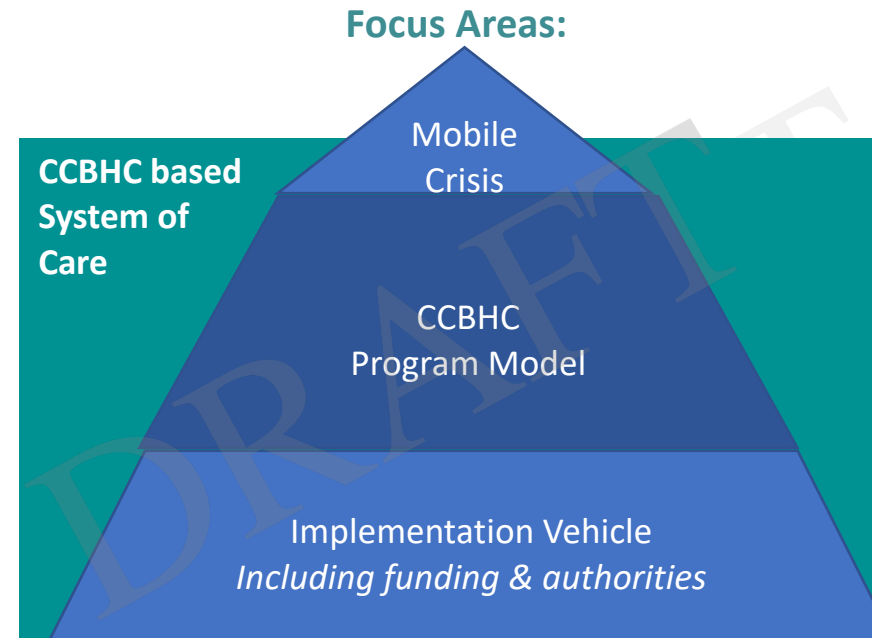
- Serves as an **entry point** for timely, high-quality mental health and SUD treatment across the continuum
- Provides **extended hours** (24/7/365)
- Provides care **across the lifecycle** for all ages (children, adults, and older adults), including:
 - Crisis stabilization for youth as well as adults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

Next Steps: Develop Implementation Plans for 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.



2a. 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.

2b. Implementation Vehicle for CCBHC – Funding and Authorities

Determine the best policy vehicle 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 outside 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.

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

Executive Summary: Upcoming

The final report will include Implementation Plan Summary in the Exec Summary

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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
- Incentivizes 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

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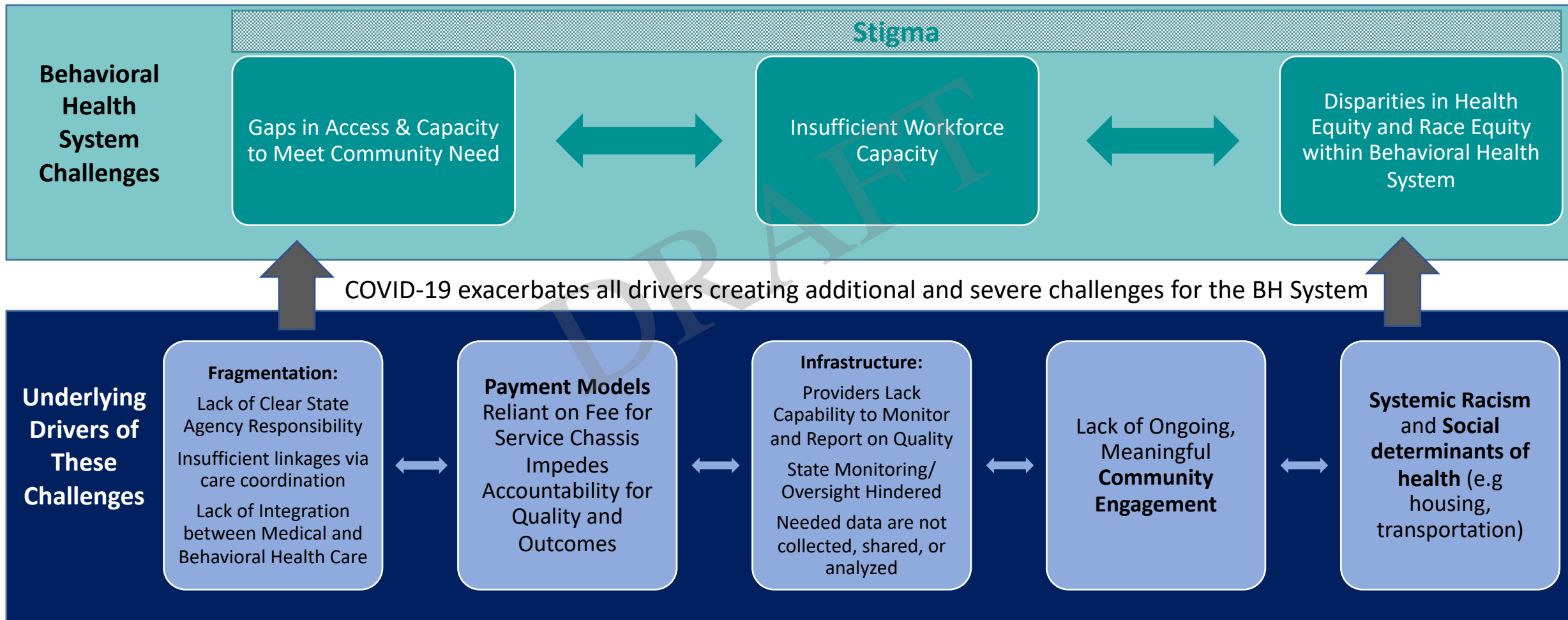
4. Key Findings

- A. Behavioral Health System Challenges*
- B. Underlying Drivers of Challenges*

- 5. Policy Proposals**
- 6. Upcoming: Implementation Plans for Recommendations*
- 7. Detailed Methodology & Key Sources**
- 8. Appendix**

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 health 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

