CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

# Welcome Pediatric IBH Practices

*Care Transformation Collaborative of Rhode Island*

*Liz Cantor, PhD, CTC-RI Pediatric IBH Practice Facilitator*

**Quarterly Pediatric IBH Meeting | January 13, 2021**

# Agenda

| Topic<br>Presenter(s) | Duration |
|---|---|
| **Welcome & Opening Remarks**<br>*Liz Cantor* | 5 minutes |
| **Workforce Development Opportunity**<br>*Susanne Campbell* | 5 minutes |
| **Pediatric IBH Timeline, reminders, screening results**<br>*Liz Cantor* | 10 minutes |
| **RI Behavioral Health System Transformation Across the Lifespan**<br>*Marti Rosenberg, Director of Policy, Planning and Research for EOHHS* | 40 minutes |

# IBH Workforce Development Opportunity: Stay Tuned

- Funding available for Accountable Entity Primary Care Practices through Real Jobs RI and HSTP
- Workforce training opportunities working with CTC-RI, University of RI & RI College
  - Provide stipends for students for their clinical IBH placement and for organizations that provide the required supervision.
  - Provide stipends for organizations who provide required supervision for post graduate staff to obtain license;
  - Provide online program to train existing behavioral health clinicians to evolve their skills in order to function effectively in an IBH practice. Coaching will also be provided to assist behavioral health clinicians with applying knowledge in the RI environment. Learners would be offered a stipend for taking the course. Organizations offering the stipend would also receive a stipend.
  - Offer behavioral health supervisors an online course including coaching sessions (through CTC-RI). Stipends would be offered to both the supervisor and the organization.

# Other Upcoming Programs

- **Pediatric Neighborhoods: Adopting DULCE (Developmental Understanding and Legal Collaboration for Everyone) to Better Serve Families and their Infants**
  - Funding confirmed with 6 month planning period and timing to be determined
- **Childhood Obesity**
  - Funding confirmed with 6 month planning period and timing to be determined

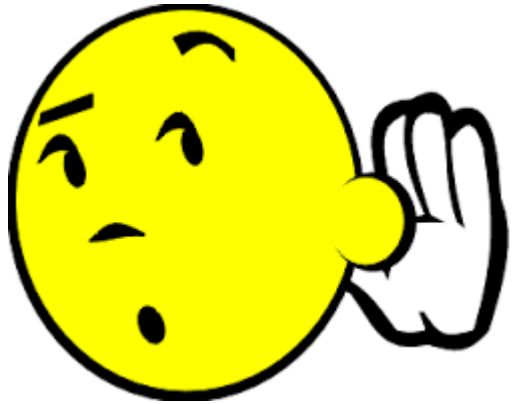
# Practices here today

- Cohort 2 (Apr 2020- Apr 2022)
  - Coastal Bald Hill
  - Coastal Waterman
  - Hasbro Med Peds Clinic
  - Northern RI Peds
  - Tri County
- Cohort 1 (July 2019-July 2021)
  - Anchor Pediatrics
  - CCAP
  - Hasbro Pediatric Primary Care

# Evaluation

- Part of the RI Foundation funding for the Pedi IBH project is to conduct a qualitative evaluation.
- Roberta Goldman & Mardia Coleman will be contacting you.

| | |
|---|---|
| **Roberta Goldman** | **Roberta_Goldman@brown.edu** |
| **Mardia Coleman** | **mardcole@aol.com** |



***We want to hear from you.***
***What worked? What could we do better?***

# Project timeline

- Due April 1
  - Final PDSA
  - Final quarterly screening rate data (for period Dec-Feb)
  - Final MeHAF

- Final LC:  April 14, 7:30-9
- Qualitative Evaluation - ongoing

# Final PDSAs

- PDSA Plan for addressing a population health need that can be addressed through improved connections to community resources
  - NRI - Implementing SDOH screening (early)
  - Coastal Waterman - Implementing SDOH screening
  - HMPC - Trying to connect patients to community providers (PediPRN)
- PDSA Plan to improve IBH processes
  - Coastal BH - WHOs
  - Tri-County - Rescreening/tracking

# RIF Cohort 2 - Coastal – Bald Hill : IBH Screening Results

| *Practice* | | *EPDS* | *PSC-35* | *PHQA/9* | *GAD%7* | *CRAFFT(N)* |
|---|---|---|---|---|---|---|
| *Targets:* | *YR1/YR2* | *40/60%* | *40/60%* | *60/75%* | *40/60%* | *40/60%* |
| Coastal - Bald Hill | Q6 | 89% | N/A | 89% | N/A | 85% |
| | Q5 | 87% | N/A | 89% | N/A | 87% |
| | Q4 | 90% | N/A | 94% | N/A | 87% |
| | Q3 | 83% | N/A | 88% | N/A | 87% |
| | Q2 | 83% | N/A | 87% | N/A | 79% |
| | Q1 | 86% | N/A | 75% | N/A | 34% |
| | baseline | 81% | N/A | 85% | N/A | 5% |

# RIF Cohort 2 – Coastal - Waterman : IBH Screening Results

| *Practice* | | *EPDS* | *PSC-35* | *PHQA/9* | *GAD%7* | *CRAFFT(N)* |
|---|---|---|---|---|---|---|
| *Targets:* | *YR1/YR2* | *40/60%* | *40/60%* | *60/75%* | *40/60%* | *40/60%* |
| Coastal - Waterman | Q6 | 98% | N/A | 87% | N/A | 93% |
| | Q5 | 95% | N/A | 82% | N/A | 87% |
| | Q4 | 98% | N/A | 85% | N/A | 89% |
| | Q3 | 96% | N/A | 81% | N/A | 91% |
| | Q2 | 92% | N/A | 82% | N/A | 84% |
| | Q1 | 97% | N/A | 78% | N/A | 59% |
| | baseline | 95% | N/A | 83% | N/A | 46% |

