CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Impact of Alcohol Use Disorders on Health and Costs in RI

CLINICAL STRATEGY COMMITTEE FEBRUARY 15, 2024

Agenda

ADVANCING INTEGRATED HEALTHCARE

Item	Time
Welcome & Announcements ***Pano Yeracaris, MD, MPH, Chief Clinical Strategist, CTC-RI***	5 min
Rhode Island Alcohol Proposal ***Moderator: Andrew Saal, MD MPH, Public Health Consultant*** ***Barry Fabius, Chief Medical Officer, UnitedHealthcare Community Plan of Rhode Island*** Thundermist Health Center ***Matt Roman, MBA, LICSW, Chief Operating Officer, Thundermist Health Center*** ***Elizabeth Lynch, LICSW, AVP of Behavioral Health and Social Services*** ***Christopher McManus, MHA, CSSBB, EMHL, FACHE, Program Director, Value-Based Care***	40 min
Certified Community Behavioral Health Clinics (CCBHC) Discussion ***Marti Rosenberg, Director of Policy, Planning, and Research, Executive Office of Health and Human Services*** ***Amy Hulberg, Medicaid Policy Director, Rhode Island Executive Office of Health and Human Services*** Discussion & Questions	45 min

Objectives

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
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ADVANCING INTEGRATED HEALTHCARE

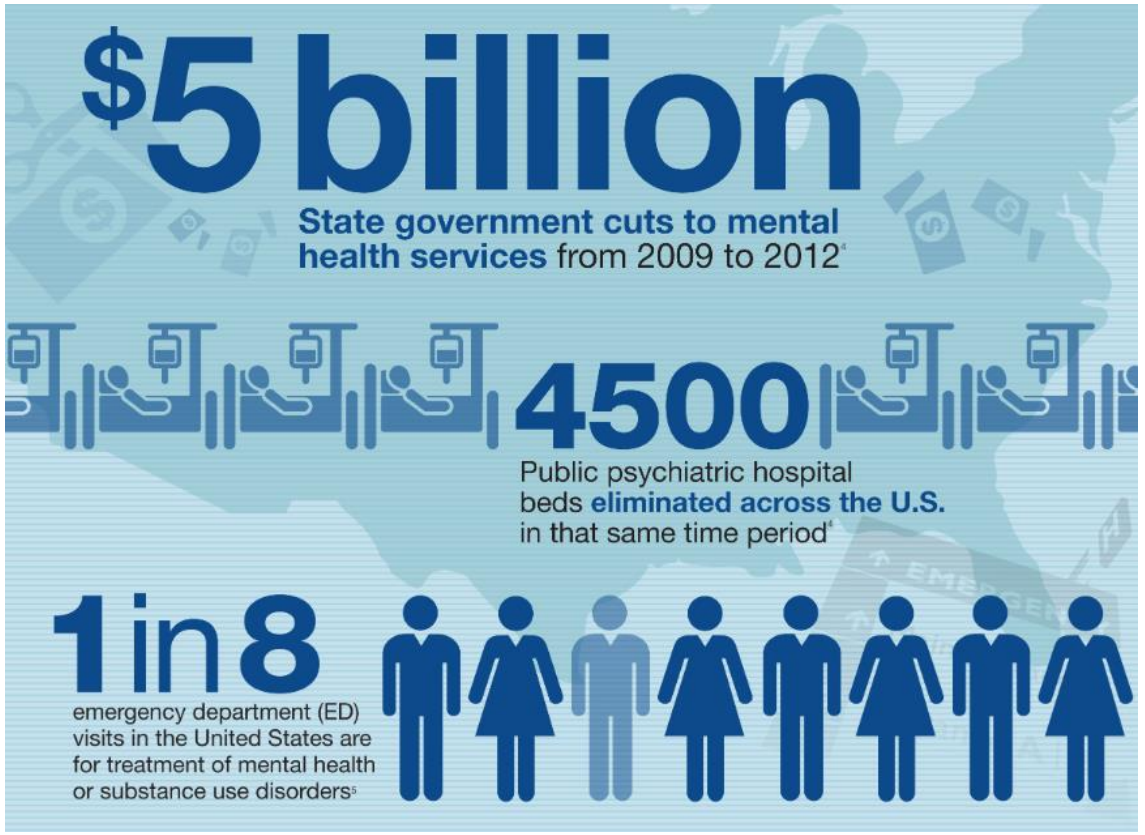
1. Reflect on the impact of alcohol use disorders in health and healthcare costs in Rhode Island and discuss

2. Learn about plans for Certified Community Behavioral Health Clinics (CCBHCs) in Rhode Island

3. Consider opportunities to leverage CCBHC partnerships with primary care systems of care

American Healthcare 101

- Historically, funding has varied with the priorities of each federal administration
- Reimbursement model is based on ***episodic***, not longitudinal care
- The Behavioral and Medical systems in the United States are both highly fragmented
- And… they don't communicate well with each other



- Grainger Healthcare

Behavioral Health? Think Medicaid

Medicaid pays for ~25% of all mental health services in the US. [1]

Medicaid is the largest payer of mental health care in the country. [2]

Medicaid covers a disproportionate number of patients with SPMI and substance abuse conditions than commercial insurance.

Adult Medicaid beneficiaries are 90% more likely to have conditions such as major depression or schizophrenia [3]

1 Mark TL, Yee T, Levit KR, Camacho-Cook J, Cutler E, Carroll CD. Insurance financing increased for mental health conditions but not for substance use disorders, 1986–2014. Health Aff (Millwood). 2016; 35(6):958–65.

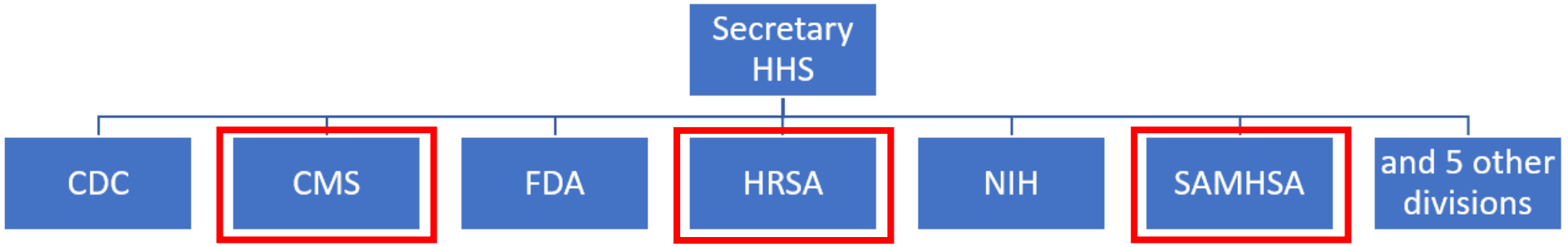
2 Mark TL, Levit KR, Yee T, Chow CM. Spending on mental and substance use disorders projected to grow more slowly than all health spending through 2020. Health Aff (Millwood). 2014;33(8):1407–15.

3 Medicaid and CHIP Payment and Access Commission. Report to Congress on Medicaid and CHIP [Internet]. Washington (DC): MACPAC; 2021 Jun [cited 2022 Dec 6]. Available from: https://www.macpac.gov/wp-content/uploads/2021/06/June-2021-Report-to-Congress-on-Medicaid-and-CHIP.pdf

Separation of Mind and Body

For better or worse, the concept is now hardwired into:

- Western Philosophy
- Federal and State Bureaucracies
- Medical Education
- Healthcare Financing



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Health Resources & Services Administration
HRSA

U.S. Department of Health & Human Services
SAMHSA
Substance Abuse and Mental Health Services Administration

What could possibly go wrong?