Group

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 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 Transition Age Youth Services				Qualitative
		Home Based Therapeutic Services			Qualitative
			SUD Treatment Enhanced Outpatient Services Home and Community Based Services Mobile Crisis		Qualitative/Quantitative
					Qualitative/Quantitative
					Qualitative
					Qualitative
Residential Services	Residential Treatment for Eating Disorders				Quantitative/Qualitative
		Residential Treatment for Adolescent Females Acute Residential Treatment			Quantitative/Qualitative
					Quantitative
Acute Inpatient			Emergency Services	Qualitative	

Problem Diagnosis: Services with No Indicated Gap or Shortages and Assessed as Adequate 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

Adult Substance Use Disorder Services:

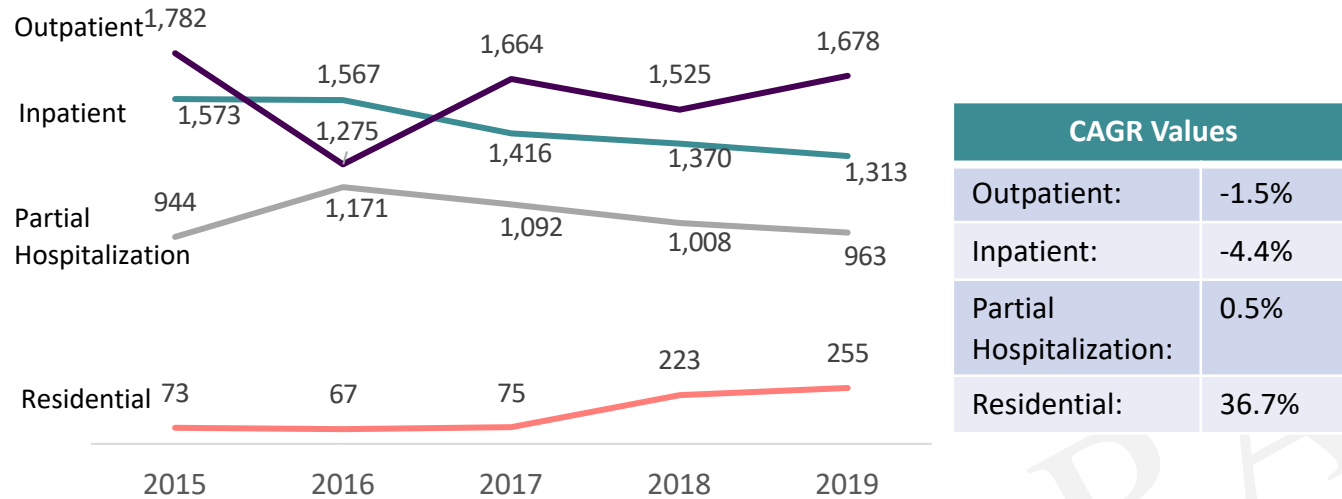
- Universal and Selective Prevention
- Early Intervention
- Crisis/Emergency Care
- Primary Care Providers
- Community Health Centers
- Outpatient Services
- Opioid Treatment Programs
- Correctional SUD Services
- Partial Hospitalization
- Medically Monitored Recovery
- Medically Managed Recovery
- Recovery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

Gap 1: Access to children’s behavioral health 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, 2015-2019¹



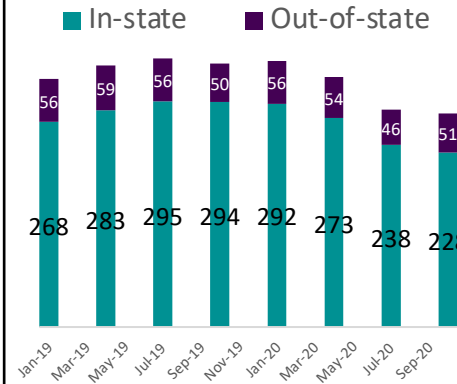
Key Takeaways

- 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.

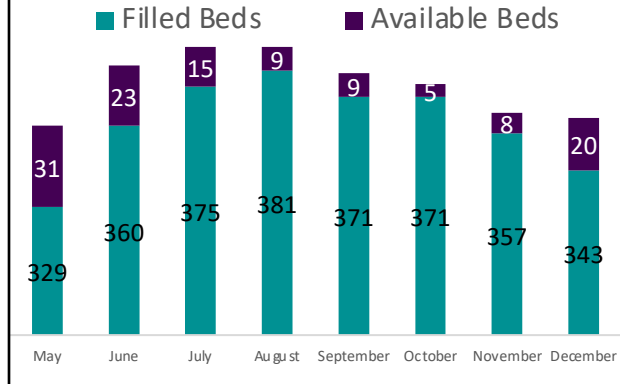
Qualitative Findings on Wait Times, Boarding and Transition Aged Youth:

- 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, 2019-2020³



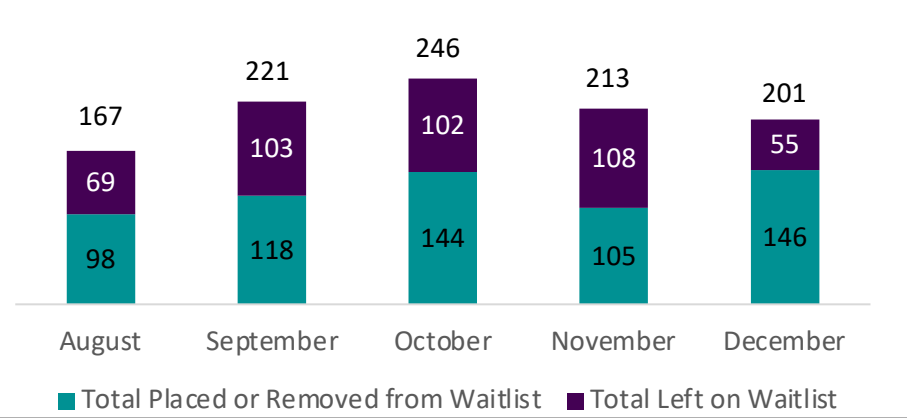
Average Available and Filled Beds for Children and Adolescents, RI, 2020²



