Governor's Council on Behavioral Health

Briefing: Behavioral Health System Review Report – Draft Findings and Recommendations

March 11, 2021

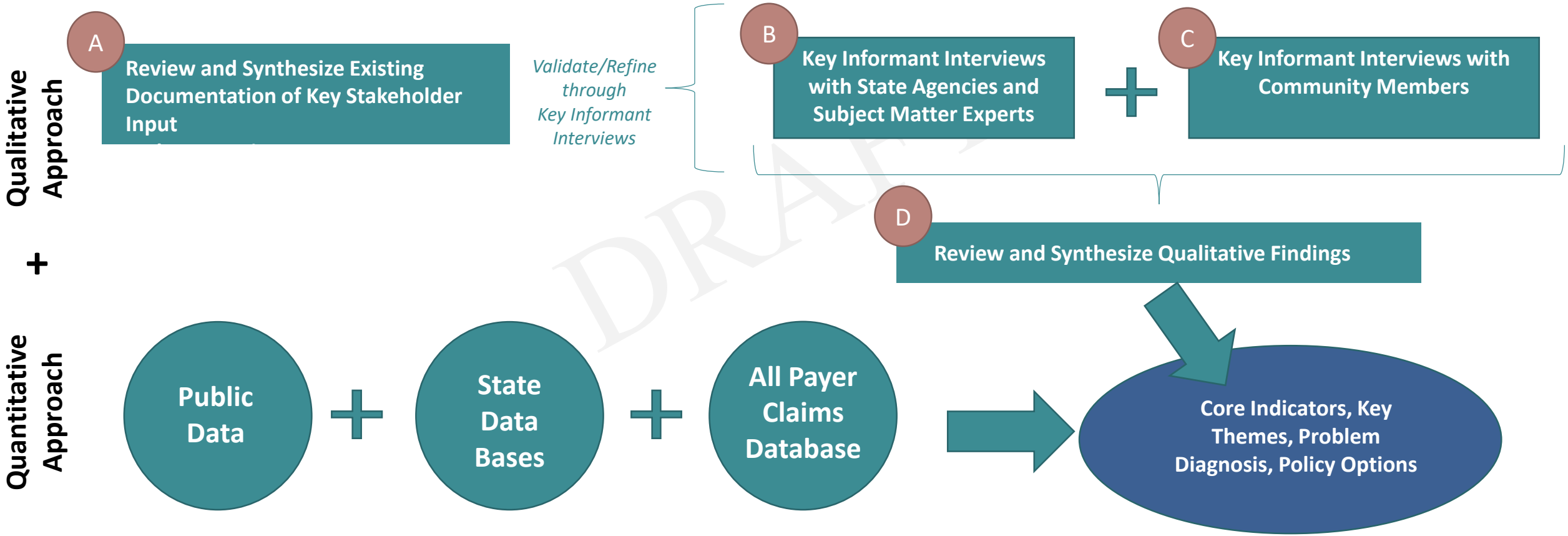
FCG Faulkner Consulting Group

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 BH Study

The team informed key themes and findings through **a mixed methods approach**, including **qualitative work engaging stakeholders** from both state agencies and the community, as well as a **quantitative assessment** of 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, the following findings have emerged:
    1. 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.
    2. Underlying drivers that perpetuate the challenges described above include:
        a. 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.
        b. Payments for behavioral health services largely rely on a fee-for-service chassis that does not account for quality or outcomes.
        c. 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.
- **Policy Recommendations:** Based on our findings, we have identified closing the gap in mobile crisis services & advancing CCBHC as priority policies to address system gaps and challenges identified in our analyses. 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 "quick win" opportunities identified through stakeholder engagement.

"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).

FCG Faulkner Consulting Group

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

HEALTH MANAGEMENT ASSOCIATES

"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.