Who Would Have Thought That Health Care Could Be So Complicated?

- **Social Stigma**
- **Parallel delivery systems that don't communicate easily or well**
- **Fragmented financing and regulatory oversight**
- **Fragmented payor mechanisms**
  - Heavily Medicaid… with many "dual-eligible" patients (Medicare + Medicaid)
  - Complex billing pathways
  - Expensive chronic conditions and medications
  - *Frequent ER over-utilization and hospitalization secondary to…*

Human Behavior in Complex Healthcare Systems

- Whenever a person cannot easily access primary care services, the path of least resistance is to go to…
- Whenever a person faces a barrier to one of the social determinants of health, the path of least resistance is to go to…
- And if they don't have access to reliable transportation, they…

Alcohol Use Disorders and Population Health

Rhode Island AE Inpatient and Emergency Room Trends

United Healthcare

Summary

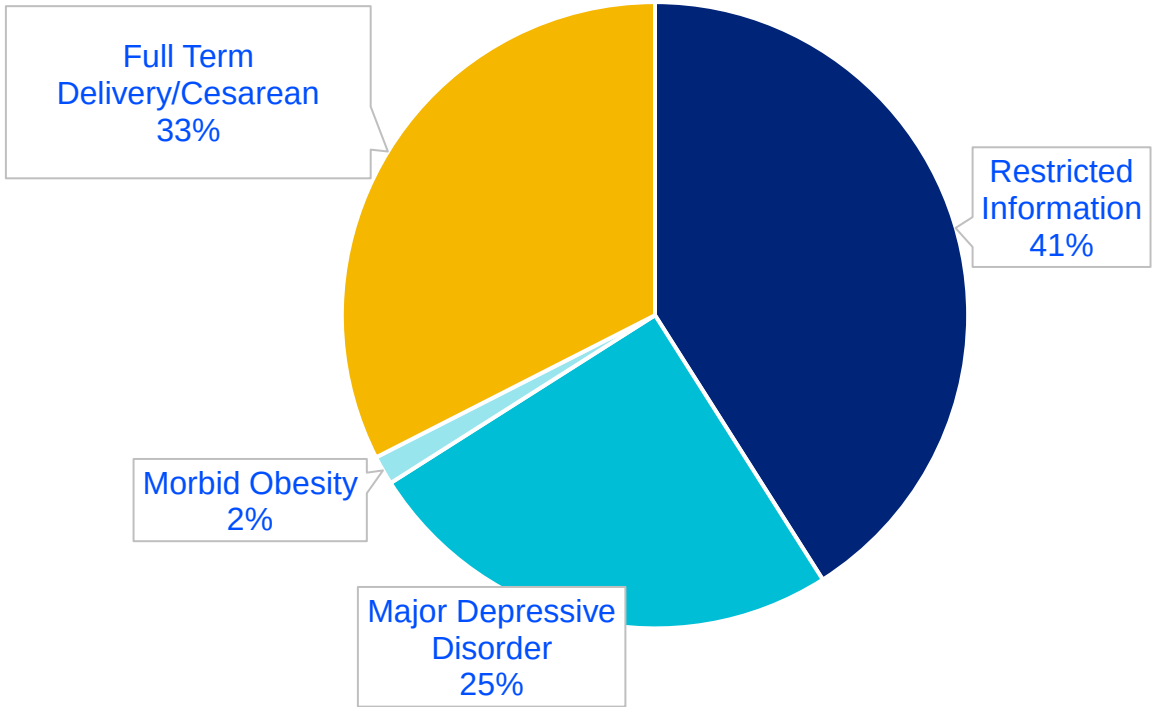
Inpatient

- ❑ Total of 5,888 Admits in 2023 across 6 Rhode Island Accountable Entities
- ❑ 17% were Readmits within 30 Days

Emergency Room

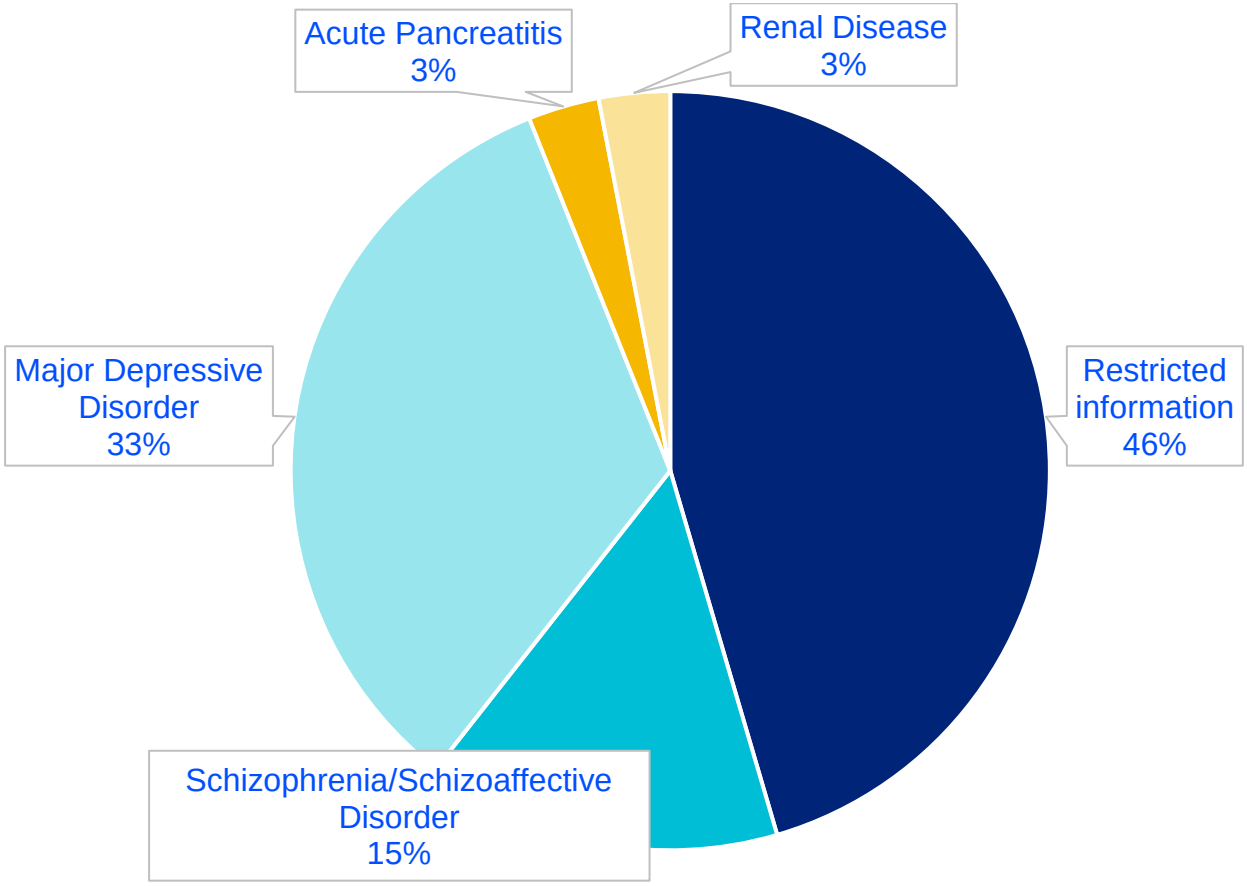
- ❑ 24,989 Emergency Room Visits
- ❑ 5% were Avoidable ER Visits