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, 2020³

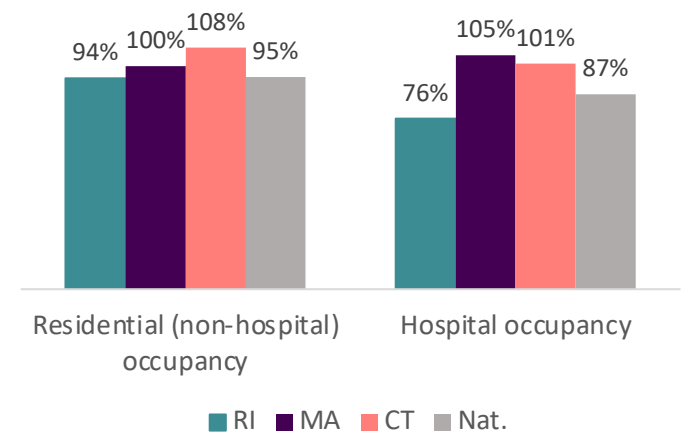


"We have a total lack of intensive/ED services in Rhode Island: the Hasbro ED is full of kids waiting for psych beds, waiting 24 hours for a bed. It is not ideal to have kids (in crisis) waiting for psych beds."
 -- Community Stakeholder

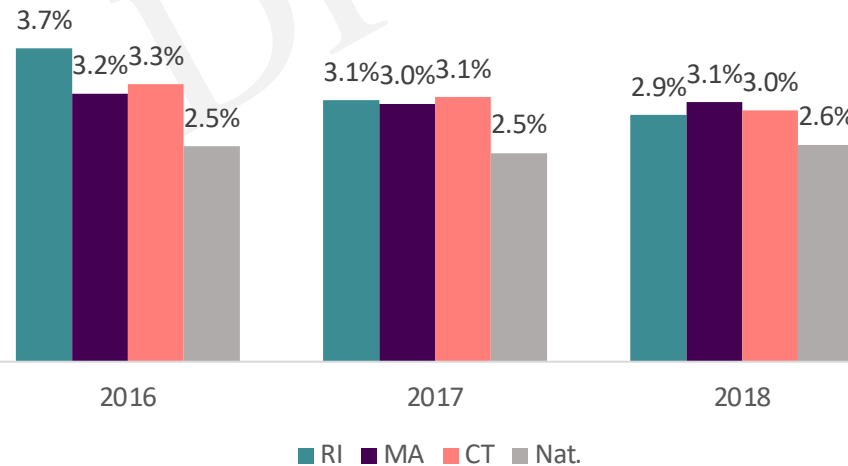
Key Takeaways

- 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.

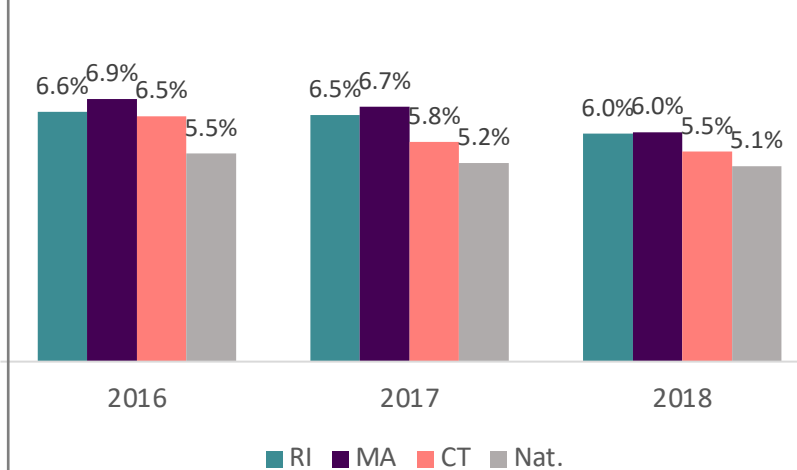
Occupancy Rate for Residential/Hospital Inpatient Services at SUD Treatment Facilities, March 29th 2019²



Needing But Not Receiving Treatment for Illicit Drug Use in the Past Year, 2016-2018¹



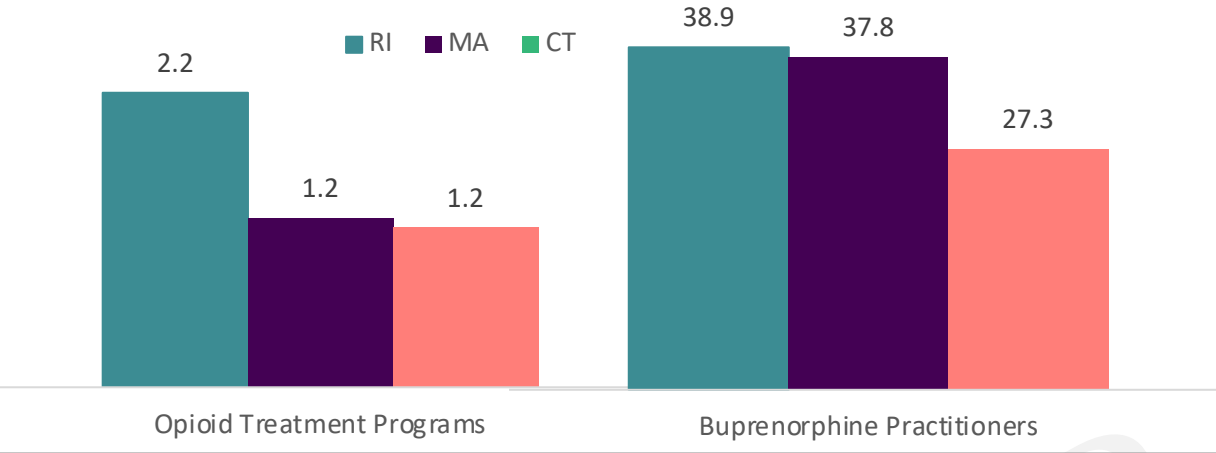
Needing But Not Receiving Treatment for Alcohol Use in the Past Year, 2016-2018¹



Source 1: National Survey on Drug Use and Health: Model-Based Prevalence Estimates, SAMHSA, <https://www.samhsa.gov/data/sites/default/files/reports/rpt23235/2k18SAEEExcelTabs/NSDUHsaePercents2018.pdf>, Tables 24/25
 Source 2: <https://www.dasis.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.