# RIF Cohort 2 – Hasbro Med Peds : IBH Screening Results

| *Practice* | | *EPDS* | *PSC-35* | *PHQA/9* | *GAD%7* | *CRAFFT(N)* |
|---|---|---|---|---|---|---|
| *Targets:* | *YR1/YR2* | *40/60%* | *40/60%* | *60/75%* | *40/60%* | *40/60%* |
| Hasbro Med Peds | Q6 | N/A | 79% | 78% | N/A | 77% |
| | Q5 | N/A | 75% | 77% | N/A | 73% |
| | Q4 | N/A | 78% | 74% | N/A | 82% |
| | Q3 | N/A | 66% | 61% | N/A | 65% |
| | Q2 | N/A | 45% | 54% | N/A | 60% |
| | Q1 | N/A | 17% | 47% | N/A | 50% |
| | baseline | N/A | 0% | 46% | N/A | 60% |

# RIF Cohort 2 – Northern RI : IBH Screening Results

| *Practice* | | *EPDS* | *PSC-35* | *PHQA/9* | *GAD%7* | *CRAFFT(N)* |
|---|---|---|---|---|---|---|
| *Targets:* | *YR1/YR2* | *40/60%* | *40/60%* | *60/75%* | *40/60%* | *40/60%* |
| Northern RI | Q6 | 83% | 82% | 87% | N/A | N/A |
| | Q5 | 97% | 86% | 88% | N/A | N/A |
| | Q4 | 88% | 94% | 91% | N/A | N/A |
| | Q3 | 94% | 82% | 64% | N/A | N/A |
| | Q2 | 86% | 81% | 44% | N/A | N/A |
| | Q1 | 80% | 67% | 16% | N/A | N/A |
| | baseline | 82% | 90% | 0% | N/A | N/A |

# RIF Cohort 2 – Tri-County : IBH Screening Results

| *Practice* | | *EPDS* | *PSC-35* | *PHQA/9* | *GAD%7* | *CRAFFT(N)* |
|---|---|---|---|---|---|---|
| *Targets:* | *YR1/YR2* | *40/60%* | *40/60%* | *60/75%* | *40/60%* | *40/60%* |
| Tri-County | Q6 | N/A | N/A | 55% | 56% | 47% |
| | Q5 | N/A | N/A | 59% | 45% | 52% |
| | Q4 | N/A | N/A | 49% | 33% | 40% |
| | Q3 | N/A | N/A | 44% | 24% | 32% |
| | Q2 | N/A | N/A | 33% | 39% | 36% |
| | Q1 | N/A | N/A | 22% | 34% | 25% |
| | Baseline | N/A | N/A | 12% | 19% | 25% |

# RIF Cohort 1 – *Anchor* : Screening Rates

| *Practice* | | *EPDS* | *PSC-35* | *PHQA/9* | *GAD7* | *CRAFFT(N)* |
|---|---|---|---|---|---|---|
| *Targets:* | *YR1/YR2* | *40/60%* | *40/60%* | *60/75%* | *40/60%* | *40/60%* |
| Anchor | 9th Qtr | | N/A | | | N/A |
| | 8th Qtr | 94% | N/A | 87% | 87% | N/A |
| | 7th Qtr | 97% | N/A | 89% | 89% | N/A |
| | 6th Qtr | 97% | N/A | 86% | 85% | N/A |
| | 5th Qtr | 95% | N/A | 82% | 65% | N/A |
| | 4th Qtr | 91% | N/A | 79% | 36% | N/A |
| | 3rd Qtr | 92% | N/A | 82% | 30% | N/A |
| | 2nd Qtr | 95% | N/A | 85% | 4% | N/A |
| | 1st Qtr | 88% | N/A | 66% | 2% | N/A |
| | baseline | 95% | N/A | 75% | 0% | N/A |

# RIF Cohort 1 – *CCAP* : Screening Rates

| *Practice* | | *EPDS* | *PSC-35* | *PHQA/9* | *GAD7* | *CRAFFT(N)* |
|---|---|---|---|---|---|---|
| *Targets:* | *YR1/YR2* | *40/60%* | *40/60%* | *60/75%* | *40/60%* | *40/60%* |
| CCAP | 9th Qtr | N/A | N/A | 88% | 62% | 41% |
| | 8th Qtr | N/A | N/A | 69% | 52% | 35% |
| | 7th Qtr | N/A | N/A | 95% | 65% | 46% |
| | 6th Qtr | N/A | N/A | 87% | 52% | 43% |
| | 5th Qtr | N/A | N/A | 97% | 66% | 45% |
| | 4th Qtr | N/A | N/A | 94% | 43% | 37% |
| | 3rd Qtr | N/A | N/A | 64% | 28% | 37% |
| | 2nd Qtr | N/A | N/A | 71% | 21% | 40% |
| | 1st Qtr | N/A | N/A | 86% | 7% | 28% |
| | baseline | N/A | N/A | 88% | 1% | 42% |

