

**SENATE HEALTH  
&  
HUMAN SERVICES  
COMMITTEE**



**Mental Health Hearings  
Findings & Recommendations**

**February 2017**

## Table of Contents

<b>Executive Summary</b>	<b>1</b>
<b>Introduction</b>	<b>4</b>
<b>Issues &amp; Recommendations</b>	<b>7</b>
<b>Addenda:</b>	
<b>Written Testimony &amp; Presentations</b>	<b>19</b>

## Executive Summary

### **Purpose:**

A priority of the RI Senate has been to enhance the behavioral health service system in RI. There was a major emphasis on the opioid overdose epidemic over the past several legislative sessions, with a comprehensive package of legislation and budget investments adopted to address substance use disorders. However, substance use disorders are only one component of mental and behavioral health. These issues are complex, and finding solutions requires creative and comprehensive approaches. Unmet needs are high, and a state policy agenda of multi-faceted interventions and investments is necessary to improve the mental health status of the Rhode Island population.

In the fall of 2016, the Senate Health and Human Services Committee held a series of five hearings to assess the status of mental health services in Rhode Island, and to compile a list of recommendations for legislative action. This effort was not intended to be a comprehensive and intensive review of every aspect of the mental health system in our state. Nor does it serve to replace ongoing needs assessment, system planning, and interventions that are conducted by numerous other public and private entities. The Senate's goals have been to promote leadership, public awareness and action to address a critical, yet often overlooked, health care crisis.

The Committee's identified issues and suggested recommendations are as follows:

### **1) Address payment for mental health direct care workers**

- Work to increase wages for lowest paid direct care mental health workers
- Address delays in Medicaid claim reimbursement for services rendered by providers

### **2) Minimize risk by focusing on mental health prevention and early intervention**

- Expand the Home Visiting Program at DOH to meet the need among all at-risk families
- Work with health care providers of young children to implement psycho-social and behavioral assessments as preventive visits per the Bright Futures Guidelines and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) to implement screening for early childhood adversity and risk factors for toxic stress
- Work with RI Department of Education (RIDE) to implement universal screening for adverse childhood experiences (ACEs), including:
  - Early screening of children in schools
  - ACEs training for teachers to detect and refer
  - Increase public awareness of toxic stress
- Identify funding for after-school programs for youth (e.g., Boys and Girls Clubs) to build support networks and feelings of community
- Fund suicide prevention programs in schools
- Increase students' awareness of existing school-based mental health resources
- Work with RIDE to better utilize Medicaid matching funds for school districts to hire mental health workers

**3) Address the serious mental health workforce shortages (particularly adult and child psychiatrists and psychologists)**

- Improve access to psychiatrists and other mental health providers
  - Expand the DOH/RISLA loan forgiveness program to attract mental health professionals in varied settings
  - Encourage mental health professionals working at Federally Qualified Health Centers (FQHCs) to apply to the National Health Services Corps' (NHSC) student loan forgiveness program
  - Support state and private efforts to recruit and retain psychiatrists
  - Ensure professional licensure consistency and/or reciprocity with other states
  - Encourage insurers to improve the credentialing process
  - Encourage adequacy of commercial insurers' reimbursement of mental health and behavioral health services and treatment including tele-psychiatry, and remove licensure barriers for mental health providers to provide tele-psychiatry
  - Streamline and clarify RIDOH provider license reciprocity regulations to address the shortage of mental health professionals
  - Explore the application of waivers for disqualifying information on background checks for peer recovery coaches
  - Support the State Innovation Model (SIM) Child Psychiatry Access Program

**4) Fund training for law enforcement, sheriffs, and Department of Corrections (DOC) officers/staff**

- Identify funding to expand continuing education and training for all levels of law enforcement and DOC officers/staff to ensure accurate identification of situations involving mental health emergencies, and to develop strategies for proper responses

**5) Reduce high prevalence of individuals with mental health issues in the criminal justice system**

- Support Justice Reinvestment legislation, including 2017 Senate Bill 10 that authorizes a superior court diversion program, enhances pre-trial screening for behavioral health issues of defendants, and allows law enforcement to transport individuals to appropriate settings in lieu of jail
- Expand forensics capacity at Eleanor Slater Hospital to improve the treatment of inmates with serious mental illness
- Establish a mental health court—and/or expand scope of existing diversionary courts or calendars

**6) Reduce the high prevalence of individuals with mental health issues who are homeless**

- Address the mental health issues of individuals who are homeless through increased housing subsidies and vouchers
- Support the development of mobile outreach efforts which provide screening and access to services to persons living on the street

**7) Increase alternative models to emergency departments in mental health crisis intervention**

- Increase capacity and reduce obstacles to use of Crisis Stabilization Units (or similar model) that serve as alternatives to unnecessary emergency department visits for mental health needs
- Support the Governor’s Overdose Prevention and Intervention Task Force Emergency Department and Hospital Standards for Opioid Safety
  - Expand the scope of this project to include standards for mental health care
  - Ensure that these proposed standards include adequate safeguards for appropriate transfers of care in a tiered system

**8) Improve access to community-based services**

- Support team-based approaches, such as collaborative care models that treat both the mind and body of patients
- Support state Medicaid efforts on Assertive Community Treatment (ACT) teams, and mobile van for individuals who are homeless
- Support the implementation of evidence-based practices in the community mental health center and alternative payment models
- Support crisis mental health services, including: 24-hour mobile crisis teams, crisis hotlines, emergency crisis intervention, and crisis stabilization
- Address the need for a comprehensive and effective Olmstead plan for serving qualified people with mental disabilities in less restrictive settings

**9) Ensure mental health parity**

- Support OHIC’s ongoing review of insurers’ compliance with mental health parity
- Fund social workers to assist the Mental Health Advocate and Child Advocate
- Reduce insurer barriers to mental health care:
  - Reduce or eliminate certain prior authorization requirements
  - Consider an exception to “step therapy” (patient trial and error of generic drugs) for severe mental illness

**10) Address cost sharing requirements for mental health and behavioral health treatment which serve as a barrier to access of care**

- Examine insurance plan design and ensure that patient payment obligations are not a barrier to care for mental health and behavioral health patients

**11) Increase identification and treatment of depression and substance use disorder in pregnant and postpartum women**

- Support DOH’s efforts to educate and encourage medical professionals serving pregnant women to screen for mental health issues and refer for appropriate treatment and support services

## Introduction

Mental illness and substance use disorders can have a powerful effect on the health of individuals, their families, and their communities. In 2014, an estimated 9.8 million adults aged 18 and older in the United States had a serious mental illness, and 1.7 million of which were aged 18 to 25.<sup>1</sup> Also 15.7 million adults (aged 18 or older) and 2.8 million youth (aged 12 to 17) had a major depressive episode during the past year.<sup>2</sup> In 2014, an estimated 22.5 million Americans aged 12 and older self-reported needing treatment for alcohol or illicit drug use, and 11.8 million adults self-reported needing mental health treatment or counseling in the past year. These disorders can create various degrees of disability and carry a high burden of disease in the United States, resulting in significant costs to families, employers, and publicly funded health systems. By 2020, it is predicted that mental and substance use disorders will surpass all physical diseases as the major cause of disability worldwide.<sup>3</sup>

According to the CDC, suicide is the 2<sup>nd</sup> leading cause of death for young people age 10-34, and the 4<sup>th</sup> leading cause of death for adults age 35-54. Tragically, more than 1,200 Rhode Islanders have lost their lives to suicide since 2006.<sup>4</sup> In 2015, there were 125 suicides in RI; this represents an almost 50% increase in annual suicides in RI in the past decade.<sup>5</sup> Given the gravity of the problem, Rhode Island's vision is to ensure that all of its residents have the opportunity to achieve the best possible mental and behavioral health and well-being within healthy local communities that promote empowerment, inclusion, and shared responsibility.

In 2016, The Lancet performed a global return on investment (ROI) analysis on mental health that focused on depression and anxiety. These are the most prevalent mental health disorders and lead to large losses in work participation and productivity that lend themselves to effective and accessible treatment.<sup>6</sup> Results from the analysis suggest that financial benefits of better health and work force outcomes outweigh the costs of achieving them by 3.3 to 5.7 to 1; this means that every dollar invested in treatment yielded \$3.30-5.70 in savings. Because treatment of common mental disorders leads to significant improvements in economic production and health outcomes, the study's authors recommend that clinicians increase the detection and management of people with depression and anxiety disorders.

In its continuing efforts to fulfill this vision, and in response to a legislative directive, the Rhode Island Executive Office of Health and Human Services (EOHHS); the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH); Department of Health (DOH); and the Office of the Insurance Commissioner (OHIC) contracted with Truven Health Analytics to develop a series of reports that quantify statewide demand, spending, and supply for

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<sup>1</sup> Substance Abuse and Mental Health Services Administration (SAMHSA), <http://www.samhsa.gov/prevention>.

<sup>2</sup> *Ibid.*

<sup>3</sup> *Ibid.*

<sup>4</sup> Deborah Garneau, Chief of the Office of Special Health Care Needs, RI Department of Health, Presentation to Senate HHS Committee (October 2016).

<sup>5</sup> *Ibid.*

<sup>6</sup> Chisholm, Dan; Sweeny, Kim, et al., Scaling-up treatment of depression and anxiety: a global return on investment analysis, *The Lancet Psychiatry* Vol.3-5 (2016), pp.415-424.

the full continuum of behavioral health services in the state.<sup>7</sup> Subsequent to these analyses, Truven Health was asked to develop a summary report recommending practices, policies, and system structures to further the goal of providing accessible, high quality, and affordable care.

According to the Truven report, the following examples are of primary concern in RI:

- Children in Rhode Island face greater economic, social, and familial risks for developing mental health and substance use disorders than children in other New England states and the nation.
- Individuals in Rhode Island are more likely to report unmet need for behavioral healthcare services than adults in any other New England State.
- One in five Rhode Island Medicaid beneficiaries hospitalized for a mental illness had no follow-up mental health treatment 30 days after discharge.
- Rhode Island has fewer behavioral health and substance abuse counselors per capita than other New England states. The lack of substance abuse human resource capacity is significant given clients with persistent high service needs i.e. those that use acute inpatient care.
- Rhode Island has no mental health programs offering specialized services for traumatic brain injury (TBI), and had the lowest % of mental health facilities offering programs specifically designed for Veterans or for individuals with Alzheimer's disease or Dementia.
- Recently, Rhode Island closed a number of residential treatment beds, with adolescent substance use disorder residential treatment being hit the hardest.

The report made the following overarching recommendations:

- **Recommendation 1.** Children in Rhode Island face greater economic, social, and familial risks for developing mental health and substance use disorders than children in other New England states and the nation. These greater risks necessitate that Rhode Island place greater emphasis on investments in proven, effective, preventive services and supports for children and families.
- **Recommendation 2:** Rhode Island should shift financing and provision of services away from high-cost, intensive, and reactive services toward evidence-based services that facilitate patient-centered, community-based, recovery-oriented, coordinated care.
- **Recommendation 3:** Rhode Island should enhance its state and local infrastructure to promote a population-based approach to behavioral healthcare. Specifically, Rhode Island should: (1) routinely generate and disseminate behavioral healthcare need, supply, use and spending information across funding and organizational silos; (2) develop planning processes that involve and incentivize disparate organizational, financing, and delivery systems; and (3) create accountability measures that are tied to population-level outcomes.

Additionally, in July 2016, the Governor's Council on Behavioral Health highlighted several areas of need related to mental health services: residential treatment services for adolescents; disparities

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<sup>7</sup> Rhode Island Behavioral Health Project: Final Report, <http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Truven%20Rhode%20Island%20Behavioral%20Health%20Final%20Report%209%2015%202015.pdf> (September 2015).

between physical and behavioral health in Medicaid managed care plans; a shortage of behavioral health providers to meet the increased demand created by Medicaid Expansion; and the shortage of affordable housing.

These studies and recommendations provide an overarching framework for the series of Senate mental health hearings. The goal of each of hearing was to outline the constraints to improved mental health services in our state, and to discuss model or proposed solutions that will help remedy each concern. Appropriate stakeholders have been engaged in the process of identifying the issues and involved in the genesis of the recommended solutions.

The Senate HHS Committee would like to thank all the experts and members of the public who shared their valuable insights and experiences during the hearing series, including: Secretary Elizabeth Roberts, Meg Clingham, Jim McNulty, Ruth Feder, Dr. Susan Storti, Richard Harris, Dr. Michael Silver, Dennis Roy, Mary Dwyer, Dr. Peter Oppenheimer, Dr. Dale Klatzker, William Emmet, Dr. Nicole Alexander-Scott, Rebecca Boss, Dr. Elinore McCance-Katz, John Holiver, Dr. Richard Goldberg, Dr. Lisa Shea, Dr. Jeffrey Hunt, Dr. Monica Darcy, Denise Panichas, Col. Ann Assumpico, Dr. Gary Bubly, Margaret Holland-McDuff, Kathy Heren, Sabrina Rivera, Bridget Bennett, McKenna Colman, Kim Colman, Lori Ziegler Halt, Marc Dubois, Michelle Taylor, David Spencer, Jane Hayward, Dr. Robert Swift, Dan Kubas-Meyer, Dr. Craig Kaufman, Megan Smith, Attorney General Peter Kilmartin, A.T. Wall, Linda Johnson, Michael Dexter, Dr. Matthew Collins, Yuriel Melendez, Ruth Feder, Jamia McDonald, Deb Garneau, Michael Reis, Yuriel Melendez, Col. Hugh T. Clements, Jr., Dr. Francisco “Paco” Trilla, Stephen Kozak, Deb Florio, Al Charbonneau, and Ben Lessing.



## Issues & Recommendations

### 1) Address payment for mental health direct care workers

- **Findings:**

Multiple presenters lamented the low pay for direct care workers and the detrimental effect this has on staff retention, training costs, and, as a result, quality of care. This is a national problem; as demand for direct care workers has grown, their wages have fallen. From 2005 to 2015, total direct care worker employment grew by nearly a million workers, from 2.6 to 3.6 million.<sup>8</sup> The majority of this growth occurred in home- and community-based settings, where employment doubled, from 700,000 in 2005 to nearly 1.5 million in 2015.<sup>9</sup>

The Bureau of Labor Statistics (BLS) lists national level wage data for Health Support Occupations. This category includes several types of direct care and support workers, who provide routine individualized healthcare to persons with disabilities at a patient's home or in a care facility. In 2015, the average private-sector direct care worker in RI earned \$10.82 per hour, and the average annual staff turnover rate was approximately 33%.<sup>10</sup>

Over the last five years the Health Support Occupation industry has experienced a stagnant wage growth as compared to the minimum wage growth rate. The minimum wage has increased by 30% since 2012, but the rate paid to these essential direct care providers has remained flat. This problem will be only be compounded by the fact that the demand for direct care workers is expected to rise dramatically in the coming decades as the population ages. It is estimated that the U.S. will need one million new direct care workers by 2024, meaning that the number of homecare workers will grow more than any other occupation, with 633,000 new jobs.<sup>11</sup>

Additionally, multiple local providers have experienced significant reimbursement delays due to the new Integrated Health Home (IHH) and Assertive Community Treatment (ACT) Medicaid managed care program implementation. The IHH Program is a team-based service that provides patient-centered care approaches to healthcare that assist the client in accessing the medical, behavioral health and substance use providers, as well as other medical specialists, in a coordinated manner.<sup>12</sup> The ACT Program is a mental health program made up of multidisciplinary staff who work as a mobile team that provides psychiatric treatment, rehabilitation and support services in community locations.<sup>13</sup> Mary

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<sup>8</sup> American Society on Aging, <http://www.asaging.org/blog/wage-increases-direct-care-workers-insufficient-build-workforce>.

<sup>9</sup> *Ibid.*

<sup>10</sup> U. S. Department of Labor, Bureau of Labor Statistics, *Residential Intellectual and Developmental Disability, Mental Health, and Substance Abuse Facilities*, <http://www.rilegislature.gov/pressrelease/layouts/RIL.PressRelease.ListStructure/Forms/DisplayForm.aspx?List=c8baae31-3c10-431c-8dcd-9dbbe21ce3e9&ID=12236> (October 2016).

<sup>11</sup> Paraprofessional Healthcare Institute, <http://phinational.org/policy/states>.

<sup>12</sup> RI Executive Offices of Health and Human Services (EOHHS), [http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/SPA/15-016\\_Notice\\_to\\_Public.pdf](http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/SPA/15-016_Notice_to_Public.pdf) (December 18, 2015).

<sup>13</sup> *Ibid.*

Dwyer (RI Nurses Association), Dave Spencer (Leadership Council) and Ben Lessing (Community Care Alliance) testified that the payment delays for these programs have led to cash flow issues and staff layoffs at several Community Mental Health Organizations (CMHOs).

- **Recommendation(s):**

- Work to increase wages for lowest paid direct care mental health workers
- Address delays in Medicaid claim reimbursement for services rendered by providers

## **2) Minimize risk by focusing on mental health prevention and early intervention**

- **Findings:**

Preventing mental health and substance use disorders in children, adolescents, and young adults is critical to Americans' behavioral and physical health. Behaviors and symptoms that signal the development of a behavioral disorder often manifest two to four years before a disorder is present.<sup>14</sup> In addition, people with mental health issues are more likely to use alcohol or drugs than those not affected by a mental illness. A 2014 report showed that of those adults with any mental illness, 18.2% had a substance use disorder, while those adults with no mental illness only had a 6.3% rate of substance use disorder in the past year.<sup>15</sup>

Federal Medicaid law requires mental health screening as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program.<sup>16</sup> Margaret Holland-McDuff (Family Services of RI) testified in support of early screening for adverse childhood experiences (ACEs). Individuals with high ACEs scores have poor mental and physical health outcomes. If communities and families can intervene early, behavioral health disorders might be prevented, or symptoms can be mitigated. Data have shown that early intervention following the first episode of a serious mental illness can have an impact. Coordinated, specialized services offered during or shortly after the first episode of psychosis are effective for improving clinical and functional outcomes.<sup>17</sup>

Yuriel Melendez (Generation Citizen, Juanita Sanchez School) testified that he witnesses students struggling in school, acting out, sleeping at their desks, chronically absent, and having thoughts of suicide. The severity of the problem is increasing, and there is a need for additional mental health support services in schools. Also, school outreach and guidance needs to be a priority so that students are aware of the support systems that are in place.

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<sup>14</sup> Substance Abuse and Mental Health Services Administration (SAMHSA), <http://www.samhsa.gov/prevention>.

<sup>15</sup> SAMHSA, *Behavioral Health Trends in the United States*, Results from the 2014 National Survey on Drug Use and Health, <http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf>.

<sup>16</sup> National Alliance on Mental Illness (NAMI), *State Mental Health Legislation, 2015: Trends, Themes and Effective Practices*, <https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/State-Mental-Health-Legislation-2015/NAMI-StateMentalHealthLegislation2015.pdf> (December 2015).

<sup>17</sup> SAMHSA, <http://www.samhsa.gov/prevention>.

A multi-pronged approach at different ages and in different settings is likely to be most effective strategy. Since children spend significant hours per day in school, training staff and students in suicide prevention and awareness makes sense, and can lead to recognition and intervention that saves lives. In response to this, several states have recently passed legislation that supports suicide prevention training for school staff.<sup>18</sup> A recent issue brief by Rhode Island Kids Count outlined the prevalence of bullying in Rhode Island, as well as the effects and outcomes of bullying on children.<sup>19</sup> Importantly, evidence suggests that bullying is a leading contributor to future drug use, mental health disorders, and is associated with higher rates of overall risky behavior. Providing mental health screenings and appropriate interventions in schools ensures that all children have access to mental health care.

In addition to improved outcomes, early intervention saves money. An Institute of Medicine report notes that cost-benefit ratios for early treatment and prevention programs for addictions and mental illness programs range from 1:2 to 1:10.<sup>20</sup> This means a \$1 investment yields \$2 to \$10 savings in health costs, criminal and juvenile justice costs, educational costs, and lost productivity.

- **Recommendation(s):**

- Expand the Home Visiting Program at DOH to meet the need among all at-risk families
- Work with health care providers of young children to implement psycho-social and behavioral assessments as preventive visits per the Bright Futures guidelines and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) to implement screening for early childhood adversity and risk factors for toxic stress
- Work with RI Department of Education (RIDE) to implement universal screening for adverse childhood experiences (ACEs), including:
  - Early screening of children in schools and childcare personnel
  - ACEs training for teachers to detect and refer
  - Increase public awareness of toxic stress
- Identify funding for after-school programs for youth (e.g., Boys and Girls Clubs) to build support networks and feelings of community
- Fund suicide prevention programs in schools
- Increase students' awareness of existing school-based mental health resources
- Work with RIDE to better utilize Medicaid matching funds for school districts to hire mental health workers

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<sup>18</sup> NAMI, *State Mental Health Legislation*, 2015: Trends, Themes and Effective Practices, <https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/State-Mental-Health-Legislation-2015/NAMI-StateMentalHealthLegislation2015.pdf> (December 2015).

<sup>19</sup> Rhode Island KIDS COUNT, Issue Brief: Preventing Bullying in Rhode Island Schools, <http://www.rikidscount.org/Portals/0/zUploads/Documents/Issue%20Briefs/12.16%20Bullying%20Issue%20Brief-RIKC-Final.pdf> (December 2016).

<sup>20</sup> Institute of Medicine, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities* (2009).

### **3) Address the serious mental health workforce shortages (particularly adult and child psychiatrists and psychologists)**

- **Findings:**

While the U.S. is facing an overall shortage of doctors, there is more of a shortfall of mental health providers than in any other category. According to the Health Resources and Services Administration (HRSA), 89.3 million Americans live in federally-designated Mental Health Professional Shortage Areas.<sup>21</sup> Dr. Michael Silver (RI Psychiatric Society) testified that, according to the American Medical Association, the total number of physicians in the U.S. increased by 45% from 1995 to 2013, while the number of adult and child psychiatrists rose by only 12%. Nationally, the number of psychiatrists graduating from residency programs from 2007-2013 was essentially flat, showing only a slight uptick in 2015.

According to Dr. Silver, reimbursement rates in Rhode Island are lower than in surrounding states. While only certain counties in Rhode Island are federally-designated Mental Health Professional Shortage Areas, there are statewide shortages of psychiatrists available to see people in community settings. This is especially true for child psychiatrists. One critical problem affecting the supply of psychiatrists available to see patients in the community is the trend away from psychiatrists accepting any kind of insurance. A study published in the journal JAMA Psychiatry, found that approximately 50% of psychiatrists accepted health insurance, compared to approximately 80% of non-psychiatrists.

Dr. McCance-Katz (Chief Medical Officer, BHDDH) stated that in RI, 38% of all psychiatrists are over age 55, so many may be retiring soon. Since only 4% of medical students choose psychiatry as a career, there will be an even greater shortage in the coming years. Despite focused efforts, she has not been able to recruit a single new full-time psychiatrist to Eleanor Slater Hospital (ESH) due to the low state salary. Dr. McCance-Katz has started a training program that allows senior residents in the Brown Psychiatry Residency Program to take on-call shifts at ESH. This effort aims to encourage residents to stay in RI after their training is completed.

Educational loan repayment is a long-standing, effective strategy to boost the mental health workforce. Emerging professionals benefit from student loan repayment in return for a post-graduate period of practice with an underserved population.<sup>22</sup> Also, the State Innovation Model (SIM) is launching a Child Psychiatry Access Program that aims to improve access to mental health treatment for children. The program will establish a consultation team to work with primary care providers to meet the needs of children with mental health needs. The program is based on the model implemented in Massachusetts, which consists of regionally based teams that provide real-time telephone consultation

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<sup>21</sup> Health Resources and Services Administration (HRSA), <https://datawarehouse.hrsa.gov/topics/shortageAreas.aspx>.

<sup>22</sup> Rural Iowa Primary Loan Repayment Program, <https://www.iowacollegeaid.gov/content/rural-iowa-primary-loan-repayment-program>.

with child psychiatrists, face-to-face appointments for acute evaluations, and assistance with accessing community-based behavioral health services.<sup>23</sup>

- **Recommendation(s):**

- Improve access to psychiatrists and other mental health providers through:
  - Expand the DOH/RISLA loan forgiveness program to attract mental health professionals in varied settings
  - Encourage mental health professionals working at Federally Qualified Health Centers (FQHCs) to apply to the National Health Services Corps' (NHSC) student loan forgiveness program
  - Support state and private efforts to recruit and retain psychiatrists
  - Ensure professional licensure consistency and/or reciprocity with other states
  - Encourage insurers to improve the credentialing process
  - Encourage adequacy of commercial insurers' reimbursement of mental health and behavioral health services and treatment including tele-psychiatry, and remove licensure barriers for mental health providers to provide tele-psychiatry
  - Streamline and clarify RIDOH provider license reciprocity regulations to address the shortage of mental health professionals
  - Explore the application of waivers for disqualifying information on background checks for peer recovery coaches
  - Support the State Innovation Model (SIM) Child Psychiatry Access Program

#### **4) Fund training for law enforcement and Department of Corrections (DOC) officers/staff**

- **Findings:**

In the absence of adequate crisis response systems, law enforcement officers have increasingly become default first responders to mental health crises. First responders and correctional officers need training in mental health crisis de-escalation. A new state law requires the Commission on Standards and Training to provide training and instructions for police officers to more accurately identify complaints involving mental health emergencies, and to develop appropriate responses to such emergencies. The training is designed to help law enforcement officers recognize the signs and symptoms of common mental health issues, de-escalate crisis situations safely, and initiate timely referrals to appropriate resources in the community.

Colonel Hugh T. Clements, Jr. (Chief, Providence Police) and Colonel Ann Assumpico (Superintendent, RI State Police) testified about the importance of officer training. A police officer today has a dual role, both as a police officer and a social worker, when dealing with mental health issues. Officers' reactions are extremely influential in the outcome of a call. Officers have received some training, but there is a need for additional training for both new recruits and for seasoned officers. Trained officers are needed specifically for psychiatric issues; there are models for specially trained units throughout

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<sup>23</sup> The Massachusetts Child Psychiatry Access Project, <http://www.mcpap.com/Default.aspx>.

the country, and funds are needed to implement these programs. A.T. Wall (RI Department of Corrections (DOC)) also testified about the importance of training. He advocated for funding to increase in the mental health staff at the ACI, as well as for evidence-based training for all correctional officers and staff.

- **Recommendation(s):**

- Identify funding to expand continuing education and training for all levels of law enforcement and DOC officers/staff to ensure accurate identification of situations involving mental health emergencies, and to develop strategies for proper responses

#### **5) Reduce high prevalence of individuals with mental health issues in the criminal justice system**

- **Findings:**

There is significant overrepresentation of people with mental illness in the criminal justice system.<sup>24</sup> The goal of mental health or diversion courts is to link offenders to long-term community-based treatment as an alternative to prison. These courts rely on mental health assessments, individualized treatment plans, and ongoing judicial monitoring to address both the mental health needs of offenders and public safety concerns of communities.<sup>25</sup> Like other problem-solving courts such as drug courts, domestic violence courts, and community courts, mental health courts seek to address the underlying problems that contribute to criminal behavior.<sup>26</sup>

- **Recommendation(s):**

- Support Justice Reinvestment legislation, including 2017 Senate Bill 10 that authorizes a superior court diversion program, enhances pre-trial screening for behavioral health issues of defendants, and allows law enforcement to transport individuals to appropriate settings in lieu of jail
- Expand forensics capacity at Eleanor Slater Hospital to improve the treatment of inmates with serious mental illness
- Establish a mental health court—and/or expand scope of existing diversionary courts or calendars

#### **6) Reduce the high prevalence of individuals with mental health issues who are homeless**

- **Findings:**

Stable housing provides the foundation upon which people build their lives. Without a safe, affordable place to live, it is almost impossible to achieve good health or to achieve one's full potential. According to the Office of National Drug Control Policy,

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<sup>24</sup> The U.S. Department of Justice reports that 16% of inmates in the U.S. reported either a mental condition or an overnight stay in a mental hospital, and were identified as mentally ill. See "Mental Health and Treatment of Inmates and Probationers" U.S. Bureau of Justice Statistics, <https://www.bjs.gov/index.cfm?ty=pbdetail&iid=787>.

<sup>25</sup> Principles of Problem-Solving Justice, Bureau of Justice, <http://www.courtinnovation.org/sites/default/files/Principles.pdf>.

<sup>26</sup> *Ibid.*

approximately 30% of people experiencing chronic homelessness have a serious mental illness, and around two-thirds have a primary substance use disorder or other chronic health condition.<sup>27</sup> These health problems may create difficulties in accessing and maintaining stable, affordable, and appropriate housing.

Ruth Feder (Mental Health Association of RI) testified that U.S. Housing and Urban Development (HUD) funded housing is not available to people with criminal records – which sometimes include only charges not actual convictions – from housing. Dan Kubas-Meyer (Riverwood Mental Health Services) estimates that there are currently 400 people in RI who are chronically homeless. Approximately 40% of these individuals suffer from severe mental health issues, at a tremendous cost to taxpayers.

Improved mental health services would combat not only mental illness, but homelessness as well. Megan Smith and Craig Kaufman, MD (House of Hope) testified that outreach programs are most successful when workers establish a trusting relationship through continued contact with the people they are trying to help. Because of policies and guidelines, people who are homeless are sometimes terminated from programs (i.e. for missed appointments). Systems of care are very structured and people without homes need more flexibility, for example, having access to walk-in care, mobile outreach vans, day centers, and shelters. Even if individuals with mental illnesses who are homeless are provided with housing, they are unlikely to achieve residential stability and remain off the streets unless they have access to continued treatment and services. Investment in housing not only enhances recovery, it saves states money that is otherwise spent on crisis services, homeless services, and criminal justice systems.

The costs of homelessness are high, and there is significant evidence supporting the relationship between housing interventions and health outcomes among individuals who are homeless. One example is the Housing First model, a harm-reduction approach in which adults who are homeless and who have mental and behavioral health conditions are provided supportive housing without having to abstain from drugs and alcohol.<sup>28</sup> This model has been associated with lower healthcare utilization and net annual per person cost savings of \$29,388.<sup>29</sup> These costs include jail bookings, days incarcerated, shelter and sobering center use, hospital-based medical services, publicly funded alcohol and drug detoxification and treatment, emergency medical services, and Medicaid-funded services.<sup>30</sup> Another study, the 10<sup>th</sup> Decile Project, found that for every \$1 spent, there was a savings of \$2 in reduced spending the following year and \$6 savings in subsequent years.<sup>31</sup>

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<sup>27</sup> Executive Office of the President, Office of National Drug Control Policy, <https://obamawhitehouse.archives.gov/ondcp/chapter-integrate-treatment-for-substance-use-disorders>.

<sup>28</sup> Larimer, M. E., et al. Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. *JAMA*, 301.13 (2009), 1349-1357.

<sup>29</sup> *Ibid.*

<sup>30</sup> *Ibid.*

<sup>31</sup> Burns, P., et al. Getting Home: Outcomes from Housing High Cost Homeless Hospital Patients. *Economic Roundtable* (2013).