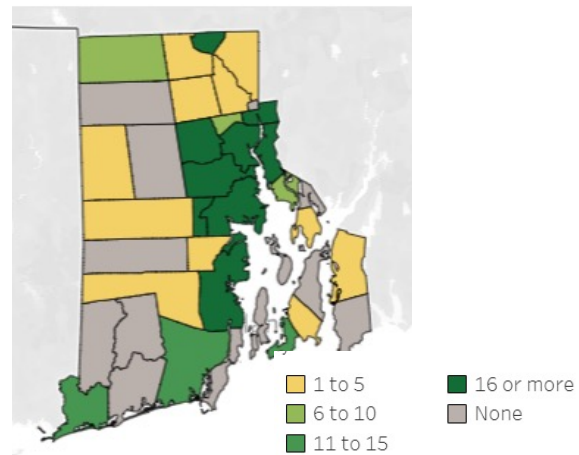
Number of OTPs and Buprenorphine Practitioners by State per 100,000 Population, 2020^{N,2}



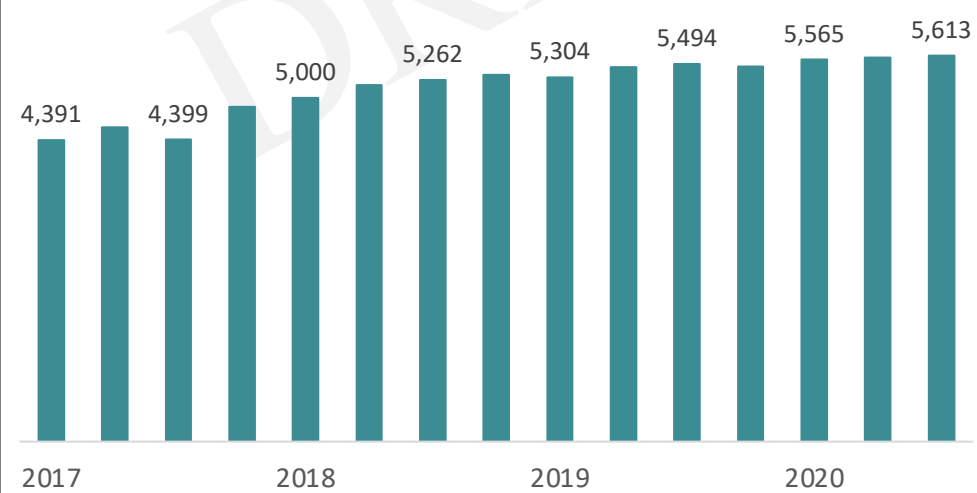
Key Takeaways

- 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 Columbia³.

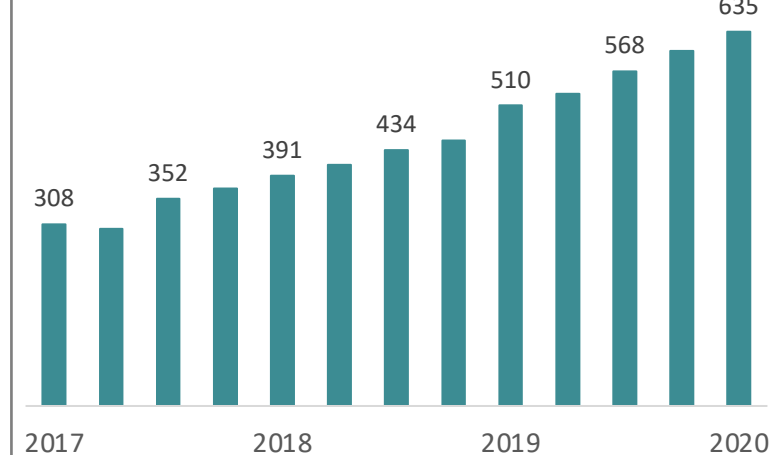
Waivered Providers Able to Prescribe Buprenorphine, Opioid Treatment Programs for Methadone, and Vivitrol Providers¹



Number of Patients Actively Receiving Buprenorphine, 2017-2020¹



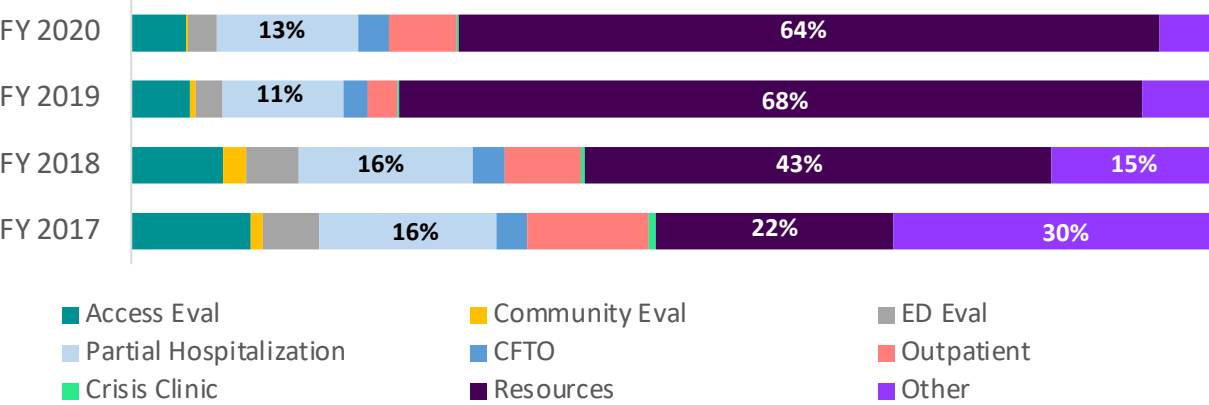
Number of Trained and DATA-Waivered Practitioners, 2017-2020¹



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 2020¹



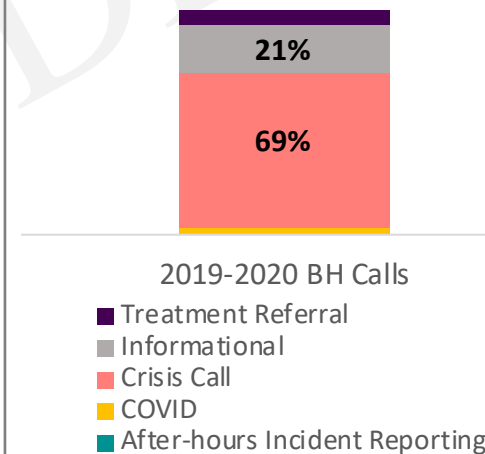
Key Takeaways

- 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.