Top Admits by Diagnosis



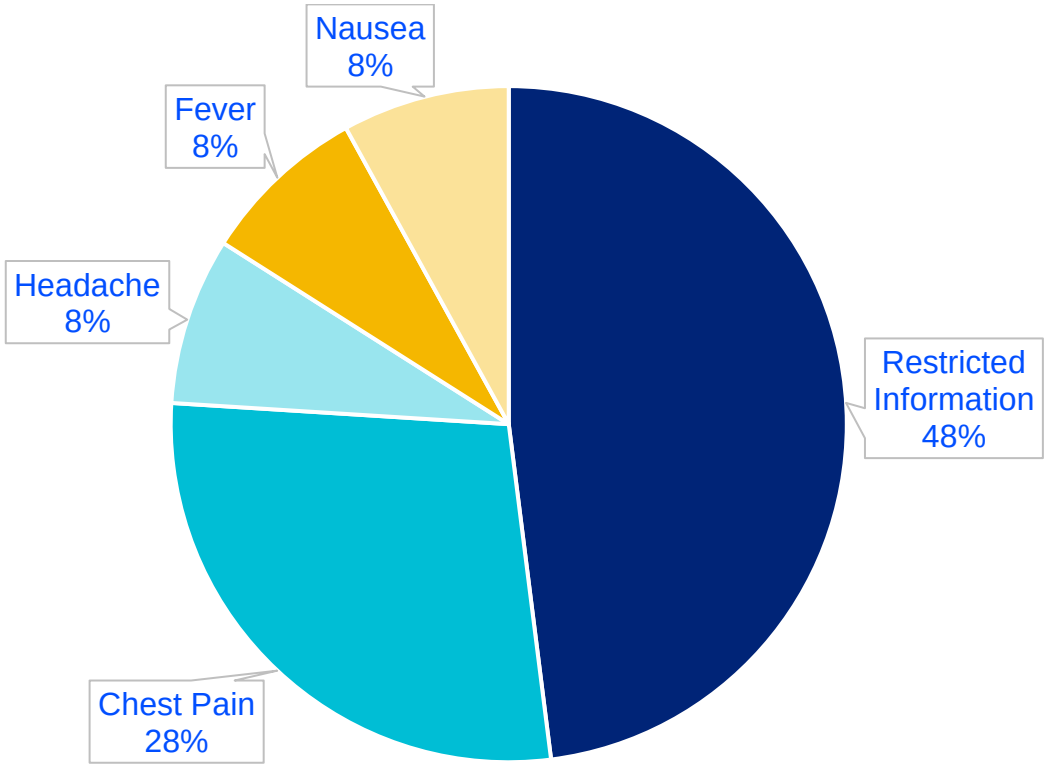
Data source: December 2023 iPCA Scorecard

Top Readmissions within 30 Days by Diagnosis



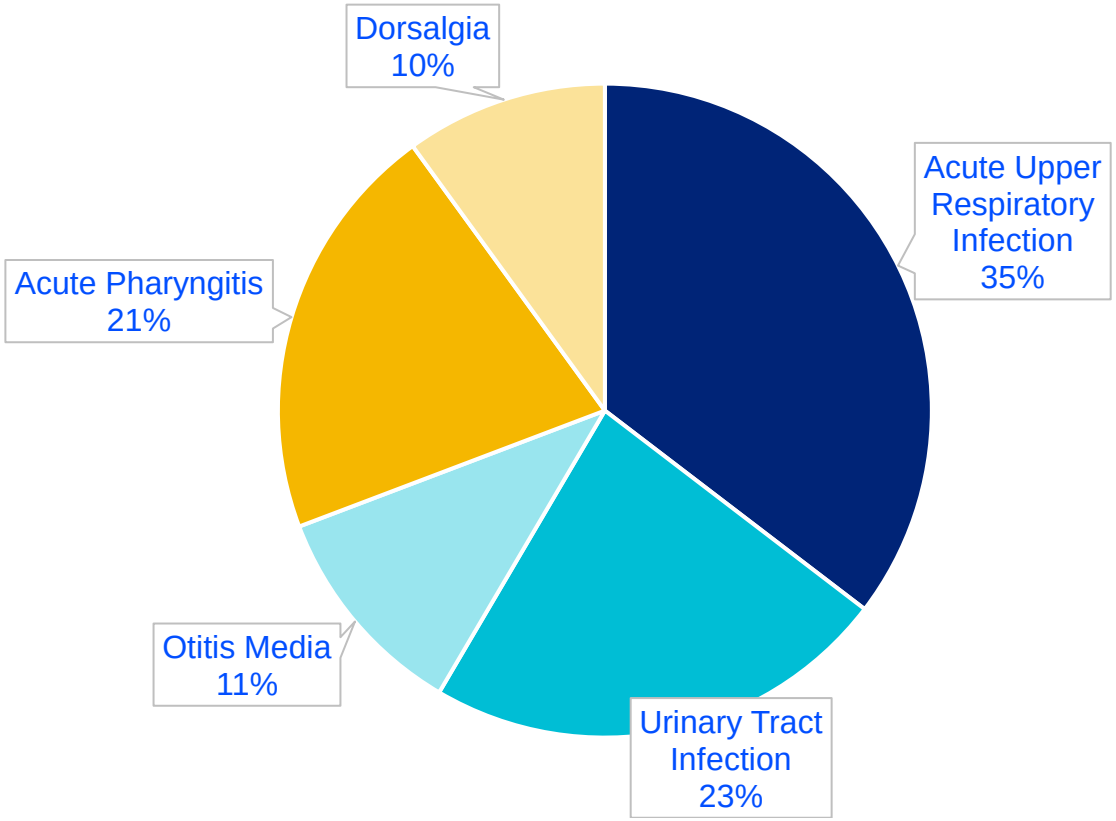
Data source: December 2023 iPCA Scorecard

