CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Welcome

2021 QUARTERLY IBH COMMITTEE MEETING 8-12-2021

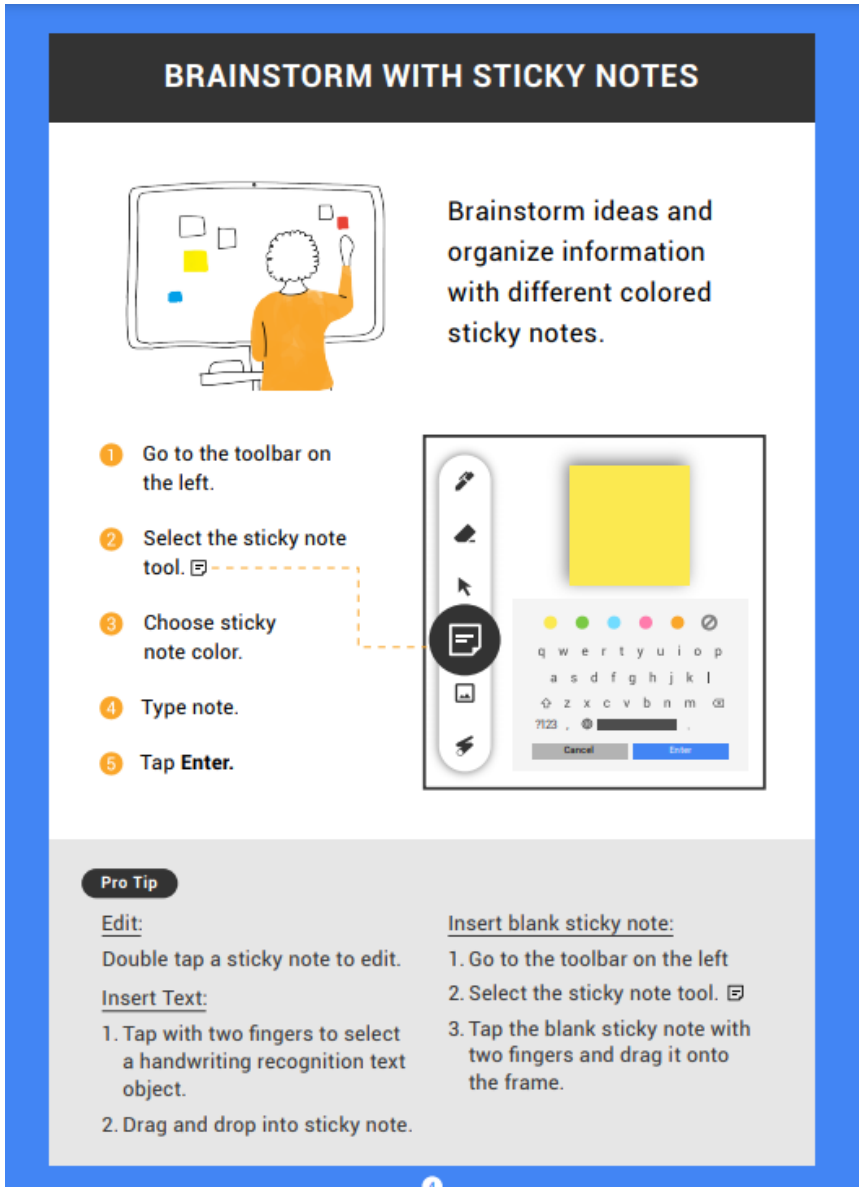
Agenda

Topic *Presenter(s)*	Duration
Welcome & Introductions *Rena Sheehan, MBA, LICSW & John Todaro, PhD*	5 minutes
CTC-RI Strategic Planning Discussion, using Jamboard technology *Debra Hurwitz to facilitate*	25 minutes
Behavioral Health System Review Technical Assistance *Angela Sherwin, Faulkner Consulting Group* *Marti Rosenberg, OHHS*	30 minutes

CTC-RI Strategic Planning Discussion

[CTC-RI IBH Strategic Planning Session using Jamboard]

Jamboard is a collaborative whiteboard used to brainstorm ideas.