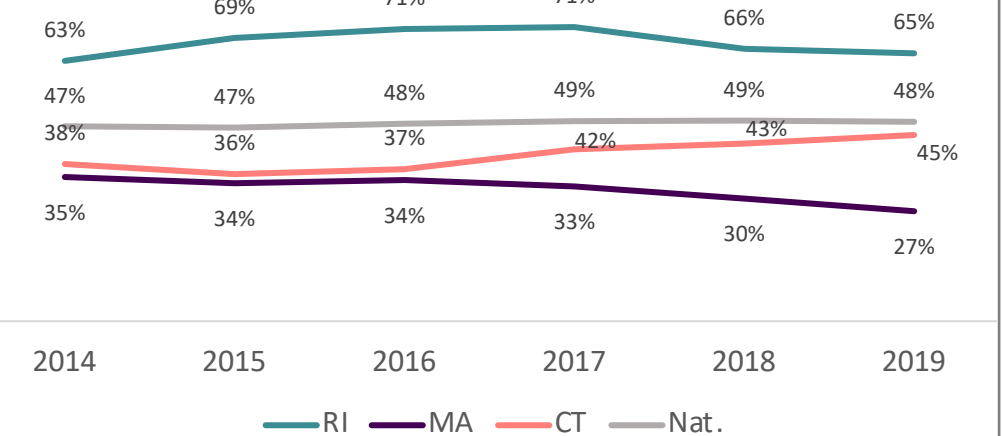
Qualitative Findings on Access to Mobile Crisis Treatment

- 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, 2019-2020³



% of MH Treatment Facilities that Employ a Crisis Intervention Team, 2019²



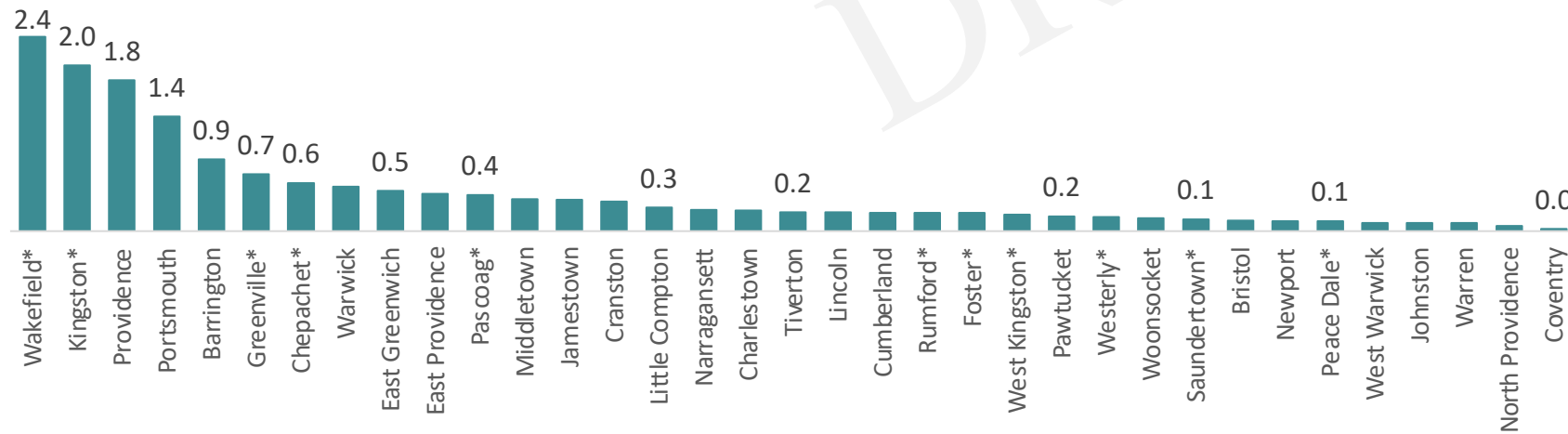
Gap 5: Access to counseling and other professional services in the community is mixed.

Upcoming: Seeking additional quantitative & qualitative data on Gap 5

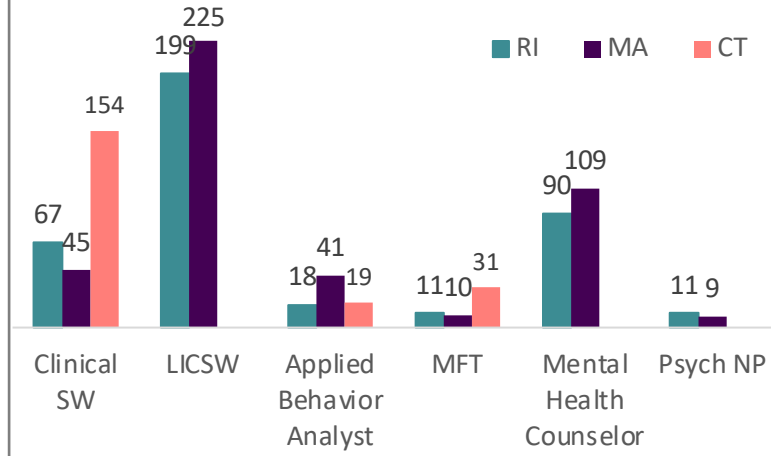
Key Takeaways

- 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, 2020¹



BH Health Professionals per 100,000 Population, May 2019²



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

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
- 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