# RIF Cohort 1 – *Hasbro Pediatric PC* : Screening Rates

| *Practice* | | *EPDS* | *PSC-35* | *PHQA/9* | *GAD7* | *CRAFFT(N)* |
|---|---|---|---|---|---|---|
| *Targets:* | *YR1/YR2* | *40/60%* | *40/60%* | *60/75%* | *40/60%* | *40/60%* |
| Hasbro Pediatric PC | 9th Qtr | 36% | N/A | 73% | N/A | 72% |
| | 8th Qtr | 52% | N/A | 84% | N/A | 83% |
| | 7th Qtr | 55% | N/A | 79% | N/A | 77% |
| | 6th Qtr | 48% | N/A | 65% | N/A | 63% |
| | 5th Qtr | 50% | N/A | 68% | N/A | 66% |
| | 4th Qtr | 55% | N/A | 71% | N/A | 55% |
| | 3rd Qtr | 60% | N/A | 64% | N/A | 41% |
| | 2nd Qtr | 68% | N/A | 67% | N/A | 39% |
| | 1st Qtr | 39% | N/A | 73% | N/A | 37% |
| | baseline | 45% | N/A | 44% | N/A | 44% |


GREAT JOB!

# Rhode Island Behavioral Health System Transformation Across the Lifespan

January 13, 2022

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# Planning in Process: Behavioral Health System of Care for Children & Youth

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# Rhode Island children & youth are having a tough time and COVID has made it worse.

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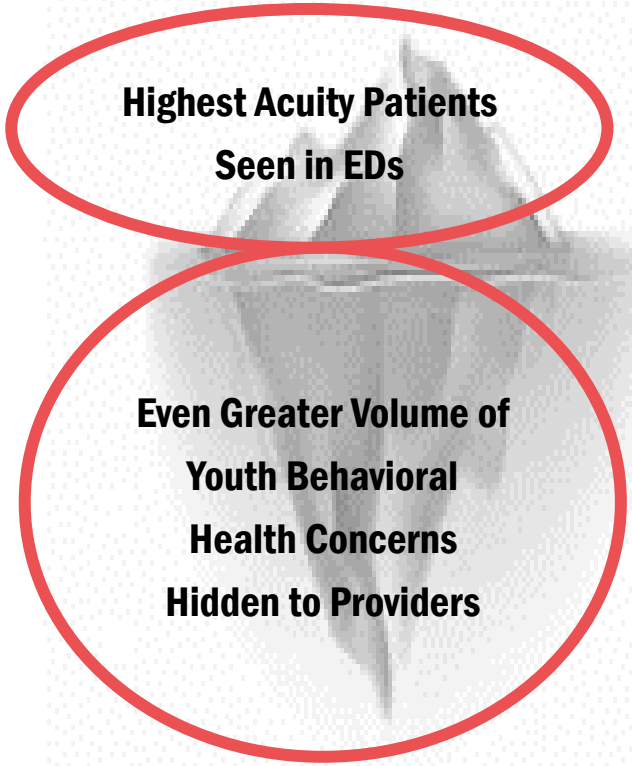
# Our Rhode Island Children are Having a Tough Time

- In late May 2021, the Rhode Island Department of Health (RIDOH) and community partners (i.e., Bradley and Hasbro hospitals) shared information with the state about a growing increase in suicide-related emergency department visits.
  - The number of hospital visits increased among youth and adolescents under the age of 18 – and the severity of the attempts were also rising.
  - Doctors were seeing more and more children taking over the counter pills leading to brain injury, liver failure, and the need for more and more care for those young people
  - Why is this happening? The state and doctors think that the ongoing challenges of depression and loneliness from COVID is a big part of it.
  - And we think that there are even more problems that we're not seeing.