For more information about Jamboard, click here

Behavioral Health System Review Technical Assistance

Final Draft Report

August 12, 2021

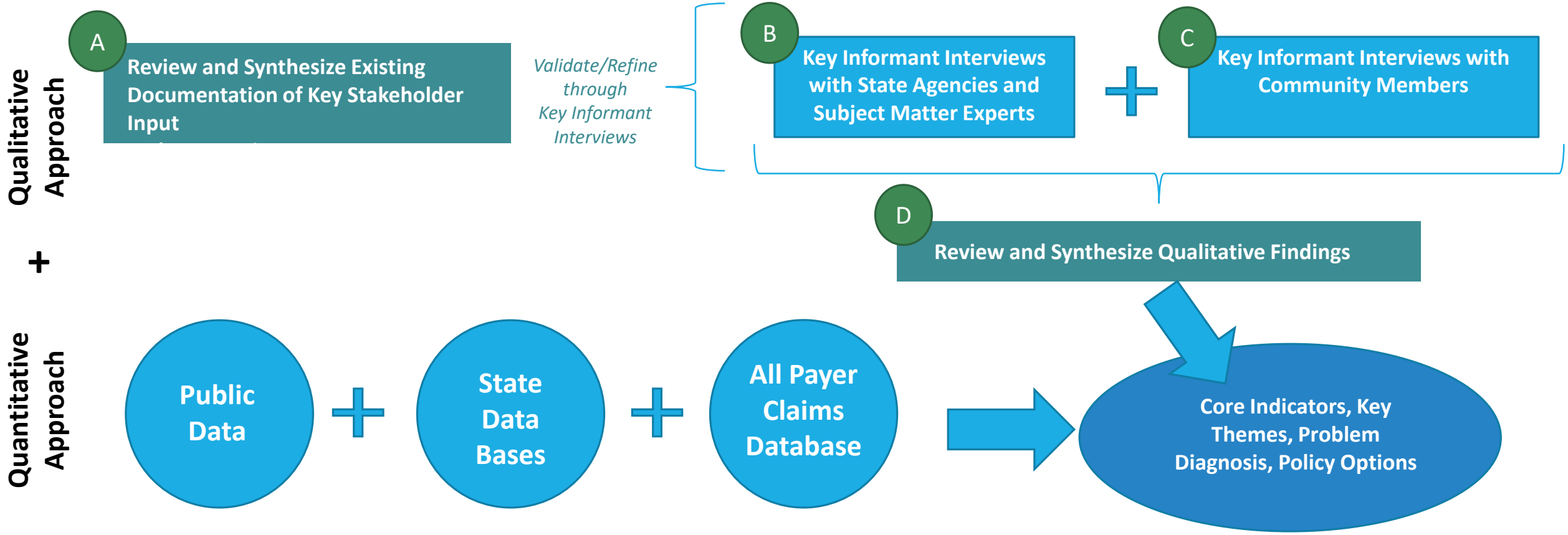
FCG Faulkner Consulting Group

HEALTH MANAGEMENT ASSOCIATES

This project is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling **$329,XXX** with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

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 (1/2)

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

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

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

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

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

Executive Summary (2/2)