- **Recommendation(s):**
  - Address the mental health issues of individuals who are homeless through increased housing subsidies and vouchers
  - Support the development of mobile outreach efforts which provide screening and access to services to persons living on the street

## **7) Increase alternative models to emergency departments in mental health crisis intervention**

- **Findings:**

Dr. Gary Bubly (Medical Director, Emergency Medicine, Miriam Hospital) testified that hospital emergency departments currently play a critical role in evaluating patients with suicidal ideation and in psychiatric crisis. They are the safety net available for an illness that presents 24/7, but managed by a care system that does not always operate as continuously. Most patients identified with suicidal ideation and or substance abuse problems are usually brought by emergency medical services (EMS) to emergency departments for medical clearance and psychiatric evaluation. Unfortunately, these patients are often “boarded”— or held – in emergency departments awaiting consultation and/or an inpatient bed if needed. This added emergency department wait time can range from a few hours to as long as 10 days.

Psychiatric patients wait an average of three times longer than patients waiting for medical bed.<sup>32</sup> However, not all psychiatric patients need inpatient care; approximately 70% of psychiatric emergencies can be stabilized in less than 24 hours.<sup>33</sup> Additionally, 90% of patients with mental health issues do not need medical clearance, and even if they do, it can be done in a less costly environment.<sup>34</sup> Regionalized, dedicated emergency psychiatric facilities can provide a less expensive and more therapeutically effective model to traditional emergency departments.

Governor Raimondo’s Overdose Prevention and Intervention Task Force is creating voluntary best practices standards to address opioid use disorders and overdoses in the hospital, clinic, urgent care, and emergency department settings.<sup>35</sup> The standards propose a three-level tiered designation for hospitals, with Level 1 providing the most comprehensive array of services.

- **Recommendation(s):**
  - Increase capacity and reduce obstacles to use of Crisis Stabilization Units (or similar model) that serve as alternatives to unnecessary emergency department visits for mental health needs

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<sup>32</sup> Moulin A, Jones K. The Alameda Model: An Effort Worth Emulating, *Western Journal of Emergency Medicine* 15.1 (2014): 7-8.

<sup>33</sup> *Ibid.*

<sup>34</sup> *Ibid.* Insurers can negotiate a crisis hospitalization rate that is less than what an inpatient stay would cost

<sup>35</sup> Prevent Overdose RI, <http://preventoverdoseri.org/wp-content/uploads/2016/07/draft-ed-standards-1.pdf>.



- Support the Governor’s Overdose Prevention and Intervention Task Force Emergency Department and Hospital Standards for Opioid Safety
  - Expand the scope of this project to include standards for mental health care
  - Ensure that all proposed standards include adequate safeguards for appropriate transfers of care in a tiered system

## **8) Improve access to community-based services**

- **Findings:**

Dr. Peter Oppenheimer (Psychologist, Chair, RI Primary Care Behavioral Health Network) testified that mental health and behavioral health services have long been devalued in our system of care in favor of expensive technologically-driven medical care. There is a great need for community-based services that provide a broad range of evidence-based interventions. People with mental illness often need access to treatment, rehabilitation, and support services within the community through a variety of social, health, and mental health agencies. Gaining access to the right agency is often a difficult and complicated process.

Mary Dwyer (RI Nurses Association) testified that better care coordination between physicians, other providers, and care managers can help to facilitate access, improve outcomes, and avoid hospitalizations. Dr. Matthew Collins (Blue Cross & Blue Shield of RI) described an innovative collaboration between BCBS and Bradley Hospital for children with behavioral health needs. The Mindful Teen Program uses an alternative payment model, and it aims to keep children in the least restrictive setting during treatment.

The Governor’s Committee on Behavioral Health is looking at creating an Olmstead plan.<sup>36</sup> Many states have Olmstead Plans, which help keep people with mental illness in the community by ensuring seamless transitions across the lifespan, including transportation and housing.

Best practices are designed to provide a comprehensive range of mental health and behavioral health services, particularly to vulnerable individuals with the most complex needs, offering the following services, directly or through approved referral networks:

- Crisis mental health services including 24-hour mobile crisis teams, crisis hotlines, emergency crisis intervention, and crisis stabilization
- Screening, assessment, and diagnosis including risk management
- Patient-centered treatment planning
- Outpatient mental health and behavioral health services integrated with primary care

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<sup>36</sup> *Olmstead v. L.C.*, 527 U.S. 581 (1999); In *Olmstead*, the U.S. Supreme Court held that under the Americans with Disabilities Act, individuals with mental disabilities have the right to live in the community rather than in institutions if "the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated...."

- Connections with other providers and systems (i.e. criminal justice, foster care, child welfare, education, primary care, hospitals)
- Psychiatric rehabilitation services
- Peer support, counseling services, and family support services
- **Recommendation(s):**
  - Support team-based approaches, such as collaborative care models that treat both the mind and body of patients
  - Support state Medicaid efforts on Assertive Community Treatment (ACT) teams, and mobile van for individuals who are homeless
  - Support the implementation of evidence-based practices in the community mental health center and alternative payment models
  - Support crisis mental health services, including: 24-hour mobile crisis teams, crisis hotlines, emergency crisis intervention, and crisis stabilization
  - Address the need for a comprehensive and effective Olmstead plan for serving qualified people with mental disabilities in less restrictive settings

## **9) Ensure mental health parity**

- **Findings:**

The US Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 requires health insurers to guarantee that financial requirements on benefits (e.g. co-pays, deductibles, and out-of-pocket maximums) and limitations on treatment benefits (e.g. caps on visits with a provider or days in a hospital visit) for mental health and behavioral health services are not more restrictive than the insurer's requirements and restrictions for medical and surgical benefits. The challenge is to ensure that insurers are properly implementing mental health parity in all areas of coverage, from plan design to patient co-sharing responsibilities.

Many people testified about the lack of parity for mental health, particularly with non-quantitative treatments, such as incomparable provider networks or formulary tiers. Linda Johnson (OHIC) and Michael Dexter (DOH) testified about their respective state roles in ensuring mental health parity. OHIC is restarting a previously begun Mental Health Parity Market Conduct Examination to determine whether each of RI's four major health insurance companies are meeting their legal obligations with respect to covering mental health and behavioral health benefits. In addition to the market conduct exam, OHIC is monitoring the number and type of patient complaints received. OHIC looks at both the quantitative and qualitative parity issues that are embedded in insurer plan design documents.

Dave Spencer (The Substance Use and Mental Health Leadership Council of RI) commented that the average length of stay for residential treatment for substance abuse used to be four months; now, the average is only twenty days due to restrictive insurance practices. Individuals are often being denied payment for initial residential treatment admission or continued lengths of stay after 2-3 weeks. He has documented cases of

individuals who have ended up in the emergency room due to denials of payment for residential treatment. There are also cases of drug overdoses and some suicides in this same population.

- **Recommendation(s):**
  - Support OHIC’s ongoing review of insurers’ compliance with mental health parity
  - Fund social workers to assist the Mental Health Advocate and Child Advocate
  - Reduce or eliminate insurer barriers to mental health care:
    - Reduce certain prior authorization requirements
    - Consider an exception to “step therapy” (patient trial and error of generic drugs) for severe mental illness

**10) Address cost sharing requirements for mental health and behavioral health treatment which serve as a barrier to access of care**

- **Findings:**

Even with insurance or financial assistance, mental healthcare services can be costly. Copays and deductibles add up quickly when a diagnosis requires regular therapy, complicated medication management, or intensive treatment programs. Patients who cannot afford out-of-pocket costs may forgo treatment, leading to poor management of the patient’s mental illness. Testimony included statements that many patients’ mental health treatment plan necessitates both a weekly individual and group counseling session. These two co-pays can conservatively amount to \$75-\$100 per week, which can be cost-prohibitive and a barrier to adherence to the treatment plan. Cost sharing may disproportionately affect people with mental illness, who have lower family incomes and are more likely to be living in poverty than those without mental illness.<sup>37</sup>

- **Recommendation(s):**
  - Examine insurance plan design and ensure that patient payment obligations are not a barrier to care for mental health and behavioral health patients

**11) Increase identification and treatment of depression and substance use disorder in pregnant and postpartum women**

- **Findings:**

Depression is one of the most common complications in pregnancy. As many as 12.7% of pregnant women experience a major depressive disorder.<sup>38</sup> Depression during pregnancy is not only the strongest risk factor for post-natal depression but

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<sup>37</sup> Rowan, Kathleen et al., Access and Cost Barriers to Mental Health Care by Insurance Status, 1999 to 2010, *Health Affairs* (Millwood) 32.10 (2013): 7.

<sup>38</sup> Lancaster, Christie A. et al., Risk Factors for Depressive Symptoms during Pregnancy: A Systematic Review, *American Journal of Obstetrics and Gynecology* 202.1 (2010): 5–14.

also leads to adverse obstetric outcomes.<sup>39</sup> Studies have shown that babies and toddlers with depressed mothers are subject to a myriad of problems; they may be more difficult to console, less likely to interact, and more likely to have sleeping problems. Therefore, addressing the mother's illness helps to prevent potential future childhood disorders.

The U.S. Preventive Services Task Force (USPSTF) and the American Congress of Obstetricians and Gynecologists recommend screening for depression in the general adult population, including pregnant and postpartum women. There is convincing evidence that screening improves the accurate identification of adult patients with depression in primary care settings, including pregnant and postpartum women. Evidence-based screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.<sup>40</sup>

One of the risks of mental health issues in pregnancy is substance use. In utero exposure to certain substances can cause the newborn to go through withdrawal after birth when the exposure ends. Neonatal withdrawal most commonly results from in utero exposure to opioids but is also associated with pre-birth exposure to benzodiazepines, barbiturates, and alcohol. Neonatal Abstinence Syndrome (NAS) refers to clinical findings associated with the newborn's withdrawal symptoms, e.g. neurological excitability and gastrointestinal dysfunction. Deb Garneau (RIDOH) testified that between 2005 and 2012, the rate of NAS in Rhode Island resident births increased from 4.4 to 8.3 cases per 1,000 live births. Identification and treatment of the mother's illness will result in a healthier start for the baby.

- **Recommendation(s):**
  - Support DOH's efforts to educate and encourage medical professionals serving pregnant women to screen for mental health issues and refer for appropriate treatment and support services

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<sup>39</sup> Ajinkya, Shaunak, et al., Depression during Pregnancy: Prevalence and Obstetric Risk Factors among Pregnant Women Attending a Tertiary Care Hospital in Navi Mumbai, *Industrial Psychiatry Journal* 22.1 (2013): 37–40.

<sup>40</sup> Siu AL, and the US Preventive Services Task Force (USPSTF), Screening for Depression in Adults: US Preventive Services Task Force Recommendation Statement, *JAMA* 315.4 (2016):380-387.

**Written Testimony  
&  
Presentations**

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# SENATE COMMITTEE ON HEALTH & HUMAN SERVICES

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## NOTICE OF MEETING

**DATE:** Thursday, September 15, 2016

**TIME:** 3:30 - 5:00 PM

**PLACE:** Senate Lounge - State House

### AGENDA:

#### **Mental Health Hearing #1**

##### **1) Opening remarks – Senate HHS Committee Chair Joshua Miller**

- Introduction to the series of mental health hearings and topics

##### **2) Introduction: Mental Health Issues in RI**

– **Executive Office of Health & Human Services Secretary Elizabeth Roberts**

- Truven RI Behavioral Health Report
- Overview of mental health challenges, resources, and state policy options

##### **3) Panel Discussion: Priorities in Mental Health Advocacy**

- Meg Clingham, Esq., RI Mental Health Advocate
- Jim McNulty, Executive Director, Mental Health Consumer Advocates of RI
- Ruth Feder, Esq., Executive Director, Mental Health Association of RI

##### **4) Public Comment**

- Written testimony is encouraged and copies will be shared with the Committee members. Please forward to Marea Tumber in the Senate Policy Office: [mtumber@rilegislature.gov](mailto:mtumber@rilegislature.gov)

Senate Legislative Office

222-2381

[SLegislation@rilegislature.gov](mailto:SLegislation@rilegislature.gov)





## **Presentation to the Senate Committee on Health & Human Services**

September 15, 2016

**SECRETARY ELIZABETH ROBERTS, EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES**

### **Introduction**

- ▶ Truven Report Findings
- ▶ Truven Report Recommendations
- ▶ Current Activities
- ▶ Questions/Comments





## Truven Report on Behavioral Health Services

### Truven Report: Key Findings

#### Demand Report

- ▶ Rhode Island has a **higher rate of hospital admissions for mental health** than any other New England state
- ▶ Rhode Island has **one of the highest rates of adult illicit drug use** in New England

#### Spending Report

- ▶ Rhode Island spent **\$853M on behavioral health treatment** in 2013
- ▶ **Highest behavioral health spending** per private insurance enrollee in New England
- ▶ RI spends nearly **10 percent of total state budget providing services that stem from behavioral health conditions**, including incarceration costs, child welfare services and social services.

## **Truven Report: Key Findings**

### **Supply Report**

- ▶ Rhode Island is under-resourced in community-based services, particularly in behavioral health professions in FQHCs, access to behavioral health and substance abuse counselors and community residential treatment beds for adolescents and adults.
- ▶ Children and adolescents face higher rates of poverty, compared to neighboring states.
- ▶ Rhode Island lacks step-down services for children and adolescents following a psychiatric hospitalization.

## **Truven Report: Recommendations**

1. Prioritize care coordination and integration to create a more cost-effective behavioral health system.
2. Enhance state and local infrastructure to promote a population-based approach to behavioral healthcare.
3. Greater investment in evidence-based prevention.



## Current Activities

**Recommendation 1:** Prioritize care coordination and integration to create a more cost-effective behavioral health system.

### Current Activities

- ▶ Reinventing Medicaid: SPMI
- ▶ Opioid Treatment Health Homes
- ▶ Centers for Excellence
- ▶ Collaboration with CTC-RI and Multi-Payer PCMH practices.

## Reinventing Medicaid: SPMI

- ▶ **9,317** enrollees in SFY16.
- ▶ Preliminary data since January 1, suggests:
  - ▶ **7% decline** in inpatient service utilization
  - ▶ **9% increase** in outpatient service utilization
  - ▶ **22% increase** in home- and community-based utilization.
- ▶ Cost trends are **not increasing**.

## Other Service Coordination Efforts

- ▶ **Opioid Treatment Health Homes**
  - ▶ Opioid Treatment Programs provide an opportunity for daily contact with Medical and Clinical professionals who have on-going therapeutic relationships with patients.
- ▶ **Centers for Excellence**
  - ▶ A specialty center that utilizes evidence-based practices and is responsible for providing treatment to and coordinating the care of individuals with moderate to severe opioid use disorder. The goal is to ensure timely access to appropriate, high quality Medication Assisted Treatment (MAT), including methadone, buprenorphine products and naltrexone, for individuals diagnosed with opioid use disorder.
- ▶ **All Payer Integrated Primary Care & Cedar Services**
  - ▶ In partnership with the Care Transformation Collaborative, Medicaid has worked to connect Cedar services to all-payer, patient-centered pediatric medical homes, providing community-based care coordination to children enrolled in PCMH-practices.

**Recommendation 2:** Enhance state and local infrastructure to promote a population-based approach to behavioral health care.

### Current Activities

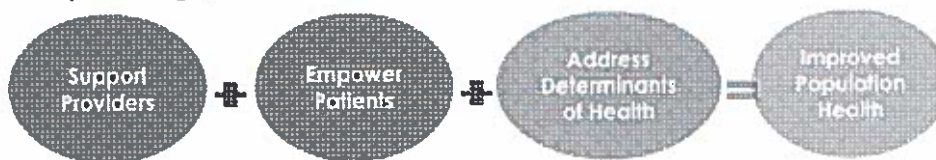
- ▶ State Innovation Model Test Grant (SIM)
- ▶ Children's Cabinet
- ▶ System Planning Grants
- ▶ Workforce Development

## State Innovation Model (SIM)

### ▶ Project Goal:

- ▶ State-wide innovation, through broad stakeholder input and engagement, to accelerate delivery system transformation to provide better care at lower costs.

### ▶ Theory of Change:



### ▶ Strategies:

1. Link Payment to Outcomes
2. Develop Infrastructure
3. Plan for a Healthy Population

## State Innovation Model (SIM)

### ► Population Health Plan:

- A report describing the **physical** and **behavioral** health of Rhode Islanders in 7 focus areas.

SIM Health Focus Areas						
Obesity	Tobacco	Chronic Disease (e.g., such diabetes, heart disease, and stroke)	Depression	Children with Social and Emotional Disturbance	Serious Mental Illness	Opioid Use Disorders

### ► Operational Plan:

- **Collaboration:** Multi stakeholder table for development of population health plan and implementation approach that focuses on integrating physical and behavioral health.
- **Coordination:** Coordinated regulatory and contracting approach focused on value-based payments and integrated population health.
- **New Investments:** Pilot or expansion of supply- & demand-informed interventions.

## Children's Cabinet

### ► Priority Area: Children's Behavioral Health

- Developing Shared Vision for Children's Behavioral Health Services.
- Mapping services and funds across Cabinet agencies.
- Prioritizing transitions of care between systems.

## System Improvement Grants

▶ **Health Transitions Grant**

- ▶ A planning and program grant to provide early identification and intervention for mental illness (especially first episode psychosis) to transition aged youth.

▶ **State Youth Treatment Planning Grant**

- ▶ A two year planning grant to assess our adolescent substance use disorder treatment system.

▶ **Screening, Brief Intervention, and Referral to Treatment (SBIRT)**

- ▶ A coordinated effort of BHDDH, SIM, and DOH, designed to provide early screening and intervention for Substance use disorders in healthcare settings.

▶ **Certified Community Behavioral Health Centers (CCBHC)**

## Workforce Development

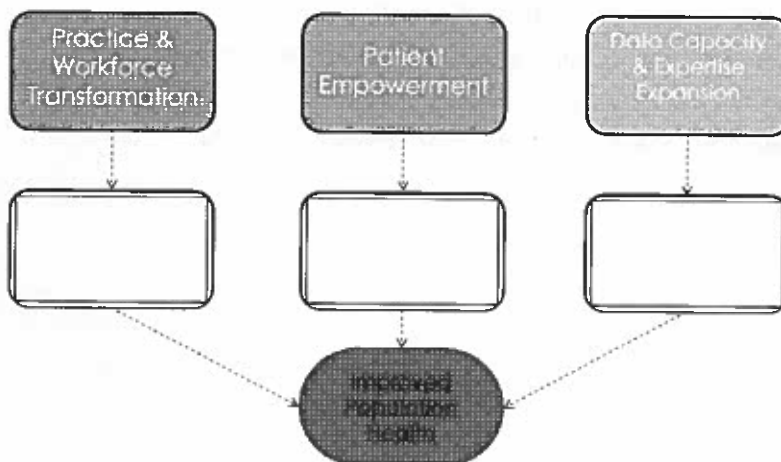
- ▶ Integrating behavioral health awareness and competencies into training.
- ▶ Peer Recovery Coaches

### Recommendation 3: Greater investments in prevention.

#### Current Activities

- ▶ SIM Investments
- ▶ Overdose Investments

### SIM Investments





## SIM Practice & Workforce Investments

- ▶ **\$1.72M – Behavioral Health Transformation**
  - ▶ Practice Coaching at Community Mental Health Centers
  - ▶ Integrated Behavioral Health Analytics, Training, etc.
  - ▶ Care Management Dashboards
- ▶ **\$650k – Child Psychiatry Access Program**
- ▶ **\$480K – SBIRT Provider Training**
- ▶ **\$2M – Community Health Teams**

## FY2017 Overdose Investments

- ▶ **\$3.5M to support Prevent Overdose RI strategies**
  - ▶ \$2M to support medication-assisted treatment for inmates at the ACI
  - ▶ \$1.5M to expand access to peer recovery coaches.
  - ▶ ~\$40k to provide naloxone kits to police departments state-wide.



**Questions?  
Comments?**



celebrating **125** years 1891-2016

September 15, 2016

Chairman Miller and Members of Senate Health and Human Services Committee:

I am submitting this written testimony on behalf of Community Care Alliance (“CCA”) located in Woonsocket, Rhode Island and serving Northern RI and other parts of the state. We are a comprehensive human services agency with over 50 programs serving vulnerable children, families and adults. Thank you for the opportunity to submit this testimony. I am focusing comments on the following issues and concerns related to the mental health system in Rhode Island.

Financing IHH/ACT (Integrated Health Homes and Assertive Community Treatment Teams)

First, let me clarify that IHH/ACT are the safety-net programs serving the seriously mentally ill and persons with severe and persistent mental illness. They are comprehensive programs that encompass treatment, case management, and vocational services, as well as collaboration and integration with primary care providers to assure that this population’s behavioral health and medical needs are addressed in an integrated manner.

In January 2016, behavioral health providers of these services transitioned from the previous health home model developed by BHDDH to IHH/ACT of which both models had demonstrated empirical effectiveness in serving the SPMI (severe and persistently mentally ill) population. While the speed and lack of planning was disruptive to the population, overall, this transition has been made and has more or less moved forward in a positive manner from a clinical point of view.

Whereas the practice shift has been accomplished, there has been serious problems encountered where financing and payment has occurred. I would summarize these issues where Community Care Alliance is concerned as follows:

- EOHHS/BHDDH shifted payment for IHH/ACT from a single Medicaid payer (i.e. the State of RI through its vendor Hewlett Packard) to two additional managed pay sources (i.e. NHP and United).
- The impact of additional pay sources was felt immediately relative to a lack of a predictable payment schedule and three different claims processes.
- As a result of cash flow problems, Community Care Alliance was forced to request an advanced payment of \$700k from the State’s Medicaid Entity (i.e. Hewlett Packard) and had to agree to repay the amount within 3 months. Subsequently, while this provided temporary short term assistance, it also had the effect of reducing cash flow in later months.
- Throughout the transition process EOHHS repeatedly asserted that rates had not been reduced. This was not the case; relative to CCA, this resulted in a \$45,000 reduction in revenue attributed to IHH/ACT services.
- Owing to severe cash flow concerns, Community Care Alliance was forced to reduce salaries by 10% across all programs in the month of July.

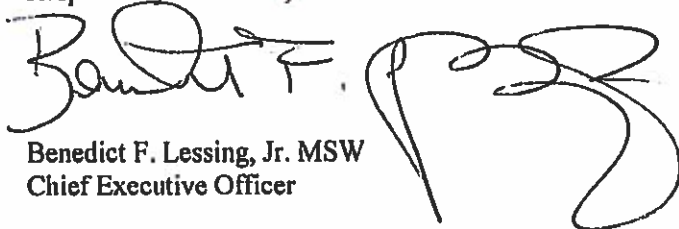
In July 2016, CCA and EOHHS worked together to develop an alternative repayment approach that would allow payments to begin at a later time in smaller increments. This agreement also restored cash flow through the state's Medicaid entity (Hewlett Packard). This process was enormously helpful in allowing CCA to begin to catch up relative to vendor payments, meeting payroll etc. However, in August 2016 United began recouping \$303,000 in claims going back to October 2015 – January 2016 without notification. We attempted to stop this process and work with United to make whatever corrections to claims were necessary, to no avail. Again, EOHHS was asked and did intercede to assist us; however, as of this testimony, United removed a total of \$303,000 from CCA revenue which we are attempting to have restored. While we have not had as severe consequences with NHP, we have had issues which has resulted in inconsistent payments.

**Recommendations:**

1. The State of RI must make a decision as to whether or not to continue doing business with United. Their business operations owing to their multiple corporate layers is neither efficient nor responsive to the state's responsibility for serving vulnerable populations.
2. Create financial penalties within MCO contracts that are immediately enforceable by EOHHS.
3. Legislatively mandate and create a financial safety net that maintains business continuity while claims issues are being addressed. This may operate similar to a line of credit that can be paid back subsequent to reconciliation.
4. The claims process should be consistent from payer to payer. I believe this would improve administrative efficiency and problem solving.
5. EOHHS may need additional staffing capacity in order to rapidly address emergent payment concerns that place community based non-profits providing IHH/ACT at risk. The State of RI cannot simply turn over safety net services to Managed Care Organizations and hope for the best. We have seen similar instances of this occurring with respect to Children's Behavioral Health that has been detrimental to the population and resulted in greater utilization of psychiatric inpatient care where effective community based services could have been an alternative were they available.

In conclusion, the State of RI needs to take responsibility for assuring its providers of community based services are appropriately funded and paid on time. Given that this transition has occurred where practice and payment methodology is concerned we are not advocating returning to the prior system. The recommendations above represent concrete, systemic approaches to improving the system of care for adults with severe and persistent mental illness. I would urge members of Senate HHS to work closely with the administration in a proactive manner to assure stabilization. One year ago these were non-issues; if not corrected, community based mental health services will continue to struggle, thereby destabilizing populations and organizations committed to addressing their needs.

Respectfully submitted,



Benedict F. Lessing, Jr. MSW  
Chief Executive Officer

# MENTAL HEALTH CONSUMER ADVOCATES OF RHODE ISLAND, INC.

Oasis Wellness & Recovery Center | Tel: 401.831.6937 | Fax: 401.453.1876

Mail: MHCA-RI, Inc. | 1280 North Main Street | Providence, RI 02904



## Survey of Oasis Wellness and Recovery Center Members:

In 2015, with funding being jeopardized, and Oasis members voicing concern and fear for their future, we at the Oasis Wellness and Recovery Center in Providence decided to ask our members what the Oasis means to them and why they feel it is important that the Oasis centers keep going. Here are highlights of what they said:

**Brenda says:** "I was able to return to full-time employment and get better from my time at Oasis. The program helped me gain self-confidence again and I currently work as a state employee and have never been happier in my life."

**Jude, who currently coordinates the volunteers at Oasis, says:** "Spending time with others who live with the daily challenges of mental illness reassures me that life has value, after years of despair." He says: "Being unable to work [for physical reasons] . . . [at Oasis] my mood has consistently improved. This has been observed by my therapist and family members."

**Certified Peer Recovery Specialists:** Here are some of their thoughts. **Dawn says:** "I feel safe and able to express myself without be criticized, or feeling different. Oasis Staff is not just 'staff', but has become a family and a home. **Ed is proud that the Oasis helped him get his first paycheck in over 20 years. Ed says:** "Facilitating my own [support] groups at Oasis [built] my confidence in myself as a helper." **Janice says:** "I find the peer support groups extremely supportive and helpful." **Bill states:** "I came with a lot of anxiety and apprehension. . . . I am now in a position where I can serve others." **Bill says that when he came to Oasis at first, he was "broken", and now he volunteers most evenings helping the homeless. Jon, who currently works full-time as a Peer Specialist, credits Oasis with "improv[ing] my overall quality of health and "helping [me] learn all the time about wellness and recovery". Judy, who has returned to work full-time after a long hiatus, says that:** "It has opened a new world to me. . . . I am exploring the world instead of isolating in my illness." **Mary recounts that "I have been . . . for 30 years [in] traditional therapy with some degree of success, [but] the first class I took at Oasis, the Wellness and Recovery Action Plan (WRAP), was empowering to a degree I had never experienced. . . . I think the peer support model is so effective at giving people living with mental health the hope, support and tools necessary to live with a sense of purpose and happiness, being as productive and independent as possible." Rick echoes this thought:** "I have been in therapy for 15 years and have gotten as much if not more recovery here [in 1 ½ years] than in all the other places combined."

**Art Program Members:** Their views: **Angel says that Oasis helped him "to discover my talents". In the art class, he found that he has a natural talent for painting, and hopes to start his own art business. Angel also said the Oasis "keeps me out of trouble", and he is passionate about recovery centers like Oasis being an alternative to incarceration. Angel is not the only member who says that the art program has been a spur to recovery, socialization, and skill building. Cynthia says:** "My peers notice when I am 'off' and talk to me about my symptoms in a kind an understanding manner. This helps me to talk to my

professionals more quickly." Cynthia says she was referred to Oasis by Butler Hospital, and that Oasis helps her discover community resources. Ida found the art room a place where she could "relate to other people's illness. It also helps me to get out of the house and get out of my shell." Ida has now returned to work. Jean, of retirement age, feels that "[the art program] has become my home away from home," and that "Otherwise I would spend my time idle and useless." Joyce says that before she came to Oasis, "I was unable to get through the day," and that "Now I can keep up every day and I am looking forward to more education [at] Oasis." Louise says that: "The Oasis literally became my 'Oasis' when my mental illness left me out in the desert by making me disabled. . . . I found . . . friends who are a lot like me in many ways. . . . I'm forced to face [my illness] without the distractions of a purposeful life. . . . Since I can no longer function in life, I need an oasis, the Oasis." Louise has since gone on to volunteer at an art museum, and at the art program at Oasis. Sonja says: "Many days I just don't want to get out of bed. I know that I should and once I get here there is bound to a meeting or activity that will make me feel better. I forget to eat a lot but when I come to Oasis I get enough nutrition. . . . I meet people that I wouldn't meet because I am very full of anxiety so I don't talk, but in Oasis I am included. I especially like the Arts and Crafts. It takes my mind off of my problems and gives me time to relax and feel normal for a few hours."

Bill says that Oasis makes him feel "needed", which he doesn't find elsewhere in his life.

Like many of our members who have co-occurring substance use issues, Denise says: "It has supported me by helping me stay drug-free. . . . It's a safe place to go to help keep me sober."

Howie credits the Oasis with keeping him out of the hospital. Of retirement age, he feels more comfortable at Oasis, where he is able to find understanding with his peers, than at a senior center.

Jared feels safe at the Oasis: "The Oasis is there for me when I have no safe place to go during the day."

John values the Oasis as a source of "contact with peers", "contact with resources", and keeping him out of the criminal justice system.

Susan says: "The [Wakefield] Oasis Center gives my brother confidence, self-esteem, friends who bear similar crosses which is huge, to feel like a man, an adult, something to look forward to in his otherwise lonely week in his apartment, to not feel ostracized by society."

Paul says: I have been a very active participant of [Oasis] since . . . 1999. On numerous occasions I have been rescued from the depths of depression. Their wholesome activities and therapeutic . . . sessions have shaped my recovery from a life-long battle with mental illness."

For more information, please contact Jim McNulty at [jmcnultyri@gmail.com](mailto:jmcnultyri@gmail.com) or Charlie Feldman at [cfeldmanri@gmail.com](mailto:cfeldmanri@gmail.com)

# Community Care Alliance

empowering people  
to build better lives

401.235.7000  
CommunityCareRI.org  
PO Box 1700 Woonsocket, RI 02895

September 15, 2016

Chairman Miller and Members of Senate Health and Human Services Committee,

My name is Lori Ziegler Halt and I am the Human Resources Director at Community Care Alliance in Woonsocket, RI. After working in the private sector for 18 years, I found myself entering the world of non-profit social services 4 years ago. As frustrating and decidedly unglamorous as it is, I wouldn't trade it for the world.

I have always wanted to make a difference in the world and these days I'm a little closer to meeting that goal, supporting and working with people who make a huge difference on a daily basis. The staff I work with are the most dedicated, caring, professional people I've ever met. They are out in the community providing face-to-face support and resources to the people who need it the most. They are walking into homes where they cannot put their bags down or sit down because of bugs. They sometimes walk into life & death situations they have been trained to handle but don't expect. Every single day, they are meeting with people who are ill, frustrated, scared, crying, angry, sad, and sometimes feeling hopeless. They work tirelessly to find these people a roof, a job, someone to just hear them; a way to get their lives back on track, to get their children back, to secure basic needs, to battle addiction, to help their babies get and stay healthy and to address their serious and persistent mental health concerns. They work long hours doing critical work with people who need hope. And they're doing it for \$11-\$13 an hour.