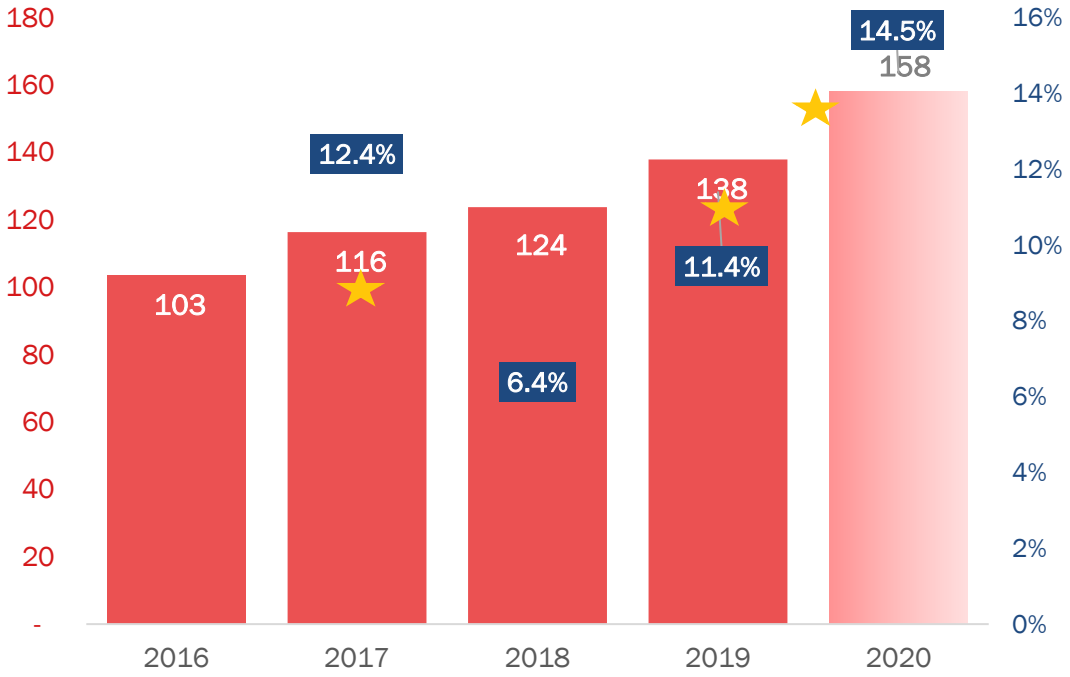


# Here's an Example: Spikes in Depression and Anxiety

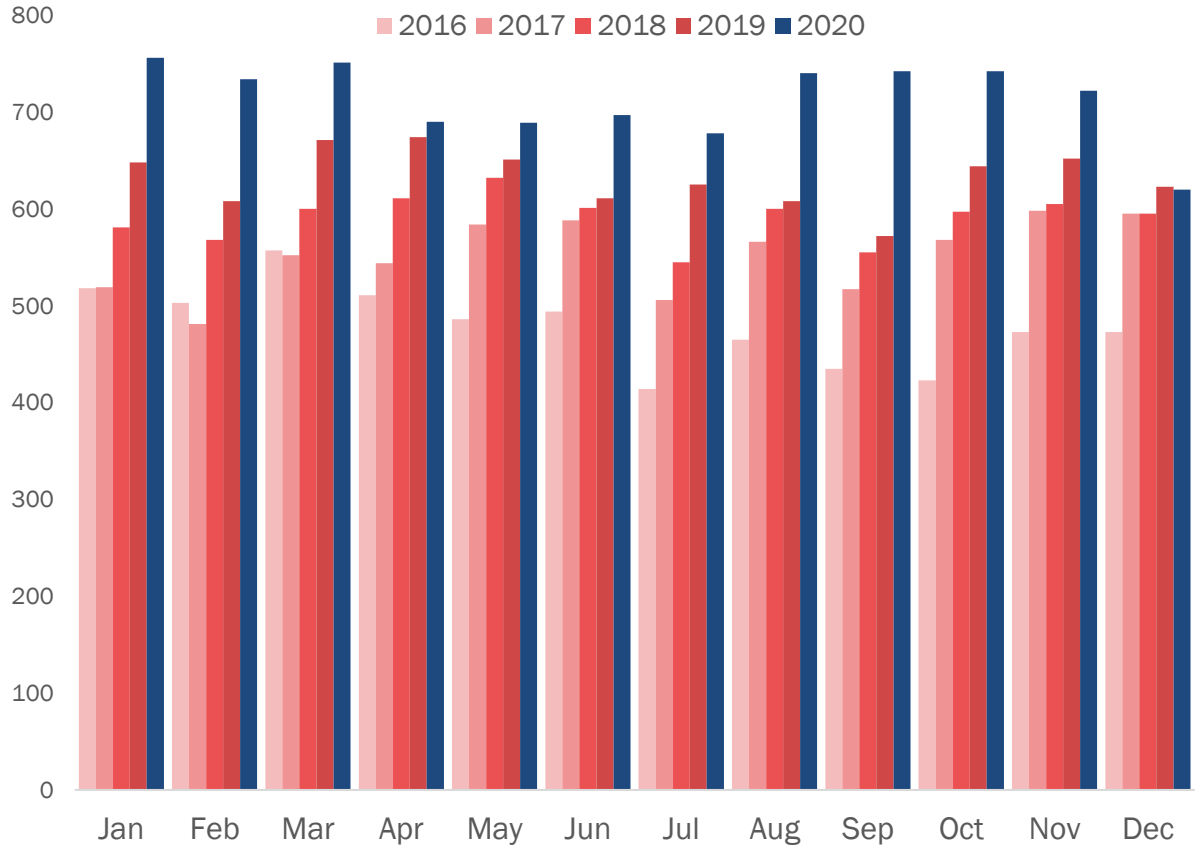
*Anxiety for Adolescent females, Commercial insurance shown | Similar trends for Medicaid and for Depression*

★ *Statistically significant change from prior year ($p < 0.05$)*

Rate for Selected Diagnosis per 1,000 Kids in Selected Population
Diag: Anxiety | Age: 12-18 | Gender: Female | Payer: Commercial




Counts of Kids with Selected Diagnosis
Diag: Anxiety | Age: 12-18 | Gender: Female | Payer: Commercial



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# Our Children's System of Care isn't strong enough to help our kids who are experiencing tough times.

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# Children's Behavioral Health in Rhode Island Today

## Lack of Clarity for Caregivers

Using the children's behavioral healthcare system in Rhode Island can be difficult, particularly when a child is having a behavioral health crisis, and especially for families of color. Parents may not know what to do, or who is available to help meet their child's needs in their own language, or for the child's development needs.

## Lack of Alignment within the System

Our current system is doesn't work for families because it can often be hard to find the right providers or services. The people in state government who are responsible for helping make the system work are spread across many agencies. This makes it hard for the system to work like it should, to make sure all Rhode Island children and families have the care they need.

## Need for a More Organized System

Rhode Island needs a more organized system, with providers who can talk to each other to help coordinate care. **All** families should be able to find providers who meet their cultural needs, who speak their languages, and understand their children's developmental needs - instead of the confusion that families find today.