Top ER Visits by Diagnoses



Data source: December 2023 iPCA Scorecard

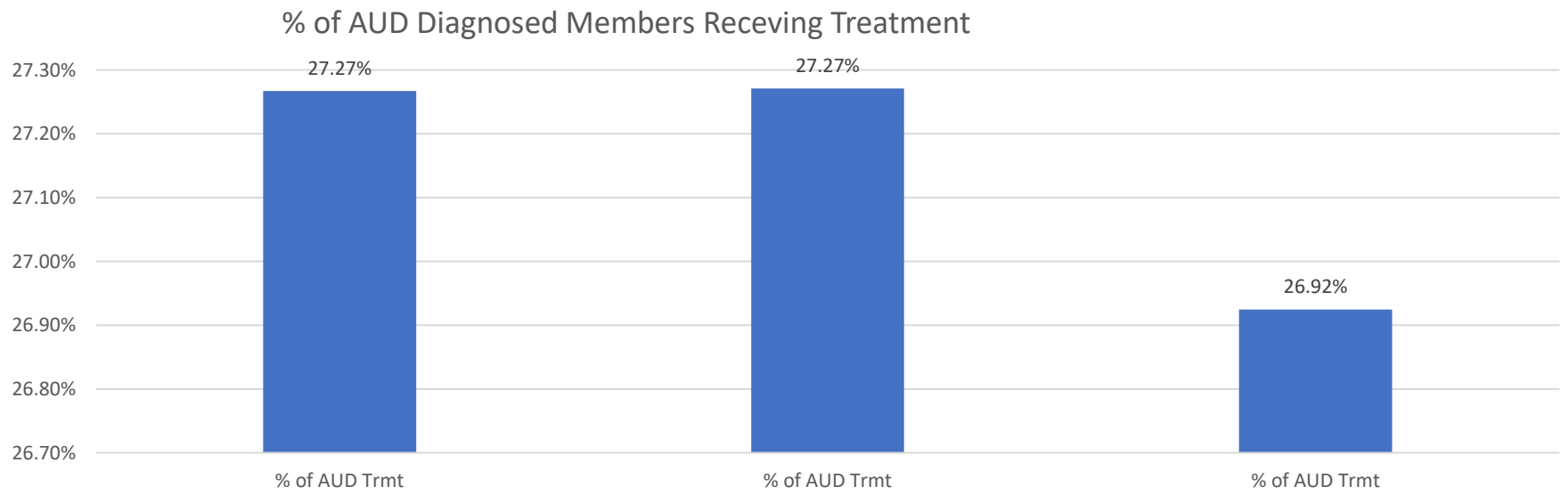
Top Avoidable ER Visits by Diagnosis



Data source: December 2023 iPCA Scorecard

AUD w/Treatment

C&S Codes	Q42020 - Q32021			Q42021 - Q32022			Q42022 - Q32023		
	Total AUD	AUD w Trmt	% of AUD Trmt	Total AUD	AUD w Trmt	% of AUD Trmt	Total AUD	AUD w Trmt	% of AUD Trmt
UHGRI	4,951	1,350	27.27%	4,987	1,360	27.27%	5,430	1,462	26.92%



High Utilizers (reviewed 100 cases)

- Reviewed members with 2 or more IP admissions with a "restricted information" diagnosis
  - 80% had AUD
- Reviewed members with 3 or more ER admissions with a "restricted information" diagnosis
  - 100% had AUD ER admits

A Pervasive Problem

Alcohol use disorders are linked to some of the most frequent conditions treated in emergency rooms – particularly ambulatory sensitive conditions (ASC) – medical and behavioral conditions potentially better treated in outpatient facilities instead of emergency rooms[1,2]

Even when alcohol is not listed as the main reason for an emergency room visit, it is often ***"the cause behind the cause"*** of the patient's acute condition[2,3]

1 LaCalle E, Rabin E. *Frequent users of emergency departments: the myths, the data, and the policy implications.* Ann Emerg Med. 2010;56(1):42–8. https://www.annemergmed.com/article/S0196-0644(10)00105-8/fulltext

2 Giannouchos TV, Kum H-C, Foster MJ, Ohsfeldt RL. *Characteristics and predictors of adult frequent emergency department users in the United States: a systematic literature review.* J Eval Clin Pract. 2019;25(3):420–33. https://onlinelibrary.wiley.com/doi/10.1111/jep.13137

3 Pham JC, Bayram JD, Moss DK. *Characteristics of frequent users of three hospital emergency departments.* Agency for Healthcare Research and Quality; 2017. https://www.ahrq.gov/patient-safety/settings/emergency-dept/frequent-use.html

HEALTH BY NUMBERS

UTPALA BANDY, MD, MPH
INTERIM DIRECTOR, RHODE ISLAND DEPARTMENT OF HEALTH
EDITED BY SAMARA VINER-BROWN, MS

PUBLIC HEALTH

Deaths Involving Fully Alcohol-Attributable Chronic Conditions in Rhode Island: 2018–2022

EMILY M. LEDINGHAM, MPH, MA; KRISTEN ST. JOHN, MPH; BENJAMIN D. HALLOWELL, PhD

3.5% of all deaths are ***directly*** attributable to alcohol, an average of 367 deaths per year between 2018 – 2022

This number underestimates the total since alcohol-*related* chronic diseases were not included in this survey

The number of deaths directly attributable to alcohol has increased among women and individuals 65+

A disproportionate burden of deaths involves veterans and individuals who are divorced/separated

Ledingham, E. St. John, K. Hallowell, B. “Deaths Involving Fully Alcohol-Attributable Chronic Conditions in Rhode Island: 2018–2022.” *Rhode Island Medical Journal*, 2023 (11). https://health.ri.gov/publications/reports/alcohol-attributable-chronic-conditions-deaths.pdf

Additional Costs When Someone with a Chronic Disease Also Has a Co-Occurring Mental Health Disorder

	PPPY Without MH	PPPY With MH	Cost of Co-Occurring Condition [10]
Heart Condition	$4,697	$6,919	**+ $2,222**
High Blood Pressure	$3,481	$5,492	**+ $2,011**
Asthma	$2,908	$4,028	**+ $1,120**
Diabetes	$4,172	$5,559	**+ $1,387**

PCMH Congress

10. Corso, K.A., Hunter, C.L., Dahl, O., Kallenberg, G.A and Manson, L. (2016) **Integrating Behavioral Health into the Medical Home: A Rapid Implementation Guide.**

Healthcare Systems Sharing Patient Information - 2024

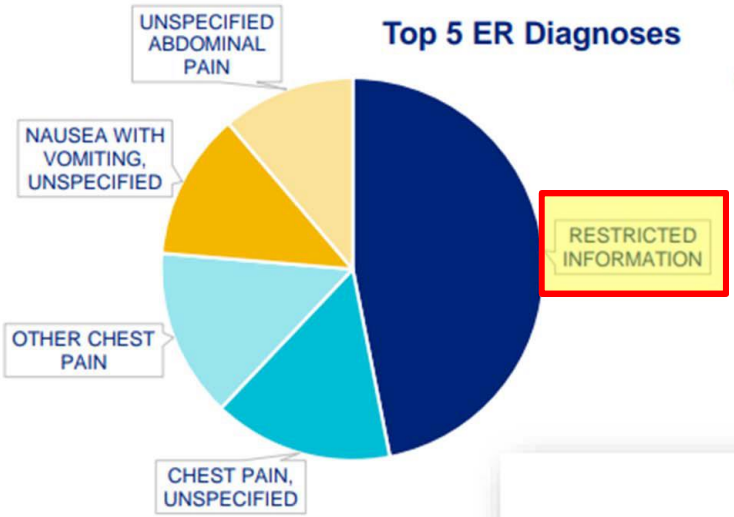
Thundermist!
HEALTH CENTER

Alcohol and SUD impacts in ED and Inpatient Utilization for Thundermist Accountable Entity

January 2024

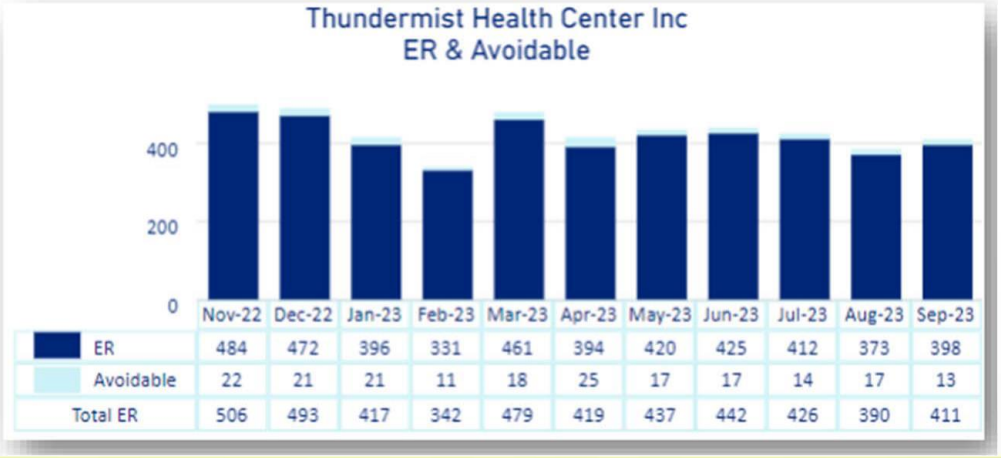
Thundermist/UHC ED Utilization

Total Population: ~7,915 patients / Dates of Service: 10/18/2022 to 10/08/2023



Observations:

- 38 members with 10 or more ER visits
- Members with 10 or more visits accounted for 726 ER visits
- 702 ER Visits for Restricted Information, MI, SUD Dx – accounting for 14% of the total ER Visits
- Avoidable ER 4%

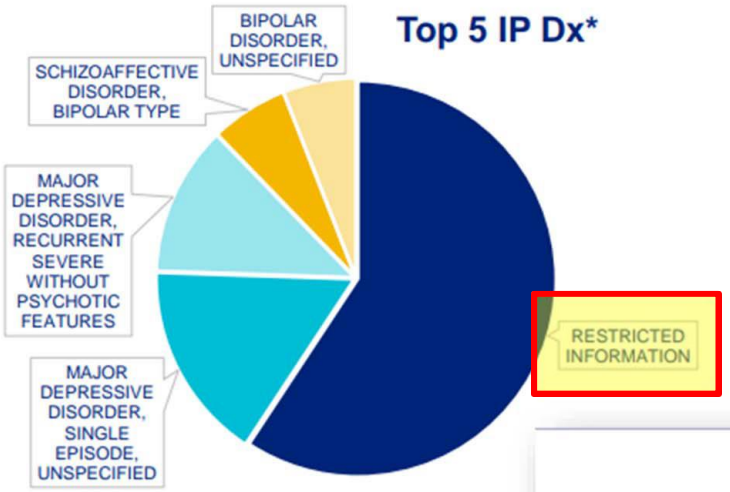


	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
ER	484	472	396	331	461	394	420	425	412	373	398
Avoidable	22	21	21	11	18	25	17	17	14	17	13
Total ER	506	493	417	342	479	419	437	442	426	390	411

Thundermist HEALTH CENTER

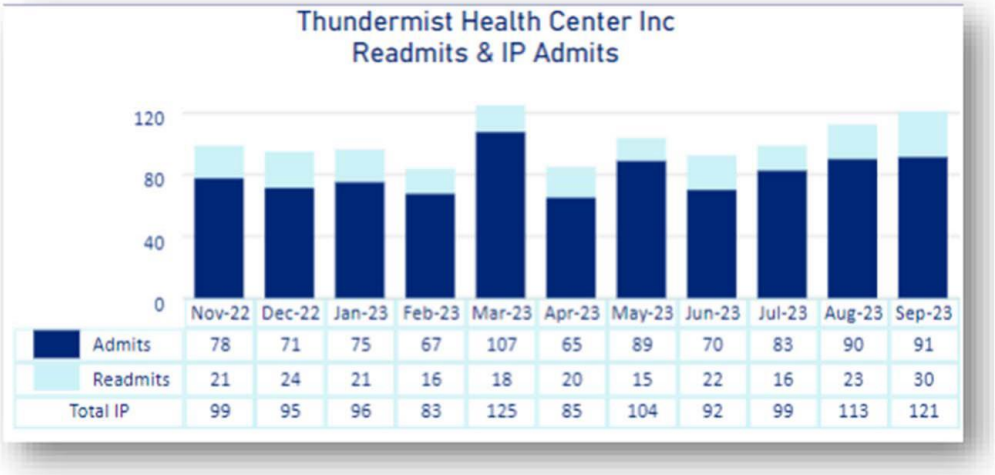
Thundermist/UHC Inpatient Utilization

Total Population: ~7,915 patients / Dates of Service: 10/18/2022 to 10/08/2023



Observations:

- 1229 Total IP Admissions
- Top 5 IP Dx are Restricted and Mental Illness
- 92 Admissions for Ambulatory Care Sensitive Conditions. Top 3 Conditions – COPD, Pneumonia, Acute Kidney Failure.
- 10 Members with 10 or more admissions accounted for 138 total admissions



	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Admits	78	71	75	67	107	65	89	70	83	90	91
Readmits	21	24	21	16	18	20	15	22	16	23	30
Total IP	99	95	96	83	125	85	104	92	99	113	121

Thundermist HEALTH CENTER

Thundermist/NHPRI ED Utilization

Total Population: ~19,110 patients / Dates of Service: July 2022 to June 20, 2023

Table SummER 1.1: Top 10 Diagnosis Categories Driving ER Volume

Diagnosis Category	# Visits	# Members	Total Paid	Average Paid/Visit
Abdominal pain & other digestive/abdomen symptoms	611	506	$442,804	$725
Sprains and strains, initial encounter	436	417	$211,341	$485
Alcohol-related disorders	433	206	$286,997	$663
Nonspecific chest pain	367	325	$273,270	$745
Superficial injury; contusion, initial encounter	364	349	$208,094	$572
Musculoskeletal pain, not low back pain	350	324	$189,797	$542
Other specified upper respiratory infections	304	285	$158,089	$520
Viral infection	294	268	$148,524	$505
Other specified complications in pregnancy	264	164	$155,411	$589
Headache; including migraine	261	206	$184,524	$707

Table SummER 3.1: Top 5 Diagnosis Categories Driving ER Volume Among the Mentally Ill

Diagnosis Category	# Visits	# Members	Total Paid	Average Paid/Visit
Alcohol-related disorders	383	166	$257,728	$673
Abdominal pain and other digestive/abdomen signs and symptoms	339	268	$254,058	$749
Nonspecific chest pain	211	186	$163,639	$776
Sprains and strains, initial encounter	196	181	$102,369	$522
Headache; including migraine	171	126	$124,434	$728

Alcohol use disorder is always our 2nd highest cost driving diagnosis and often our 1st or 2nd frequency driver for our NHP Population.

Thundermist HEALTH CENTER

Thundermist/NHPRI Inpatient Utilization

Total Population: ~19,110 patients / Dates of Service: July 2022 to June 20, 2023

Table SummIP 1.1: Top 10 Diagnosis Categories Driving Medical Hospital Admissions

Diagnosis Category	# Admissions	# Members	Total Paid	Average Paid/Admission
Liveborn	236	236	$352,763	$1,495
Alcohol-related disorders	68	34	$775,988	$11,412
Prolonged pregnancy	51	51	$349,406	$6,851
Septicemia	49	47	$1,124,308	$22,945
Hypertension with complications and secondary hypertension	39	36	$568,102	$14,567
Diabetes mellitus with complication	39	26	$372,848	$9,560
Obesity	36	36	$334,351	$9,288
Complications specified during childbirth	34	34	$244,180	$7,182
Previous C-section	32	32	$255,449	$7,983
Epilepsy; convulsions	31	23	$298,914	$9,642

Table SummIP 2.1: Top 5 Diagnosis Categories Driving Medical Hospital Readmissions

Diagnosis Category	# Admissions	# Members	Total Paid	Average Paid/Admission
Alcohol-related disorders	21	8	$247,793	$11,800
Septicemia	7	7	$140,430	$20,061
Respiratory failure; insufficiency; arrest	6	6	$110,753	$18,459
Diabetes mellitus with complication	6	5	$56,674	$9,446
Epilepsy; convulsions	6	4	$53,159	$8,860

Alcohol use disorder is always our 2nd highest cost driving diagnosis and often our 1st or 2nd frequency driver for our NHP Population.

Thundermist HEALTH CENTER

Questions?