They work 2-3 extra jobs in order to make ends meet. They take any extra on-call hours they can get their hands on, working nights and weekends on top of their regular full-time jobs and/or school. They take loans out on their 403b. They fall into the pay-day-loans black hole. They put off necessary health procedures and surgeries because they can't afford to be out that long. Again, I'm talking about our employees, not our clients. Let us think of ourselves as "us" and the people we serve as "them," I have learned that the line between is a very thin one. One health issue, lay off, family change, salary cut or even just plain bad luck and "us" could be "them." Last year we discovered that one of our case managers had been homeless for months and living out of their car.

And now we are losing them. This summer, because of cash flow issues brought on by changes and delays in IHH/ACT funding and payments, we had no choice but to make a 10% salary cut for all but our lowest paid employees. Although the salary cut was temporary, the effects were not. We have had an exodus of excellent employees leaving for more pay, more stability- about 20 or so, just over the last couple of months. This has resulted in a critical shortage of nurses, programs running with skeleton crews, and staff pulling double and triple duty to cover and help out. It is resulting in low morale and exhaustion. It is resulting in a huge rise in leaves of absence, with our staff putting their well-being on the backburner, despite wellness programs and health and time benefits. Stress leaves are becoming the norm.

In the private sector, I would have just called a few head hunters, bought postings on some of the big job sites, enticed employees with large sums of money for referrals and, of course, offered bonuses, stock options or higher salaries for critical positions. I could usually get positions filled pretty quickly, with programs only feeling a small blip. But in the non-profit world, we just don't have the resources to do that. It's taking weeks or months to find people to fill our positions with the salaries we are able to offer. Then, it takes time to get them trained and acclimated.



Vacant positions mean clients are not being served and it means the agency is not only not generating money but actually having to spend money in order to sustain itself. In some cases, we are running programs with per-diem nursing temps that cost as much as \$50/hour, because we cannot find people to backfill our positions because nurses are in demand and can make much more money elsewhere. This is an incredibly expensive solution, but we have no choice.

I recently talked with an excellent recruiter/head-hunter who offered a special deal contract because we are a non-profit. Their cost to hire one of their candidates was 30% of the candidate's first-year salary, based on 40 hours. So, even if we were only hiring them part time, we'd be paying out at full-time.

Our residential program staff has been decimated- with remaining staff, managers and team leaders working as much as possible to cover the shifts themselves, in order to keep the 24/7 facilities up and running. We are providing job and career assistance programs with the director teaching classes in addition to the hands-on management of all the programs under her. Our youth program had to "borrow" some staff from other programs just to make our summer youth job program run this year. These are just a few examples of the impact lack or delay of funding has.

There is also a major impact when changes are made without feedback from the non-profit organizations providing services. It has had a direct effect on clients in some cases. When requirements have suddenly changed, we've had to reorganize and sometimes completely change the way successful programs have run for years. Staff who have been working with certain clients for years, carefully building trust and relationships, have suddenly found themselves reorganized and moved to a new team, with their clients having to start over with someone new. And they sometimes find themselves without services because we are no longer permitted to serve clients in the way we have been for years.

In order for our staff to be able to provide stability to our clients, our agency needs stability. Much of that stability comes from funding. Funding that we don't have the luxury of time to jump through endless hoops for. Funding that shows up, fully, when it is expected and when it was promised. Stability also comes with reliability and steady communication without sudden changes that come, seemingly, from out of the blue. It requires open and frequent conversations with human services providers being at the table when decisions are made.

We desperately need your help so that we can continue to help others. Without regular, dependable funding and stability, we will be without staff. Without staff, we will be unable to maintain all the good we do for the community and the people in it. Thank you.

Respectfully,



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**TESTIMONY BEFORE SENATE COMMITTEE ON HEALTH & HUMAN SERVICES**

***Mental Health Issues***

**September 15, 2016**

**Ruth A. Feder, Esq. M.S.W, Executive Director**

- **Truven Report**
  - Too much spent on “high-end” services
  - Need to expand array of services in the community
  
- **Olmstead Plan**
  - Rhode Island needs a fully funded Olmstead Plan.
  - Need to address Truven report findings by implementing a comprehensive system, with seamless transitions between agencies for consumers and families
  
- **Mental health system cuts—restore funding**
  - Community mental health system currently not serving needs of Rhode Islanders
  - Need Support for Certified Community Behavioral Health Clinics (CCBHC) Grant Application
  
- **Transition from children’s services to adult—DCYF to BHDDH**
  - Need to solve the disconnect that frequently occurs for youth transitioning between departments
  
- **Prison system functions as mental health facility**
  - Confining individuals who live with mental illness—need diversion program
  
- **Health Insurance Issues**
  - Lack of true mental health parity
    - Persistent issues with non-quantitative treatment limitations
  - “Fall-First” requirements
  - Excessive out of pocket expenses
  - Inadequate reimbursement rates lead to small provider networks
  
- **Prevention—in addition to addressing the opiate crisis, we must also look at bigger picture of prevention.**
  
- **Stigma**



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# SENATE COMMITTEE ON HEALTH & HUMAN SERVICES

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## NOTICE OF MEETING

**DATE:** Thursday, September 29, 2016  
**TIME:** 3:30 PM - 5:00 PM  
**PLACE:** Senate Lounge - State House

### AGENDA:

#### Mental Health Hearing #2

1) Access to Evidence-Based Services

Providers will discuss the importance of evidence-based, outpatient mental health services. Focus areas will include the coordination of care through case management, primary care integration, social supports, and peer specialists. Presenters will also discuss challenge and potential solutions in their areas of expertise.

- Susan Storti, Ph.D, Leadership Council of RI
- Richard Harris, MSW, LICSW, Executive Director, RI National Association of Social Workers
- Michael Silver, MD, RI Medical Society
- Dennis Roy, President & CEO, East Bay Community Action Program
- Mary Dwyer, RN, MSN, APRN-PCNS, Board Member, RI Nurses Association
- Peter Oppenheimer, PhD, Chair, RI Primary Care Physicians Corporation  
Behavioral Health Network
- Dale Klatzker, Ph.D., President, The Providence Center
- William Emmet, Former Executive Director, the Kennedy Forum
- State Response

2) Public Comment

Written testimony is encouraged and copies will be shared with the Committee members.  
Please forward to Marea Tumber in the Senate Policy Office: [mtumber@rilegislature.gov](mailto:mtumber@rilegislature.gov)

Senate Legislative Office

222-2381

[SLegislation@rilegislature.gov](mailto:SLegislation@rilegislature.gov)





## The Substance Use and Mental Health Leadership Council of RI

Good Afternoon.

My name is Dr. Susan Storti and I am the Administrator of the Opioid Treatment Program Health Homes and Mental Health Policy at the Substance Use and Mental Health Leadership Council of RI. Previously I served as the National Project Director for the National Institute on Drug Abuse's Blending Research and Practice Initiative and as research faculty at Brown University's Warren Alpert's Medical School, Center for Alcohol and Addiction Studies. Over the past 25 years, I have assisted in facilitating systems change through the translation, implementation, and adoption of evidence-based approaches in the treatment of medical and behavioral health disorders in to clinical practice. Thank you for the opportunity to speak with you today regarding evidence-based treatment with a specific focus on care coordination, barriers to implementation, and potential solutions for your consideration.

### **Evidence based Practices**

Patients who have complex health needs account for a disproportionate share of health care spending or may be at risk of incurring high spending in the near future.<sup>1</sup> These individuals typically suffer from multiple chronic health conditions and/or functional limitations.<sup>2</sup> Moreover, their health care needs may be exacerbated by unmet social needs.<sup>3</sup> They are often poorly served by current health care delivery and financing arrangements that fail to adequately coordinate care across different service providers and care settings.<sup>4</sup>

A significant approach to increasing the value gained from the expenditure of health care dollars is adoption of evidence-based practices: that is, the purchase of treatments and services that have been scientifically confirmed to improve outcomes. With respect to treatment for persons with mental illnesses, the news is both good and bad. The good news is that solid scientific evidence suggests that many potentially available treatments and services are *efficacious*; substantial gains in the form of improved symptoms and functioning are possible with the right treatment. The bad

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<sup>1</sup> Schoenman, J. A. (2012). *The concentration of health care spending*. NIHCM Foundation Data Brief Washington, D.C.: National Institute for Health Care Management Research and Educational Foundation.

<sup>2</sup> Alexth, L., S. Shen, S., Chan, I. et al. (2010). *Individuals living in the community with chronic conditions and functional limitations: A closer look*. Washington, D.C.: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

<sup>3</sup> Bachrach, D., Pfister, H., Wallis, K. et al., (2014). *Addressing patients' social needs: An emerging business case for provider investment*. New York: The Commonwealth Fund.

<sup>4</sup> Asch, S. M., Kerr, E. A., Keeseey, J. et al. (2006). Who is at greatest risk for receiving poor-quality health care? *New England Journal of Medicine*, 354(11), 1147-56.

news is that there are substantial gaps between what sciences tells us to do and what is possible in the real-world setting.

Evidence-based care coordination interventions represent a wide range of approaches at the service delivery and systems level.<sup>5</sup> Their effectiveness is dependent upon appropriate matching between identifying and engaging appropriate patients, matching team composition and interventions to patient needs, and developing trust and effective communication between providers to facilitate care coordination

### **Overcoming Barriers to Sustainability**

As we know providers are caring for patients with increasing needs for coordination services in a system that has progressively become more fragmented. Coordinating care for patients takes time; time that is typically not reimbursed. As the population ages, as the number of people with multiple chronic medical problems increases, and as patients see more doctors and receive care at a greater number of healthcare settings, the need to coordinate care will continue to increase. This increase in need is occurring in an environment in which cost containment efforts result in decreased access to social support services. While the need for coordination increases, community mental health and primary healthcare providers frequently lack the infrastructure and resources to respond to their patient's needs. Other contributing factors include -

- **Workforce:** Effective mental health systems that provide quality, evidence-based treatment must rely upon a well-trained and available workforce. Producing such a workforce is a daunting task. For the most part, mental health practitioners, in the appropriate circumstances and given the appropriate training and incentives, will be willing to adopt practices that improve outcomes. Too often, however, practitioners are overworked and underpaid, lack training in many of the evidence-based practices, and lack incentives to change. Additionally, payers require specific licensure of staff for reimbursement, thus adding another barrier to providing services to select groups of the population receiving mental health services.
- **Access to Services:** Although evidence-based practices are necessary for a quality mental health system, they are not sufficient. Interventions need to be culturally and linguistically appropriate and be tailored to meet the needs of community residents. Throughout RI access to services for specific populations (i.e., the visually and hearing impaired, developmentally disabled, older adults, etc.) are limited or non-existent.
- **Infrastructure:** Presently there is inadequate electronic health records systems and

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<sup>5</sup> By system-level policymakers I am referring to those who have responsibility for paying for health care services for large numbers of individuals (i.e., health plan enrollees, Medicare beneficiaries) and make decisions about how to coordinate care at a *system level* in ways that minimize their financial risks and maximize the health care outcomes of their population of patients. By service-level decision makers I am referring to individuals who are involved in providing health care services to individual patients or a panel of patients, and therefore tackle care coordination at the *service delivery level*.

- interface to support integrated care management and coordination across the care continuum, including payment of claims.
- **Capacity to Change:** Decisions related to the expenditure of public mental health dollars often hold practitioners accountable to provide evidence-based practices and to eliminate practices that do not help people. And while there are evidence based practices related to care coordination for individuals with mental health disorders (i.e., Assertive community treatment (ACT), incorporation of on-site mental health worker, community mental health team management, case management, disease management, etc.), implementation of these practices require a financial commitment including educating existing staff, hiring new staff, and developing and/or revising clinical pathways to incorporate new practices.
- **Financing Services:** Public funding for mental health services in various instances is often inadequate, or is constrained in such ways as to make support for certain evidence-based practices difficult .

### **Potential Solutions**

Simply identifying barriers and enabling factors does not produce change. To advance the field, federal, state, and community and primary health care providers need to come together to identify existing system strengths, gaps and challenges, and develop strategies to facilitate a cost-effective, time-efficient approach to patient care and care coordination. Suggested approaches include:

**Workforce:** Practitioners need opportunities and incentives to learn new, evidence-based approaches, combined with the expectation that they will avail themselves of such opportunities and put into practice what they learn. It must be noted, too, that whereas substantial efforts are needed to address the performance of the existing workforce, comparable efforts are also necessary within the institutions of higher learning that are training the *future* workforce.

**Services:** Whereas services that are consuming substantial resources should be subjected to evaluations that can guide decisions about their value, it is important to remember that some services are of self-evident value, for example, provision of shelter and food to homeless persons with severe mental illness has value. Other services may warrant continued support but with the expectation that some evaluation occur to ensure that resources are well spent.

### **Building a New Framework to Enhance Prevention and Wellness:**

- **Reimbursing for essential preventive services:** Examine opportunities to work with the health insurance system to incentivize providers to promote basic preventive services such as screenings for diabetes, depression, etc.
- **Removing barriers to preventive services:** Remove barriers to preventive services that discourage individuals from participating in screenings and preventive initiatives. Studies show that even small copayments and deductibles cause individuals to forego essential



screenings and annual physicals which detect health problems before they become full blown conditions.

- Promoting community wellness: Health reform must occur in communities as well as in medical settings. Most chronic diseases can be prevented through lifestyle and environmental changes. Community prevention programs encourage physical activity, good nutrition, and the reduction of tobacco use, helping individuals to make healthy choices easier. Strengthening our public health system is critical to protecting people from health threats beyond their control, such as natural disasters, infectious outbreaks, and environmental hazards.
- Promoting the benefits of wellness and prevention: People need information to take charge of their health. This includes educating the general public and health care providers about the benefits of lifestyle changes that keep people healthy and out of the hospital. Also, we must support health literacy programs to relay information in the most understandable manner.
- Encouraging workplace wellness programs: We must give employers technical assistance and evaluations of effective workplace wellness programs.

#### **Implications for Policy**

In regard to implications for policy, there are a number of points for your consideration

- A substantial body of outcomes research supports the efficacy of a wide range of evidence-based mental health treatments.
- Funding and policy entities should be held accountable for creating an environment that enables service providers to deliver evidence-based practices.
- Outcomes should be monitored regularly as a part of good practice.
- The wide array of effective treatments should be available within a community, because even when treatments are equally effective in general for the entire population, many of them are not equally effective for significant subgroups.
- Treatment choice and wide selection are essential in order to maximize treatment response and adherence to treatment.

These recommendations, if implemented, could help balance the costs of care and treatment with the advantages to patients and the benefits to society.

September 29, 2016

**To: Senate Committee on Health & Human Services**  
**From: Rick Harris, LICSW-Executive Director**  
**Re: Mental Health Hearing #2 Evidence-Based Practice**

I want to thank this Committee for giving me an opportunity to testify on Evidence-Based Practice relating to mental health and substance abuse/use services in Rhode Island. Even though this is a relatively (30 years or so) new discussion in human services, there is nothing new about the subject matter. It has been around since the beginning of humanity.

I actually know something about Evidenced-Based Practice and there is no way to adequately cover the topic in a 5-7 minute testimony or in this written document. In other words, it complicated. I would be glad to set an appoint with any individual or group of legislators for a three to six hour workshop on the topic, however, I know you probably won't have the time in your very busy schedules.

In my professional career, I have been all over the country providing consultation to hundreds of individuals, agencies, and government entities on this specific subject matter. I also consulted once a week for the Federal Department of Education for an eight year period as a grant reviewer and team leader, which in itself is a form of evaluating evidence-based practice. I have served as an administrator in a large mental health agency; have served on many statewide planning committees; was a Director (principal) of a public alterative school in Massachusetts; have been an advocate and testifier in this fine building since 1983; a provider of clinical mental health services for thousands of hours; am an adjunct professor at two colleges; am a community organizer; a Licensed Independent Clinical Social Worker; and am currently representing the National Association of Social Workers - Rhode Island Chapter (NASW - RI) presenting the following testimony.

The written portion of this testimony will contain two parts:

- Part I.** This section will contain information related to Evidence-Based Practice which will briefly discuss, from a Social Work perspective, regarding various aspects of Evidence-Based Practice: policy decision making, agency programming, clinical practice and guiding principles regarding ethical and scientific application of practice.
- Part II.** This section will address, warnings against the exclusive use or mis-use of evidence-based practice. The section will also provide information and thoughts regrading a

number of concerns based on, biases, presumptions, perspectives, ideologies my professional experiences which I believe can impede on effective client services, at times, can be actually be destructive to the client.

## **Part I: Information Related to Evidence-Based Practice**

There are three major areas in which the social work profession is primarily concerned regarding Evidence-Based Practice. **1. Policy Development and Implementation. 2. Mental Health and Substance Abuse/Use Services. 3. Private Practice.** The application of Evidence-Based Practice has some commonality and differences as it applies to the principles of each area. All three areas are subject to bias related to funding, political, professional, geographical and demographic influences.

The social work profession certainly agrees with the basic premise of utilizing principles of Evidence-Based Practice as long as many of the areas of concern that will be covered in Part II are also considered and not allowed to control the process. Following is a short definition of Evidenced -Based Practice from NASW.

### **NASW Practice Snapshot: Evidence-Based Practices—For Social Workers Office of Social Work Specialty Practice**

The issue of evidence-based practices (EBPs) is raising questions for social workers about the role of these interventions in providing effective treatment, and their resulting implications for practice. Recent attention by researchers, clinicians, consumers, consumer advocates, and others has brought EBPs to the forefront of the social work field

### **DEFINITION**

Evidence-based practices are broadly defined as interventions for which scientific evidence consistently shows that they improve client outcomes. In *Crossing the Quality Chasm: A New Health System for the 21 st Century* (2001), the Institute of Medicine defines EBPs as including the following factors:

- Best Research Evidence;
- Best Clinical Experience;
- and Consistent with Patient Values.

<http://www.socialworkers.org/practice/clinical/csw081605snapshot.asp>

The NASW Code of Ethics helps to ensure, within previously stated parameters, the use of Evidence-Based Practice

There are two guiding principles that apply to Evidence-Based Practice: (**Bolded printed areas are from the NASW Code of Ethics**)

**1. Social Workers Should Behave in a Trustworthy Manner.** This principle helps ensure that social workers utilize evidence-based practice in a way that is as effective as possible, while not letting biases interfere with sound clinical judgement.

**2. Social workers should practice within their areas of competence and develop to enhance their professional expertise.** This principle requires the social worker to keep up-to-date on the latest practices as scientifically, practically and experientially within their scope of practice.

Several specific ethical standards apply to Evidence-Based Practice as follows:

**1.01 Commitment to Clients.** Social workers' primary responsibility is to promote the well-being of clients. This standard includes therapeutic services that have been proven within the professional community standards to be effective with clients.

**1.03 (a) Social workers should provide services to clients only in the context of professional relationship based on, when appropriate, on valid informed consent.** This standard helps guard against bias driven evidence-based practices that potentially could violate the client/helper relationships.

**1.04 Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultations received, supervised experience, or other relevant professional experience.** Professional social workers will guard against using evidence-based practice that does not seem to meet the specific needs of the client. In reverse, a social worker in accordance to evidence-based indicators, will seek training to gain expertise in a specific skill area to meet client needs.

**5.02 Cultural Competence and Social Diversity.** Social workers should understand culture and its function in human behavior in society, recognizing the strengths that exists in all cultures. Once again, professional social workers will guard against any evidence-based practices that does not take cross cultural factors into consideration and will emphasize evidence-based practices that do take cross cultural factors into account.

**1.06 Conflict of Interest.** There are examples or potential scenarios where evidence-based practice standards have been applied by various entities that have created a "conflict of interest" for practitioners. I would be glad to provide examples where this is taking place upon request.

### **Summary of Part I**

There is a great need for Evidence-Based Practice. Our whole Western world thinking is primarily based on the scientific /problem solving method. Without it we would be in the dark ages still. **There is no basic reason not to utilize Evidence-Based Practice in mental health and substance abuse/use services as long as we take certain precautions to not over utilize the concept and let it totally drive our services and service development without reason and fairness to the client and helper. That we cannot do.**

### **Part II. Warnings Regarding the Exclusive Use or in my Opinion, Mis-Use of Evidence-based Practice.**

**In the opinion of this author, there is no such thing as a non-bias report, policy analysis, testimony or research product.** I constantly read GAO reports prepared for Congress and find bias, although not necessarily on purpose. The fact is: It is impossible to include all information, to have all the facts, or to analyze everything necessary to write a completely non-bias document of any kind. Information we must leave out or can not obtain alone guarantees bias. Who orders, who pays for, or who request the document influences the outcome of any research project. Once completed, the many users and the various interpreters at all levels, influences the outcome.

Just last week in the sports section of the ProJo a sub headline read; **"Dodgers Score Two Late to Defeat Yanks"**. This is an simple example of how this headline can be interpreted differently in different situations. A sighted person will interpret this headline correctly. Dodgers win. A visually impaired person being read to hears: **"The Dodgers Lose"**. An English as a second English language person may be totally confused by the use of the word two. For we also use **"too, two, to"**. A person with a cognitive language or process communication disability may be totally confused by the headline, altogether. When I read this headline to my highly educated social work class, they naturally assumed that the Dodgers had lost the game, just like the visually impaired person would. **This is a very simple example demonstrating how easy it is to misperceive what others may think is a straightforward easy to interpret message. Think how many ways we can misinterpret evidenced-based findings and them implement the findings wrongly if not careful.**

Another example, if we apply evidence-based practice to a simple medical procedure as follows: I am using a cutting tool to trim my bushes in my backyard. I slip and end up with a three-inch gash in my wrist requiring stitches. I then go to the friendly medical walk-in center. The doctor does the following procedures.

1. Inspect the wound.
- 2.. Clean the wound.
2. Put some antibiotic on the wound.
3. Stitches the wound.
4. Bandages the wound.
5. I pay the bill.
6. I get better.
7. All goes well and I have a minimal scar.

I should be able to go to any qualified medical center and, based on evidence-based practice procedures, the results should be the same. Easy as apple pie. The same just isn't true for the subject matter of the hearing this afternoon.

In mental health and substance abuse/use services, we are adding a number of infinite variables, including the few listed below:

1. A lot of different methods to provide services.
2. Different environments/settings in which the services can be and should be provided.
3. Funding or lack of funding available.
4. Duration and frequency of available/allowed services.
5. Cultural competence/language availability of services provided.
6. Competence of the provider.
7. Biases of the professional provider.

8. Match between the provider and the client.
9. Independent variables of that particular day, hour, minute of service generated by the client and the provider.
10. Cognitive/intellectual and/or ability/capacity of both the client and the provider
11. Scope of practice of the provider
12. Financial ability to pay/insurance capacity of the client.
13. Social supports available to the client.
14. The client's ability to control the identified issues that are so impacting their lives within and without client's system(s).
15. Social policies which had great impact on the ability of the client's ability to get along in the world.
16. Experiences the client had which impacted on the client's life such as lack of a good public education, poverty, physical abuse, sexual abuse, criminal record, unfair social policies and host of other conditions of that were no fault of his/her own.
17. And so many more variables that we don't know about and cannot be accounted for by any model of research controlled or not.

**(Please keep in mind that humans are very complicated. The human brain is a fantastic computer which we have very little understanding of how it works and have no way of knowing the interactions of environmental factors which are constantly changing in nano seconds, none of which are duplicated ever in the history of the world or universe.)**

#### **Thoughts Concerning "Models" & Evidence-Based Practice (Not necessarily the opinion of NASW- RI)**

Throughout my career I and teams that have worked with me, have developed a number of extremely successful programs within agencies. These programs have had great outcomes. Many of these program were federally funded demonstration projects. In fact, they were so successful, I was invited several times to present nationally in Washington, DC for various programs. I presented these programs under the condition that they never would be referred to as a "Models". The problem with models, in my opinion, is that they actually cannot be duplicated anywhere. Concepts, on the other

**hand within models, should be and can be duplicated and utilized most places. Concepts are universal because the human condition is universal, for the most part.**

**I freely gave all ideas and program information to whoever wants them without charge because clients deserved that information. The conceptual frameworks contained in the services we developed worked wonderfully in most environments, but needed to be modified to meet the specific needs of the clients, neighborhoods and communities. This is the way I look at evidence-based practice also. See below for the template I recommend:**

- 1. Look at the Evidence-Base Practice you would like to use.**
- 2. Modify the practice to meet the needs of the clients served locally.**
- 3. Take into consideration all the local laws, agency protocols and other regulations.**
- 4 Modify to account for the staff skill base of the agency and/or the practitioner.**
- 5. Apply the service.**
- 6. Make sure to remove all biases to the extent possible.**

**My Final Recommendation (This is not necessarily the opinion NASW - RI)**

**Please don't take the shortcut like the Sailors of Greek Mythology who found themselves cast upon the rocks. Don't be seduced by the Sirens of some funding sources and some entity's who use "trendy flowery shortcut language" related to Evidence-Based Practice and use the "quick fix" programs that are sometimes advertised under the: very expensive; sometimes very cheap; or sometimes highly idealized; "Evidence-Based Program Pre-Packed One Size Fits All Model". Please heed the "Warnings" contained in this testimony.**

If you would like more information please feel free to call me 401-274-4940 or e-mail at [rhodeislandnasw@gmail.com](mailto:rhodeislandnasw@gmail.com)

I truly appreciate the time you have taken to read this document.  
Respectfully submitted,

Richard Nyle Harris, LICSW  
Executive Director





# Michael Silver, MD

Chief Medical Officer, The Providence Center  
on behalf of the Rhode Island Psychiatric Society

## The Number of Psychiatrists is Shrinking Nationally

- ▶ A recent survey by the Association of American Medical Colleges found that 59 percent of psychiatrists are 55 or older.
- ▶ According to the American Medical Association, the total number of physicians in the U.S. increased by 45 percent from 1995 to 2013, while the number of adult and child psychiatrists rose by only 12 percent. During that span, the U.S. population increased by about 37 percent.



## In Rhode Island

- ▶ Among the Butler Hospital Medical Staff, the leading factor for staff resignations is psychiatrists moving out of state - 39% of total resignations.
- ▶ While Rhode Island is not a federally-designated Mental Health Professional Shortage Area, we see shortages of psychiatrists available to see patients in community settings. This is especially true for child psychiatrists.



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## Insurance Issues

- ▶ A study published in the journal JAMA Psychiatry found that only 55 percent of psychiatrists accepted private insurance, compared to 89 percent of other doctors.
- ▶ Likewise, the study found, 55 percent of psychiatrists accept patients covered by Medicare, compared to 86 percent of other doctors.
- ▶ 43 percent of psychiatrists accept Medicaid, which provides coverage for low-income people, while 73 percent of other doctors do.



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## Bureaucratic Roadblocks

- ▶ Another significant factor affecting psychiatrists and job satisfaction is engaging in the tug of war of pre-authorization, authorization, and re-authorization with insurers.



## Three Possible Areas for Action

- ▶ Review the adequacy and variability of fee-for-service rates for behavioral health services.
- ▶ Incentivize moving away from fee-for-service to bundled rates, case rates, and other structures that reduce administrative complexity.
- ▶ Explore strategies that would make loan forgiveness and other incentives available to community-based psychiatrists in the same way that Rhode Island has provided such supports to primary care physicians.





Good afternoon. My name is Dr. Michael Silver. I am the Chief Medical officer at The Providence Center where I have practiced for 39 years. I am speaking this afternoon on behalf of the Rhode Island Psychiatric Society.

I would like to talk for a little bit about what it feels like to be a community-based psychiatrist in Rhode Island.

First, we are a group that is shrinking, when we need to grow to meet unmet community needs.

A recent survey by the Association of American Medical Colleges found that 59 percent of psychiatrists are 55 or older, the fourth oldest of 41 medical specialties, signaling that many may soon be retiring or reducing their workload.

According to the American Medical Association, the total number of physicians in the U.S. increased by 45 percent from 1995 to 2013, while the number of adult and child psychiatrists rose by only 12 percent, from 43,640 to 49,079. During that span, the U.S. population increased by about 37 percent; meanwhile, millions more Americans have become eligible for mental health coverage under the Affordable Care Act.

Nationally, the number of psychiatrists graduating from residency programs from 2007-2013 was essentially flat, showing a slight uptick in 2015.

Over the last several years, the General Assembly and other state leaders have focused attention on the shortage of primary care practitioners and the state seems to be making progress. The shortage is psychiatrists is just as pressing.

In Rhode Island, there is some evidence that the dynamics of the psychiatric workforce are getting worse. At the Butler Hospital Medical Staff, the leading factor for staff resignations is psychiatrists moving out of state – 39% of total resignations. Reimbursement rates in Rhode Island are lower than in surrounding states.

While Rhode Island is not a federally-designated Mental Health Professional Shortage Area, we see shortages of psychiatrists available to see people in community settings.

This is especially true for child psychiatrists. Last week, SAMHSA's deputy director commented on the national scene saying, "Child psychiatrists are like unicorns: I've heard of them but I've never really seen them." I'm pleased to report that I work with several talented child psychiatrists, so the breed isn't completely extinct here, but it's not growing either.

One critical problem affecting the supply of psychiatrists available to see patients in the community is the trend away from psychiatrists accepting any kind of insurance.

A study published in the journal JAMA Psychiatry, found that 55 percent of psychiatrists accepted private insurance, compared with 89 percent of other doctors. Likewise, the study said, 55 percent of psychiatrists accept patients covered by Medicare, against 86 percent of other doctors. And 43 percent of psychiatrists accept Medicaid, which provides coverage for low-income people, while 73 percent of other doctors do.

There are several reasons for this. Payments by insurers for many services provided by psychiatrists are relatively low. Treatment is often subject to review by managed care companies. With more demand than supply, many psychiatrists just don't have to accept insurance. Psychiatrists are more likely than other doctors to practice on their own, and solo practitioners, regardless of specialty, are less likely to accept insurance, in part because they do not have the back-office staff to deal with insurance companies. Given the high demand and low supply of prescribers, they can afford to not accept insurance rates.

Our reimbursement system remains a mish-mash of rates that vary considerably from insurer to insurer. There are some areas of stable, sustainable rates such as the Medicaid Integrated Health Home program, but, the reimbursement for general outpatient care involving the majority of patients is problematic. Rates vary widely, and one major insurance company hasn't raised reimbursement in over 10 years. This results in difficulty in getting access to care and to the right medication.

Another significant factor affecting psychiatrists and job satisfaction is engaging in the tug of war of pre-authorization, authorization, and re-authorization with insurers. By and large, these processes result in care decisions that are made for all sorts of reasons unrelated to the best medical evidence. What ends up determining what care gets provided is whether psychiatrists can spend hours on hold, waiting to speak to insurers' utilization review staff. For example, although it certainly makes sense for managed care companies to require the use of cheaper generic medications whenever possible, this is not always the right choice for an individual patient. For the sole purpose of saving money, the managed care companies have created barriers making the appeals process time consuming and difficult. The most recent creative idea by a major managed care company was to require that the physician obtain written permission from the patient to "allow" the physician (the very one who ordered the medication and had already obtained informed consent) to pursue the appeal. The logistics of this of course leads to delays, and within the past month contributed to a hospitalization of one of my patients who was unable to obtain a medication I prescribed.