# We know even more about our System of Care from some key research we've just finished.

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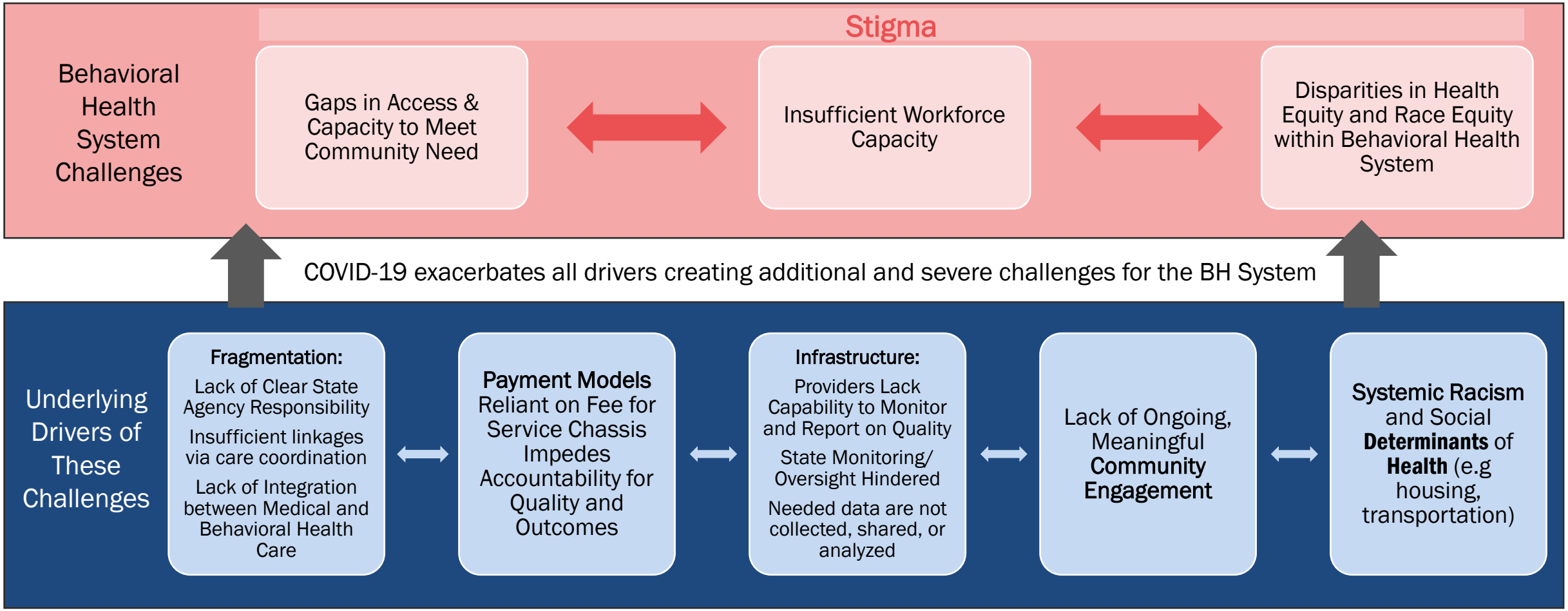
# Problem Diagnosis: Underlying Drivers, from the RI Behavioral Health System Review

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.



# There are ways to improve our System of Care for Children and Families.

# We start with a Vision and a Theory of Change.

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# Rhode Island System of Care Vision

Families deserve a true System of Care for mental health and substance use conditions that that is

- easy to navigate,
- that provides high quality care,
- that recognizes and addresses historical structural racism and other disparities, and
- that the state sustains financially and administratively.

We envision a

- partnership among communities, youth, families, schools, pediatricians, government, and provider agencies that
- improves outcomes,
- increases access to services and supports, and
- promotes positive change in the lives of children and their families.

# Rhode Island System of Care Theory of Change

**If** Rhode Island creates an **integrated, culturally, linguistically,** and **developmentally competent** continuum of behavioral health care for all children in the state that begins with prevention and provides an organized pathway to both ongoing care and crisis services and supports,

**Then**, families will be able to **move away from the multiple, typically confusing paths** they must deal with today and **into a true System of Care that works for them**.

**Overarching Goal:** Our children and families will become **healthier, more resilient, and ready to make plans for their futures**, including participation in the state's education system and our economy.

# We've been working on a plan to improve our System of Care.

**About one hundred Rhode Islanders have weighed in on the plan so far – and we're always looking for more input.**

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# System of Care Planning: A Public/Private Partnership:

Here are the Work Groups that have been meeting since May 2021, to help create the System of Care for Children and Youth Plan.

**Public/private workgroups, each co-led by a state and community representative:**

1. Prevention (began in July)
2. Crisis Continuum - Mobile Response and Stabilization Services/Single Point of Access
3. Increasing the Children's Service Array
4. Creating Care Coordination
5. Ensuring Equity: Race Equity, Families Members with IDD, and LGBTQ+ Families
6. Workforce Transformation
7. Community Outreach and Education
8. Data Systems for Outcome Measurement & Evaluation

# And here’s how all the parts of the plan come together:

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# Rhode Island Children's Behavioral Health System of Care
## System Components & Connectors

Ensuring Racial Equity & Eliminating Disparities

Sustainable & Braided Funding

Universal Screening and Prevention Activities, with a Focus on the Social Determinants of Health

Single Point of Access for the system, with No Wrong Door

Data Systems for Outcome Measurement and Evaluation

**System of Care Key:**
Program Components
Foundational Components
Connector Components

Mobile Crisis

Care Coordination

Home & Community-Based Services

Residential

Significant Investment in Workforce Transformation

Strong Community Outreach & Family Engagement

# Want to read more?

Here is a link to the current

Rhode Island System of Care Plan for Children and Youth.