Limited Information Exchange

- EHRs don't talk to each other
- **HIPAA** is the foundation of privacy
- **42-CFR** provides a higher-level of privacy for BH and SUD conditions

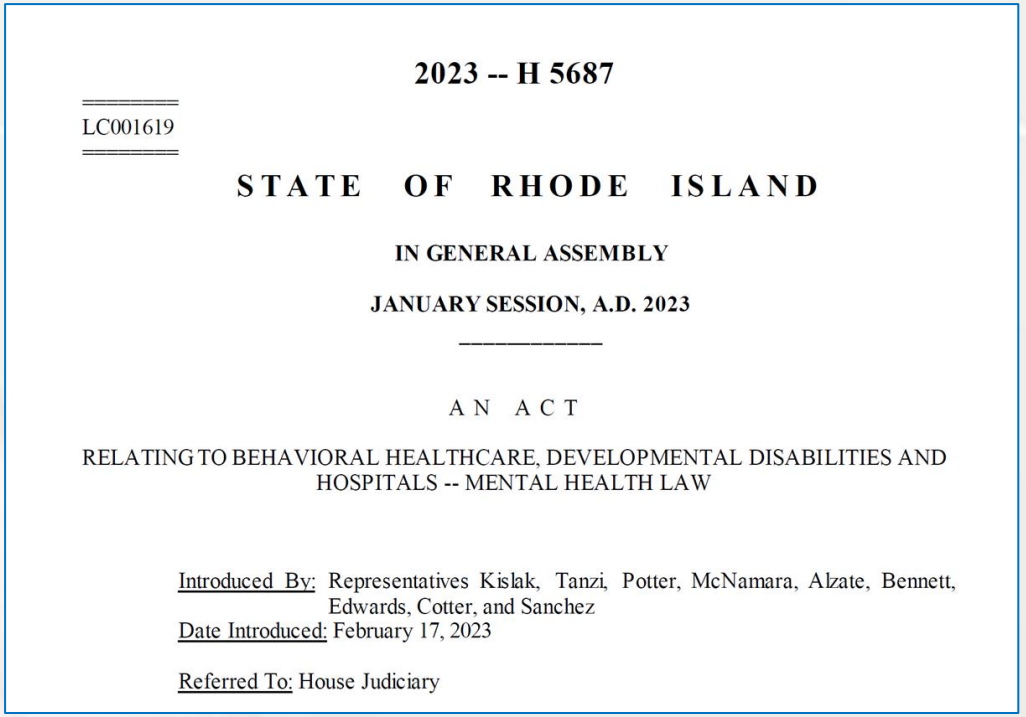
Net sum – Information doesn't flow easily to primary care

Trying to Bridge the Data Divide

Allows CurrentCare to Facilitate Sharing of Certain BH / SUD Information:

- **Diagnoses**
- **Medications**
- **Allergies**
- **Admissions / Discharges**

- **But *NOT* therapy notes**



2023 -- H 5687

LC001619

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2023

AN ACT

RELATING TO BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS -- MENTAL HEALTH LAW

Introduced By: Representatives Kislak, Tanzi, Potter, McNamara, Alzate, Bennett, Edwards, Cotter, and Sanchez
Date Introduced: February 17, 2023

Referred To: House Judiciary

Signed into law in 2023.
Now in rules-making process…

CTC-RI Alcohol Grant Proposal

Goals

- Foster dialogue between community partners and patients
- Share best practices
- Increase primary care resiliency to better manage patients with substance use disorders

Format – A Series of Virtual Discussions

- Primary Care Practices
- Community Partnerships
- Value-Based Care Organizations and Hospitals/First Responders
- Housing and SDOH Organizations

Identify and describe barriers and best practices.
Develop curriculum for a training series

Innovation and Hope

The Payment Mechanism Matters

- Fee-for-Service Is **Inflationary** and **Amplifies** Healthcare Disparities.
- Value-Based Care Empowers Population Health Strategies…
- And Vice-Versa

Medicaid Dollar Expenditures

Integrated Behavioral Health !

- IBH is a core strategy of value-based care
- “SBIRT” strategy - Universal screening for depression, anxiety, substance abuse
- Embedded counselor within the primary care clinic (warm hand-offs or expedited referral)
- CBT – Focused on resiliency and prevention

SBIRT = Screening, Brief Intervention, and Referral to Treatment

THE PRACTICE OF MEDICINE

By Lisa S. Rotenstein, Samuel T. Edwards, and Bruce E. Landon

Adult Primary Care Physician Visits Increasingly Address Mental Health Concerns

DOI: 10.1377/hlthaff.2022.00705
HEALTH AFFAIRS 42,
NO. 2 (2023): 163–171

Cause or Effect?

Visits that addressed mental health concerns increased from 10 percent in 2006 to 16 percent by 2016.

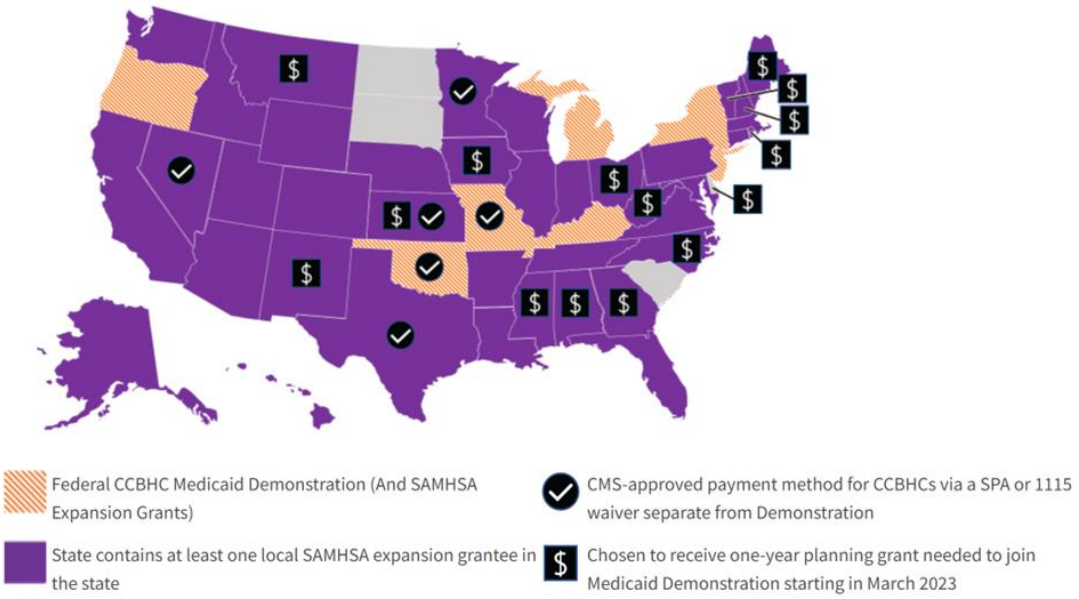
Black patients were 40 percent less likely than White patients to have a mental health concern addressed during a primary care visit

Hispanic patients were 40 percent less likely than non-Hispanic patients to have a mental health concern addressed during a primary care visit.

Certified Community Behavioral Health Clinics (CCBHCs)

Map of CCBHCs Across the United States (as of March 6, 2023)

Currently, there are over 500 CCBHCs operating across the country, as either CCBHC-E grantees, as clinics participating in their states' Medicaid demonstration, or as a part of independent state CCBHC programs.



Federal CCBHC Medicaid Demonstration (And SAMHSA Expansion Grants)

State contains at least one local SAMHSA expansion grantee in the state

CMS-approved payment method for CCBHCs via a SPA or 1115 waiver separate from Demonstration

Chosen to receive one-year planning grant needed to join Medicaid Demonstration starting in March 2023

What Is a CCBHC?