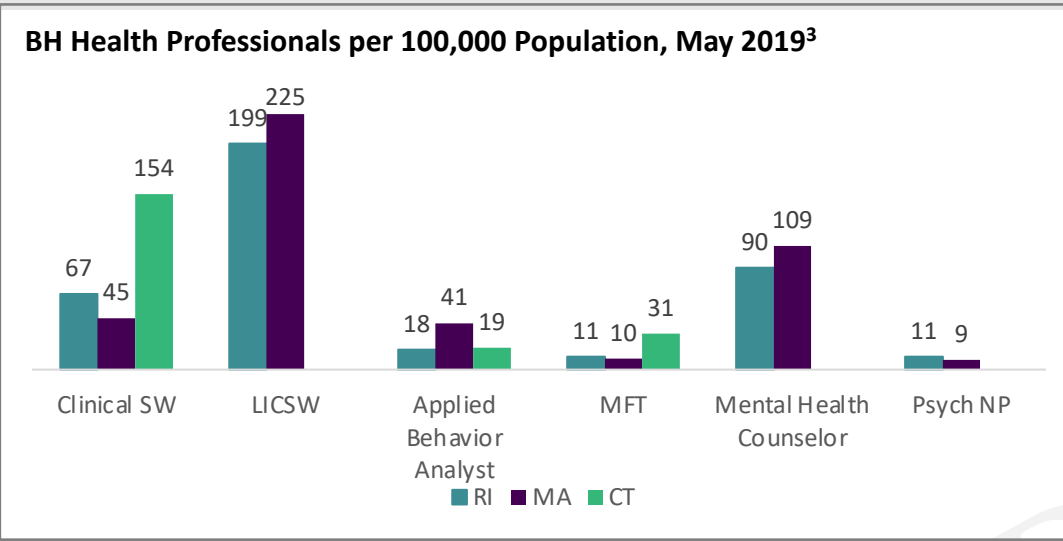
Challenges: Insufficient Workforce Capacity

- 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.”

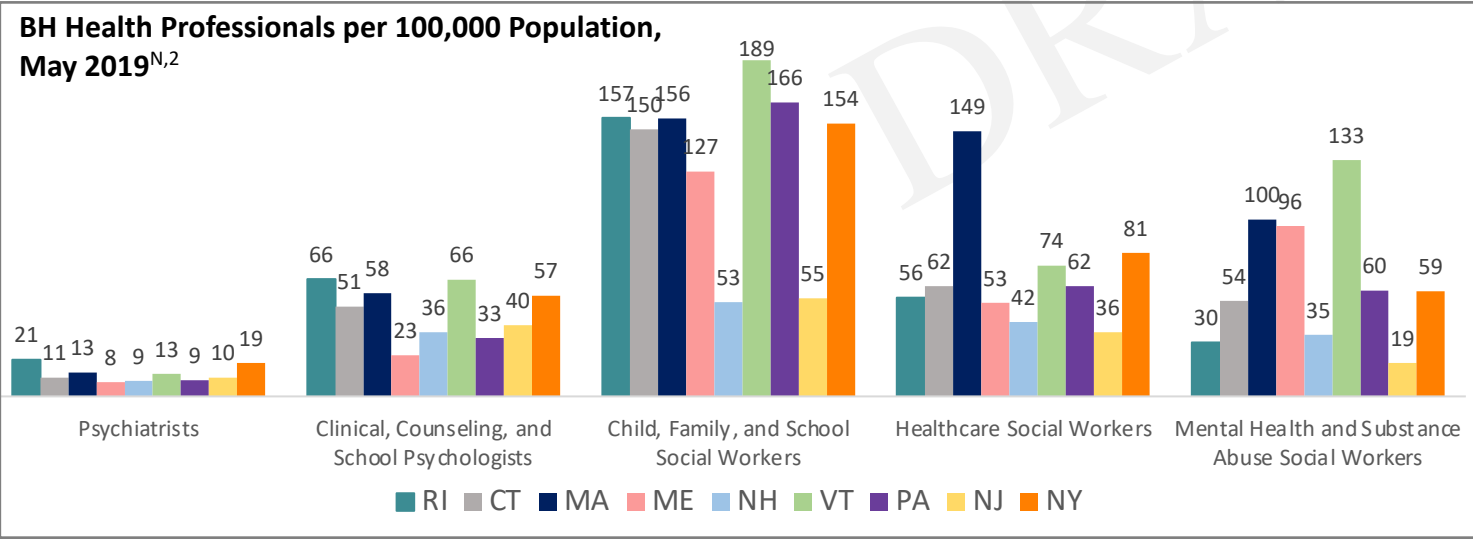
– Community Stakeholder,
on the challenges faced by
providers in the community

Challenges: Insufficient Workforce Capacity



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

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

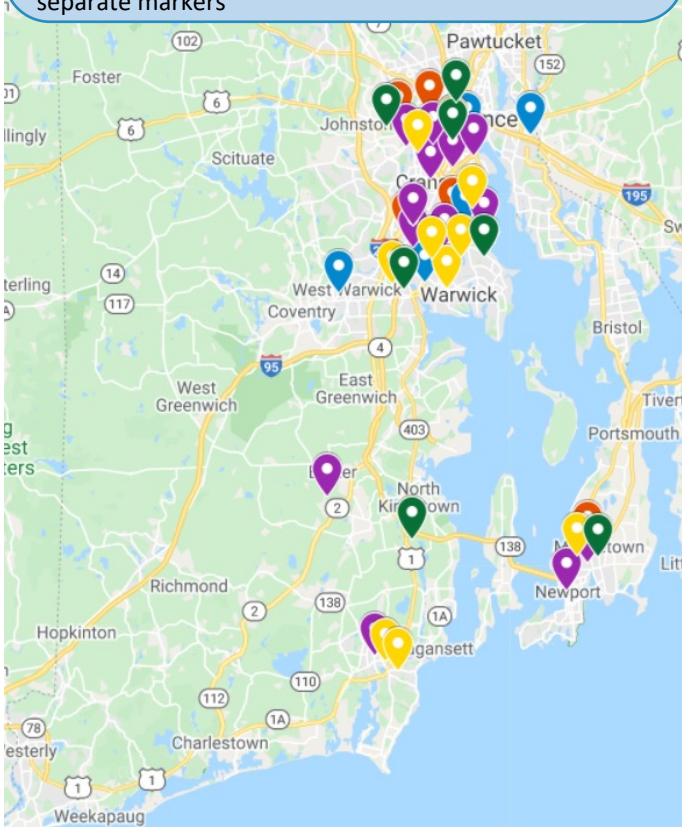
“The behavioral health continuum in Rhode Island is set up to address people who are of the white majority.”
– Community Stakeholder