Or go to the **Children's Behavioral Health System of Care Initiative** on the EOHHS Website: https://eohhs.ri.gov/initiatives/childrens-behavioral-health-system-care

Contact Ellie Rosen for more information or to get on our distribution list: Ellie.Rosen.CTR@ohhs.ri.gov

# Q&A #1

- How can we best support Integrated Behavioral Health principles in the plan?
- What should we know about primary care workflows, in order to align with the System of Care?
- What else should we know?

# Adult System Transformation - Certified Community Behavioral Health Clinics

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# Faulkner Behavioral Health System Review

Initial Focus:

1. System Concerns
2. Gaps
3. Significant Shortages
4. Moderate Shortages
5. Slight Shortage

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

1. Summary

**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<br>Hospital Diversion<br>State Sponsored Institutional Services<br>Nursing Home<br>Residential |
| | Moderate Shortages | Non-CMHC Outpatient Providers<br>Intensive Outpatient Programs<br>Dual Diagnosis Treatment<br>Crisis/Emergency Care<br>Inpatient Treatment<br>Home Care<br>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<br>Correctional SUD Transitional Services<br>Recovery Housing<br>Residential – High & Low Intensity* |
| | Moderate Shortages | Intensive Outpatient Services<br>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<br>Transition Age Youth Services<br>Residential Treatment for Eating Disorders** |
| | Significant Shortages | Universal BH Prevention Services<br>Hospital Diversion<br>State Sponsored Institutional Services<br>Nursing Home<br>Residential/Housing** |
| | Moderate Shortages | SUD Treatment<br>Enhanced Outpatient Services<br>Home and Community Based Services<br>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. |

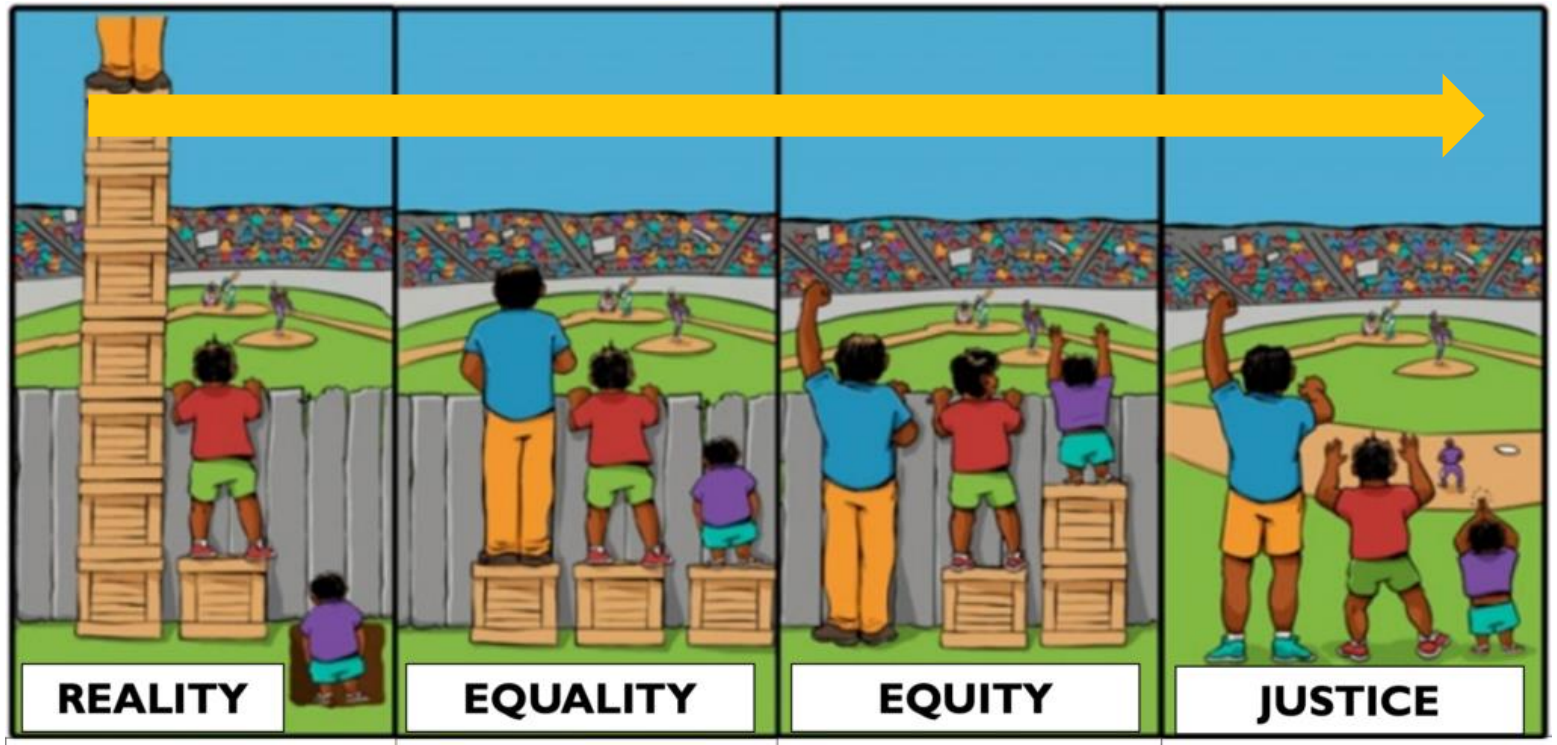
FCG Faulkner Consulting Group

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

HEALTH MANAGEMENT ASSOCIATES

# Embedding Behavioral Health Equity in System Reform

Everyone should have a fair and just opportunity to be healthy and achieve their full potential.