Website
https://www.samhsa.gov/certified-community-behavioral-health-clinics

Quick Video
https://youtu.be/OzBUpyIEBpU

Rhode Island Health and Human Services Certified Community Behavioral Health Centers (CCBHCs)

CTC-RI Clinical Strategy Committee Meeting
February 16, 2024

RHODE ISLAND

Agenda

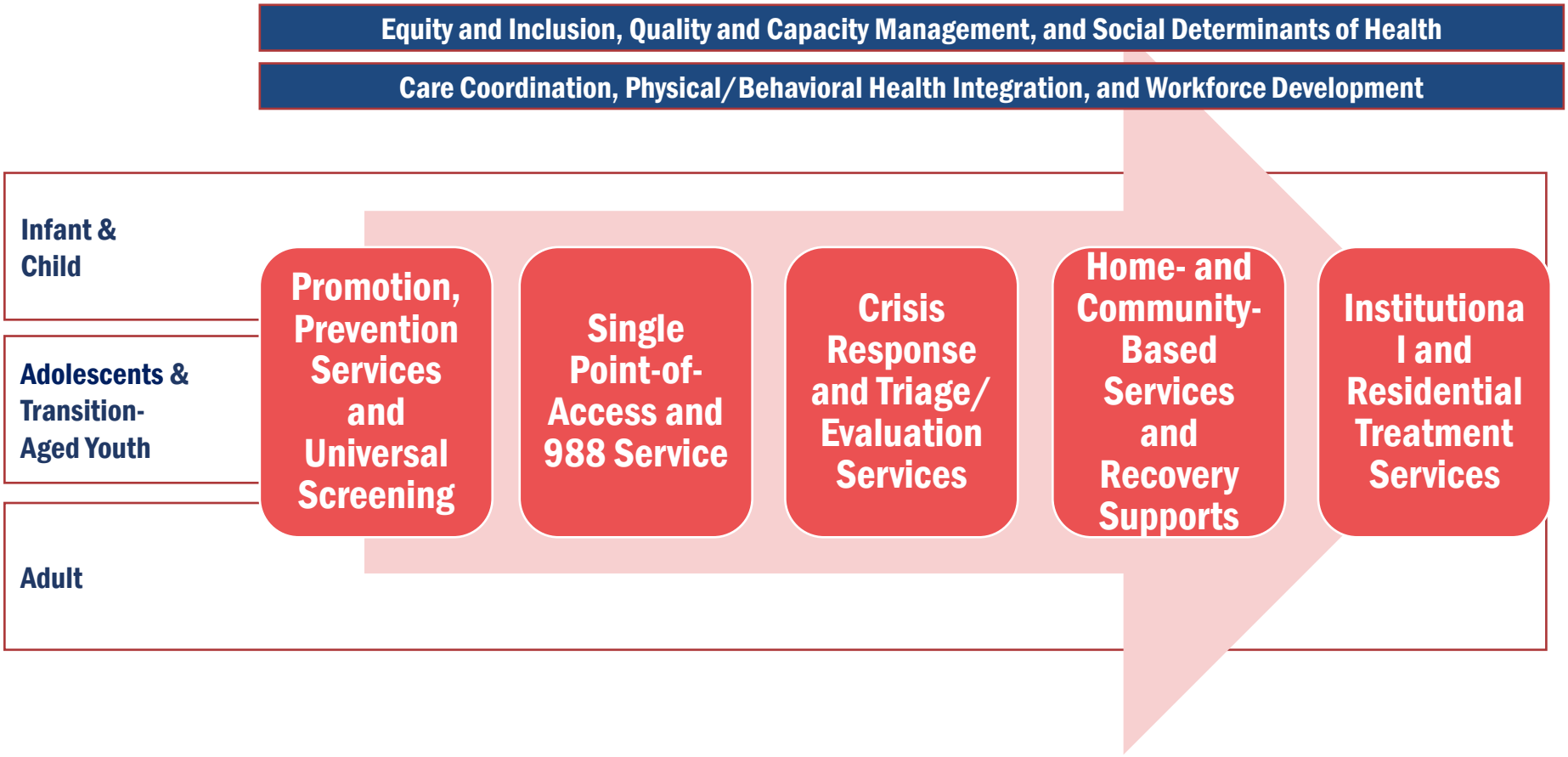
- Introduction
- Background: Rhode Island's Continuum of Care & the Rhode Island Behavioral Health System Review
- Certified Community Behavioral Health Clinics (CCBHCs) Components
- Discussion: Integration of CCBHCs and Primary Care

Food for Thought

These are the questions that we are looking forward to discuss at the end of the meeting – we encourage you to think about these as we present.

1. If you could wave a magic wand, how can CCBHCs help you to better serve your patients?
2. What information do you need most? How can we better help you understand the CCBHC model?
3. How can we support you and your clients to connect with CCBHCs when appropriate?
4. What are best practices for the CCBHCs in terms of ongoing collaboration and coordination with primary care providers?
    a. Ideal referral pathways?
    b. Information exchange needs?
    c. Care coordination processes?
5. Is there anything else that's top of mind for you and/or that you'd strongly encourage us to consider as we continue to build and strengthen the CCBHC program?

Rhode Island Vision of a Behavioral Health Continuum of Care



Rhode Island 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 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.

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

Overview: Certified Community Behavioral Health Clinics (CCBHCs), Designated Collaborating Organizations (DCOs), and other partnerships

RHODE ISLAND

What are CCBHCs?

CCBHC is a federally defined service delivery model that provides a comprehensive range of coordinated mental health and substance use services.

CCBHCs Must Provide Nine Core Services Directly or Through Formal Partnerships[1]

- Targeted Case Management
- Outpatient Mental Health & Substance Use Services
- Outpatient Primary Care Screening and Monitoring
- Person- & Family – Centered Treatment Planning
- Psychiatric Rehabilitation Services
- Community - Based Mental Health Care for Veterans
- Screening, Diagnosis, and Risk Assessment[2]
- Peer, Family Support & Counselor Services
- Crisis Services

Additional Required Service in Rhode Island

- Assertive Community Treatment (ACT)

PPS: Monthly cost-based rate replaces FFS billing

[1]Services can be provided by *either* the CCBHC or the DCO, with at least 51% directly provided by the CCBHC

[2]Beginning July 1, 2024, this includes HIV and HEP screenings

CCBHC Populations of Focus and RI's Priority Populations

CCBHCs are required to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, or age - including developmentally appropriate care for children and youth.

Populations of Focus:

- Adults with severe and persistent mental illness (SPMI)
- Children and youth with severe emotional disorders (SED)
- Individuals with substance use disorders (SUD)

RI's Priority Populations:

- Black, Indigenous, People of Color (BIPOC); people with co-occurring Behavioral Health/Intellectual/Development Disabilities; older adults; transition-age youth; people who identify as LGBTQ+; individuals who are justice involved; adults and families who are unhoused; and those from historically under-resourced communities

RI CCBHC Program Requirements

SAMHSA identified the following six program requirements for CCBHCs that States must refine, with descriptions of their scope.

1. **Staffing:** Community Needs Assessment, general staffing requirements, licensure, credentialling, cultural and linguistic competency and confidentiality.
2. **Availability and Accessibility of Services:** Timely access, comprehensive evaluation, access to crisis management, no refusal of services due to inability to pay and regardless of residence.
3. **Care Coordination:** Required Care Coordination partners and activities.
4. **Scope of Services:** See the nine required services
5. **Quality and other reporting:** Data collection, tracking, reporting and analytics; Continuous Quality Improvement (CQI) functions.
6. **Organizational authority, Governance, and Accreditation:** Community/Consumer Advisory Councils (CACs).