“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

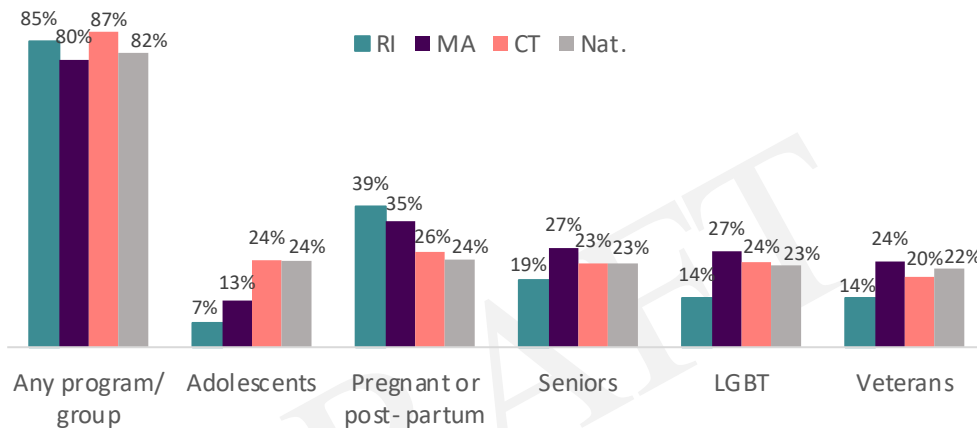
Rhode Island has lower rates of specialized SUD programs both regionally and nationally for seniors, LGBT, veteran, and adolescent populations.

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

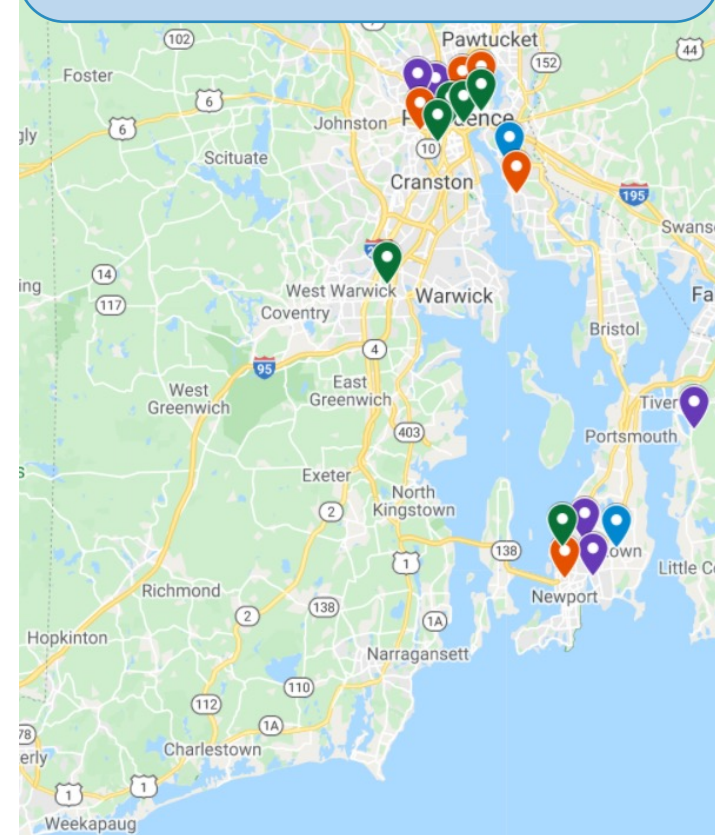


% of SUD Facilities Offering Special Programs for Specific Client Types, 2019

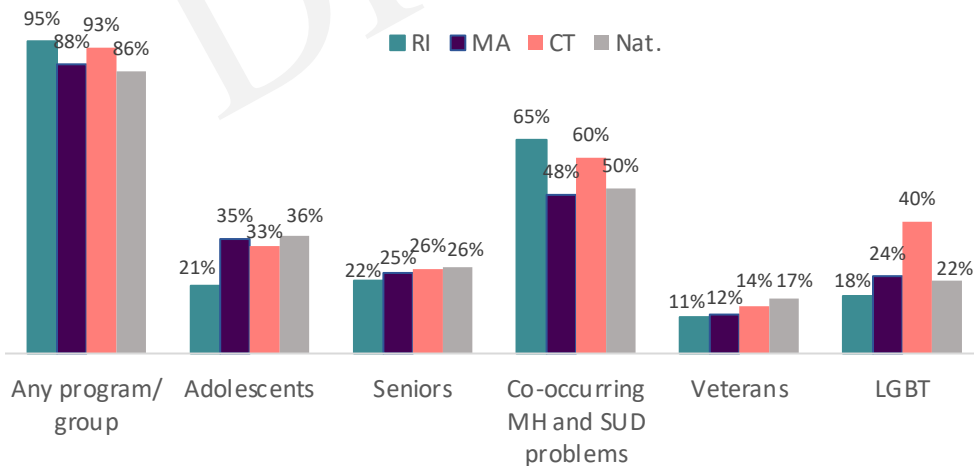


Total: 12 MH facilities

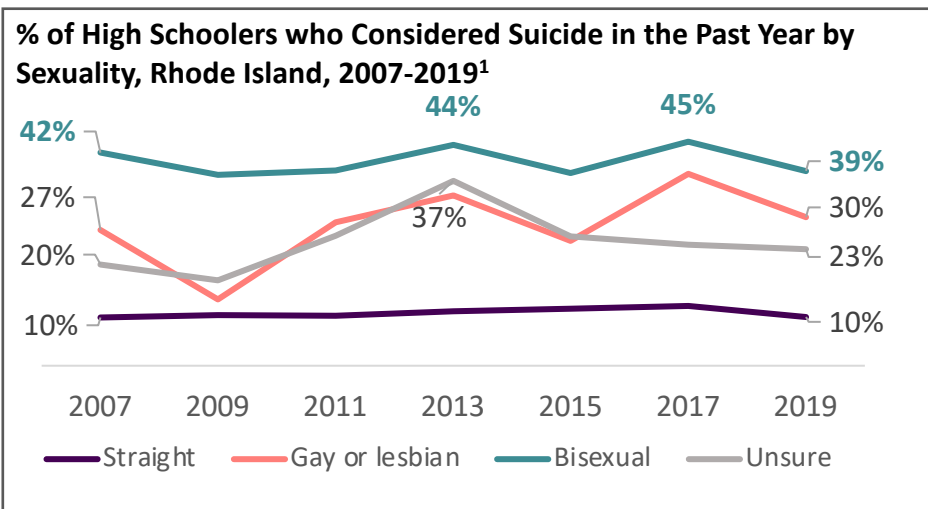
- Red: LGBT programs (5)
- Blue: Adolescent programs (2)
- Purple: Senior/older adult programs (5)
- Green: Veteran programs (6)
- Note: Facilities with multiple specialties shown as two separate markers