| REALITY | EQUALITY | EQUITY | JUSTICE |
|---|---|---|---|
| One gets **more than** is needed, while the other gets **less than** is needed. Thus, a huge disparity is created. | The assumption is that **everyone benefits from the same supports**. This is considered to be equal treatment. | **Everyone gets the support they need**, which produces equity. | All 3 can see the game without supports or accommodations because **the cause(s) of the inequity was addressed**. The systemic barrier has been removed. |

# System of Care Transformation Strategies

Our approach and theory of change for this Adult Behavioral Health System of Care Transformation proposal is based on the following strategic framework that was informed by the BH System Review Report:

I. **Improve capacity, alleviate social barriers, and close continuum of care gaps to treat mild to moderate to complex adult behavioral health conditions across the adult lifespan in RI.**

II. **Transform practices and behavioral health centers to provide high-quality, integrated, value-based, evidence-driven, and community-focused behavioral health services in the least restrictive settings.**

III. **Invest in prevention, equitable access, comprehensive addiction treatment, and necessary supportive services for vulnerable and marginalized populations.**

IV. **Forecast and address emerging needs and priorities that will challenge the existing and future systems.**

# Certified Community Behavioral Health Clinics (CCBHCs)

**Certified Community Behavioral Health Clinics (CCBHC):**

- Based on the Federal definitions within the Excellence in Mental Health Act.
- Designed to provide a de-institutionalized, comprehensive range of behavioral health (i.e., mental health, substance use) and social services to particularly vulnerable populations with complex needs across the life cycle.
- **CCBHCs are required to offer the following array of services:**
  - *Crisis mental health services, including 24-hour, mobile response teams, emergency intervention, and crisis stabilization;*
  - *Screening assessment and diagnosis, including risk management;*
  - *Patient-centered treatment planning within the least-restrictive and appropriate setting;*
  - *Outpatient mental health and substance use services;*
  - *Primary care screening and monitoring;*
  - *Targeted case management;*
  - *Psychiatric rehabilitation services;*
  - *Peer support, counseling, and family support services; and*
  - *Inter-system coordination and connections (e.g., other providers, criminal justice, developmentally-disabled, foster care, child welfare, education, primary care, community-based, etc.).*

# Statement of Need/Identified Gap: Why CCBHC

## RI BH Gaps Identified

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

## Goals Addressed by CCBHC Model

a) Expanded access to evidence-based assessment, treatment, and referral

b) Focus on equity issues

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

d) Coverage throughout the state for all ages

e) Emphasis on MH/SUD care in one location

f) Required 24/7 mobile crisis services

g) Focus on community-based intervention

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

i) Maximize federal support in the form of matching funds or other revenue opportunities.

## 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

# Certified Community Behavioral Health Clinics (CCBHCs)

| Goal | A state-defined payment model based on historical rates and provider cost data that considers infrastructure and quality performance in alignment with state reform programs that drive the BH system toward value. |
|---|---|

## Principles

1. Measure & **link payment to outcomes**, quality performance & expanded system capacity across the continuum of BH care
2. **Advance Equity** - Include financial incentives that drive performance improvement for most at-need Rhode Islanders
3. Fund important **one-time and ongoing infrastructure** and workforce investments
4. **Transition away from FFS toward value-based payment** methodologies that sustainably support ongoing infrastructure and performance goals
5. **Maximize federal support** in the form of matching funds or other revenue opportunities
6. Manage revised payment model within Rhode Island **Medicaid's budgetary constraints**
7. **Align with other payment models and program investments** within Medicaid and across payors and the RI market

## Objectives

| | |
|---|---|
| **Services** | • Reimburse for services that are currently not billable outside of the health home (IHH/ACT) model<br>• Fund expanded service offerings - specifically 24/7 mobile crisis |
| **Populations** | • Address IHH/ACT "cliff"- encourage expanded services to be provided to all populations – not just complex, HH eligible (IHH/ACT participants)<br>• Include kids in the CCBHC care delivery model and funding model |
| **Providers** | • Enable expanded provider participation<br>• Encourage CMHOs to become CCBHCs, support non-CMHO BH providers who may wish to become CCBHCs |
| **Other** | • Build in mechanisms to address variation in services, delivery model for specified populations<br>• Address reporting gaps of a bundled payment model<br>• Keep it simple |

# CCBHC Program Model: RI Specific Considerations

Rhode Island's CCBHC model, based on definitional standards codified in the Mental Health Excellence Act and implemented by SAMHSA, will address challenges of treatment access; health and racial equity; consistency of quality of care; workforce capacity; integration and coordination of MH/SUD, medical and CBO services; and community engagement.

**Critical design elements to address RI-specific gaps include:**

1. Requirement to **treat all ages** (children to adults) **at every level of acuity**, including prevention.
2. Requirement to provide directly or provide access to **24/7 mobile crisis services**.
3. Requirement to **increase provider training in health equity and racial equity**, with specific emphasis on increasing numbers of linguistically and culturally competent providers, including non-licensed providers with lived experience.
4. Strong emphasis on provision of **evidence-based MH and SUD services**.
5. Emphasis on provision of MH and SUD services in **one service location**.
6. Increased **integration/coordination of BH and medical services**.
7. Increased **integration/coordination of BH and CBO services** to address SDOH.
8. Increased **integration/coordination of BH and IDD services.**
9. Require **Patient and Family Advisory boards as part of governance structure**, which also factor in specific demographic representation to match the community being serviced.
10. Require **participation in Health Equity Zones** or other place-based initiatives.