Key Health Conditions: Screening Requirements for CCBHCs

The CCBHC Medical Director will develop organizational protocols to **ensure screenings for people receiving services who are at risk for common physical health conditions** experienced by CCBHC populations across the lifespan.

Protocols will include:

- Identifying people receiving services with chronic diseases;
- Ensuring that people receiving services are asked about physical health symptoms; and
- Establishing systems for collecting and analyzing laboratory samples (i.e., the CCBHC should have the ability to collect biologic samples directly, through a DCO, or through protocols with an independent clinical lab organization).

The CCBHC must also coordinate with the primary care provider to ensure that screenings occur for the identified conditions. If the person receiving services' primary care provider conducts the necessary screening and monitoring, the CCBHC is not required to do so as long as it has a record of the screening and monitoring, and the results of any tests that address the health conditions included in the CCBHCs screening and monitoring protocols developed.

Primary Care Monitoring Requirements for CCBHCs

The CCBHC will provide ongoing primary care monitoring of health conditions as identified in the CCBHC SAMSHA standards, and as clinically indicated for the individual. Monitoring includes the following:

1. Ensuring individuals have access to primary care services;
2. Ensuring ongoing periodic laboratory testing and physical measurement of health status indicators and changes in the status of chronic health conditions;
3. Coordinating care with primary care and specialty health providers including tracking attendance at needed physical health care appointments; and
4. Promoting a healthy behavior lifestyle.

Note: The provision of primary care services, outside of primary care screening and monitoring as defined in the standards are not within the scope of the nine required CCBHC services. CCBHC organizations may provide primary care services outside the nine required services, but these primary care services cannot be reimbursed through the Section 223 CCBHC demonstration PPS.

CCBHC Evidence-Based Practices (EBPs) and Programs

- **Required EBPs for Adult and Children:** Motivational Interviewing; Cognitive Behavioral Therapy; Dialectic Behavioral Therapy; Family Psychoeducation; Screening, Brief Intervention and referral to treatment (SBIRT); Coordinated Specialty Care (CSC); Integrated Dual Diagnosis treatment; Trauma Informed Care; and Zero Suicide
- **Required EBPs for Adults:** Assertive Community Treatment (ACT); Permanent Supported Housing/Housing First; Individual Placement and Support (IPS); Medication Assisted Treatment (MAT); and 12 Steps Facilitation Therapy.
- **Required for EBPs for Children:** Mobile Response and Stabilization Services (MRSS); and Seven Challenges.
- **Training, Coaching, and Fidelity requirements**

CCBHC Quality Measurement – Clinic Collected Measures

CCBHCs and States are required to report specific federal measures which will be used to assess how care is provided and accessed, and to ensure quality improvement.

There are five CCBHC clinic-collected measures:

1. Time to services (I-SERV)
2. Depression remission after 6 months (DEP-REM-6)
3. Preventive care and screening for unhealthy alcohol use (ASC)
4. Screening for depression and follow-up plan (CDF-CH and CDF-AD)
5. Screening for social drivers of health (SDOH)

CCBHC Quality Measurement – State Collected Measures

CCBHCs and States are required to report specific federal measures which will be used to assess how care is provided and accessed, and to ensure quality improvement.

There are 13 CCBHC State collected measures:

1. Patient experience of care survey
2. Youth/family experience of care survey
3. Adherence to antipsychotic meds for individuals with schizophrenia
4. Follow-up after hospitalization for Mental illness ages 12 to 17
5. Follow-up after hospitalization for Mental illness ages 18+
6. Initiation and engagement of alcohol and other drug dependance treatment
7. Follow-up after Emergency Department visits for Mental Illness
8. Follow-up after Emergency Department visits for alcohol and other drug dependance
9. Plan all cause readmission rates.
10. Follow-up care for children prescribed ADHD meds.
11. Antidepressant medication management.
12. Use of pharmacotherapy for opioid use disorder.
13. Hemoglobin A1C control for patients with diabetes.

CCBHC Quality Measurement – Sample Performance Measures

CCBHCs are required to report on specific additional performance measures to indicate compliance with the CCBHC certification standards.

Other CCBHC performance measures, e.g.:

1. Mobile Crisis response time.
2. Contact with hospital discharges within 24 hours.
3. Urgent appointment time within 24 hours and routine within 7 business days.
4. Tracking and CQI plans for deaths by suicide and attempts, fatal and non-fatal overdoses, all case mortality, and 30-day hospital readmissions.
5. All individuals receive primary care screening.

What is a DCO?

- **Designated Collaborating Organization (DCO):** A DCO is an entity that is engaged in a formal relationship with the CCBHC and delivers services under the oversight of the CCBHC, to help them provide the services they are required to carry out.
- These DCO arrangements are a way for a CCBHC to ensure services are available to its consumers that it does not provide directly.
  - Payment for DCO services are included within the scope of how the CCBHCs are paid. DCO encounters will be treated as CCBHC encounters for purposes of the PPS.
  - The CCBHC maintains clinical responsibility for the services provided to CCBHC consumers by the DCO.
  - Typically, referrals go from CCBHCs to DCOs, but there are instances where it could go in the other direction for contracted services.

Recruiting RI DCOs: Specialty Services

In Rhode Island, we've focused on recruiting DCOs that have:

- A specific focus on **SUD services, DD services, Veteran services, healthy aging services, children/youth services, AND**
- At least three (3) years of experience offering one or more of a specified set of CCBHC services to either all or a specified subset of the eligible population
- **Plus, we've focused on Equity Partners, who have a demonstrated ability to facilitate the engagement of diverse populations** who are impacted by behavioral health conditions in their target communities, **thereby helping CCBHCs reduce disparities and promote health equity among the communities they serve as demonstrated by a history of at least three (3) years of service to that community.** These include organizations focused on working with the BIPOC, LGBTQ+, disability, or racial and ethnic minority communities

Care Coordination Partnerships

- CCBHCs are required to provide care coordination services in partnership with appropriate organizations, this can either be with DCOs or Care Coordination Organizations (CCOs).
- Care coordination is:
  - Typically memorialized in agreements between CCBHCs and other providers/social service agencies in their area
  - Meant to enhance the quality of care, improve CCBHC consumers' access to services and create seamless transitions between service settings
- The benefits of a care coordination relationship are achieved primarily through referrals and the exchange of health information and information about the consumer's needs and preferences. They also provide individuals with a more robust array of services outside of the realm of behavioral healthcare including social determinants of health.

CCBHC Go-Live Plan

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Go Live Dates for CCBHC Cohorts

Here are the possible go-live dates for which CCBHCs will be eligible, as determined by the State

Cohort	Go-Live Date	Providers who are eligible to participate in each cohort
1	July 1, 2024	Community Care Alliance, Newport Mental Health, and Thrive Behavioral Health
2	Oct 1, 2024	Family Service of RI, Gateway (3 sites), and The Providence Center
3	July 1, 2025	TBD

Discussion Questions

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Where your insights are needed

1. If you could wave a magic wand, how can CCBHCs help you to better serve your patients?
2. What information do you need most? How can we better help you understand the CCBHC model?
3. How can we support you and your clients to connect with CCBHCs when appropriate?
4. What are best practices for the CCBHCs in terms of ongoing collaboration and coordination with primary care providers?
    a. Ideal referral pathways?
    b. Information exchange needs?
    c. Care coordination processes?
5. Is there anything else that's top of mind for you and/or that you'd strongly encourage us to consider as we continue to build and strengthen the CCBHC program?

Building Healthier Communities for All Rhode Islanders