I estimate that I spend 5% of my time each week trying to get authorization for care, medication, or needed services.

Our patients are often resourceful. Most know how to get needed care most immediately – and that's to go to the emergency department and from there to get admitted.

This is a leading factor in how inadequate rates, the friction of working with insurance companies, and a workforce that's inadequate add up to higher levels of behavioral health utilization in our state.

I'd like to recommend that the General Assembly examine three possible areas for action:

- Review the adequacy and variability of fee-for-service rates for behavioral health services.
- Incentivize moving away from fee-for-service to bundled rates, case rates, and other structures that reduce administrative complexity.
- Explore strategies that would make loan forgiveness and other incentives available to community-based psychiatrists in the same way that Rhode Island has provided such supports to primary care physicians.

Thank you for your time and consideration.

**September 29, 2016**

**Members of the Senate HHS Committee:**

East Bay Community Action Program (EBCAP), a Federally Qualified Community Health Center (FQHC) and Community Action Agency in partnership with East Bay Center, a state certified Community Mental Health Center (CMHC) completed a merger with EBCAP as the surviving agency in January of 2016. We are in the process of completing a fully integrated, transformed and merged model of health care; one which ensures the availability and access to a comprehensive array of primary and behavioral health, wellness, recovery, and social services and programs. Working as a single, merged organization, this enriched model of care includes Newport County, the city of East Providence and Bristol County thus representing 10 cities and towns.

EBCAP is keenly aware that a fully integrated model of care is more than just combining treatment for mental illness and physical health. Interventions that target social determinants of health into clinical care must be incorporated and financially supported as part of any payment systems for care. With behavioral health and an increasingly robust set of site-based community and home based services, EBCAP has positioned itself to play a critical role in the rollout of EOHHS's Integrated Care Initiative which will bring Medicaid-Medicare dual eligible patients into a managed care environment. EBCAP will be well equipped to implement key activities and make essential investments necessary to inform the discussion and to provide real examples of the benefits of developing unified health strategies that promote healthy lifestyles. Finally, this initiative will assist EBCAP to strengthen its advocacy and financial leverage as it collaborates with community partners and advances its efforts in developing our Accountable Entity.

We view Integrated Care as that care that results from a practice team of primary care and behavioral health clinicians working with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.



The integration of Physical and Behavioral Health Care is transformational for a number of important reasons. Some of the underlying factors which have informed our efforts to integrate care include:

- mild and moderate behavioral health problems are common in primary care settings
- people with chronic medical disorders have high rates of behavioral health concerns
- people with significant, persistent mental illness have higher rates of chronic medical illnesses
- care for persons with mental disorders is more costly
- the lifespan for people with serious mental illness is compromised often by chronic physical illness.

Our research into the development of integrated care approaches has led to many definitions of care ranging from consultation to co-location to shared values about treating the “whole” person. An issue briefing from the SAMHSA-HRSA Center for Integrated Health Solutions (enclosed with this testimony) is helpful in defining levels of integrated Healthcare and serves as a set of standards for EBCAP’s goals for integration.

Broadly defined, the spectrum for integration follows five levels of collaboration.

- 1) Minimal Collaboration- separate systems, separate facilities, limited behavioral health and primary health interaction
- 2) Basic Collaboration from a Distance-separate systems, separate facilities, view each other as outside resources
- 3) Basic Collaboration Onsite-separate systems, same facilities, regular communication, consultant approach
- 4) Close Collaboration, Partly Integrated-same share systems, same facilities, basic appreciation of roles, coordinated treatment plans, collaborative approach is not always on shared values and is somewhat disjointed
- 5) Fully Integrated-shared systems and facilities, consumers and providers have similar expectations, patient experience is seamless and collaboration is routine, a team approach to a system of care on behalf of consumers.

EBCAP is committed to a fully integrated approach to care within the framework of a transformed/ merged integrated practice that aspires to the level five approach defined above. EBCAP’s goals to achieve an integrated care model include :

- 1) We are in the same space in the same facilities, sharing all of the practice space.
- 2) Key systems issues have been resolved, functioning in an integrated manner
- 3) Communication is consistent at the system, team and individual levels
- 4) There is a shared concept of team care
- 5) Formal and informal meetings support integrated care
- 6) Our provider and administrative roles have blended across behavioral and primary health
- 7) Population based medical and behavioral health screening is standard practice with results available to all and data analysis and actionable items are in focus
- 8) One treatment plan for all patients
- 9) Evidenced based practices are team selected and implemented across all disciplines.
- 10) All patient health needs are treated for all patients by a team, who function effectively together
- 11) Patients experience a seamless response to all healthcare needs as they present at the practice
- 12) Organizational leaders strongly support integration as a practice model with an expected change in service delivery
- 13) Integrated care approach is embraced by all providers
- 14) Funding is integrated based on multiple sources of revenue
- 15) Financial resources are shared across the practice
- 16) A single billing structure that maximizes billing through the integration
- 17) The practice is truly committed to treating the whole person
- 18) Shared knowledge base of providers increases and allows each professional to respond more adequately to patient issues.

The agency is now eight months into the establishment of an integrated system of patient centered care. Our accomplishments to date include:

- 1) A single, integrated Electronic Medical Record that will support our data analysis and patient care needs
- 2) The introduction of Screening, Brief Intervention and Referral to Treatment (SBIRT) and other behavioral health screenings at our two primary care sites with the opportunity for “warm hand-offs” to behavioral health clinicians on site to address issues identified. We are also screening patients to determine if ACT or Health Home eligibility is available.

- 3) An ongoing analysis and refinement of work flow issues as they relate to patient care with a team approach to quality improvement
- 4) A commitment to Medication Assisted Therapy to assist in combatting the Opioid and heroin crises in our State
- 5) A plan to integrate a primary care practice into our SPMI behavioral health practice within the next six months at our facility in Barrington
- 6) The development of a core of committed behavioral health and primary care professionals who are committed to this work.
- 7) A renewed focus on the work of nurse care managers in supporting high risk patients
- 8) The understanding that social determinants play an important role in a patient's physical and behavioral health well-being and a committed effort to address safety net issues such as food insecurity or housing problems. EBCAP has the resources to bring social services supports to our patients.

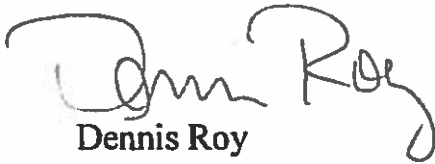
The benefits of implementing an Integrated Care model are well documented. More and more states are looking to roll out models of care that recognize and assign value to care that includes a variety of interventions including embedded behavioral health and enabling support services. In the last several months, CTC-RI, the PCMH multi-payor quality and payment reform initiative has been meeting with a number of key stakeholders including RI's major payers, and CTC participating partners to develop an Integrated Behavioral Health Business Case proposal. A summary of the business Case Proposal underscores the fact that behavioral health is a main driver of individuals seeking out care with a primary care provider and of escalating costs, reducing quality of life and increasing the likelihood of multiple chronic conditions. Furthermore, the proposal points out that most traditional payment methodology is counter to good patient care and does not take into consideration many clinical and non-clinical services that are essential to good integrated care. For example, EBCAP offers a full cadre of enabling services such as case management, WIC, heating assistance, food pantry services, housing assistance and support, means tested eligibility assessments and a host of other services which are critical in the delivery of a fully integrated patient centered care experience; however few, if any are reimbursed by the payers.

In summary, I present a number of key points to consider:

- 1) The success of our Accountable Entities in providing quality care and reducing cost is predicated on an integrative health strategy that treats the whole person and addresses the underlying issues of co-occurring primary health and behavioral health disorders. The fully engaged patient with a

single treatment plan and the resources necessary to address behavioral health, primary care and social determinant issues in a single setting will be a more satisfied patient. On the reverse side, a patient who receives quality behavioral health services but does not have seamless, coordinated access to quality primary care services may not be able to experience a high level of positive health outcomes and will be more costly to the system.

- 2) Patients should be afforded to opportunity to get access to integrated care at a practice that is known and welcoming to them.
- 3) Managed Care Organizations are recently involved with Medicaid/Medicare Dual Eligible patients and are charged with supporting the behavioral health care for the Significantly and Persistently Mentally Ill (SPMI) populations. An opportunity exists for the MCO's and community providers to shape and refine a system of care that responds to the patient with a coordinated approach to illness.
- 4) State leaders should promote and incentivize those community provider practices that are designing integrative approaches to patient care and well-being.



Dennis Roy  
Chief Executive Officer  
East Bay Community Action Program

Presentations that informed this testimony include:

“Understanding Primary and Behavioral Healthcare Integration”

Laurie Alexander and Karl Wilson

“A Standard Framework for Levels of Integrated Care”

SAMSHA-HRSA Center for Integrated Health Solutions



September 29, 2016

Senator Miller and Members of the State Health and Human Services Committee:

My name is Mary Dwyer. I am a psychiatric clinical nurse specialist and I am here to represent the Rhode Island State Nurses Association. Donna Pollicastro, Executive Director, asked me to speak as I have over 30 years of experience working in the behavioral health field. The majority of my experience is working in a Community Mental Health Center. I am currently the Senior Vice-President of Community Support and Recovery Services at Community Care Alliance ("CCA"), and I am the supervisor of the Director of Nursing at CCA.

My focus will be concerning Care Coordination as it relates to evidence-based practice. There is no question that the nurse care coordinator/care manager is a critical role in the health care delivery system. Federally Qualified Health Centers and Managed Care companies are only a couple of examples of organizations that effectively utilize these roles in the industry.

In the behavioral healthcare delivery system of Rhode Island, Assertive Community Treatment (ACT) and Integrated Health Home (IHH) teams serving individuals with serious mental illness include RN care managers in the team composition. Their role includes coordinating care, assisting with physical and mental health integration, addressing population-based interventions for chronic disease management, entering data for outcome evaluation as well as the more traditionally recognized tasks of client assessment, medication administration, etc. There is a staffing requirement of a number of RN full time equivalents (FTEs) to number of clients served per team. This staffing pattern makes sense on paper. The problem is this: The vacancy rate for RN positions in the community mental health centers is very high. The RNs are covering the absolute basics, much of which includes medication reconciliation, medication access (refills, obtaining new prescriptions, prior authorizations, etc), and reviewing and signing multiple regulatory documents that require a "qualifying signature." Each RN is performing the work of at least two RNs. Those agencies fortunate enough to have a nurse manager are using this position as direct service. The anxiety level of the nursing workforce is high, each helping one another as much as possible fearing that their co-worker will quit and go elsewhere.

I recognize that workforce issues will be addressed at the hearing scheduled for October 13. I am sure that you will be hearing directly from RNs on that date about the unmanageable workloads and expectations.

I commend this Committee for having hearings related to behavioral health issues. It brings a sense of caring and support to the individuals living with mental health issues and addictions and also to the providers caring for this population. There is a fundamental underlying problem here. Populations such as those living with mental illness, addictions, developmental disabilities, the elderly, the poor, etc. are marginalized. Providers working with these populations are not as valued as well. There is concrete evidence in the paychecks. The same nursing care manager role in medical facilities yields a higher salary. This is a parity issue.

Community based health services in general do not rank high on the reimbursement list. Acute care, "saving a life" is valued as it should be. Helping people live day to day in their community with ongoing life issues, reaching for wellness, needs to be equally valued. There is continual talk of how essential community services are, but the money does not back up the words.

We need a paradigm shift and I challenge you to Champion the Cause.

**Recommendations:**

- Advocate for the submission of Rhode Island's application to the Substance Abuse and Mental Health Services Administration (SAMHSA) for Certified Community Behavioral Health Centers. The anticipated rates for services will be higher allowing for competitive salaries, improving recruiting and retention efforts, and allowing for implementation of evidence-based/informed practices. This comprehensive model addresses community service gaps over the entire lifespan.
- Help in our advocacy with the Managed Care Organizations to improve the timeliness of paid claims. Unpredictable payments are shaking the financial stability of CMHOs. We are losing qualified staff.
- Please help to change the narrative. Individuals living in the community with serious mental health and addictions issues are not costing a tremendous amount to serve. But for these services they would be placed in higher cost facilities such as community hospitals, Eleanor Slater Hospital or the ACI. Community services are bargain rates compared with the alternatives and community rates need to be higher for sustainability. Stop comparing their cost with the worried well. The true comparison should be with institutionalized settings.

Perhaps the discussion of access to evidence-based practices will be more robust once we have the personnel to implement them.

Thank you for your consideration of this testimony. Feel free to contact me with any other questions or ideas for system improvement.

Sincerely,



Mary F. Dwyer, MS, MEd, PCNS

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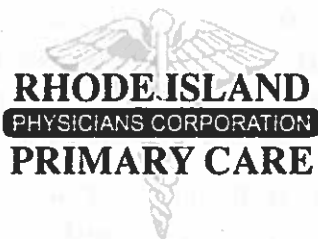
**Access to Behavioral Health Care:  
Creating a Collaborative Care Network**

**Senate Health and  
Human Services  
Committee  
September 29, 2016**

Peter M. Oppenheimer, Ph.D.  
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**RHODE ISLAND  
PHYSICIANS CORPORATION  
PRIMARY CARE**







## Core Issues we are addressing

- While the ACA promotes the Triple Aim and Population Health based care, we need to provide care in a way that is effective and acceptable to Rhode Islanders.
- The requirements to provide services as prescribed by federal laws are very complex and expensive, and oriented toward large providing entities.
- The importance of behavior as a determinant of health has been neglected in health care. Behavioral Health professionals are under-resourced.

## What we have done so far

- We have organized a multidisciplinary network of over 100 behavioral health professionals including prescribers.
- We have created a referral database to assist our primary care physicians to make effective referrals. Our network will be included in RIPPC's and Integra's new referral systems.
- We have developed protocols for how we respond to referrals and follow up with primary care offices.
- We are providing reports to primary care physicians.
- We are providing continuing education to our members to help them enhance their skills sets in evidence based practice.
- We are developing screening and quality improvement protocols in coordination with our primary care offices that will help us assess our patient's progress and our performance.
- We are encouraging our practices to use electronic medical records to assist them to meet the procedural expectations of our program.

## Our plan

- Provide a broad range of evidence based interventions that meet the needs of our community
- Be more involved in care coordination with PCPs and care managers
- Help implement integrated screening procedures at annual check-ups that can monitor patient status, help primary care physicians choose the most appropriate interventions when needed and follow the care of their patient's behavioral health needs through treatment and beyond
- Provide educational and treatment services to help people stay healthy
- Provide educational and treatment services to help people better manage their chronic illnesses
- Be able to have network members available for consultations to physicians when needed
- Coordinate with our referral services to have network members available to take emergency referrals
- Implement scientifically sound quality improvement programs
- Have an integrated EMR system that facilitates our collaborative practice and data collection and reporting

## Rhode Island Barriers

- Stigma continues.
- Rhode Island lacks intermediate level services.
- Rhode Island lacks ancillary services.
- The public and private behavioral health service systems are largely disconnected. It is difficult to provide people continuity when they move between the systems.
- Benefit Design
  - Commercial health plans are designed to keep the premiums relatively low by shifting costs to co-pays, deductibles and coinsurance. These fees are often significant and they clearly serve as barriers to some people to seek or continue care.
  - People who see their primary care physician and a behavioral health clinician in the same day have to pay a co-pay for each service.
  - People who need intensive services have to pay a co-pay for each service.
  - Plans do not cover education and prevention services.

## Federal Barriers

- The cost of the infrastructure (especially technology) and staffing needed to meet the expectations of the ACA are high for behavioral health clinicians.
- Current reimbursement methodologies do not enable behavioral health clinicians to do all the things that we could do to help.
- Future reimbursement methodologies for how independent behavioral health practitioners would participate in performance incentivized payment methodologies do not exist.
- Psychologists are excluded from the Medicaid definition of Physicians.
- Federal policy continues to favor the use of psychopharmacological interventions to the disregard of behavioral interventions.

## Recommendations

- Update state laws to include clinicians where they now only refer to physicians.
- Update Coverage for Mental Illness and Substance Abuse to make consistent with federal parity and Sections 27-38.2 for rate parity.
- Require the insurance companies to reimburse providers for the full fee for covered services, and then they can be responsible for collecting the co-pays, deductible and co-insurance from their insured.
- Update professional licensing statutes to address changes in practice that will be part of healthcare reform (telehealth).
- Support mechanisms for people to be able to stay with their primary care providers when they move between the private and public sectors, or change commercial health plans.
- Support the development of services at intermediate levels of care and ancillary services.
- Support clinician directed teams.
- Resolve the conflict between the goals of population health, and consumer choice and responsibility.
- Support innovation.





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September 29, 2016

Senator Joshua Miller  
Chair  
Senate Committee on Health & Human Services  
82 Smith St.  
Providence, RI 02903

Dear Chairman Miller and Members of the Committee.

Thank you for holding these hearings to address the behavioral health needs of Rhode Islanders and our state's ability to meet them. Healthcare reform policies stress the importance of behavioral health in making healthcare more effective and efficient. Despite the wide acceptance of this principal there is a decided lack of action implementing behavioral health strategies in healthcare. Mental illness and behavioral health services have long been devalued in our system of care in favor of expensive technologically driven medical care. There are many things we can do improve access to behavioral health care and the quality and impact of that care for the citizens of Rhode Island.

For years the behavioral health provider community has strived to bring high quality services to all Rhode islanders who need them. We know the need is great. Even though more Rhode islanders per capita than the national average access behavioral health services, we know our existing resources do not meet their needs. We also know that there are significant barriers impeding our ability to provide Rhode Islanders with the care they need.

I want to tell you what some of us in the behavioral health community are doing to promote the inclusion of the full breath of what behavioral health has to offer our health care system in service of meeting the Triple Aim<sup>1</sup>. Since 2010 we have been working with the physicians of Rhode Island Primary Care Physicians Corporation to create a statewide behavioral health network of professionals who are working with RIPCCP's primary care physicians to help them bring behavioral health into their practices and to help them access a full range of behavioral health care for their patients throughout the state. We now have over 100 qualified behavioral health clinicians throughout Rhode Island in our network. Our RIPCCP behavioral health practices range in size from individual to large

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<sup>1</sup> Institute for Healthcare Improvement. <http://www.ihl.org/>.



practices and include community mental health centers. Since most of RIPCPC's primary care practices are too small to incorporate an on-site behavioral health clinician, we have devised a model where we will collaborate between primary and behavioral health practices. We view that one of the strengths of our model will be the patients in the primary care practices will have access to a wide array of qualified clinicians who are distributed throughout the state who can collaborate with their primary care physician in their care.

While our initial goal is to bring the benefits of coordinated care and improved referrals to the RIPCPC Primary practices, RIPCPC has since joined the Integra ACO. We are now working with the members of Integra; Care New England, The Providence Center and Blue Cross Blue Shield of Rhode Island; to develop a comprehensive behavioral health system within Integra that can meet the needs of our community from providing educational and consultative services within primary care offices to inpatient hospitalization. We recognize that we can extend the benefits of collaboration and coordination throughout the entire system.

The policy and goals of the Affordable Care Act are very ambitious<sup>2</sup>. It's relatively easy to talk about the concepts of healthcare reform in principal. We have come to learn that it is extremely difficult to implement these concepts in practice, and that it is even more difficult to implement these principals when we are starting with the extremely limited resources we actually have. The devil is in the details, and there are many many details.

We have learned a lot in the six years we have been working on this project. There are many issues, rules, laws and policies that are barriers in the way of implementing what we are trying to do.

These are some of the core issues we are addressing:

- While the ACA promotes the Triple Aim and Population Health based care, we need to provide care in a way that is effective and acceptable to Rhode Islanders.
- The requirements to provide services as prescribed by federal laws are very complex and expensive, and oriented toward large providing entities.
- The importance of behavior as a determinant of health has been neglected in health care. Behavioral Health professionals are under-resourced. Behavioral health professionals have not been properly reimbursed by payers or provided the government funding to support the infrastructure and systems necessary to participate as have physicians. We recognized from the start that the challenge is

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<sup>2</sup>PATIENT PROTECTION AND AFFORDABLE CARE ACT HEALTH-RELATED PORTIONS OF THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 ("PPACA"; Public Law 111-148)  
<https://www.hhs.gov/healthcare/about-the-law/read-the-law/>



to meet these expectations starting with the resources we actually have and to try to develop the resources we need to participate successfully.

In service of our goals this is what we have done so far:

- We have organized a multidisciplinary network of over 100 behavioral health professionals including prescribers.
- We have created a referral database to assist our primary care physicians to make effective referrals. Our network will be included in RIPCPC's and Integra's new referral systems.
- We have developed protocols for how we respond to referrals and follow up with primary care offices.
- We are providing reports to primary care physicians.
- We are providing continuing education to our members to help them enhance their skills sets in evidence based practice.
- We are developing screening and quality improvement protocols in coordination with our primary care offices that will help us assess our patient's progress and our performance.
- We are encouraging our practices to use electronic medical records to assist them to meet the procedural expectations of our program.

We would like to do the following:

- Provide a broad range of evidence based interventions that meet the needs of our community
- Be more involved in care coordination with PCPs and care managers
- Help implement integrated screening procedures at annual check-ups that can monitor patient status, help primary care physicians choose the most appropriate interventions when needed and follow the care of their patient's behavioral health needs through treatment and beyond
- Provide educational and treatment services to help people stay healthy
- Provide educational and treatment services to help people better manage their chronic illnesses
- Be able to have network members available for consultations to physicians when needed
- Coordinate with our referral services to have network members available to take emergency referrals
- Implement scientifically sound quality improvement programs
- Have an integrated EMR system that facilitates our collaborative practice and data collection and reporting





These barriers impair our ability to implement our project:

#### Rhode Island Barriers

- Stigma
- Rhode Island lacks intermediate level services.
- Rhode Island lacks ancillary services.
- The public and private behavioral health service systems are largely disconnected. It is difficult to provide people continuity when they move between the systems.
- Benefit Design
  - Commercial health plans are designed to keep the premiums relatively low by shifting costs to co-pays, deductibles and coinsurance. These fees are often significant and they clearly serve as barriers to some people to seek or continue care.
  - People who see their primary care physician and a behavioral health clinician in the same day have to pay a co-pay for each service.
  - People who need intensive services have to pay a co-pay for each service.
  - Plans do not cover education and prevention services.

#### Federal Barriers

- The cost of the infrastructure (especially technology) and staffing needed to meet the expectations of the ACA are high for behavioral health clinicians.
- Current reimbursement methodologies do not enable behavioral health clinicians to do all the things that we could do to help.
- The future reimbursement methodologies for how independent behavioral health practitioners would participate in performance incentivized payment methodologies do not exist.
- Psychologists are excluded from the Medicaid definition of Physicians.
- Federal policy continues to favor the use of psychopharmacological interventions to the disregard of behavioral interventions.

These issues stand between the success or failure of healthcare reform. The goals of primary prevention and disease management cannot be met without the full implementation of behavioral health strategies. The goals of reducing the devastating impact of mental illness and substance abuse on people's lives, and the impact of mental illnesses have on work attendance and productivity cannot be met without the full implementation of behavioral healthcare strategies.



## Recommendations

Please support updating state laws and regulations to remove the barriers, and support our local stakeholders to find practical solutions that will enable us to implement the broad range of behavioral health services needed for healthcare reform.

- Update state laws to include clinicians where they now only refer to physicians.
- Update Coverage for Mental Illness and Substance Abuse to make consistent with federal parity and Sections 27-38.2 for rate parity.
- Require the insurance companies to reimburse providers for the full fee for covered services, and then they can be responsible for collecting the co-pays, deductible and co-insurance from their insured.
- Update professional licensing statutes to address changes in practice that will be part of healthcare reform (telehealth).
- Support mechanisms for people to be able to stay with their primary care providers when they move between the private and public sectors, or change commercial health plans.
- Support the development of services at intermediate levels of care and ancillary services.
- Support clinician directed teams.
- Resolve the conflict between the goals of population health, and consumer choice and responsibility.
- Support innovation.

Healthcare reform is an immensely complex process. No one or no one group can do it all. We look forward to working with all stakeholders to devise and implement a system that works for Rhode Island. If our state government really wants this process to work we need the executive and legislative branches to step up and work with all the stakeholders to remove the barriers and enable change to succeed. Thank you.

Sincerely,

Peter M. Oppenheimer, Ph.D.  
Chair  
Rhode Island Primary  
Care Physicians Corporation



My name is Dale Klitzker. I am President of The Providence Center, a community mental health center that serves more than 14,000 adults, children, and families each year. At The Providence Center, we are working hard to meet the challenge of unmet community need. We are working hard to build partnerships and alliances and to open programs to serve people with complex needs. We develop innovative approaches to mental health and substance use disorder issues, often working with government and payor partners.

I'd like to offer some comments on how we need to change how we think about our behavioral health care system in order to speed the pace of needed change for Rhode Island.

We need, as a community, to step back and change our perspective on the behavioral health system. Sometimes, I illustrate this perspective problem by asking people to draw a circle on a piece of paper and to hold the piece of paper up to their nose. You can't really see the big picture at all. You're too close to it.

In the same way, we've had a lot of planning efforts that have looked at the service delivery system, the supply of professionals, and the supply of evidence-based programs and all sorts of efforts to fund them – SIM, CCBHC, etc. In general, I think our focal point is wrong. **What our state needs is a concerted planning process that builds a comprehensive vision for a behavioral health system as part of the larger healthcare system.** Then, that planning process can take a concerted look at the gaps and shortcomings and imbalances in our system and create a plan to address them. That plan must utilize the budgetary resources we have today and use them in new ways. Efforts to pursue short-term infusions of Federal support or short term grants tend to produce short-term fixes.

The second suggestion I'd like to make is something that could be labeled "Well, **you get what you pay for.**" The majority of our health care system is still in a hodge-podge of fee-for-service payment mechanisms. The result is analogous to what would happen if I purchased auto parts one-by-one over the internet over a period of years and then tried to assemble a Mercedes in my driveway. The results wouldn't be pretty.

We need to step back and see what look at what we've paid for and understand how it results from the complicated, mixed-up way we pay for it. As other presenters today have discussed, a major goal of community mental health centers is to provide clients with the right treatment and supports at the right time and get them in a position where they can thrive. The problem here is that outpatient rates, particularly those in Medicaid, are all over the place, without much rational basis for the differences. Private psychiatrists (if you can find them) often refuse to take insurance payments because of the low rates of reimbursement and the high degree of micromanagement and paperwork. Indeed, one insurer has not adjusted The Providence Center's rates since 2005.

In a rational system, we would want to see a robust system of outpatient care, with new groups entering the field. Instead, we see providers reducing the scope of services or fighting to try to figure out how to sustain themselves on any insurer's rates.

The third point I'd like to make is that **we need to design a stably-funded system of healthcare and behavioral health care and stick with it.** Our model for serving adults with serious mental illness has shifted three times in the last few years. The most recent switch to Integrated Health Homes involved a move away from state payments to reimbursement through the Medicaid managed care organizations. Today, ten months into the new model billing systems and insurance companies' payment systems still haven't adjusted to one another. At The Providence Center, one result is that our accounts payable – what the managed care organizations owe us – has shot through the roof, now totaling several million dollars. The pace of payment is a real stressor on our balance sheet and that of other community mental health centers.

A fourth recommendation I'd like to make is that **providers and insurers consider how they can trust each other and partner, encourage some prudent risk taking and design new models of care.** The most successful experiment we have been involved with is the HealthPath program, which was born out of a partnership of Care New England, Butler Hospital, The Providence Center, and Blue Cross Blue Shield of Rhode Island. HealthPath is designed to serve adults with serious mental illness. Most come to the program immediately after a mental health inpatient stay. The program uses a team-based approach to providing all the services and supports clients need to return to full functioning in the community, with their families, and at work. A goal is to reduce the need for subsequent hospitalizations. And, of course, a goal of all the partners is to reduce overall health care expenses for participants. Importantly, Blue Cross made some important changes to insurance product design allowing for a once-monthly co-payment, reducing an obstacle that could prevent participants from accessing all the services they need. HealthPath is a little more than two years old and has posted good preliminary results. This kind of experiment can provide lessons in how the system can work better and, importantly, build trust and new relationships between insurers and providers.

Fifth, and most importantly, **we must dramatically accelerate our movement toward a true population health approach to behavioral health care.** Imagine how much services and programs would change if the incentives and patterns of care shifted. Imagine if we could bundle all of what we spend on outpatient, inpatient, pharmacy, and primary care and put all this money in a single bucket and hold providers accountable for an agreed-upon set of quality and cost measures in exchange for flexibility in doing or creating the right service array. My strong belief is that we could see dramatically improved outcomes at the right cost. Until we can get to a true bundled model, we will be limited to painstakingly slow work to close service gaps and experiments whose scope is limited by the availability of whatever capital we can scrounge up.

I can't think of anything else that we do in this state where our prevalence rates are so great and we do so little in response—I was struck this week when I saw how Rhode Island rated nationally on road infrastructure and another soon to be released rating on behavioral health services. As bad as our roads are, we rank higher on repairing them than we do and treating these pervasive serious illnesses.

I believe strongly that Rhode Island's health care sector can deliver the kinds of innovation we need to once again lead the country in the quality of our behavioral health services. But, it won't be until how we eliminate the silos and really get working to provide Rhode Islanders the care they deserve and need.

Testimony Summary  
RI Senate Committee on Health & Human Services  
Senator Joshua Miller, Chairman  
MENTAL HEALTH HEARING  
September 29, 2016  
William Emmet

Thank you, Mr. Chairman, for the opportunity to appear before you this afternoon. As someone who has spent over thirty years advocating for improved mental health care here in Rhode Island and across the nation, I greatly appreciate your convening this series of hearings and your commitment to applying what you learn in them to our state's approach to the delivery and financing of services for people with mental health and substance use disorders.

My name is William Emmet, and I was among the founders of the Rhode Island affiliate of organization now known as the National Alliance on Mental Illness in the 1980s. I have since had the privilege to work with NAMI on the national level, as well as with the National Association of State Mental Health Program Directors and the Campaign for Mental Health Reform. In 2013, I joined with our former Congressman, Patrick Kennedy, to launch the Kennedy Forum whose goal it is to fulfill the vision of his uncle, President Kennedy, in bringing services for people with mental health disorders fully into the mainstream of our society. Although I left the Kennedy Forum earlier this year and am working as a consultant, my remarks today rest on that vision.

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- Despite all of the acknowledged shortcomings in the RI behavioral health system, it is unlikely that significant new resources will become available soon. This is certainly true of the ongoing shortage of specialty care providers – specifically, psychiatrists. We therefore need to be ever more strategic about how we use the resources we have.
- One question that this raises is how we can best determine who should be served in the specialty system and who can be appropriately and effectively served in non-specialty (primary care) settings.
- We know that only about 40% of those with diagnosable mental health conditions get care, and of those who do, a majority are served in non-specialty settings. It seems likely that those who do seek services are more affected by their conditions and need (and use) more and more costly services. We don't really know how effective the services are for those being served in non-specialty settings or, for that matter, how effective they are in specialty settings.