# The Evidence is Compelling

**There are multiple studies providing substantive evidence in support of CCBHC and mobile crisis savings opportunities.**

## Overall CCBHC Model Savings (Inclusive of Mobile Crisis)

### Emergency Department

**New York Case Study[1]**
- 26% decrease in BH ED service monthly cost
- 30% decrease in ED health services monthly cost

**Missouri Case Study[1]**
- 75% decrease in ED services after Year 1

**SAMHSA[2]**
- 62% decrease in ED visits for program participants as of Jan 2020 (3-yr program)

### Inpatient Hospitalization

**New York Case Study[1]**
- 27% decrease in BH inpatient service monthly cost
- 20% decrease in inpatient health services monthly cost

**Missouri Case Study[1]**
- 83% decrease in hospitalizations after Year 1

**SAMHSA[2]**
- 62% decrease in IP stays for program participants as of Jan 2020 (3-yr program)

## Mobile Crisis Savings

### ED/IP

**NIH Study[3]**
- Youth who used a Mobile Crisis service were 22% less likely to have a subsequent BH ED visit

**Connecticut Case Study[4]**
- Youth who used a Mobile Crisis service were 25% less likely to have a subsequent BH ED visit

**Psychiatric Services Journal[5]**
- Community-based crisis intervention reduced hospitalization rates by 8 percentage points.


Sources:
[1] Certified Community Behavioral Health Clinics (CCBHC), *The New Model for Mental Health and Addiction Care Gaining Momentum in States*, January 29, 2021, National Council for Behavioral Health
[2] SAMHSA FY 2021 - *Justification of Estimates for Appropriations Committees*
[3] NIH, *Impact of Mobile Crisis Services on Emergency Department Use Among Youths with Behavioral Health Service Needs*, October 2019
[4] Child Health and Development Institute of Connecticut, *Evaluation of Connecticut's Mobile Crisis Intervention Services*, 2018
[5] Psychiatric Services Journal, February 2001 Vol. 52, No. 2

# Certified Community Behavioral Health Clinics (CCBHCs) Summary

| | |
|---|---|
| Initiative Summary | CCBHC is a federally defined service delivery model that will address identified gaps in Rhode Island's behavioral health system and improve BH and SUD-related outcomes for Rhode Islanders. The State is proposing to establish and sustain a network of these community-based behavioral healthcare providers who, through this model, will be obligated to ensure consistent access to a defined set of non-hospital outpatient behavioral health services. Our overall goal for CCBHCs is to strengthen our community-based behavioral healthcare system. |
| Funding Recipients | Eligible BH organizations will be able to be certified as full CCBHCs. Other organizations can partner with CCBHCs as Designated Collaborating Organizations (DCOs). Funds will be allocated via: a) CCBHC service base rate, b) quality performance, and c) infrastructure incentives. |
| Problem Diagnosis and Connection to Hospital Capacity | The recently completed Rhode Island Behavioral Health System Review identified that 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. These challenges, plus issues of 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, all call for system changes. (Please see the System Review for more details.) These burdens also have a negative impact on hospital capacity throughout the state, leading to overcrowding. The System Review identified CCBHCs as the service delivery innovation most likely to address the greatest number of challenges - and the State sees the value in ensuring adequate community-based services to help prevent the need for hospital-level services for patients who should get help elsewhere. |
| Benefits of the Model | • SAMHSA study revealed a 62% decrease in ED visits for program participants as of January 2020 (three-year program)<br>• SAMHSA study also revealed a 62% decrease in Inpatient stays for program participants as of January 2020 (3-year program)<br>• Missouri has seen a 75% decrease in ED services and 83% decrease in hospitalizations after Year 1<br>• New York has seen BH ED, ED Health Services, BH Inpatient, and Inpatient Health Services Costs decrease by 20-30% monthly |
| Community Engagement | The Behavioral Health System Review included qualitative research with close to 100 individuals and BH experts. EOHHS has also been working with a group of providers throughout the implementation discussions and is preparing to expand that community partner group with extensive additional outreach. Additional CCBHC information sessions will be made available. |

# Other Supportive Service Enhancements

- **Residential Substance Use Disorder and Mental Health Bed Capacity**
  - Example: ASAM Level 3.1 and 3.3
- **Specialized Mental Health Psychiatric Rehabilitative Residences**
- **Housing Stabilization and Supportive Housing Services**
  - Example: Homeless Response Teams, Recovery Housing, and Respite Services
- **Other Non-CCBHC Practice Transformation**
  - Example: Integrated Behavioral Health for MAT Providers, SBIRT Integration, Small Practices
- **Home- and Community-Based Behavioral Health Supportive Infrastructure**
  - Example: Mobile Crisis and 988 Integration, Harm Reduction Systems and Street Outreach, Adult PRN
- **Older Adult, Veteran, and Geri-Psych Behavioral Health Services**
  - Alzheimer's, Dementia, and Geri-Psych Services and Enhancements, Veterans Behavioral Health Prevention and Supports
- **Adult Behavioral Health and Addiction Prevention and Recovery**
  - Example: Comprehensive Suicide Prevention, Recovery Community Center Expansion, Imani Breakthrough Project

# Q&A #2

- What are the ways that you'd want to engage with or refer to CCBHCs?
- What should we know about primary care workflows, in order to align with CCBHCs?
- What else should we know?

# Thank you!!

RHODE ISLAND

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

# Thank you
# Stay Healthy and Safe

*Final Quarterly Pediatric IBH Meeting: April 14, 2022*