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

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

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

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

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

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

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

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

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

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

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

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

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

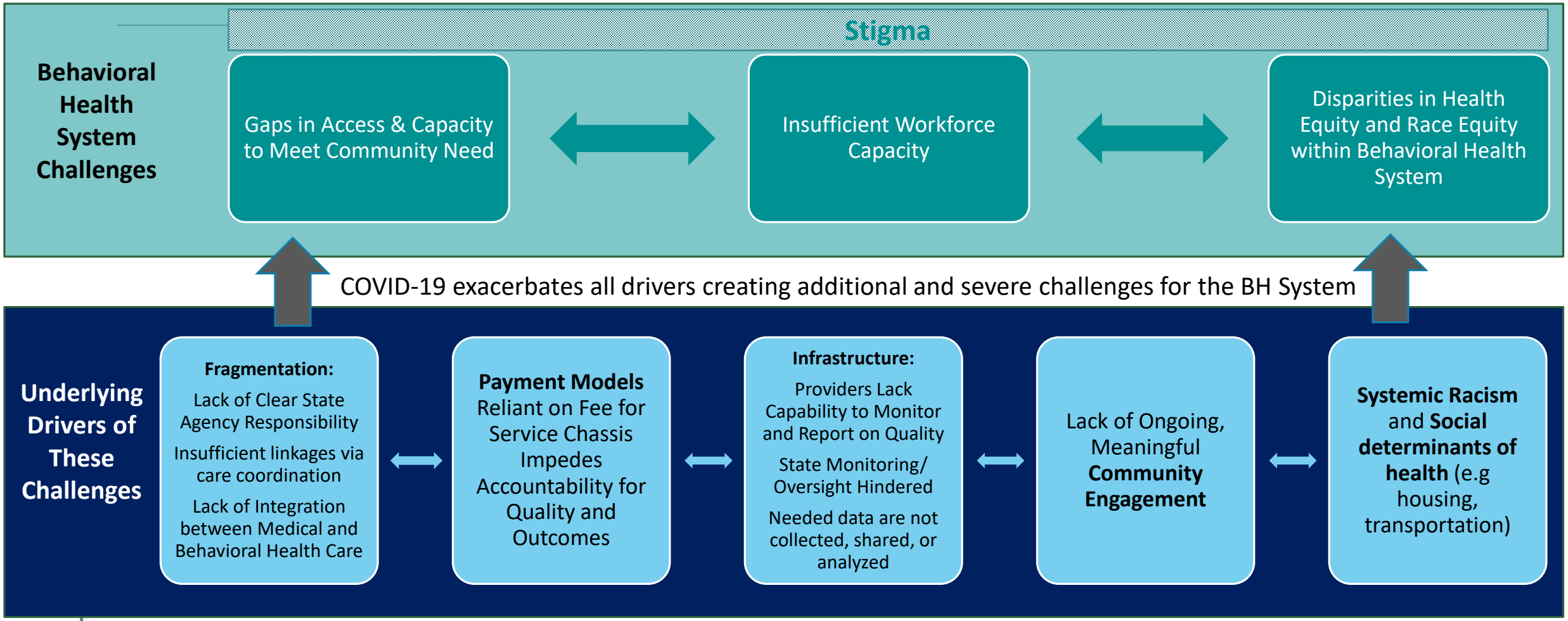
Findings for each core indicator are summarized below. Section 3 provides detailed data in aggregate and stratified by demographics, when available.

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

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

Problem Diagnosis: Underlying Drivers

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



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

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

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

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

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

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

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

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

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

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

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

Priority Policy Options: Informed by Best Practices

National Model

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

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

State Model

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

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

Specialty Models

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

Accountable Entities

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

Other Models Identified by Stakeholders

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

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

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

Principles To Drive and Prioritize Policy Options

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

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

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

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

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

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

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

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

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

Priority Policy Options

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

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

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

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

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

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

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

Goals Addressed by CCBHC 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

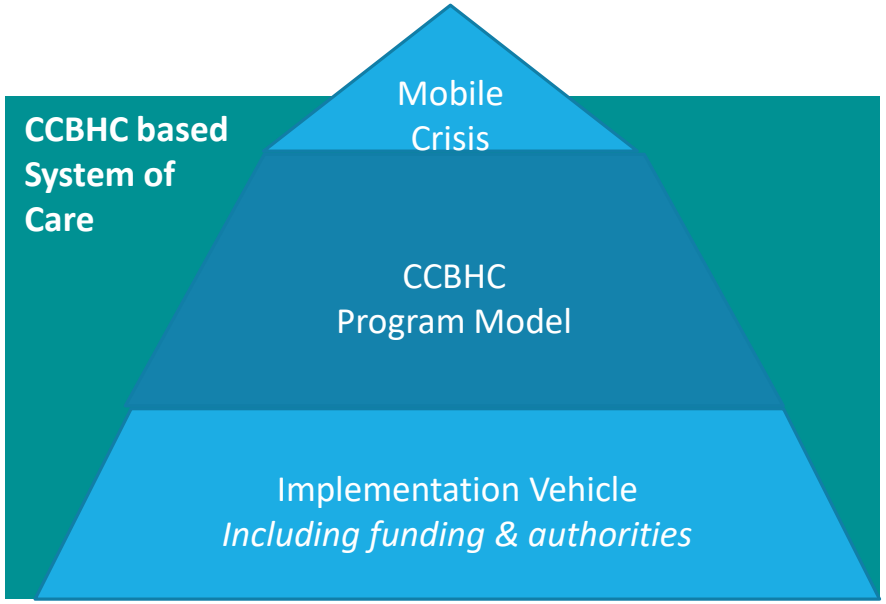
Detail of Two Synergistic Policies

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

Focus Areas:

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

Licensing/Workforce:

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

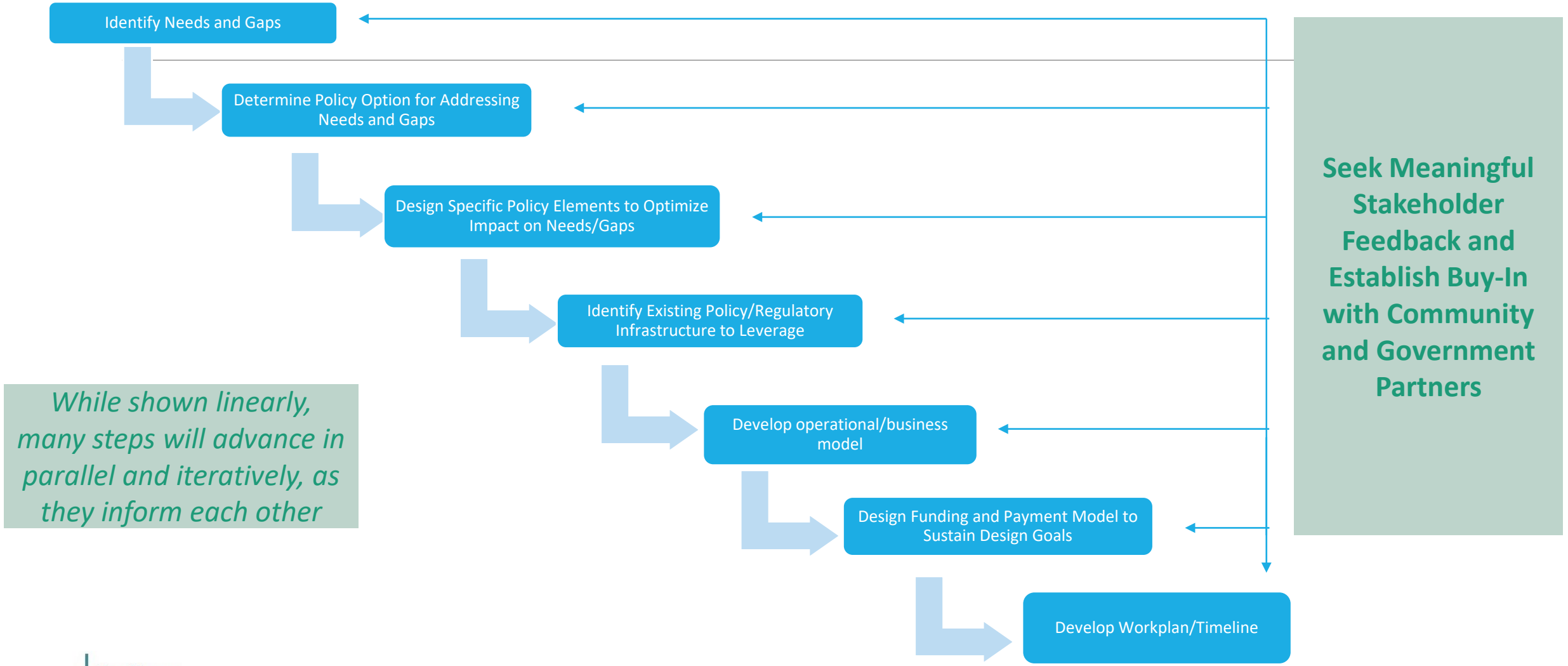
Emergency Services and Correctional Recommendations:

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

KidsLink:

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

Approach to Implementation Plans



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

CCBHC Implementation Plans: Key Elements

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

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

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

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

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

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

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

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

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

VIII. Potential Federal Sources of Revenue

IX. Workplan/Timeline

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

Mobile Crisis Implementation Plans: Key Elements

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

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

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

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

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

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

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

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

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

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

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

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Friendly Reminder

- Thursday, **September 9, 2021,** Quarterly IBH Meeting – NCQA Behavioral Health Distinction and Tele-IBH Learning Collaborative
- Thursday, **October 14, 2021** Quarterly IBH Meeting – Pediatric IBH Learning Collaborative