- We need to provide support to those in the non-specialty (primary care) system so they can effectively serve those they are already seeing and so they can make appropriate referrals to the specialty system before their cases become dire.
- The Collaborative Care model is supported by over 80 randomized controlled studies showing that it is more effective than usual care for common mental health conditions such as depression and anxiety. (see The Kennedy Forum, [http://thekennedyforum-dot-org.s3.amazonaws.com/documents/KennedyForum-BehavioralHealth\\_FINAL\\_3.pdf](http://thekennedyforum-dot-org.s3.amazonaws.com/documents/KennedyForum-BehavioralHealth_FINAL_3.pdf))
- Collaborative Care is:
  - Team-based, led by a primary care provider with support from a care manager and consultation from a mental health specialist who provides treatment recommendations for patients who are not achieving clinical goals;
  - Population-based, whereby the care team uses a registry to monitor treatment engagement;
  - Patient-centered, with proactive outreach to engage, activate, promote self-management and treatment adherence and coordinate services;
  - Measurement-based, with screening and monitoring of patient-reported outcomes over time to assess treatment response;
  - Evidence-based, with demonstrated cost-effectiveness in diverse practice settings and patient populations;
  - Practice-tested, with sustained adoption in hundreds of clinics across the country; and
  - Accountable for the care provided and for continuous quality improvement to meet care goals.
- As noted above, one element of Collaborative Care is measurement-based care. The Kennedy Forum recommends: “All primary care and behavioral health providers treating mental health and substance use disorders should implement a system of measurement-based care whereby validated symptom rating scales are completed by patients and reviewed by clinicians during encounters. Measurement-based care will help providers determine whether the treatment is working and facilitate treatment adjustments, consultations, or referrals for higher intensity services when patients are not improving as expected.” (see The Kennedy Forum, [https://thekennedyforum-dot-org.s3.amazonaws.com/documents/KennedyForum-MeasurementBasedCare\\_2.pdf](https://thekennedyforum-dot-org.s3.amazonaws.com/documents/KennedyForum-MeasurementBasedCare_2.pdf))
- Incorporating measurement-based care into the efforts in both specialty and non-specialty settings also helps with patient engagement, patient empowerment, and shared decision making by providing a real-time picture of a patient’s health status and the departure point for meaningful conversations between clinician and patient.
- Payers, too, benefit from measurement-based care, as regular assessments can assist in determining the effectiveness and impact of services and treatment an individual is

receiving, as well as the impact of a particular treatment approach at the population level.

- When used in primary care settings, both the Collaborative Care Model and measurement-based care facilitate early identification of MHSUD and thus pave the way for intervention at much earlier stages, preventing untold pain, disability, and lost productivity for individuals and families, and saving money at multiple levels of the health and human services systems.
- While the Collaborative Care Model and measurement-based care are effectively used to improve the care of people with mental health and substance use disorders in primary care settings, there is great potential for the use of measurement based care in the public behavioral health system.
- Standardized tools for individuals served by public behavioral health systems are typically used for four main purposes:
  - *Level of Care*: to assist in determining a level of care, set of services or supports, or programs that an individual may be eligible for. These tools are typically used for initial eligibility determinations, to assist in establishing medical necessity, and as a guideline for the type of care or supports an individual requires.
  - *Functional Assessment*: to assess the functional ability in key life domains and/or assist in determining the specific support needs of an individual. These tools are typically used to help formulate treatment goals and/or determine need for specific services and/or supports. These tools may also assist in differentiating diagnoses and/or clarifying eligibility based on functional status.
  - *Outcomes*: to determine the effectiveness or impact of services/support or treatment- at an individual or population level
  - *Symptom Severity/Risk*: to assess the severity of symptoms or impairment due to a behavioral health condition or the level of risk an individual presents to themselves or others.
- Standardized tools may be effectively used at a variety of levels within an organization or system:
  - At the individual level, to screen for various conditions, as a factor in medical necessity and eligibility determination, understanding service and support needs, and informing treatment planning
  - At the program level, to design services that meet the needs of people seeking services; for program evaluation and outcomes management, and for utilization management
  - At the population/plan/state level, to understand the needs, conditions, and severity of illness of persons in services; for planning and evaluation
- To provide an example of how measurement-based care is used in public specialty care systems, let's look at a new study sponsored by Southwest Michigan Behavioral Health,



the public behavioral health plan covering eight counties in Michigan. That state's Behavioral Health and Developmental Disabilities Administration now requires the use of some standardized tools across all of its service populations for programs providing specialty behavioral health services.

- Some states, including Minnesota, Ohio, New Mexico, and South Dakota, do not require specific screening tools but require certain screening elements that providers can meet by utilizing the tool of their choice. Wisconsin, Idaho, and Colorado require the use of validated tools but do not endorse any specific tools. Other states like Nevada and Delaware have worked with the creators of validated tools to construct adapted versions that meet the needs of their state.
- It is unclear how data collected from the required screening, assessment, and outcomes tools is being used currently at the state or plan levels, but there are many opportunities for this data to drive treatment decisions and assure clients are receiving the appropriate levels of care.
- Despite the lack of consistency or national consensus on which tools should be used, there is certainly a growing trend and research to support measurement based care and its potential to improve the quality and effectiveness of behavioral health services. This trend is expected to grow as more payers move to performance-based or outcomes-based payment models, holding providers to a higher level of accountability in treatment<sup>4</sup>. Governing and accreditation bodies like CMS and The Joint Commission are moving towards the use of measurement-based care systems, which will increase provider urgency for the use of screening tools and outcomes measures.
- Making the Collaborative Care Model and measurement-based care general practice would benefit both the publicly funded system and the commercially paid health care system in the state of Rhode Island.



## The Substance Use and Mental Health Leadership Council of RI

My name is David Spencer, President/CEO of the Substance Use and Mental Health Leadership Council of RI – Formerly the Drug and Alcohol Treatment Association and the RI Council of Community Mental Health Organizations.

One of our most important goals at the Leadership Council is to advocate for and influence those that are in need of behavioral health treatment and to help individuals access those treatment services. I'm here to tell you that we have a major problem with access to these services in this state.

With the advent of the Affordable Care Act, we have seen thousands of individuals who previously lacked health insurance obtain coverage.

This has been an excellent accomplishment. However what we have seen are a significant number of these individuals with an insurance plan unable to access these badly needed services. The unaffordable co-pays and high deductibles prevent access. This is true of many of the low cost and supposedly affordable plans being offered in the market place today.

This has been consistent for both our Substance Abuse and Mental Health treatment Centers. I'd like to give just two examples: One of our substance abuse programs has indicated that they are seeing patients referred by the Criminal Justice system and required to follow the treatment plan recommended. Often time, the individual's treatment requires participation in both a weekly individual and group counseling session. This necessitates two co-pays per week. This could easily end up being \$75-\$100 per week. This becomes cost prohibitive and adherence to their treatment plan is difficult at best and more importantly the patient ends up at risk of being out of compliance with the courts and probation department.

Continued on page 2

The second example is from one of our mental health centers with the patients they served last year in three RI communities. They provided services at a total cost of \$471,000. The insurance companies re-imbursed them for \$267,000 or 57% of their cost. This left \$187,000 of patient liability. They were able to collect only \$16,000 or 15% of this total. This left the program on the hook for nearly \$172,000. This was the total of uncompensated care which was not able to be paid by the patients and left the program with a significant financial burden.

Lastly, the Truven Report also highlighted the access problems in this state by identifying the need to adopt a population health approach. It was recommended we identify what prevention, intervention and treatment is needed for the five age groupings 0-5, 6-12, 13-24, 25-64 and 65 years and over.

Currently we have no common vision amongst state agencies and no agreed upon plans as to what prevention, interventional and treatment services should be delivered to these age groups. As an example, the highest frequency of Mental Health and Substance Abuse is by the 12-25 year old age group yet we have two different state agencies—DCYF and BHDDH independently involved with their care. This becomes fragmented and inconsistent at best.

We've witnessed recent closures of adolescent Substance Abuse residential treatment facilities due to low reimbursement rates from the state. Concerned with adolescents being able to access needed care' – We've asked DCYF on numerous occasions "where are these kids going for treatment?" – A report was presented which showed nearly none. – A follow-up response elicited the response" we do not have any kids in out of state Substance Abuse residential Treatment and "we don't treat Substance Abuse" – Well what state agency has the responsibility for providing Substance Abuse Treatment to the state's adolescents that are in need.

I think it's obvious we have more than access problems. We have a lack of age appropriate services to address the Behavioral Health needs of age groups in this state.

We're asking that going forward we work to establish a local prevention and treatment network of services to address these needs as defined in the Truven Report.

Thank you for the opportunity to present these concerns.

Sincerely,

A handwritten signature in black ink, appearing to read "David Spencer", with a long horizontal flourish extending to the right.

David Spencer  
President /CEO

The Substance Use and Mental Health Leadership Council of RI



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# SENATE COMMITTEE ON HEALTH & HUMAN SERVICES

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## NOTICE OF MEETING

**DATE:** Thursday, October 13, 2016  
**TIME:** 3:30 - 5:00 PM  
**PLACE:** Senate Lounge - State House

### AGENDA:

#### Mental Health Hearing #3

- 1) **Opening remarks – Senate HHS Committee Chair Joshua Miller**
- 2) **Panel Discussion: Overview of State-Based Mental Health Services**
  - Nicole Alexander-Scott, MD, Director, RI Department of Health
  - Rebecca Boss, Acting Director, RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
  - Elinore McCance-Katz, MD, Chief Medical Officer, RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
- 3) **Panel Discussion: Access to Facility-Based Services**

Providers will discuss the importance of facility-based inpatient and residential mental health services as part of the continuum of care. Potential areas of focus include mental health services capacity, bed availability and tracking systems, and care integration with community-based services and supports.

  - John Holiver, CEO, CharterCare Health Partners
  - Richard Goldberg, MD, SVP, Psychiatry & Behavioral Health, Lifespan
  - James Sullivan, MD, SVP, Chief Medical Officer, Butler Hospital
- 4) **Panel Discussion: Workforce Issues**

Presenters will discuss mental health workforce training and retention issues. Potential areas of focus include licensing and regulatory concerns, training, and workforce supply issues.

  - Jeffrey Hunt, MD, Training Director, Residency and Fellowship Programs in Child and Adolescent Psychiatry, Brown University's Alpert Medical School
  - Jim McNulty, Executive Director, Mental Health Consumer Advocates
  - Monica Darcy, PhD, Associate Professor, Counseling Program Director, Rhode Island College
- 5) **Public Comment**

Written testimony is encouraged and copies will be shared with the Committee members. Please forward to Marea Tumber in the Senate Policy Office: [mtumber@rilegislature.gov](mailto:mtumber@rilegislature.gov)

Senate Legislative Office  
222-2381  
[SLegislation@rilegislature.gov](mailto:SLegislation@rilegislature.gov)



**10-13-2016 Senate Hearing**

**Elinore McCance-Katz, MD, PhD  
Chief Medical Officer**

**Rhode Island Department of Behavioral Health, Developmental Disabilities, and Hospitals  
14 Harrington Road  
Cranston, RI 02920-3080**

**[Elinore.mccancekatz@bhddh.ri.gov](mailto:Elinore.mccancekatz@bhddh.ri.gov)**

**Tel: BHDDH: 401-462-3157**

**Eleanor Slater Hospital: 401-462-1525**

**Fax: 401-462-3204**

The ESH has had a longstanding problem with hiring of physicians, particularly psychiatrists, which has reached a critical point in recent years. There are multiple reasons for this problem. One is that the only medical school in the state is private. Brown University School of Medicine admits few Rhode Islanders. Graduating medical students will often choose residency closer to their homes where they then establish practices after completing their training. Resident physicians come to Rhode Island from across the country to train at Brown-affiliated programs. Many then leave to return to their homes to establish practices leaving Rhode Island with a small pool of physicians to meet their healthcare needs.

National statistics tell us several additional factors that exacerbate an already severe psychiatrist shortage in Rhode Island: 38% of all psychiatrists are over age 55 (nearing retirement) which makes psychiatry the medical specialty with the oldest physicians second only to preventive medicine and only 4% of medical students choose psychiatry as a career (1). It is estimated that there is a shortage of 45,000 psychiatrists in the United States (2). The number of psychiatry training programs in the U.S. is 210 and these have positions to accept 1354 psychiatric residents for the nation. In 2015, 94% or 1273 positions were filled which represents the maximum number of psychiatrists that will be graduated from programs yearly. While the total number of physicians in the U.S. rose by 45 percent from 1995 over 19 years, the number of psychiatrists rose only by 12% (3) further demonstrating the shortage of psychiatrists in a time of greater access to care through the Affordable Care Act.

Since coming to ESH in October, BHDDH with the help of AMS has made the recruitment of psychiatrists a priority. Despite working with 6 locum tenens companies to search for psychiatrists, in nearly 4 months we had not had a single psychiatrist produced. Outside of the locum tenens process, I have now been able to recruit two part-time psychiatrists providing 24 hours of care per week as of December 2016. We also have placed several national ads for psychiatrists and I advertised at the state DATA waiver training for psychiatrists as well as other clinicians. BHDDH put out an RFP and now has two physician recruitment companies who could look for psychiatrists, but until the physician contract is settled we will not be able to recruit due to the low state salary for psychiatrists (starting



salary of \$116,000). The process of their finding a psychiatrist is one that will likely take many months. Another mechanism by which I have worked on recruitment is through outreach to the Brown Psychiatry Residency program. I have established training at ESH for psychiatric residents and, hopefully, will attract psychiatrists through exposure to our system over time. I have also restructured on call for psychiatrists and made on call opportunities available to senior psychiatry residents so that they may get experience working at ESH. I also teach second and third year residents so I hope that over time we might attract psychiatrists to ESH. This is a long term plan that will not produce results in less than 2 years.

1. <http://www.nimh.nih.gov/about/director/2011/psychiatry-where-are-we-going.shtml>
2. <http://www.psychiatrictimes.com/articles/45000-more-psychiatrists-anyone-0>
3. <http://www.usnews.com/opinion/blogs/policy-dose/2015/09/15/the-us-needs-more-psychiatrists-to-meet-mental-health-demands>

**All Hospital placement applications (ESH) are processed by hospital staff for appropriate ES hospital level of care. ES Hospital staff also work with Forensic staff on transfers.**

Eleanor Slater Hospital is the state's long term, acute care hospital providing services to individuals with serious medical or mental disorders who require long term, hospital level of care and rehabilitation. Referrals for admission come from community providers—mainly hospitals who cannot continue to be paid for services when a patient is deemed no longer in need of acute care services. ESH has a structured application process and an admissions team that reviews all admission applications. Physicians and other team members go to hospitals to make an assessment as to whether ESH can provide for care needs of the patient.

The hospital is licensed for 495 beds, but because of limitations on the numbers of physicians available to provide services to patients, we currently run a census of approximately 250. The current plan is to consolidate medical patients at the Zambarano Hospital in Burrillville, RI while the Cranston campus is planned to serve those with serious and persistent mental disorders. At the present time, we have one medical unit in the Regan building in Cranston which provides ventilator-assisted care to those with severe medical conditions that have impacted pulmonary function. Presently, Zambarano Hospital requires significant renovation in order to be able to support patients with ventilator needs. This includes installation of a new generator for the hospital that can accommodate at least 15 ventilator-dependent patients. We are waiting for a report to be completed on the required renovations and costs to provide continuing medical/mental health services at the hospitals.

The Cranston campus has three hospital buildings in current use. These include Regan, Adolph Meyer, and Pinel. The Regan building houses one geropsychiatry unit and, as stated, one medical unit. The Adolph Meyer units house civil psychiatric patients, with a unit for female forensic patients, and forensic overflow from Pinel is also placed in Adolph Meyer. Pinel houses men with mental illness who are charged with various crimes ranging from murder to minor infractions such as trespassing or disorderly conduct and who are ordered by the courts to ESH to undergo competency restoration services before they can stand trial. Pinel also houses individuals with serious mental illness convicted and serving sentences who are transferred by ACI to receive psychiatric services. The renovation plan for ESH includes demolition of Pinel. It is a very old facility with many structural problems and is not salvageable.

Because we lack adequate psychiatrist staff, we have not been able to accept civil admissions to the ESH psychiatry service since January, 2016. However, the criminal mental health law requires that ESH immediately accept all individuals ordered in by the courts. These numbers are substantial. For a long period of time the census of forensic

patients was approximately 45. However, this summer we have had up to 50 forensic patients ordered into ESH by the courts. We expect this upward trend to continue and this represents a challenge for the hospital because we struggle with having the necessary resources to accommodate all of the forensic patients and it prevents us from admitting civil patients.

We have not been able to attract physicians to ESH in recent years for a variety of reasons including an overall lack of available physicians in the state, low pay, and poor working conditions. We hope to come to agreement with the physician union soon which may make it easier to recruit physicians.

We also have difficulty discharging patients back to community settings. Community providers often refuse to consider those who have had a stay at ESH. They cite lack of resources to be able to keep the person safe and are concerned about the histories of patients who have had difficulties with behaviors that could threaten others or themselves. This results in ESH having to keep people who should have been discharged for a far longer period even though they have benefitted maximally from what hospital services can offer—in some cases we expect permanently. This means that Rhode Islanders in need to ESH services cannot access them.

#### **Centers of Excellence \* Training physicians to be data waived prescribers \* Developing medical curriculum to address opioid use disorders**

To address the serious problem of opioid misuse and abuse and overdose deaths the Governor's Task Force on Opioid Overdose Prevention and Intervention endorsed the idea of Centers of Excellence (COE) for the Treatment of Opioid Use Disorder and the necessary training of physicians in Rhode Island so that they could provide medication assisted treatment to patients with opioid use disorders from their office based practices. The COEs provide comprehensive services directed at the treatment of opioid use disorders including assessment with medical history and physical examination, education about treatment options, induction onto medication assisted treatment, counseling, case management, vocational rehabilitation, and other medical and psychiatric services as needed. COE staff work with providers in the community who can continue MAT. A unique facet of COEs are that they will re-admit a patient if they fail treatment in the community and need more intensive services.

Part of what is needed in establishing COEs is that doctors (and now allied providers including nurse practitioners and physician assistants who have recently been permitted by law to engage in office based treatment of opioid use disorder through prescribing of medication assisted treatments) obtain a waiver from the DEA and SAMHSA to write prescriptions for buprenorphine products. This waiver is obtained upon completion of 8 hours of training (doctors) and 24 hours of continuing education for nurse practitioners and physician assistants. We have been offering these trainings to practitioners over the course of this year and will continue to do so as a primary means of increasing access

to treatment. We offer 8 hour all day trainings or single trainer sessions which take place in small group settings after trainees have taken 4 hours of self-study. To date, we have trained over 300 physicians and allied providers in less than one year. We expect to meet the Governor's goal of training 700 doctors over 3 years.



**Lisa Shea, MD**  
**Medical Director, Butler Hospital**  
**Committee on Health and Human Services**  
**Senator Joshua Miller, Chairperson**  
**October 13, 2016**  
**Senate Lounge**

Thank you Mr. Chairman and members of the Committee. My name is Lisa Shea and I am the medical director at Butler Hospital.

The discussion regarding access to facility based services for psychiatric care is crucial to our ability to provide the appropriate level of care to the patients we serve, and I appreciate the opportunity to speak with you today. As you are well aware, given the recent Community Health Needs Assessment, one of the biggest challenges we face is a lack of physician providers. While this is obviously a complex issue, and there are no easy answers, there are several major factors to consider in determining where the problems lie and what we can do to help alleviate some of the pressure we are all facing on how to best serve the members of our community who are looking to us for help.

Butler Hospital is a member of Care New England Health System. As such, we are creating processes and programs that connect our service areas across the system. Butler has a 186-bed capacity with 157 beds licensed to Butler and 29 beds licensed to Kent Hospital. Annually, we conduct about 13,000 patient evaluations, admit approximately 6,300 inpatients and treat 3,500 people creating 20,000 treatment days in our five partial hospital programs. Additionally, we provide 21,000 outpatient treatment visits.

Our average daily census for fiscal year ending September 30, 2016 is 174.6 but numbers can be misleading - patients with the need for hospital level of care is not a consistent number on a daily basis, and there are more days than not that capacity is not sufficient. Specialty beds – such geriatric and intensive treatment unit beds are often scarce. In fact, the weekend of September 24 there were no psychiatric beds available in the state and patients were waiting in hospital emergency room departments, including ours at Butler Hospital, for extensive periods of time.

In our partial programs, which provide patients intensive all-day treatment for one to two weeks, we manage our available program slots with greater capacity for transfers from our inpatient units versus self or community provider referrals. This helps us create appropriate transitions to next level of treatment for people in our care. Each program varies in wait times, with our Women's Program often the lengthiest. From program to program, people can enter program within a day or two and upwards of a couple of weeks.

These capacity constraints are a concern as the issues our patients present with are significant and often traumatic to them and their family members, in particular in crisis situations. I'm sure we can all agree these common scenarios are not in the best interest of patients, families or providers. While we have not solved all of the challenges we face dealing with issues regarding access, I would like to share some of what we are doing at Butler.

Within weeks we will launch a Care New England centralized Call Center for behavioral health services. This effort led by Butler Hospital creates a single point of access for inpatient, partial and outpatient services offered throughout the system. This allows us to triage patients efficiently and effectively deliver the right level of care in the right place, addressing the Triple Aim goals of health care delivery improvement. To be as responsive to need as possible, the call center team has full visibility and control of the hospital's bed tracking system to alert inpatient teams to begin the process of preparing a unit for admitting a patient. The center is available 24 hours a day, seven days a week ready to screen callers and provide instructions – and begin the admitting process – on how and where to access the level of care needed.

Coinciding with the opening of the call center, Butler is also redesigning our Patient Assessment Services. The process changes are moving from a physician-centric care model to a coordinated team model. This will allow us to triage people – of which more than 60 percent self-present unannounced for care – and quickly evaluate who is appropriate for ambulatory services and who needs a higher level of care immediately. With this change we are creating an ambulatory service supported by a licensed clinician that will help people seeking assistance with medication management or other

support care. This will increase capacity for our care team to attend to people with higher acuity symptoms, deliver care in a timely fashion and expedite their transfer to a bed for a full complement of treatment.

Two new programs introduced this past year have increased capacity in two different populations.

In fall 2015, Butler launched its Young Adult Partial Hospital program to serve people age 18 to 26 years old who are suffering with anxiety, depression, mood disorders or psychosis. Like all our partial hospital programs, the Young Adult program offers individual, group and family therapy plus medication management, all to support understanding and skill development. The program has a capacity of 20 people each day with a fully-staffed team including physician oversight. Candidly, we have had difficulty with physician coverage which has led to variability in our volume. Despite this, this program has opened up capacity in our adult partial programs by 50 percent with the addition of these program slots.

Also last fall, Butler opened its Ambulatory Detox Clinic, which directly combats the opioid crisis through medically managing detoxification through a physician-directed outpatient program. Over a period of three to five days, people are safely withdrawn from prescribed and illicit drugs working with an experienced team. We also require the patient have a strong home-based support system who participate in the process. Post detox, we assist people in finding the next level of care needed to continue on their recovery journey.

Without addressing mental health issues, it is clear that resolving other medical issues becomes much less likely. Key to success is appropriate transitions to different levels of care. Butler began to focus on this issue ten years ago when it established an internal transitions team. Today, through our efforts that team has grown to include twenty-one different disciplines from admissions to compliance to pharmacy to payers to billing as well as different types of care providers, not only from Butler and our Care New England partners but health care organizations from throughout the state. The more than 50 members are known as Transitions of Care Coalition (TOCC) and meet regularly to coordinate care for people with mental health disorders.

Members of the coalition include Beacon Health Strategies, Blackstone Valley Community Health Center, Blue Cross/Blue Shield of RI, Brown University, Butler Hospital, CharterCare, Care New England, Community Care Alliance, Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, East Bay Center, Executive Office of Health & Human Services, Fellowship Health Resources, Gateway Healthcare, Healthcentric Advisors, Kent Hospital, Optum, Riverwood Mental Health Services, Seven Hills Rhode Island, The Kent Center and The Providence Center.

Other complex barriers Care New England is working to address include changing insurance coverage and reimbursement rates. Our partnership with BlueCross BlueShield of Rhode Island in collaboration with Butler Hospital, The Providence Center and Continuum Behavioral Health to develop a program called HealthPath represents the nation's first health home program for commercially insured and Medicare covered adults. Enrollees in the program are pre-approved for one year with the care team receiving bundled monthly payments to cover all services, including support services not previously covered by insurance. Its team-based model allows for a range of services including psychiatry, case management, nursing, therapy, peer support, transportation, housing and employment placement assistance and coordination with primary care and other medical specialties as needed. What's even more impressive is the team has created literal pathways for communication and coordination of the treatment plan.

This open, honest partnership is delivering real health solutions for HealthPath members: 1) Eighty-six percent report either significant (53%) or some (31%) improvement in daily living activity scores 2) Eight percent reduction in behavioral health costs 3) Significantly lower readmission rates.

This represents some of the work Care New England is undertaking to support mental health in Rhode Island. All of us are focused on our central mission to provide excellent patient care. It is our goal to come together in collaboration to do what is right for our patients, hospitals, for our workforce, and for our community. We are committed to be part of the solution to break down barriers to behavioral health services which limit many people's ability to achieve health.

Again, I appreciate your interest in these important issues and look forward to answering any questions you may have.

**Senate Committee on Health and Human Services:  
CharterCARE Health Partners - Testimony**

**John Holiver  
Chief Executive Officer**

**October 13 2016**

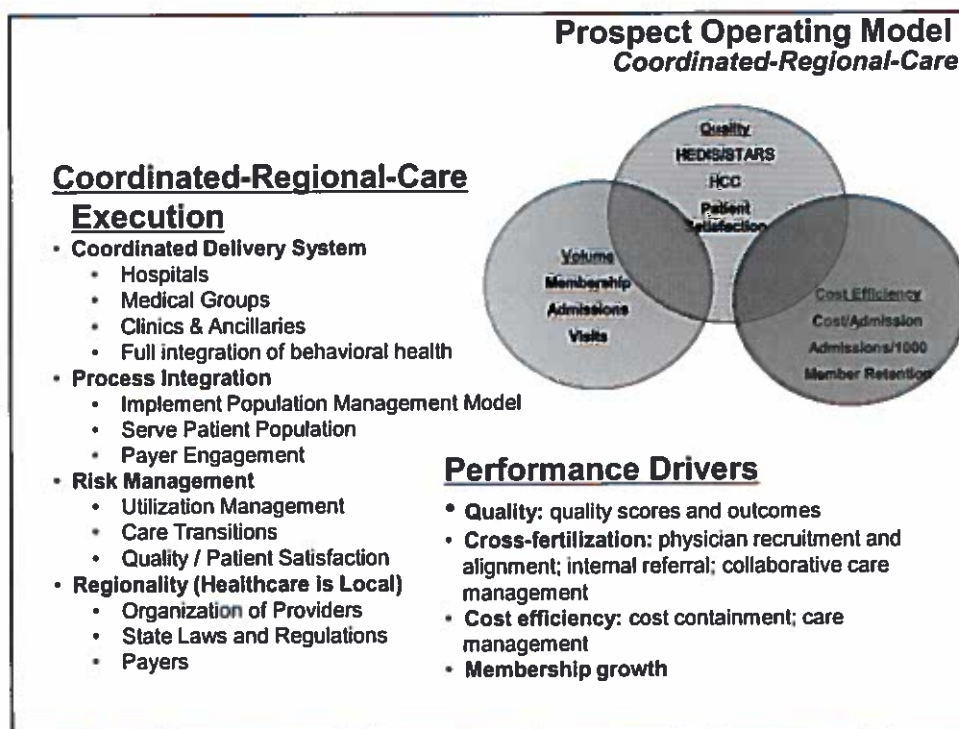
**CharterCARE Health Partners**

- A joint venture with Prospect Medical Holdings that has brought financial stability and capital strength to our affiliate organizations while at the same time driving quality of care and improving operating efficiency,
- That provides the right level of quality care at the right time and place and at low cost, and
- That has RWMC, OLF, Elmhurst, SNERC, CharterCARE Home Health Services, St. Joseph Health Center, PPGRI and CharterCARE Medical Associates



## We Are Different

- We are not hospital-centric.
- Our Coordinated Regional Care (CRC) model is a regional, multi-level network of providers that give patients easy access to the right level of care at the right time and place.
- A key feature of our CRC model is our strong integration and partnership with the physician community, utilizing Prospect Provider Group of Rhode Island (PPGRI) and CharterCARE Medical Associates (CCMA).
- Behavioral Health services are core to our mission, and are fully integrated in our system of care



**Behavioral Health in Rhode Island:  
Our Observations**

- Insufficient services in many program and geographic areas
- Lack of coordination and integration
- Funding mechanisms are misaligned with the best clinical outcomes
- Workforce shortages in certain areas

**What Have We Done and  
What Will We Do to Help?**

- We're growing and improving
  - Long-term care solutions for the severely mentally ill
  - Expanded Substance Use Disorder services
- We're integrating the mind and body
  - In primary care *and* specialty settings
- We are one of the first Accountable Entities in the State, and we can do more
  - We have extensive experience with Alternative Payment Models (APM) and can bring more of that to Rhode Island
- We're addressing workforce issues
  - Bringing new MDs and other professionals to Rhode Island and equipping them to provide the best care



## **Why Peer services? Why now?**

Rhode Island way behind the curve – Georgia has been doing them since 2001

Peer services complement traditional mental health services, resolutely non-clinical, recovery-oriented

Recovery: A safe decent place to live, a sense of purpose in life and a social life - not necessarily symptom-free

Ample evidence that traditional mental health services are overwhelmed by demand for the service.

There is a documented shortage of mental health professionals, including peer providers Rhode Island, and nationally, fewer than 50% of psychiatrists accept insurance. Psychiatrists are in very short supply.

In the community mental health system prescribers are scarce, and the turnover is very high. Peers can help smooth out some of the bumps in the transition to new prescribers.

Gresham's Law applied to mental health services - the more experienced providers transition to treating patients who are less ill, leaving the more ill patients to be treated by those with less experience (conversation with Paul Appelbaum MD)

What do Peers bring to the party:

- you don't need it
- Personal Responsibility
- Education
- Self Team You Advocacy
- Support
  
- Retention issues
- Recruiting issues
- HR Issues
- Licensing issues

Bright Signs on the horizon: Parents Support Network training CPRS (peers) (BHDDH Initiative)

McNulty Bullets Senate HHS, October 13, 2016





### Rhode Island College Graduate Counseling Programs

Rhode Island College (RIC) has 2 graduate counseling programs that are aligned to state licensing requirements for licensed mental health counselors (LMHCs).