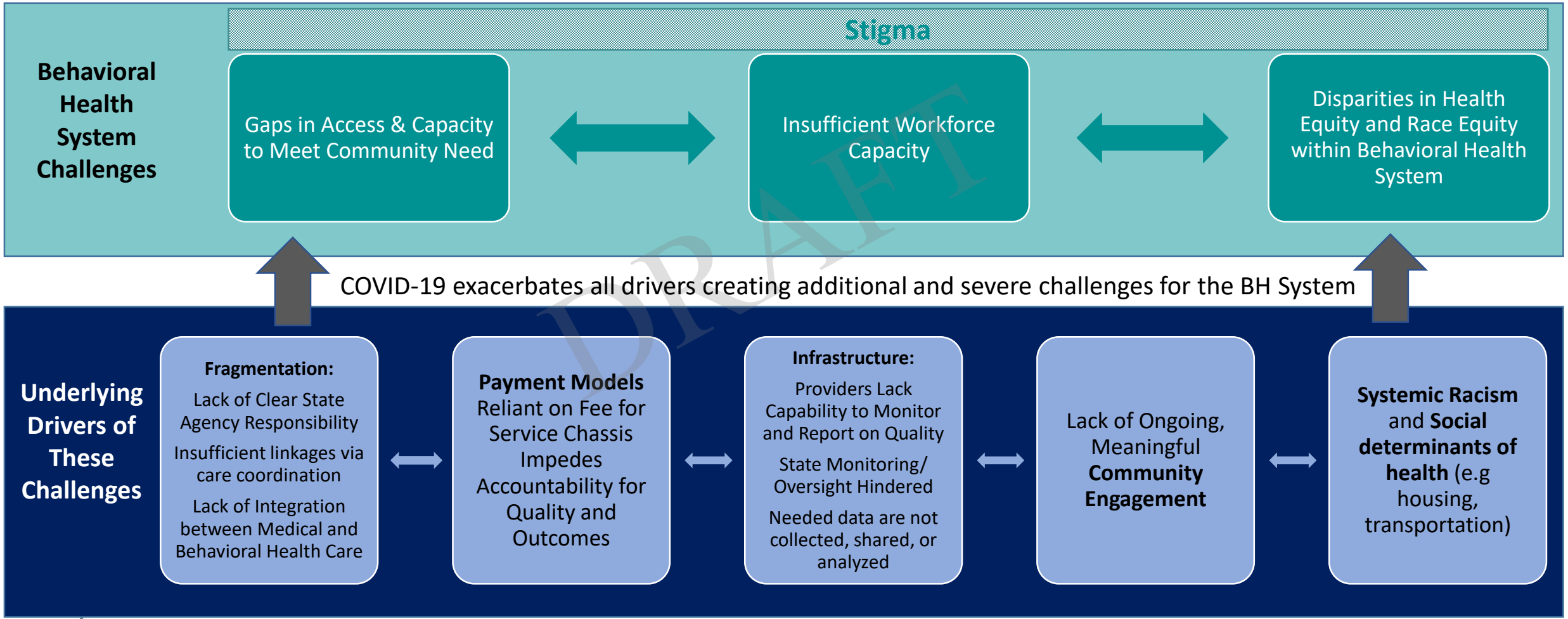
FCG Faulkner Consulting Group

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

HEALTH MANAGEMENT ASSOCIATES

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	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 Centers

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

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. Qualitative feedback showed that individuals need acute level of services. Our recommendation is *not* to build additional inpatient capacity, rather to invest resources in better community support to alleviate the bottleneck for 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.

*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.

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

Foundational Services That Can 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.

Principles To Drive and Prioritize Solutions

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

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

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

4. **Invest in sustainable solutions**, including 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.

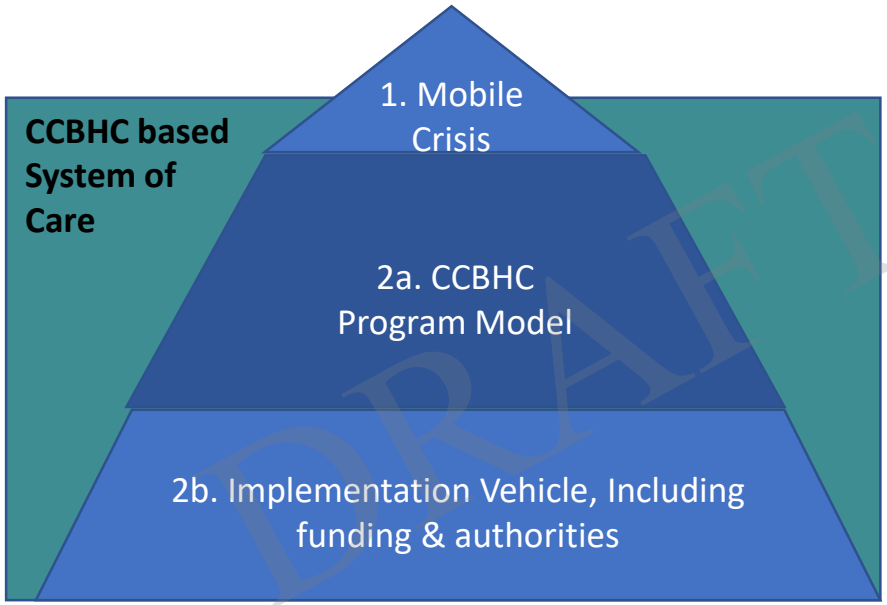
Recommendation: Develop Implementation Plans for Synergistic Policies

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 a central part of CCBHC

- Prioritize critical capacity gap identified in Task 1 AND
- Enable the efficient implementation of CCBHC.
  - Reduce the 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.

Focus Areas:



2a. Program Model Design for CCBHC

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

- Ensure that the plan also discusses an approach to payment for outcomes for CCBHC participants.
  - Will include base requirements (to the extent applicable to gaps/needs RI driven by gap/need analysis) and any modifications/additions determined necessary to address RI's unique needs.
  - The plan will include programmatic design, including required staffing, governance, care coordination, and 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-term and long-term financing options and phased implementation model.
  - Plan will include specific agency grants, congressional appropriations, state plan amendment, waiver options, and demonstration programs. Will 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.