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

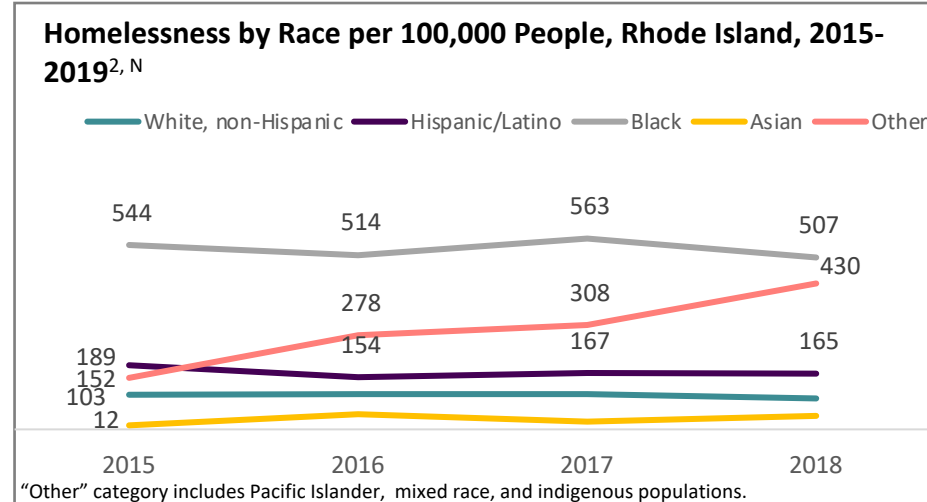
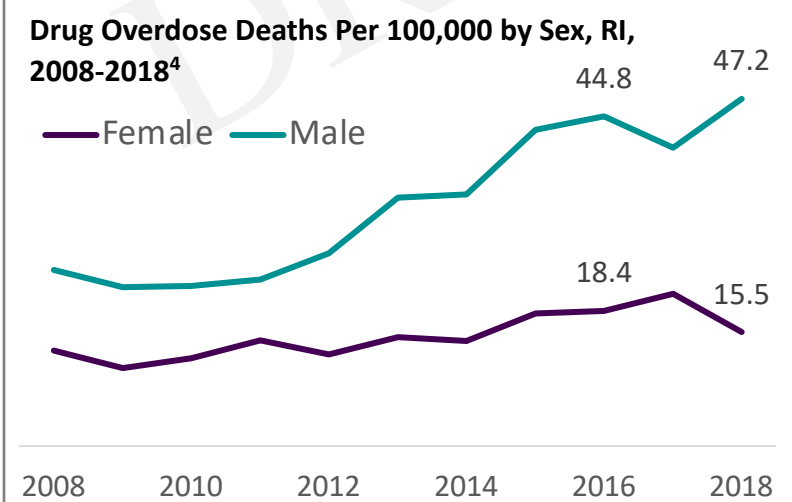
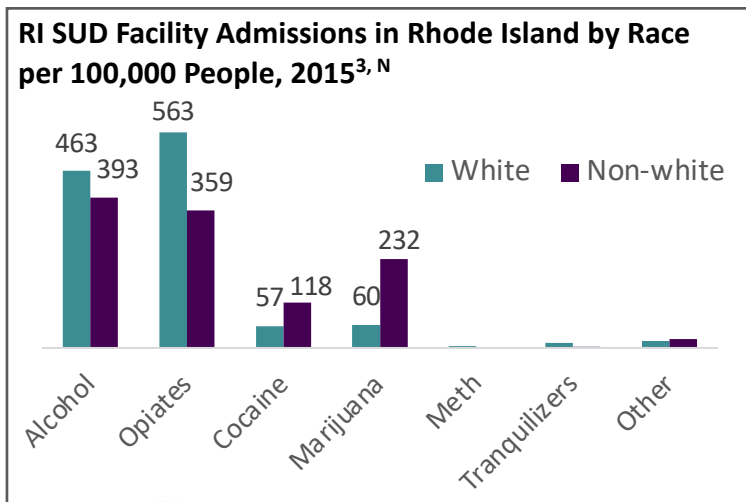


Major behavioral health disparities are present in Rhode Island across many metrics and demographics.



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.



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 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
- 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

“There’s a need for more connection between the ground level and the state level.”
– Community Stakeholder

“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 preferable 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	<p>In October 2020, 22% of Rhode Islanders reported needing mental health care (counseling or therapy), but not receiving it¹.</p> <p>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 year².</p>	<p>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 2020¹.</p> <p>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 caretakers³.</p> <p>In November 2020, only 34% of Americans reported their mental health as “excellent”, a 9 point decline from 2019⁷.</p>
Substance Use	<p>In Rhode Island, drug overdoses have increased by 25%, from 308 in 2019 to 384 in 2020⁶. July 2020 had the highest number of fatal overdoses in the state since tracking began in 2014⁵. 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 burden⁴.</p>	<p>More than 35 states have also seen an increase in overdoses⁶.</p> <p>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 decades⁴.</p>
Behavioral Health		<p>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.</p> <p>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.</p>
Homelessness	<p>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 2019¹². In order to promote social distancing, the number of available year-round beds dropped from 486 to 325⁹.</p>	<p>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.</p>

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 (ISMIC) 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/6159177001/>

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.lebtmap.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 not 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 House¹.
- 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.

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.

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