- **Masters of Science in Clinical Mental Health Counseling** - 60 credit hour program which received Council for Accreditation of Counseling and Related Educational Programs (CACREP) accreditation in July 2016. CACREP has been recognized as the "gold" standard for counselor education programs and has been selected by the Institute of Medicine, TRICARE and Veterans Administration as the requisite credential for mental health counselors.
- **Certificate of Graduate Studies in Advanced Counseling** is a 15 to 24 credit hour program which enables students who already have a Master's degree in counseling or a related field, which is fewer than 60 credits, to obtain 60 credits needed for licensure as a mental health counselor in the state of Rhode Island.

The RIC graduate counseling programs have approximately 100 students enrolled each year with close to 40 students completing academic requirements each spring. In a survey we conducted several years ago, over 60% of the LMHCs in RI completed some or most of their academic requirements in our counseling program at RIC.

The graduate counseling curriculum includes both the requisite coursework to satisfy RI state licensing requirements for LMHCs and for certification of licensed chemical dependency professionals (LCDPs).

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#### Training issues

**License Portability:** RI requirements for LMHCs include 4 practicum courses. This is unique to RI and surpasses the requirements in most other states. Academic programs within RI have developed methods to satisfy these requirements. Applicants with degrees or licenses from out of state need to make up any deficit in their academic work.

**Recommend:** Add language such as this to Item 6.1 of RI DOH licensing rules for LMHCs - *For licensed mental health counselors, an applicant whose qualifying degree is awarded by a CACREP accredited program in mental health counseling totaling sixty (60) or more semester hours or ninety (90) or more quarter hours shall be considered equivalent to the requirements established pursuant to the Act.*

**Training locations:** pre-Masters level clinicians in practicum or internship settings are not billable for the agencies or practices providing the learning experience. This significantly limits settings in which students can participate in supervised training.

**Recommend:** Re-establish a status such as "principal counselor" allowing an expanded number of training site locations to incorporate students in their practice.

**Clinical hours:** current licensing regulations allow applicants to accrue the requisite 2000 clinical hours after a Masters degree. Other states require the hours to be accrued post 60 credit hours.

**Recommend:** Adjust licensing to require clinical hours post-qualifying 60 credit hours. Adopt a tiered license LMHC at completion of academic requirements and LIMHC at completion of clinical hours.

**Approved supervisors:** RI has relatively few LMHC approved supervisors. Training practicum students and interns under the licensed practitioner of the same professional license strengthens professional identity.

**Recommend:** create initiatives to increase pool of approved supervisors.

Respectfully Submitted,



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Monica G. Darcy, Ph.D., LMHC, NCC  
Counseling Program Director, Counseling, Educational Leadership and School Psychology Department  
Rhode Island College, Providence, RI 02908  
401-456-8023 [mdarcy@ric.edu](mailto:mdarcy@ric.edu)  
See more about our counseling programs [here](#)



MS in Clinical Mental Health Counseling



## **The Substance Use and Mental Health Leadership Council of RI**

**I would like to bring your attention to a significant problem affecting our Residential Substance Abuse treatment programs here in RI.**

**We've witnessed over the last few years, actually since the Substance Abuse Residential programs went in plan and covered by the insurance providers, a significant drop in lengths of stay. Before the residential programs went in plan, the average length of stay was four months. It has now shrunk to about two to three weeks.**

**I want to tell you that it is next to impossible for a patient to get the necessary treatment he or she needs in the number of days now being approved by the healthcare plans. In my former job for over 20 years as Executive Director of Tri-hab, I ran both male residential and female residential treatment programs. We normally provided an average of four to six months of care and we had very positive outcomes. The patients that stayed longer ended up staying alcohol and drug free for longer periods of time. They got their lives back together. They became re-employed, reunited with their significant others had no further interactions with the criminal justice system or DCYF. Costs to society and to the state were dramatically reduced.**

**What has been reported to me by our programs is that those individuals that have been denied admission or had their treatment stay reduced more often will eventually end up in the emergency room, in prison or some other much more expensive cost of care. Programs also reported drug overdoses and even suicides by patients discharged before they had completed their treatment.**




This matter was brought to the Office of the Health Insurance Commissioner and told that with the reduction in funding only cases could be reviewed on an individual basis.

We are hoping that you will look into this matter.

We want to make you aware of these serious problems so going forward you can make an informed decision.

Thank you for the opportunity to present this information to you.

Sincerely,

A handwritten signature in black ink, appearing to read "David Spencer", followed by a horizontal line extending to the right.

David Spencer  
President /CEO

The Substance Use and Mental Health Leadership Council of RI



October 13, 2016

Chairman Miller and Members of Senate Health and Human Services Committee,

As some of you know, my name is Lori Ziegler Halt and I am the Human Resources Director at Community Care Alliance in Woonsocket, RI. I gave testimony on September 15<sup>th</sup> to give this committee another perspective on what we, as a community-based mental health and human services agency face on a day-to-day basis. Chairman Miller kindly invited me back today and I just want to give a quick review.

Our staff provides care coordination, resources, support, clinical support and therapy to our clients. They work with people in the throes of anxiety, depression, anger, despair, fear, addiction and serious and persistent mental health concerns all day, every day. They go out into our community and into clients' homes where they often face extremely poor conditions (bed bugs, vermin, mold) to threatening and sometimes dangerous situations.

Our clients also come to them at the agency. We have emergency vehicles at our facilities on a regular basis. We recently had a brand-new client OD in our bathroom, whose life was saved by the quick actions of our staff who administered Narcan and CPR. A long-term client collapsed and passed away right outside our facility subsequent to years of substance abuse. Our staff worked to resuscitate the client and ensure others' safety until the ambulance arrived. Clients have outbursts, make threats and sometimes hurt themselves in our buildings. Staff de-escalate, intervene and stabilize situations like these on a daily basis and then go back to their desks to enter careful notes to make sure every I is dotted and T is crossed to meet regs and to make sure we get reimbursed. The majority of these have bachelor's degrees, make \$11-\$13 an hour and haven't received a raise in years.

This summer, because of cash flow issues brought on by changes and delays in IHH/ACT funding and payments, we had no choice but to make a 10% salary cut for all but our lowest paid employees. This has resulted in an exodus of 22 skilled employees since the middle of July, with dissatisfaction with pay and agency stability being the #1 reasons, by far. This has resulted in hard to fill vacancies, understaffed teams working twice to 3 times their normal workloads, low morale and exhaustion, a huge rise in leaves of absence, stress leaves and even an increase in our at-work injuries resulting in Workers Compensation claims.

Our staff is leaving or actively and blatantly looking for jobs. We've lost a number of clinicians and case managers to counseling groups, health centers or state-funded agencies because they can make sometimes twice the money they're making at CCA. We are also losing staff to administrative office jobs and even restaurant and retail jobs that pay more with far less stress. The majority of people get emotional at their exit interviews and express regret in having to leave, saying that they have no choice.

Filling positions is expensive and often fruitless. We struggle to get resumes for nurses, prescribers and other personnel. Headhunters and their 30% of salary charges are out of the question. Vacant positions mean clients are not being served and the agency is not only not generating money but actually having to spend money in order to sustain itself. It's a vicious circle.

I spoke about our employees working extra jobs, taking extra on-call hours to fill in, taking loans out on their 403b's and getting trapped in payday loans. Since I was here last, I've been approached by several employees

asking if there's any way the agency could loan them money. I have written letters to landlords. We put together and posted a resource list of food pantries, support/basic-needs services and financial services on our agency intranet. Again, this is for our STAFF, not the clients. I want to share a short excerpt from an email I received from a clinician a week after my last testimony:

"I have been working my 40 hours plus extra hours on-call and have been looking for a part time job on top of it. I'm in a bad place financially and I need more weekly income, so working extra is good. It does help to carry me further, but not much. That plus the 10% decrease put me even further back. I have had to make plans with bill collectors on paying bills and rent every two weeks in order to stay afloat which is very hard. I'm currently living in fear that someone is going to come take my car. I was able to make a partial payment after payday last week, so I'm hoping that will be enough. I've cleaned everything out of it, just in case. I always say I am one check from being a client here at CCA. How embarrassing would that be..."

Our CEO, Ben Lessing submitted testimony at the last hearing that included specific recommendations for solutions. And our presence here is an attempt to give a deep-dive, human perspective to something that is often discussed at a very high, broad level. Other things that will help are:

- More funding, quicker funding and less hoops to jump through to get the funding.
- Taking a look at why there seems to be a different set of rules for community-based non-profits and health centers and hospitals.
  - Non-profits are expected to operate within a much leaner financial context.
- Taking a look at pay discrepancies and equalizing rates and pay structures.
  - We cannot compete with state-funded agencies or health centers, when they are able to offer 10-20% more for salaries.
  - A case manager with a bachelor's or master's degree working at a community-based nonprofit makes much less than someone with the exact same credentials working at a state-funded agency or health center where they are often not required to go to clients' homes.
- Ensuring that MCOs provide timely payments.
- Investing in community based non-profits, which will in turn, keep more people out of hospitals and reduce expenses for the state as well as lend stability to non-profits, their staff and clients.
- Creating a financial safety net for non-profits providing community-based services.
- Having community-based nonprofit agencies at the table and actively engaged in making decisions that will directly affect them, their staff and ultimately the clients.
- Truly taking the time to understand the effects and consequences of those decisions.

We desperately need your help so that we can continue to help others. Without regular, dependable funding and stability, we will be without staff. Without staff, we will be unable to maintain all the good we do for the community and the people in it. Thank you.

Respectfully,

Lori Ziegler Halt  
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Community Care Alliance  
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<http://www.communitycareri.org>

October 11, 2016

Dear Chairman Miller and Committee Members

My name is Marc Dubois and I am the hospital/court liaison/case manager at Community Care Alliance, a non-profit mental health center in Woonsocket.

There are two topics that I would like to address today. The first topic I would like to address is staff retention. Due to the lack of appropriate mental health funding by the state, our newly hired case managers with an associate's degree start at \$13.50 an hour.

A bachelor's degree pays slightly higher. Many of our case managers have student loans and work 2-3 jobs to make ends meet. Due to these low wages, there is a very high turnover rate at our agency. A case manager is responsible for: scheduling and transporting clients to medical and psych appointments; counseling; developing and implementing a treatment plan with the client; coordinating client's treatment with medical providers, client's family, landlord, DHS, and Social Security; managing client's finances; taking client's grocery shopping; etc. Case managers are also responsible for monitoring client's medication and many high risk clients are seen once or twice a day for medication monitoring.

It takes a full year for a new case manager to become fully trained and become familiar with our agency and state regulations. Unfortunately, most of our newly hired case managers leave within the first year due to the low wages that we are forced to pay. Some of these case managers that leave us go to work in retail or fast food for the same amount of money and much less stress and regulations to deal with.

An average manageable caseload for a case manager should be 25 clients. We have several openings at our agency that we cannot fill due to the low pay and when case managers leave our agency, a case manager's caseload can reach 40 or more clients, which is unmanageable. These clients all have a severe and persistent mental illness with a high percentage of these clients also having alcohol and/or substance abuse issues. Due to a lack of case managers, a client that would benefit from being seen weekly can expect to be seen monthly. Many of our clients have no family or have been shunned by their family and rely on their case manager for support. Many clients get bounced around from case manager to case manager due to our high turnover rate. This lack of stability and lack of consistency are damaging to the clients that we serve. Some of these clients wind up being hospitalized psychiatrically due to the lack of time and support that we can offer them because of the lack of staff.

Due to the lack of funding from the state, our staff retention issues are not only with case managers but also affect our nurses, prescribers, vocational specialists, substance abuse specialists, therapists, etc. Many of these employees leave our agency to work in a hospital or the private sector.

Another issue that CCA has to deal with is the delay in IHH/ACT funding. This past summer, all employees had to take a ten percent pay cut for six weeks. Once this pay cut was announced, we lost a large number of our valuable employees who left our agency and many other employees are looking for other jobs fearful that this pay reduction may happen again or become permanent.

The second topic I would like to address is the lack of beds at group homes in this state and at the Eleanor Slater Hospital for our clients that are unable to live independently or function in society. The waiting list is very long for these much needed beds. These clients, while on a lengthy waiting list, are hospitalized and in some cases are hospitalized for a year or more before an opening becomes available. The costs associated with these lengthy hospital stays are astronomical. There are also clients who have assaulted their elderly parents and were hospitalized because of the lack of group home and Eleanor Slater beds. Because of the long stay at the hospital, many doctors are releasing these clients back home, putting the client and their families at risk. The reason these clients are being sent home is they do not want the client to occupy one of their beds for a year or more.

Thank you for listening to our concerns

Respectfully

A handwritten signature in cursive script that reads "Marc A. Dubois". The signature is written in black ink and is positioned to the left of the typed name.

Marc A. Dubois  
Hospital and Court Liaison  
Community Care Alliance



October 13, 2016

Dear Chairman Miller and Committee Members:

Thank you for your time and attention today. My name is Michelle Taylor and I am a Licensed Mental Health Counselor who serves as the Director of Outpatient Services at Community Care Alliance.

Community Care Alliance is a combined behavioral health and community action program based in Northern Rhode Island. Our mission is to support individuals and families in their efforts to meet economic, social and emotional challenges and enhance their well-being. Woonsocket is home to the highest rate of substantiated cases of child abuse and neglect in the state, including emotional, physical and sexual abuse. Our clients are among the most impoverished in RI. These two factors contribute to PTSD, anxiety, depression, and other mental health disorders. At least 50% of the people that we serve have co-occurring substance use disorders, a common maladaptive strategy utilized by individuals struggling to cope with complex trauma. Combined, these issues contribute to pervasive problems that cut across all major life domains: relationships, education/employment, housing, legal, and medical. The chronic stress of trauma and poverty contribute to poor health, limiting not only people's level of functioning, but their life expectancy, due to serious medical conditions, such as COPD, hypertension, heart disease, HIV/AIDS, hepatitis, and much more.

Imagine trying to address all of these issues from a chair in an office. Our current service delivery model is inadequate to treat and resolve the complex issues with which our clients present. Outpatient services are office-based, delivered by independently licensed professionals, and occur in 45 minute sessions, every one to two weeks. One model that offers substantially improved outcomes is the Certified Community Behavioral Health Clinic (CCBHC) for which BHDDH has recently submitted a planning grant. CCBHCs are person-centered and recovery-focused, dictating staffing patterns that incorporate qualified staff who are culturally competent to address specific areas of need across the lifespan, from early childhood to the elderly. Certain populations are identified as having unique needs, including individuals with severe and persistent mental illness, children/adolescents with serious emotional disturbance, those who have experienced trauma, those with substance use disorders, and veterans. Assessment and treatment planning occur quickly within specified timelines and include crisis management for those who are experiencing acute symptoms. Medically trained staff are critical, not only for prescribing psychiatric medications, but for the delivery of medication assisted treatment (MAT) to individuals in recovery from substance use disorders. With RI facing the challenge of the opiate epidemic, including widespread and deadly use of fentanyl, medications such as buprenorphine and naltrexone are an important recovery tool, dramatically improving individuals' chances of remaining abstinent.

Although essential, training budgets for most community health centers are often too small to provide the intensity of training needed to ensure that all staff adhere to evidence-based practices, such as cognitive behavioral therapy (CBT), dialectical behavior therapy (DBT), Motivational Interviewing, Coordinated Specialty Care, and more. This is important because these strategies are known to produce improved outcomes, with lasting impact on clients' lives.

As a CCBHC, even outpatient teams would be built utilizing multidisciplinary staff.

**Case Managers:** Prior to January 1, 2016, RI Medicaid reimbursed providers for case management services, allowing providers to go out into the community to support clients in their efforts to access entitlements and benefits, coordinate with primary care, connect to community resources, and engage in social activities to improve social connectedness. Case managers help clients to manage crises and teach them over time how to do these things independently. Depending upon the nature of a person's mental illness and cognitive functioning, some may need a longer period of assistance. Others may need lifelong support. Our goal, of course, is to shift as much of this assistance to natural supports that we help clients to develop.

**Psychiatry:** Although agencies currently offer psychiatry, most are understaffed. Few are drawn to the comparatively lower salaries and the challenges of the population we serve. Reimbursement for the services of psychiatrists and prescribing nurses is inadequate, resulting in financial loss for every one hired. In an outpatient setting, this forces agencies to limit clients who can access such services to those who are most at risk of harm to self or others.

**Peer Recovery Specialists** are individuals with lived experience with mental illness and/or substance use. They receive special training to support individuals along their path of recovery. These paraprofessionals support clients in the community, attending AA/NA meetings, and assisting clients to access appropriate community resources. Unlike professional services, Peer Recovery Specialists are available on nights and weekends and are able to share their own stories of what has/has not worked. As valuable as they are, they are not reimbursed for clients engaged in Outpatient Services.

Other services lacking in outpatient models are transportation and childcare. Both are significant barriers to engaging and continuing in outpatient treatment. Taking a bus can be a daunting task for individuals experiencing symptoms from PTSD, depression, anxiety and more. Logisticare offers assistance to some, but is inaccessible to others. Additionally, women with young children often lack natural supports to watch their children while they attend counselling appointments. Reimbursing agencies for childcare, would not only increase treatment adherence, but could offer increased opportunities to provide parenting education, screen at risk children and intervene with evidence-based programs when parenting skills are lacking, breaking the cycle of abuse and neglect that traps people in poverty and with behavioral health issues.

Outpatient treatment in its current form is effective in improving individuals' ability to tolerate distress, regulate their emotions, and improve their relationships and their level of functioning. Despite this, the current model falls far short of the needs of those we serve. But, there are models that work, helping people to achieve recovery and to become healthy, contributing members of their communities. For a relatively small cost, we have the potential to substantially improve outcomes for those we serve. In the end, we all benefit. I ask for your help in putting these critical elements in place. Thank you for your time.

Sincerely,



Michelle Taylor, MS, CAGS, LMHC  
401-808-4384  
mtaylor@communitycareri.org

I am a Registered Nurse working in Rhode Island. I am increasingly alarmed by the lack of care for Rhode Island residents with Psychiatric Illness. As a state, we seem to be returning to the age where those with such illnesses are without any rights and are routinely institutionalized. Sadly, not locked in attics or asylums, but in our very overburdened homeless shelters and jails.

Not so long ago in Rhode Island, as in most of the U.S., there was a network of community support for those with psychiatric illness. This was a wonderful alternative to the mental hospital system where people were locked up for months, years or a lifetime. Closing these hospitals was progress, it was well intentioned. But it is cruel to close the hospitals and not have a safe alternative. This is what has happened, slowly but surely here.

The situation is not limited to the poor or uninsured. I can spend an afternoon calling to try and schedule a new patient appointment. Recent deaths from overdose and suicide tell us that even in families with great wealth and influence, we are failing to provide psychiatric support. The situation is most dire though, for those with only Medical Assistance (Medicaid) for insurance. I find no one in southern RI who will see a sick child or adult without private insurance. Thankfully, Thundermist of South County is doing their best to fill the gap, their Family Doctors and Nurse Practitioners are doing Herculean work, but they do not have a psychiatrist on site.

South Shore Mental Health in Wakefield closed in 2015. The office in Charlestown is nearly inaccessible to anyone without a car. Services there are minimal.

I have accompanied children and adults to the Emergency Department at South County Hospital. Psychiatric patients wait hours and hours for an evaluation. Some with psychosis, severe depression or anxiety cannot tolerate the wait and leave. When patients are evaluated, it is not by a doctor, sometimes it is a thorough and appropriate evaluation by a Nurse Practitioner, more often it is a cursory exam by a minimally skilled evaluator. Patients who are not homicidal or suicidal are mostly sent home, not because they are not severely ill or suffering, but because there is "no bed". (Rarely is this openly acknowledged.)

For those few who make it to a psychiatric in-patient unit, the "follow-up-care" is abysmal. Patients may receive a name of a doctor or a service, it is up to them to schedule intake, sometimes the next available appointment is weeks away. It is up to patients who are still sick to find transportation. Many patients are still suffering from disorganization and immobility and organizing care is far beyond their capacity. Sometimes patients are discharged with prescriptions that insurance will not pay for. These may cost hundreds or thousands of dollars. Very rarely does a recently discharged person have the skills to advocate for their care.

Butler Hospital discharges people to Crossroads (Homeless Shelter). As wonderful as the staff at Crossroads is, as caring as they are, they are NOT a psychiatric facility. The plan for follow up appointments at The Providence Center is heartless at best. I have spoken with clients at Crossroads who see psychiatrist there only once every one to 3 months. One woman with severe illness told me she is in their "intensive program", she sees a counselor once a month. Again, this is not because the staff at The Providence Center are uncaring. It is because they are all doing their best with a horrible system.



One, of many, cruel ironies with psychiatric illness is a symptom called anosognosia. It is the inability to recognize their illness. Only those with very solid family or community support are likely to remain on medication. Regrettably, this symptom, and others so often alienates family and community. In Rhode Island, we are abandoning some of our most needy and vulnerable children and adults.

Thank you for your attention.

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*Mary Roth R.N. CTTS-M*

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# SENATE COMMITTEE ON HEALTH & HUMAN SERVICES

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## NOTICE OF MEETING

**DATE:** Thursday, October 27, 2016

**TIME:** 3:30 - 5:00 PM

**PLACE:** Senate Lounge - State House

### AGENDA:

#### Mental Health Hearing #4

- 1) **Opening remarks – Senate HHS Committee Chair Joshua Miller**
- 2) **Introduction: Crisis Intervention, Suicide Prevention & Special Populations**
  - Representative from RI Department of Health
- 3) **Panel: Crisis Intervention**
  - Denise Panichas, Executive Director, The Samaritans
  - Captain Ann Assumpico, Director of Training, RI State Police
  - Gary Bubly, MD, Emergency Medicine, Lifespan
- 4) **Panel: Special Populations (1)**

This panel will discuss unique mental health challenges of children, the elderly, people with dementia, and those with post-traumatic stress disorder (PTSD).

  - Margaret Holland-McDuff, Executive Director, Family Service of RI
  - Kathy Heren, Executive Director, Alliance for Better Long Term Care
  - Robert Swift, MD, PhD, Chief of Mental Health, Providence VA Medical Center
- 5) **Panel: Special Populations (2)**

This panel will discuss specific mental health needs of people who are homeless, housing insecure, incarcerated, or recently released from prison.

  - Dan Kubas-Meyer, Executive Director, Riverwood Mental Health Services
  - Craig Kaufman, MD, & Megan Smith, House of Hope
  - A.T. Wall, Director, RI Department of Corrections
- 6) **Public Comment**

Written testimony is encouraged and copies will be shared with the Committee members. Please forward to Marea Tumber in the Senate Policy Office: [mtumber@rilegislature.gov](mailto:mtumber@rilegislature.gov)

Senate Legislative Office

222-2381

[SLegislation@rilegislature.gov](mailto:SLegislation@rilegislature.gov)





# Behavioral Maternal & Child Health

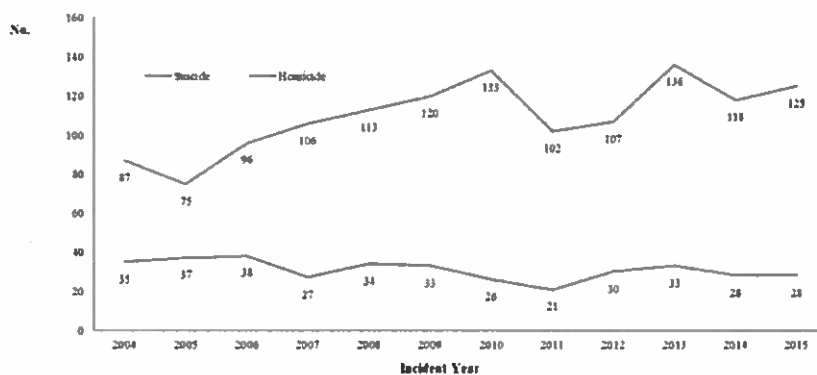
*Suicide, Neonatal Abstinence Syndrome, and Depression Screening*  
**Senate Committee on Health and Human Services**  
**October 27, 2016**

Deborah Gameau  
 Deborah.Gameau@health.ri.gov  
 Rhode Island Department of Health

## Suicide in Rhode Island

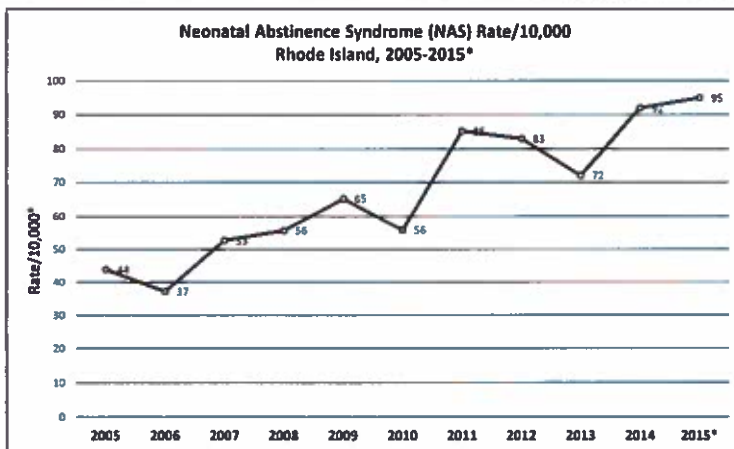


Death Manner by Incident Year, Rhode Island 2004-2015



- There is an average of one suicide every 3 days in RI
- For youth age 24 and under, the number is 1 every 25 days.

## Neonatal Abstinence Syndrome



- Note: Rate = Number of RI infants with NAS (ICD-9 code 779.5) per 10,000 live births
- Note: 2015 = Quarters 1-3 (January 1-September 30, 2015)

Source: Hospital Discharge Database, Rhode Island Department of Health

## Our Public Health Response



### Addressing Social & Environmental Determinants of Health

- Community – Clinical Linkages
- Embedding Community Health Workers/ Peer Recovery Specialists in healthcare

### Identifying Vulnerable Populations

- Epidemiology
- Surveillance

### Depression and Substance Use Screening & Response

- Primary Care
- Family Visiting
- Schools
- OB/GYN Care (prenatal and postpartum)
- Prescription Drug Overdose Program
- Violence and Injury Prevention Program
- Early Childhood Developmental Screening/Follow Up
- Adolescent Health Program

**Senate Committee on Health and Human Service  
Mental Health Hearing #4  
Thursday, October 27, 2016  
The Samaritans of Rhode Island  
Testimony by Denise Panichas, Executive Director**

**Topic: Crisis Intervention**

**“I’ve been looking at your website for a week before I called.”  
— 2015 Crisis Hotline caller in his late 30’s**

**General**

The Samaritans of Rhode Island was established in 1977. Our vision is to have a suicide free Rhode Island. We also envision The Samaritans as the “agency of choice” for individuals, families and other community stakeholders who seek information relating to suicide prevention, grief support, education and information. Because of philanthropic mission as a nonjudgmental, volunteer based befriending organization, we believe we have gained the reputation as the state’s most trusted name in suicide prevention and we are in a unique position to break the stigma associated with asking for help and increasing awareness of issues relating to depression, suicide prevention, treatment as well as the challenges facing caregivers and survivors of a loved one’s suicide.

The Samaritans helps Rhode Islanders when they are in a crisis, recovering from a crisis, and when they have recovered; when they are in care, out of care and most importantly when care is never going to be an option – and for so many reasons, for many of our fellow citizens, our nonjudgmental listening line is the only daily care and ongoing supportive services they receive over their lifetime. Through our programs, we provide free, statewide care without regard to market share, area competition, or 3<sup>rd</sup> party reimbursements. At The Samaritans, no one seeking our help is “left behind” because of an inability to pay.

Our programs include our Crisis Hotline/Listening Line, Safe Place Grief Support, Youth and Teen Education and Community Education including our Lifeline program at the Men’s Intake Center at the Rhode Island ACI. Since our inception, more than 1,539 trained volunteers have answered more than 500,000+ calls and hosted more than 1,500 guests to our Safe Place grief support group. In 2015, The Samaritans hosted more than 92,789 website visitors who viewed 198, 833 pages and connected to 1,068,208 hits. Topic specific, in 2015, our Suicide Emergency Checklist page hosted 4,002 visitors who created 16,152 hits to resource links on those pages.

To deal with suicide related emergencies, we have program support and training relationships with RI Emergency 911, the RI State Police, the RI Turnpike and Bridge Authority and local first responders.

Because there are many physical problems which can present themselves as depression, our primary Crisis Hotline/Listening Line referral is to the caller’s own primary care doctor. Additional referrals are only to RI licensed facilities including RI Emergency 911, acute care hospitals including the RI VA Medical Center, community mental health and health care facilities, community action agencies and a limited group of local crisis numbers including domestic violence, DCYF, elder services and RI 211.

**Focus of Our Crisis Intervention Program Development**

Suicide is the last desperate act and from medical experts, we have learned three things about the truly suicidal – they are hopeless, believe no cares if they live or die and in the end truly believe they have become a burden and the world would be better off without them. We also know suicide to be a missed opportunity in prevention with the World Health Organization noting one of the biggest risk factors to be the lack of connectedness - to a caring family and caring community.

At The Samaritans of Rhode Island, every program decision we make, on every level, from Crisis Hotline volunteer training to information provided on our website to services provided to grieving family members, is razor focused on consistently remembering what we know about the truly suicidal and communicating in a nonjudgmental, befriending manner - we care, we listen and we help.

**The Power of our Website**

When The Samaritans of RI began in 1977, the world-wide web, smart phones, social media and Emergency 911 did not exist. Over the years, just as in Alice's Adventures in Wonderland, our avenues of communication have been turned upside down. To meet our vision of being the agency of choice for Rhode Islanders seeking suicide prevention education and support, we challenge ourselves daily to communicate with our stakeholders in all the new ways. The website took three years to write and includes scores of international, national, state and local resources. We have resource pages for special populations as well as for all 39 cities and towns. The most visited pages of our website are the Youth and Teen Pages.

In 2004, when our website was launched, we hosted 6,139 visitors. In 2015, we had 92,789 visitors – a 140% increase. How did we do it? With the help of our tech savvy volunteers, we have utilized Google platforms, Facebook, Twitter and Constant Contact to guide people to our site. You can also find our website address on signs on all the bridges in our coastal communities. We have also incorporated the website into our training so volunteers can encourage callers – particularly friends and family concerned about loved ones – to use our online resources.

As the quote at the top of this letter suggests, connecting to our website even gives some the confidence to pick up the phone - an unexpected, positive outcome of our diverse outreach efforts. The website serves as a 24/7 safe, anonymous, empowering resource where visitors learn what to expect when they call our nonjudgmental volunteers and take the first step to helping themselves.

While 21st Century vehicles have dramatically increased our outreach by providing around-the-clock communication, they do not replace the one-on-one interactions with nonjudgmental listeners many of our clients need. Dependence on trained volunteers has not changed in our 39 years as The Samaritans of RI.

**The impact of Suicide Emergencies on Families and other Community Stakeholders**

**From 2000 to 2015, the RI Medical Examiner's office reported approximately 1,599 deaths by suicide. That number is slightly larger than the largest high schools in Rhode Island.**

In the world of suicide prevention, we often say the suicidal may end the pain for themselves but they spread that pain to everyone else for a lifetime. We would be remiss in our role as advocates not to discuss the impact of a completed suicide on the person who first arrives on the scene and the lasting impact it has over his or her lifetime.

A RI Emergency 911 telecommunicator could be the last person to speak with the suicidal or the first person to speak with a family member - maybe even be a young child - who has come upon the scene of a loved one's suicide. That family member is likely a caregiver, of any age, who has been dealing daily with the chronic hopelessness of a loved one. Often times, a family member suspecting or knowing an incident may have occurred will call the state or municipal police to be the first responder - who not only must process and deal with the site they encounter but must provide comfort to the grieving. At the Turnpike and Bridge Authority, the first responder may be a maintenance worker or worker monitoring television cameras. On the bridges, it could be the car in front of or behind a jumper. On the water, it could be a fisherman or coastal patrol. In the prison, it could be a cell mate or a guard.

Our Safe Place program is a free, peer to peer support group for adults who have lost a loved one to suicide but never replaces professional medical or behavioral health care. For everyone else, a myriad network of resources exists. The Samaritans grief support and other community resources, however, can never erase the trauma of encountering the scene of a suicide.

**The Role of Prevention and Closing**

In spite of growing mental health parity, it is impossible to predict and prevent all suicides and at the same time, the scarcity of public and private resources clearly indicates there will never be enough professional care for everyone. We consider every life valuable and the impact of just one suicide on individuals, families and the community demands we work to prevent risk factors from ever emerging and we must support building programs, services and a healthy state and local environment which strengthens resiliency, connectedness and opportunities for hope. As a state, our options for prevention awareness as well as care must include universal prevention interventions (low-cost general community awareness for all ages); selective preventive interventions (targeting those with known risk factors), and indicated preventive interventions (targeting persons at high-risk).

The year 2017 is our 40<sup>th</sup> anniversary. We have reached this milestone because of the dedication of our volunteers and the unwavering belief that suicide should never be an option.

For more information about The Samaritans of Rhode Island and its programs, visit [www.samaritansri.org](http://www.samaritansri.org)

**-End-**





**Testimony on Overview of the role of ED's in Crisis Intervention and Suicide Prevention- Dr. Gary Bubly**

10/27/16

First, I want to express my sincere thanks for the opportunity to provide this testimony to Senator Joshua Miller and members of the Senate HHS Committee and the work you are doing on Mental Health looking at "Suicide Prevention/Crisis Intervention & Special Populations" in Rhode Island's ED's.

My name is Gary Bubly and I am in the emergency physician, as well as the Medical Director of the Miriam Hospital Emergency Department, and a past president of the Rhode Island Medical Society in the Rhode Island chapter of the American College of Emergency Physicians. I was asked to provide an overview of the role that emergency departments play in crisis intervention and suicide prevention, and to offer potential solutions to the challenges we face on a regular basis.

Emergency departments play a critical role in evaluating patients with suicidal ideation and in psychiatric crisis currently. We are the safety net available 24/7 for an illness that presents 24/7, but managed by a care system that does not always operate as continuously. As you may know most patients identified with suicidal ideation and or substance abuse problems are usually brought to emergency departments for medical clearance and psychiatric evaluation. Unfortunately these patients often board or hold in emergency departments awaiting consultation and an inpatient bed when needed. This can range from hours to as long as 10 days.

In preparing for this testimony I surveyed and met with the Medical directors of all of the emergency departments in the state.

The responses were fairly consistent and reflect issues occurring nationally.

Virtually all of the acute-care hospital see a significant volume of patients sent in for suicidal ideation for medical clearance and acute mental health evaluation. The mental health evaluation is largely performed by qualified mental health professionals from a variety of agencies and occasionally by psychiatrists.

Most reported they were satisfied with the resources provided for these evaluations, but all seem to agree there are often bottlenecks and delays that can occur. Only a handful of hospitals have licensed inpatient psychiatric units to which they can admit. Even those with these dedicated inpatient psychiatric units report they frequently board patients in their emergency departments awaiting placement. The remainder need to transfer patients requiring admission to other facilities. As I mentioned previously, the wait time for a bed can range from several hours to several days. Boarding is generally viewed negatively by patients. We simply are not well suited to provide a therapeutic environment for psychiatrically ill patients. In addition, this care is costly, reportedly costing an estimated \$2,264 for an average emergency department boarding in 2012.

All of the emergency department medical directors felt that the boarding of behavioral health patients in their departments significantly reduced their emergency department throughput and all identified this as an impediment to their Department's ability respond to a disaster. In addition, there was agreement this was not the optimal place to care for these patients and they would be better served in another environment.

Although the state tracks inpatient psychiatric bed availability and ED holding and reports this in an afternoon email, that report is only received by a small percentage of the medical directors. Those who do receive it are aware there are issues reducing its utility to emergency department. A more transparent and accurate accounting of bed capacity and holding in a web-based dashboard might help increase efficiency of placement.

There was consensus that the medical clearance required prior to admission was not helpful in over 90% of the cases, excluding those with a documented overdose. In other words, most medical directors felt these patients could be safely evaluated the vast majority of the time in a more appropriate and potentially less costly environment, just as has been proposed for the chronic intoxicants.

There was also consensus that better access to outpatient services and better access to 7 day a week inpatient availability would significantly reduce this burden.

There was also consensus that improved funding, that is truer mental health parity would presumably help expand access and improve the situation.

It was hoped that in any redesign of the Healthcare System we would look to the Alameda Model in California which has largely bypassed emergency departments and essentially eliminated the holding problem at lower overall cost.

Thank you.

Gary Bubly, MD, FACEP  
Medical Director  
Department of Emergency Medicine  
The Miriam Hospital

Clinical Professor of Emergency Medicine and Clinical Professor of Medicine Alpert Medical School of Brown University

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[gbubly@lifespan.org](mailto:gbubly@lifespan.org)<mailto:gbubly@lifespan.org

## **STATE COMMITTEE ON HEALTH & HUMAN SERVICES**

**MEETING DATE: Thursday, October 27, 2016**

**TIME: 3:30 – 5:00 PM**

**PLACE: Senate Lounge – State House**

Chairman Miller, members of the committee, thank you for having us here today to talk about Crisis Prevention, Suicide Prevention and Special Populations. I'm Margaret Holland McDuff, CEO of Family Service of Rhode Island.

I am here to talk about children's mental health. As we know, children's mental health issues arise from biological, environmental and psycho-social causes which affect the function of the brain. I am going to speak to some research from environmental and psycho-social causes, the special concern of transitions in care and present some recommendations on how Rhode Island can respond.

In 1997, the CDC and Kaiser conducted a study of 17,000 adults—asking them how many of them had experienced certain kinds of childhood trauma or adverse childhood experiences. They asked participants ten questions.

Have you ever experienced:

- Physical abuse,
- Verbal abuse,
- Sexual abuse,
- Physical neglect,
- And emotional neglect.

Then they asked: did you grow up with

- A parent who was an alcoholic,
- A mother who's a victim of domestic violence,
- A family member in jail,
- A family member diagnosed with a mental illness,
- And the disappearance of a parent through divorce, death or abandonment.

For each yes answer the participant received a point. At the end of the ten questions, the researchers totaled the points and that was the ACE score.

The results of the study were startling:

- 67 % of population have at least one ACE
- 12.6% —have 4 or more ACES

The researchers went on to correlate a person's ACE score against health outcomes.

A person with an ACE score of 4 or more is:

- 3 times more likely to develop heart disease
- 4 and ½ times more likely to experience depression and anxiety
- 12 times more likely to attempt suicide than someone with an ACE score of zero.

People with six or more ACEs die nearly 20 years earlier on average than those without ACEs.

That study was conducted 20 years ago. Since then, the results have been confirmed over and over again.

These studies are important because we now understand that ACEs or childhood trauma are a root cause of poor mental and physical health outcomes and early death. And typically, once we understand the cause of something we can prevent it, screen for it, and treat it.

Unfortunately, even armed with this knowledge, we have not made significant progress in how we prevent, screen for and treat adverse childhood experiences.

- In 2014, Rhode Island experienced more child maltreatment reports, completed investigations and indicated investigations than any year since 2006.
- In Rhode Island in 2014, there were 5,265 domestic violence incidents that resulted in arrests, up 5% from 5,028 incidents in 2013. Children were reported present in 35% of incidents in 2014.
- Almost half (45%) of the victims of child abuse and neglect in 2015 were young children under age six and almost one-third (32%) were ages three and younger.
- In RI, one in five (19.0%) children ages six to 17 has a diagnosable mental health problem and one in 10 (9.8%) has significant functional impairment.
- 34% of RI children who needed mental health treatment or counseling in the previous year did not receive it.
- RI has the sixth highest rate in the nation (14.34%) for youth attempting suicide

With all this to be of special consideration is how a youth's mental health is addressed when they are in the transition from childhood to being an adults. Transition in mental health is problematic across the country. Seamless transition from child to adult systems is not the norm. Adult services are often ill equipped to meet the needs of youth with mental health problems. Young adults still require a system approach that is often the case in a child serving system including family, school and career in treatment and supports. Adult mental health systems often only provide this to the most severe in their systems leaving many youth with serious depression, anxiety and other issues falling through the cracks.

In the past, this committee has been a driver for change when it comes to how the state approaches health care, child welfare, juvenile justice, substance use intervention and other important areas that impact the overall well-being of Rhode Island citizens and our community overall. It is my hope that we can work together to further improve our approach to children's mental health.

As we move forward, there are several areas this committee may wish to explore:

- **First, implementing universal screening for ACEs, mental health, and substance abuse in primary care.**
  - As we drive more of our population to utilize primary care physicians for early detection in physical health, it is equally important that primary care physicians and pediatricians screen for risk factors. We know that 50% of all cases of mental illness begin by age 14. Pediatricians must play a crucial role in preventing, screening, and treating adverse childhood experiences.
  
- **Second, training of childcare and school personnel in identifying children who have suffered adverse childhood experiences (ACEs) and in how to address the resulting behaviors.**
  - Again, the earlier we diagnose something the sooner we can begin to treat it and the better outcomes we have. Childcare workers, school personnel, and pediatricians are, in a sense, first responders, to this crisis. Educating them in how to recognize and how to address ACEs will go a long way in developing a unified system for addressing the needs of these children and their families.
  
- **Third, educating parents and the public at large on the impact of ACEs on our children's physical and mental health.**
  - As I stated earlier, the occurrence of ACEs is very common. 67% of the population has at least one ACE. Educating parents and the community as a whole on the impact of ACEs will help to create an environment where we can all work together to prevent ACEs and an environment where the community supports screening for and treatment of the resulting issues. Historically, and still today in many cases, exhibited behaviors that are a result of ACEs have been written off as bad choices or the result of bad parenting or societal problems. We know now, that ACEs can lead to physical changes in the developing minds and bodies of children. In much the same way that we have worked to reduce the stigma of substance use disorders we must work to do the same with adverse childhood experiences.
  
- **Forth, we need to review access, coverage and reimbursement policies as they relate to ACEs and mental health issues.**
  - Knowing the cause of a disease and how to treat it will still yield poor results if patients can't access treatment and so we should look to see how we can make sure that everyone who needs help can access it without encountering long wait times and other bureaucratic obstacles.
  - Solving any problem will always require resources and it's important to make sure that we are using taxpayer dollars effectively and efficiently. But inadequate reimbursement of mental health professionals has contributed to a shortage of child psychiatrists in the state making it more difficult for people to get the help they need.
  - The state could investigate seeking a waiver from the Federal government to broaden the rules around who can provide mental health services. Peer to peer counselors might be would be an appropriate way to keep costs low and to increase access.

- Lastly we need to develop a reformed system model that is specifically addresses the unique needs of adolescents and young adults. These youth need a model that continues with what we have learned works in children's mental health intervention; a systems frame including family, mentors, education and career in treatment while being unique developmentally.

We have focused much of our energy on trying to align these youth needs with a specific state department or within diagnostic boundaries and our youth, especially those who we know score high in ACEs and are at risk for homelessness, incarceration, suicide and more, deserve better.

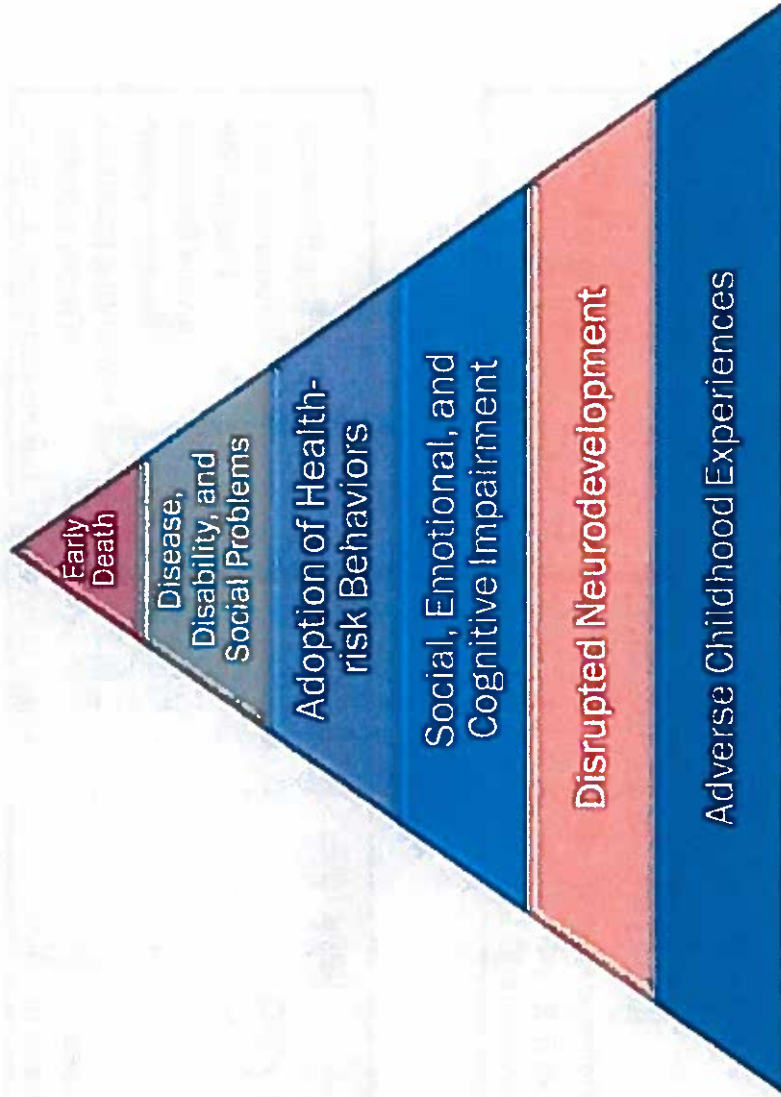
We know many of the root causes that can lead to children's mental health problems and some of the system barriers. Now that we know, Rhode Island must do better in policy and practice.

As always, I am happy to assist in any way I can.  
Respectfully submitted,

A handwritten signature in black ink, appearing to read 'Margaret Holland McDuff', written in a cursive style.

Margaret Holland McDuff  
CEO of Family Service of Rhode Island

Death



Conception



### Adverse Childhood Experiences

- Abuse and Neglect (e.g., psychological, physical, sexual)
- Household Dysfunction (e.g., domestic violence, substance abuse, mental illness)



### Impact on Child Development

- Neurobiological Effects (e.g., brain abnormalities, stress hormone dysregulation)
- Psychosocial Effects (e.g., poor attachment, poor socialization, poor self-efficacy)
- Health Risk Behaviors (e.g., smoking, obesity, substance abuse, promiscuity)



### Long-Term Consequences

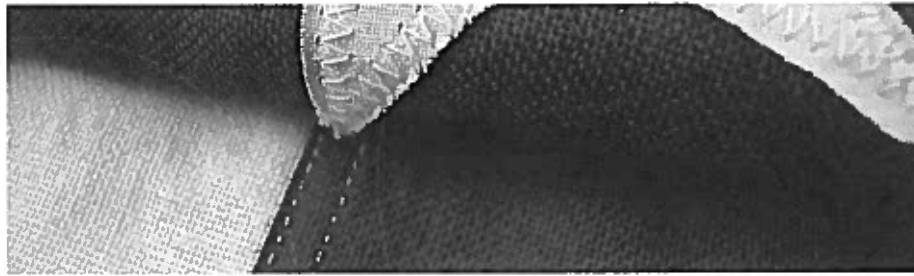
#### Disease and Disability

- Major Depression, Suicide, PTSD
- Drug and Alcohol Abuse
- Heart Disease
- Cancer
- Chronic Lung Disease
- Sexually Transmitted Diseases
- Intergenerational transmission of abuse

#### Social Problems

- Homelessness
- Prostitution
- Criminal Behavior
- Unemployment
- Parenting problems
- Family violence
- High utilization of health and social services

Source: Putnam, F., & Harris, W. (2008). Opportunities to change the outcomes of traumatized children: Draft narrative. Retrieved from [http://ohioacand4kids.org/Outcomes\\_of\\_Traumatized\\_Children](http://ohioacand4kids.org/Outcomes_of_Traumatized_Children)



**VA Mental Health and Behavioral Sciences Service**  
**Briefing to RI Senate HHS Committee**  
**Robert Swift, MD, PhD – Chief of Mental Health**  
**October 27, 2016**

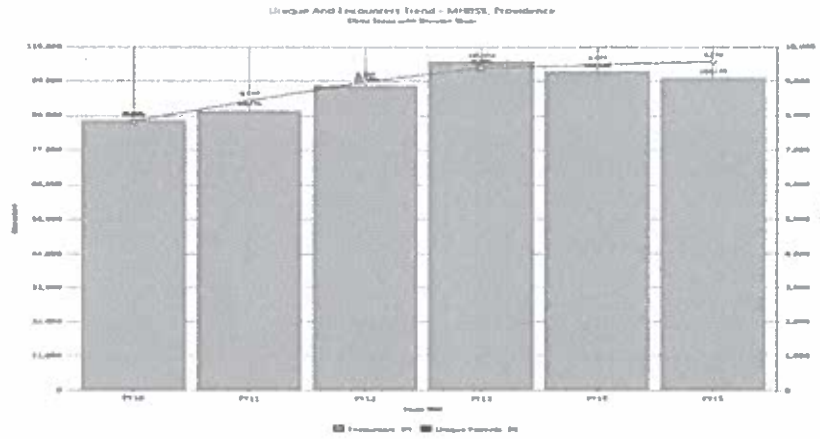


## Briefing Outline

- Overview of the Mental Health Service at Providence VAMC
- Suicide in Active Military and Veterans
- VA's Response to Suicide Prevention in Veterans

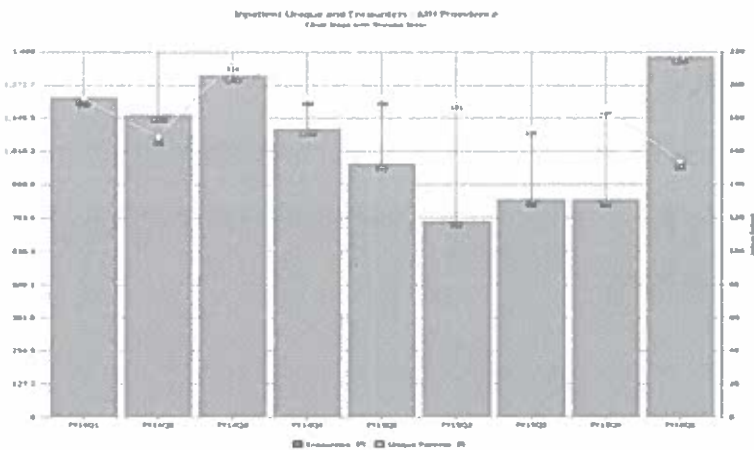


## Providence MH Care: Uniques and Encounters Trend

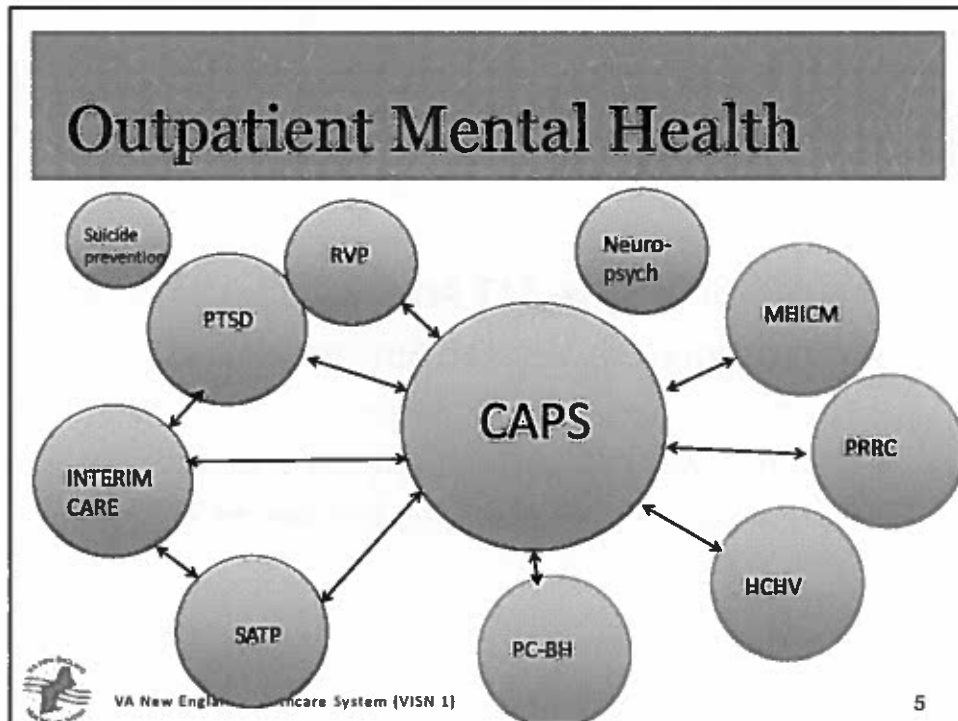


VA New England Healthcare System (VISN 1)

## Inpatient Unit 4A



VA New England Healthcare System (VISN 1)



## Suicide In Veterans

- From 1999-2010, the suicide rate in the US population among males was 19.4 per 100,000, compared to 4.9 per 100,000 in females.
- Based on the most recent data available, in fiscal year 2009, the suicide rate among male Veteran VA users was 38.3 per 100,000, compared to 12.8 per 100,000 in females.

VA New England Healthcare System (VISN 1)

6

## VA and US Army Suicides

In 2010 there were 147 Army suicides vs. 8440 (estimated) Veteran Suicides

- 93% Army suicides male, 97% Veteran
- 81% Army suicides White/Caucasian, 93% Veterans
- 67% Army suicides 29 and younger, 69% Veteran 50 and older



VA New England Healthcare System (VISN 1)

7

## Non-Lethal Suicide Attempts

In 2011 there were 440 Army attempts vs. 12,309 Veterans

- 76% Army male, 88% Veterans
- 55% Army White/Caucasian, Veteran unknown
- 78% Army 29 and younger, 51% Veterans 50 and older



VA New England Healthcare System (VISN 1)

8

## VA's Program for Suicide Prevention

*The VA program for suicide prevention is based on a public health approach which is an ongoing approach utilizing universal, selective, indicated strategies while recognizing that suicide prevention requires ready access to high quality Mental Health Services, supplemented by programs that address the risk of suicide directly.*



VA New England Healthcare System (VISN 1)

## Suicide Prevention Coordinators

- There is a Suicide Prevention Coordinator (SPC) at each VA Medical Center Facility
- Overall responsibility is to support the identification of high-risk patients and to coordinate ongoing monitoring and enhancements in care.
- Other responsibilities include:
  - Promote awareness and community outreach
  - Training – both for provider and Guides
  - “Flagging” patients at high risk
  - Tracking and monitoring high risk patients and their care
  - Participation in patient safety and environmental analysis to develop local suicide prevention strategies



VA New England Healthcare System (VISN 1)

## VA Suicide Prevention Resources

- VA Suicide Prevention Coordinators and Case Managers are present at each VA to connect with and support Veterans and providers in times of crisis.
- Veterans, family members, or care providers can initiate a free and confidential conversation with an experienced and caring VA responder by calling the **Veterans Crisis Line**. (Even if a Veteran is not registered with VA or enrolled in VA health



VA New England Healthcare System (VISN 1)

11

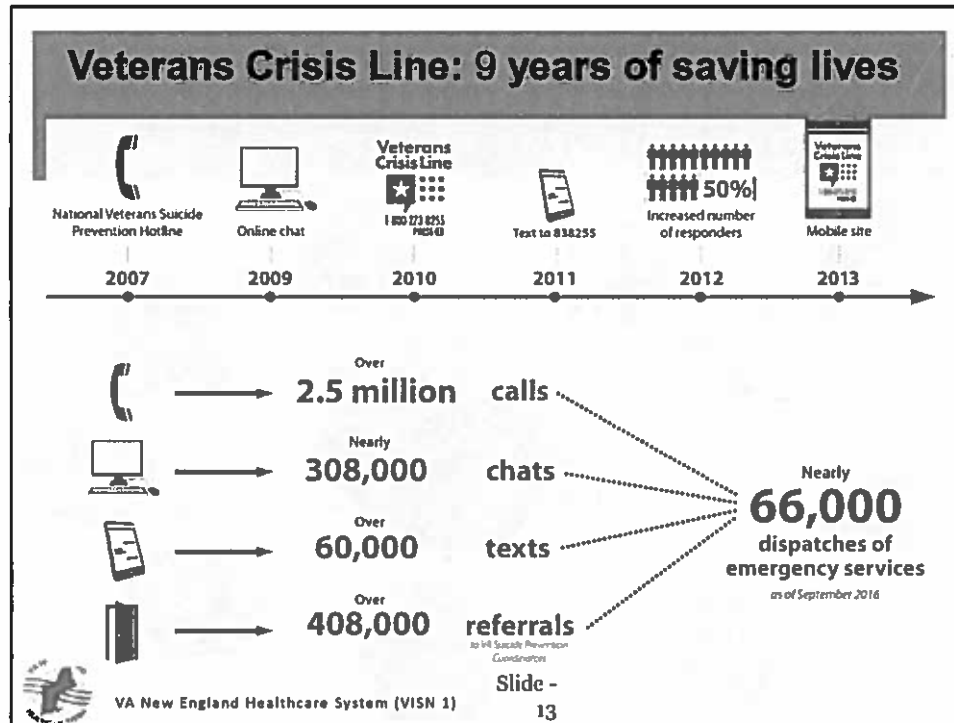
IT  
TAKES  
THE  
COURAGE AND STRENGTH  
OF A WARRIOR  
TO ASK FOR HELP.....

**If you're in an emotional crisis  
call 1-800-273-TALK "Press 1 for Veterans"**

[www.suicidepreventionlifeline.org](http://www.suicidepreventionlifeline.org)

**SUICIDE PREVENTION**

Department of Veterans Affairs



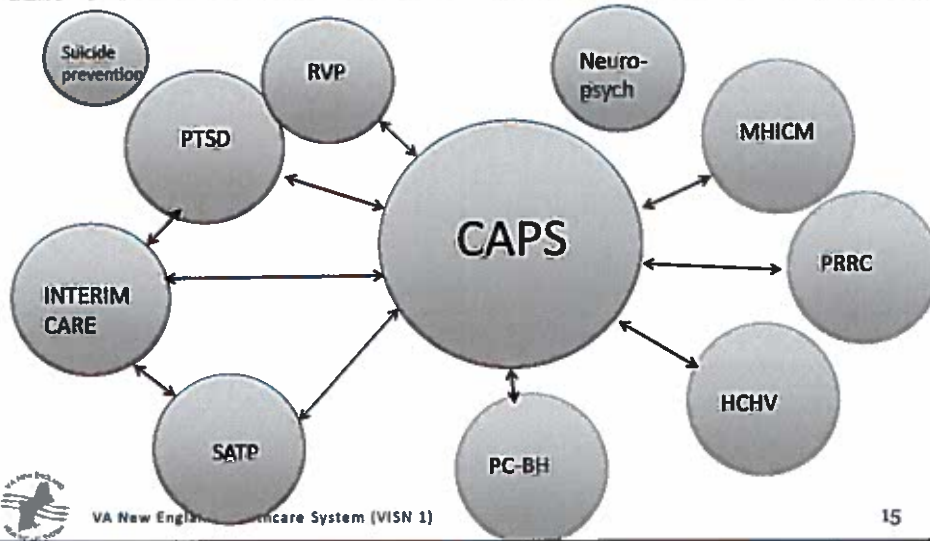
## Treatments for PTSD and Suicidal Thoughts

- Medications
  - Antidepressants
- Psychotherapies
  - Two effective treatments for PTSD, Cognitive Processing Therapy (CPT) and prolonged exposure (PE) have been shown to reduce suicidal ideation.
- Treatment of Co-morbid Substance Use Disorders, Traumatic Brain Injury, etc.





# Outpatient Mental Health



# Thank You for Your Support!

➤ Questions?



**Prevalence of mental illness at the ACI**

- The DOC must handle the needs of all individuals who are sentenced by the courts. We cannot turn offenders away — many inmates end up in the ACI due to their untreated mental illness, while some develop mental illness after being committed.
- 15-20% of all ACI inmates have severe, persistent mental illness (SPMI)
  - There are roughly 3000 inmates at the ACI at any given time
- Many more have “general” mental illness (e.g., depression or anxiety)
- There have not been any completed suicides at RIDOC since December 31, 2014 – approximately 1 year and 10 month time period

**Current capacity to provide mental health treatment in the ACI**

The ACI has the following FTEs related to mental health:

- 2.75 psychiatrists
  - 1 Clinical Director
  - 1 Supervising Psychologist
  - 11 Clinical Social Workers
  - 1 Part-time Occupational Therapist
  - 1 Mental Health Discharge Planner
- 
- DOC contracts with a number of community-based agency to provide evidence-based therapeutic programs to inmates who are diagnosed with SPMI.
  - These programs include Cognitive Behavioral Therapy programs such as AVATAR, Think First and Anger Management, as well as a DBT program and Occupational Therapy program.

**Other practices to address SPMI**

- The DOC may seek to transfer inmates whose illness cannot be addressed in a prison setting to Eleanor Slater Hospital.

## **Recommendations for Improvement/Barriers to Successful Transition for Inmates**

- For SPMI inmates, DOC's goal is to give the level of treatment that will enable successful step-down from Disciplinary Confinement to general population, and eventually to a safe re-entry into the community upon release from the ACI.
- Lengthy wait times between release from prison and engagement in outpatient mental health treatment often leads to lapses in mental health treatment for people re-entering the community following periods of incarceration.
- Difficulty securing group home placement for appropriate individuals due to their charge history (ex. Sex offenders, arsonists, assaultive behaviors), limited bed availability and lengthy waitlists, and inability to bring inmates for visits to the group homes to evaluate them for appropriateness prior to placement (which is often requested by the group homes).
- Cities and towns requiring homeless shelters to place capacities on the number of sex offenders that can be admitted into the shelters at a time, ultimately leaving many of our SPMI populations truly homeless.
- Need to increase communication between community-based providers and DOC mental health providers to improve continuity of care and strengthen the services available to SPMI individuals that we serve.

### **Potential strategies to achieve this goal include:**

1. **Increase mental health staff in the ACI:** Improve treatment in the ACI by hiring additional social workers, discharge planners, and a behavioral health secretary
2. **Strengthen community services:** Improve the community mental health system to prevent the mentally ill from cycling in and out of the ACI
3. **Increase training for Corrections staff:** Provide evidence-based training on handling individuals with mental illness to correctional officers and other staff.



## ***Preserving Families Network***

***A Tides Family Services Network***

Tides Family Services

216 Washington Street

West Warwick, RI 02816

(401)822-1360

October 27, 2016

To: Rhode Island Senate Committees on Health and Human Services

Chairperson, Sentaor Joshua Miller

Vice Person, Senator Donna Nesselbush

From: Br. Micahel Reis, MSW, LICSW, FSC

President and CEO of Tides Family Services

Special Populations: **DCYF Child Welfare and Juvenile Justice Families**

Thank you for organizing a dialogue of the provider community that services our most high risk families in RI. It is clear that DCYF under the leadership of Jamia McDonald is developing a system of care that focuses on a systematic service delivery system. The newly implemented procurement process focuses on data driven, evidenced based practices that will support an improved system of care. On any given day we are involved with 500 families in the poorest areas [Providence, Pawtucket, Central Falls, Woonsocket and West Warwick] in the State. While I support these initiatives, I have some concerns with the significant budget cuts DCYF has received in recent years and resulted in financial issues for the provider community. It is critical that the provider community receive adequate resources to assist the state in preventing placements and supporting community based services.

***MY concerns are focused mainly the DCYF Child Welfare and Juvenile Justice population.***

1. These are our most difficult families and it is my strong feeling that they are our main feeder to the Adult prison system .  
Experience in 1974 as a member of the Catholic Chaplaincy Team responsible for providing services to the ACI. Generations of families filling the system .

2. These families are not very good at follow through. They frequently miss appointments, do not cooperate and are very high risk to not complete programs.
3. Most of the programs that they desperately need [job training, etc.] need to show a certain amount of success or their funding will be eliminated according to the state monitoring successful programs.
4. When the youth turn 18 all intensive family support is dropped and the youth/family is enrolled in a medical model [enhanced outpatient services] vs. a RI Home Grown Intensive Community Based Program. Medical Model programs target signs symptoms of Axis 1 diagnosis— family is involved and active as it relates to Axis 1 diagnosis of the identified client. The home grown program is able to target the family system as a whole and addresses the child welfare issues more globally—parental mental health; basic needs; crisis intervention within the whole family system; advocacy needs within community and school. While many DCYF youth have Axis 1 diagnoses, the signs and symptoms of these diagnosis are not necessarily the reason the family is currently in need of services.
5. As a number of states are already doing, we need to seriously consider giving the Family Court and DCYF jurisdiction to keep all youth open to the Department for support until they complete their 21<sup>st</sup> birthday.
6. Medical Model programs are time limited and will terminate if client/family not participatory at a set level of expected hours. The home grown program is able to continue pursuing/engaging a family in treatment despite initial mistrust/barriers and missed appointments. Through the ability to forge on despite predictable absences in treatment these programs often are able to break down the barriers with families and take the time needed to begin the treatment. And the time necessary to reengage families during lapses in participation. Community Based Services that are able to 'stick with' a family are necessary to avoid costly placement being used as a response to a mistrustful, "non-compliant" family.
7. There has been consistent erosion in provider funding and service quality relative to existing community based and residential programming in recent years. Budgets have been cut relative to preventative services that has effectively diverted families away from deeper involvement in the child welfare system, clinical, nursing and other positions have been eliminated, resources to stabilize and support kinship families have been cut, aftercare and other community based services have been significantly reduced or are no longer viable resources.
8. The economic development context of non-profit organizations serving the state's most vulnerable children and families. This occurs in two ways A)in relation to these organization's potential to reduce long term institutional and other services expensed to the state (i.e. hospital, corrections, homelessness etc.). B) this sector employs hundreds of Rhode Island residents (i.e. social workers, clinicians, nurses, child care worker's, Psychologists, Psychiatrists etc.) that contribute to local communities and the state's economy. Providers believe that investment and strategic utilization of this sector has consistently been minimized in recent years to the detriment of the state's health and well-being.
9. The State of RI lacks a fair, systematic rate setting process across its service continuum that assesses the real cost of providing service. That said, providers know that in nearby New

England and other states community based and other strategically oriented residential services provided in RI can be significantly undervalued financially.

10. DCYF needs to effectively utilize and blend multiple funding sources (i.e. Medicaid, 4E, 4B etc.) in a coherent manner for the purpose of building greater community based service capacity. This needs to also include Child and Family Behavioral Health Services .
11. There are a number of recommendations in the Casey Report. We are in support of most of the recommendations. We strongly believe that DCYF needs a strong community based orientated cohort of Social Workers who are actively involved in a local/regional system of care focused on supporting families, foster and kinship placements and actively involved with community providers to provide the support needed to make community based programming a reality.
12. The Annie E Casey foundation has illustrated the importance of “homegrown” programs to meet the needs of families where there is not a “stable” caretaker. These programs are designed to restructure “families”.
13. We have a serious issue with sex trafficking in Rhode Island. We need to develop appropriate programs.
14. State Agency Collaboration and Cross-Coordination This includes all EOHHS agencies that have significant policy and service related impacts on children and families. This includes DCYF and BHDDH as well as DHS and Department of Health. In addition, RIDE as well as the Workforce Partnership. We need to look broadly across systems if we are going to serve families in a comprehensive manner.

Rhode Island Children’s Cabinet

Elizabeth Roberts, Secretary of the Executive Office of Health and Human Services

Jamia McDonald, Chief Strategy Officer, Dept. of Children, Youth and Families

Scott Jensen, Director of the Dept. of Labor and Training

Ken Wagner, Commissioner of Elementary and Secondary Education

Rhode Island Family Court

Chief Judge Forte

**My main concern is to help develop support programs for these most difficult of families to make sure that they can fully utilize all of the options that are available to them for both job training and medical support services. Otherwise, these families are not likely to complete these programs. Our goal is to work with all of the currently existing programs as an additional resource when needed.**



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# SENATE COMMITTEE ON HEALTH & HUMAN SERVICES

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## NOTICE OF MEETING

**DATE:** Thursday, November 17, 2016

**TIME:** 3:30 - 5:00 PM

**PLACE:** Senate Lounge - State House

### AGENDA:

#### Mental Health Hearing #5

- 1) **Opening Remarks – Senate HHS Committee Chair Joshua Miller**
  - *Generation Citizen* students from Juanita Sanchez School
- 2) **Introduction: Mental Health Financing & Reimbursement**
  - Attorney General Peter Kilmartin, Esq.
- 3) **Panel # 1: Mental Health Parity**
  - Linda Johnson, Operations Director, Office of the Health Insurance Commissioner
  - Michael Dexter, Chief, Center for Health Systems Policy and Regulation, RI Department of Health
- 4) **Panel # 2: Commercial Insurers & Medicaid**
  - Matthew Collins, MD, Vice President of Clinical Integration, Blue Cross & Blue Shield of RI
  - Francisco “Paco” Trilla, MD, Chief Medical Officer, Neighborhood Health Plan of RI
  - Stephen Kozak, Director of Behavioral Health Services, Tufts Health Plan
  - Deb Florio, Deputy Director, RI Medicaid
- 5) **Business Community Perspective on Health Insurance Costs**
  - Al Charbonneau, Executive Director, RI Business Group on Health
- 6) **Provider Comments**
  - Ben Lessing, President & CEO, Community Care Alliance
- 7) **Public Comment**

Written testimony is encouraged and copies will be shared with the Committee members.  
Please forward to Marea Tumber in the Senate Policy Office: [mtumber@rilegislature.gov](mailto:mtumber@rilegislature.gov)

Senate Legislative Office

222-2381

[SLegislation@rilegislature.gov](mailto:SLegislation@rilegislature.gov)





**Juanita Sanchez Educational Complex**  
Ms. Gormley Block 4: Generation Citizen  
Student Testimony for the RI Senate Hearing on Mental Health

There has been a lack of mental health or behavioral health support services for students in Rhode Island. Mental health issues often put a strain on students' education, due to the fact that they don't get taught coping techniques. I've witnessed students struggling: acting out in class, putting their heads down and sleeping, violence with peers or even with teachers, and making excuses to avoid going to school and becoming chronically absent. My friends talk about feeling out of sync with their body and mind, and some even have thoughts of suicide. The severity of the problem is increased because we do not have the necessary support in services provided to students. Many of my peers don't know how to ask for the help they need because they feel like they have to go through it on their own.

1 in 5 students in the U.S. show signs or symptoms of mental health problems in a given year. In Rhode Island, about 10% of teens have had at least one major depressive episode— but more than half of them do not receive treatment for their depression. Considering that an average student spends about 1,200 hours a year in school, wouldn't it make sense for school to be a priority for mental health services?

Unfortunately, teachers do not have the resources to deal with this problem. We surveyed some teachers at our school about mental health. Of the 28 teachers we surveyed 60% experienced disruptions related to mental health every day and 24% experienced disruption at least once every week. 68% of them felt strongly that mental health was a serious problem in our school. Unfortunately 93% of the teachers we surveyed do not feel they have the proper training to deal with mental health issues in the class. The two solutions that they believed were most important were increasing the number of social workers and teacher training in schools.

Experts recommend that every urban school has one social worker for every 250 students. At my school, Juanita Sanchez Educational Complex, we have one full-time social worker and one part-time school psychologist for more than 800 students. Some students don't even know that we have a social worker or school psychologist, and she is often too busy or not available when they want to talk to her. We need more mental health supports for students, but our school can't afford it right now. I am here today to ask for you to not only re-introduce and pass the Rhode Island Behavioral Health Care Reform Act of 2016, but to also amend the act to include specific provisions to prioritize support services inside our schools—like increasing funding for school social workers and teacher training. We also ask that you support House Bill 8199, which would increase the amount of money available for hiring school psychologists.

Thank you Senators, and Chairman Miller, for inviting our class to attend.



**Presented to Rhode Island Senate Committee on  
Health & Human Services  
Joshua Miller, Chairman**

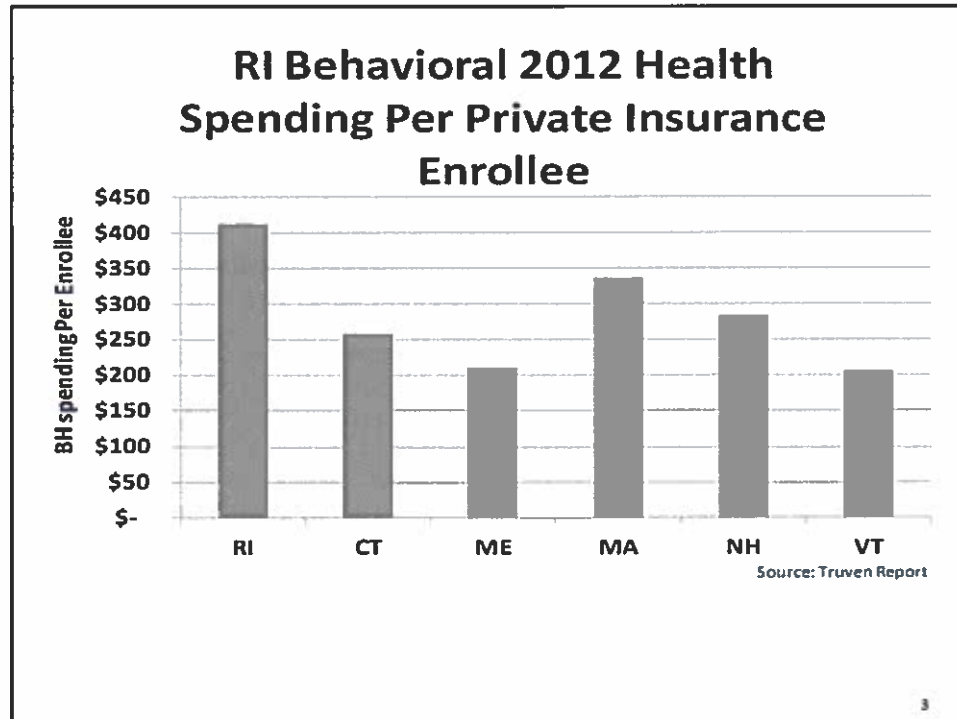
Al Charbonneau  
Executive Director  
Rhode Island Business Group on Health

1

**RIBGH Summit on Behavioral Health**

- **Truven Report**
  - High & Rising Need in Rhode Island
  - High Cost Overall
    - Inpatient Utilization
    - Prescription Drug Costs
    - Lack of Outpatient Services
  - “Too Little Bang For Behavioral Buck”

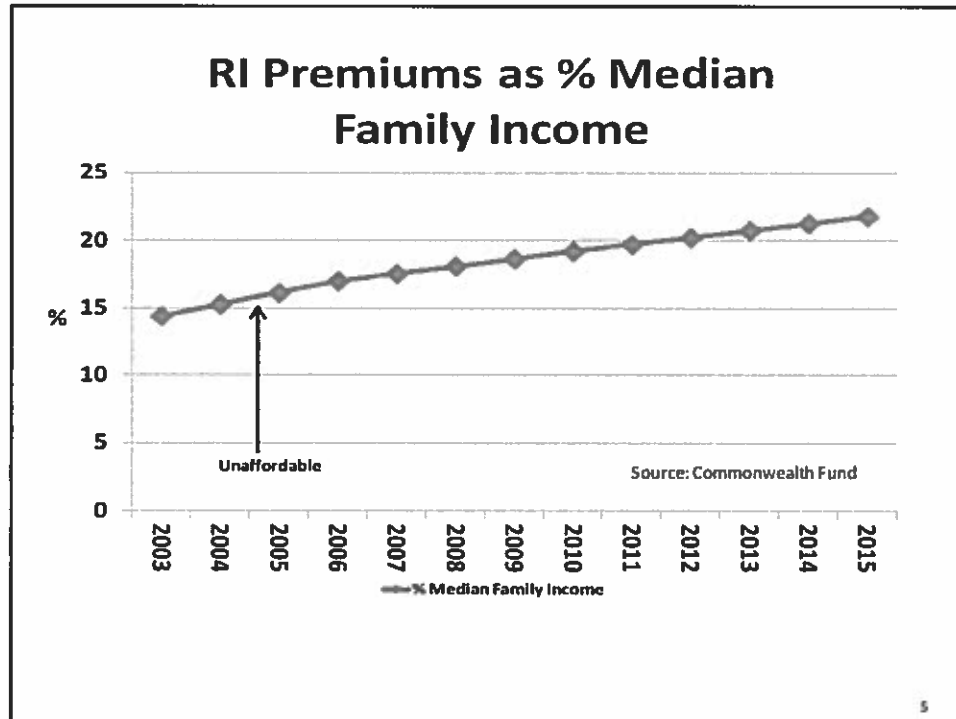
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## Need High Quality, Cost Effective Behavioral Health Solutions

- **Long Term Effects of Rising Health Insurance Premiums**
  - Every 10% Increase
    - Reduces Chance of being employed by 1.6%
    - Reduces Hours Worked by 1%
    - Offset by 2.3% Decrease in Wages
  - Less Spending in the RI economy
  - More People Uninsured or Needing Subsidies
  - Less Competitive Business Pricing

Source: National Bureau of Economic Research, RAND



## RI Needs a Behavioral Health "Call To Action"

- **BH Community Commits to Providing Services that are:**
  - High Quality
  - Affordable
  - Accessible
  - Supported by Evidence
- **Business Community Purchasing Supports the "Call To Action"**



Hi everyone,

My name is McKenna and I am a 24-year old with a mental illness. Looking at me, you might not know it. But to those who know me well, I look sick. I have been struggling with anorexia for over 6 years now; the majority of my adult life. As hard as it is to even admit that to myself, it is the unfortunate truth. As well as I hide it, I do not live a "normal" life similar to that of my friends. I get weighed weekly, I count my calories, I live by a meal plan, even the receptionist at my doctor's office knows me by name. I am not proud of these facts, but this is where I feel safe. For some reason, my eating disorder is a comfort to me. And, as painful as it is, starving myself feels good.

Over the past 6 years I have been in and out of treatment centers more times than I can count. I have been pulled from school, put on medical leave, and threatened to be cut off by my friends, family, and medical team. At this point, you could label me as a chronic case. With each year in my eating disorder, the voices in my head get stronger and the rules more engrained; it is now farther and farther out of my control. In all honesty, if I had been provided with the proper treatment right out of the gate, I truly believe the past 6 years may have been a lot different.

In the beginning, having little insurance coverage didn't bother me much. I didn't want to spend my first Christmas vacation in college locked away in treatment anyways. I was just going through the motions to satisfy other people in my life. As I have become more responsible for myself, I have realized that the number of days allotted to me equates to how far I can push myself into recovery. Each time I have been in treatment (and like I said, that's a lot) I have been cut off earlier than recommended by my treatment team. I can't eat on my own, my parents are too afraid to let me come home, and the nearest treatment center is over an hour away... it's a recipe for failure. I come so close to the end, only to be sent packing. It is extremely hard to allow myself to be vulnerable and settle into treatment when I am constantly worried I will be forced to restart the process again and again. When I am only given 2 weeks of coverage, the majority of that time is typically spent trying to convince my insurance company that I am worth more time. The rest is used up by my treatment team trying to break down the walls I have built up from being disappointed time and time again. All in all, not very productive in terms of my recovery. I am always anticipating bad news so there is no way I can focus my attention where it should be.

When I see girls enter treatment weeks before me and stay weeks after me, I am thoroughly confused. I do not understand why their insurance companies allot them time to work on themselves, while mine refuses to do the same. My team tells me that my eating disorder is absolutely serious enough to be here; so, the only other logical conclusion is that I am not worthy of their money.

It seems so simple to me -- give me the full amount of time that I need, allow me to heal fully, help me live a complete life. While to the outside, repeating the process is just a little extra time here and there, to me, it is everything. My eating disorder is all-consuming - I am unable to complete my academic requirements, I am held off from starting my career, I am unable to sustain meaningful, if any, relationships. I am unable to move on. Aside from the obvious financial factors, it just doesn't make sense. If they really understood, if they really knew what I was going through on a daily basis, if they really felt how deeply this affects my entire life, they would give me what I need.

I can't even tell you how much it infuriates me. How awful it is to feel like I am just another number in their daily quota. To know that, at the end of the day, the person who, in one 10 minute



phone call, decides the rest of my life, goes home without a second thought and enjoys a nice meal with their family. This makes me beyond angry because I am unable to do the same. That one simple act is something that I yearn for.

I cannot hold an intelligent conversation with my mom without my thoughts immediately reverting back to food. I cannot eat a pb & j sandwich without running for miles beforehand. I cannot go out with my friends without worrying about what kind of food I will eat, or not eat. But, this is not just about the food and being able to eat my meals with someone watching my every bite - That's the easy part for me. Treatment is where I have permission to eat. Everyone is doing it, which makes it okay. So, of course I am compliant, of course I gain weight, of course I look healthier on paper. But the thoughts racing through my mind, the desire to exercise to the point of exertion, the urge to crawl out of my own skin; those are things you cannot measure on paper, and will never know the true extent of. So, yes I can eat while I'm in treatment. But the minute I step outside of those 4 walls is the minute my eating disorder comes back with a vengeance. I need time to begin fighting those thoughts, to build up my repertoire of coping skills, and to practice accepting myself before being discharged. In 6 years, these are things I have yet to conquer.

To be honest I am terrified. I'm not even scared of having an eating disorder forever. I know that life. I built it, I can navigate it, I can control it. What I'm afraid of is living the in between state - being 50% in recovery and 50% in my eating disorder - because that is torture. That is where I battle myself every second of every day. This is where I am stuck.

I've been doing this for so long that I'm not even sure I have it within me. If I could have gotten better already, I would have. So, obviously, something must be wrong with me. The only other hope I hold is for someone to push me. To help me realize that there is more than this, that I can do it, and that I am strong enough. My family cannot do that; they will never fully understand. My friends are off creating their own lives, which I am envious of, but do not hold against them. My treatment team is recommending treatment that isn't covered. And I'm left standing here, crumbling under the weight of my out of control world, not sure where else I am supposed to turn. I feel as though I will always reach the same point in recovery because that is all the time I will ever be provided. After all this time I truly believe that the rest of my life is only worth what I have been given.

My name is Kim Colman and I am the mother of McKenna  
My daughter McKenna is 24 and has been suffering with the disease of an eating disorder, specifically anorexia for 6 years

I'm here today to share my opinion and story of our experience with insurance as it relates to mental health benefits and the lack accountability & transparency by the insurance companies & the companies that manage their mental health benefits.

My daughter has covered benefits available to her for the treatment of her mental health illness, but by limiting those benefits through denials ,BCBS & Beacon Health Value Options has hindered if not prevented my daughters recovery

The criteria for residential, partial and Iop treatment already indicates that a person may not enter treatment unless they are medically stable, yet insurance repeatedly includes medical stability as a reason for a denial. Thus completely disregarding the health parity laws.

My daughter enters treatment at the insistence of her team and her family. She has to give up, college, work, home, friends -everything and commit to what we all hope will be a lengthy stay in treatment.

When I tell the facility she will be denied within 2 weeks, they are doubtful but I am never wrong and they are always stunned. When She is in treatment she is only given 2 days at a time and then reviewed. Never allowing her to settle in and start working on the program. She is uncomfortable to let go and invest because she is never there long.

In August 2014 my daughters team told us she had to enter residential. We were elated to know that health parity began that same July and residential was now covered. We were so happy. Until she entered treatment. She was reviewed every 2 days and denied after 9. The denial reason stated

' pt can walk feed and bath self, pt is medically stable.' and Insurance said she was allowed to go to IOP, skipping right over partial. While we appealed this denial I called anyone who would listen in RI. The Health Dept, Health Commissioner, Attorney Generals office and the City of Providence HR dept. We were beyond happy when the city overrode the insurance denial and allowed my daughter the full 45 days of residential treatment, which was good because the appeals were denied. She was doing well and we were so relieved that maybe this would be over soon. But after the 45 days she was again dropped to IOP , only 3 days a week 3 hours at a time leaving her on her own and unraveling all the work accomplished in residential

It was a slow and inevitable decline for the next year. She needed treatment but didn't see the point if insurance wouldn't support her by allowing her covered benefits. She would again have to give everything up and knowing she had no commitment from insurance was a huge factor in her lack of willingness. A year later she again was told to

go to residential, it took 2 months to convince her but on dec 1 she went. I immediately got on the phone with anyone in RI who would listen anticipating denials. Which of course came quickly. One of the denials was identical to one from 2014. Since each review is suppose to be about the pt in that moment, a duplicate denial indicates to us there is a pre determined course regardless of the review facts with form denials.

All the denials have 2 things in common. 1)They site medical stability and compliance. This shows a lack of education for both the health parity law and lack of understanding of ED. Compliance is a behavior and not an indicator of wellness or willingness to follow a program outside of treatment.

And medical stability is not an indicator of wellness or need for mental health treatment. 2) I have all her denials for 2 of the 6 years and I also have the corresponding notes from each review, peer to peer , doc to doc from the treatment facility. If you put them together you wouldn't think they came from the same discussion. Insurance dismisses all the arguments for my daughters need to stay due to her mental health. It is a blatant disregard on the part of insurance for the immediate needs of my daughters treatment it makes me furious. The Course of treatment determined by a patients doctor for illnesses from cancer to heart disease and more is not questioned by a 3<sup>rd</sup> party or another doctor and it certainly shouldn't be any different for and Eating Disorder.

It is apparent that Insurance doesn't find a value or legitimacy in the continuum of care required to recover from and ED.

We have had to mortgage our home and even borrow money from my 80yr old mother inlaw to continue or cover treatment denied by insurance. We have nothing left. For 6 years we have appealed denial after denial. Level 1, level 2 and external appeals at all levels of care. My daughter has advocated for herself in the appeals process , And in 6 years not **one** a single appeal was won.

#### FOR THE LAST 6 YEARS

my daughters heart rate has been below normal 90% of time

my daughters weight has been below normal 90% of the time and she is still not weight restored

my daughter hasn't had a menstrual cycle

She see a doctor and therapist every week for the past 6 years.

Anorexia is a mental health illness with medical consequences. You cant treat the anorexia until you get the patients medical health in check and that's when insurance drops you. At the first sign of weight gain, or better heart rate, they dropped my daughter. I challenge them every step of the way and the response is always the same. I cant talk to the decision makers and they wont talk to me. I cant even get the recorded transcript of reviews, peer to peer or doc to doc. There is no transparency at all.

**ITS A FAILURE OF THE SYSTEM and they answer to absolutely nobody. They are not accountable for the decisions they make, the decisions that alter the very life of my daughter.**

### **EATING DISORDERS ARE LIFE THREATENING**

**Anorexia which is restricting food, has the highest mortality rate of any mental illness.& for**

**females between fifteen to twenty-four years old who suffer from anorexia , the mortality rate associated with the illness is twelve times higher than the death rate of all other causes of death.**

**One Studys show 76% of patients receiving treatment for Anorexia met criteria for full recovery but the amount of time from initial treatment to recovery ranged from 57-74 months (Strober, et al, 1997).**

**however, up to 90% of individuals with eating disorders do not receive the duration or intensity of treatment that their symptoms warrant and Without treatment, chances for recovery decline drastically**

**My family, has been through so much in the last 6 years, far to much to summize in 5 minutes, and every day I hold my breath until I talk to or hear from my daughter. We are not done with this eating disorder yet, and while I pray the outcome is a positive one, I am acutely aware that it may not be. And I'm so very angry.**

**My daughter deserves the opportunity for full recovery and to go on to live a very happy and fulfilled life. She should have to right to take advantage to the fullest extent her covered benefit for the treatment of her mental health disorder that will provided her that life.**

**Shame on the Blue Cross Blue Shield, shame on Beacon Health for withholding it.**

**I have fought for 6 years and will continue to fight. Some one has to listen, someone has to step in and help facilitate major changes in the way insurance companies cover treatment for ED , and to make sure they are educating not only in the issues they are deciding on, but educated in purpose and function of the health parity law and how it applies to the their decisions. Shame on you if you dont facilitate those changes.**

**This is my family's story in short, it is a story by no means exclusive to our family. Its the story of every family living with an eating disorder.**





401.235.7000  
CommunityCareRI.org  
PO Box 1700 Woonsocket, RI 02895

November 17, 2016

Chairman Miller and Members of Senate HHS:

Thank you for the opportunity to offer testimony today on the financing of community based mental health services for persons with severe and persistent mental illness.

In January 2016 the world for non-profit community mental health organizations serving persons living with severe and persistent mental illness changed in ways that were not predictable. As part of Reinventing Medicaid initiated by the Raimondo Administration persons served by previous community support programs or health home services within the mental health system transitioned to two new models of care. The first, Integrated Health Home (IHH) teams serving persons with a mental illness requiring ongoing case management, nursing, vocational and clinical support, but at a less intensive level. The second model, Assertive Community Treatment (ACT) team, defined as providing the same services at a greater level of intensity and smaller caseloads with the objective of stabilizing individuals that were more vulnerable for admission to inpatient psychiatric care, contact with hospital Emergency Departments or that may come to the attention of Police Departments due to their level of functioning. Given that effective long term community based psychiatric care is particularly dependent on not only competent practitioners at all level, but also consistency in relationships. A significant number of clients who had relationships with case managers, clinicians, nurses and psychiatrists for years in some cases, were reclassified based on their diagnosis and level of functioning and then transitioned to the appropriate team, thereby losing care givers with whom they had come to trust. Owing to the state's accelerated approach to these new models, these client transitions to new teams happened within a matter of weeks.

In addition to this transition to new models of care, the state who had previously managed Medicaid claiming and payments to providers through a single third party vendor (Hewlett Packard) transitioned payment responsibilities to two managed care organizations (i.e. Neighborhood Health Plan and United Health). Managed Care Organizations historically have focused on acute and primary care. In Rhode Island they have had little to no expertise in serving persons with severe and persistent mental illness or contracting for the array of flexible, community based comprehensive social services and clinical treatment necessary. The belief on the part of the state necessitating this shift in business practice was predicated in large part on managed care organizations having better "metrics" through which to measure results. It was clear to providers and managed care organizations in December 2015, as well as some officials at the state level, that billing and IT systems were not yet ready to be implemented. None the less, the transition moved forward. Almost immediately, two things occurred. Cash flow diminished to providers who had consistently been paid on a predictable schedule. Prior to the transition, Community Care Alliance had an experience rating of 97% which means that the agency received the majority of funds for services provided. Now we were dealing with three separate payers as opposed to one, all of whom had different billing procedures, practices and coding in some cases. In addition, it was assumed that community based organization's billing software would be ready on day one. It was not, which only added to further confusion and cash flow problems. Providers desperate to make payroll

began asking for cash advances on services to be provided in the future which then created additional challenges to cash flow. By late spring, early summer CCA hit a wall and nearly did not make payroll

due to delays in payment and the fact that the state had in fact reduced rates to providers. The reality that the state took nearly \$5 million out of the system was only later acknowledged and then restored late summer after a great deal of advocacy. In mid-summer, due to the continuing cash flow issues encountered at CCA we took the extraordinary measure of reducing salaries across the organization by 10%. For CCA employees already struggling to make ends meet at \$12 - \$15 per hour salaries were devastated causing a delay in their ability to pay their rent, mortgage, medical bills, transportation needs and for food. Some staff took not only second but third jobs in an effort to make ends meet. Our Human Resources staff took the extraordinary step of posting information on food pantries and other financial assistance now for the purpose of benefiting our staff. As a result, 22 staff left the agency, 21 of whom stated in exit interviews that the primary reason was salary; the majority lamented leaving a job they valued and an organization whose mission was about strengthening people. This mess which has unfolded over the course of 11 months was I believe largely a lack of planning, partnership with and listening to providers and a severe lack of leadership.

**None of this had to happen.**

Whereas cash flow has improved in large part due to advocacy and champions within the General Assembly, the system is far from repaired. In recent Senate Hearings providers have testified that in some cases they are owed hundreds of thousands if not millions of dollars. The mental health workforce has eroded sending skilled staff to hospitals, state agencies, managed care organizations, health centers and other social service providers with more secure and stable funding. Caseloads have risen which has a direct impact on quality care and community based organizations capacity to prevent increased utilization of hospitals and emergency departments.

#### **Recommendations:**

1. The state must adopt a Prospective Payment System for the delivery of community based mental health services for vulnerable populations (i.e. adults with severe and persistent mental illness and/or with serious mental illness, children and youth with severe emotional disorders etc.). Such a system should be similar to the funding methodology employed with Federally Qualified Health Centers in RI. This approach assures consistent, uninterrupted cash flow while also utilizing metrics to assess outcomes and promote program quality improvement. While claiming for services delivered would continue to occur, a reconciliation process could be established annually to determine under/over payments or in which to assess incentives to be paid.
2. Service rates must be reassessed and should be based on the true costs in which to operate community based programs and support qualified personnel. The state's lack of attention to the expenses incurred by community based organizations and the cost of training and employing a workforce inevitably will result in diminished quality and care to the populations served.
3. The Senate and House should be briefed by BHDDH personnel on its application to SAMHSA to fund Certified Community Behavioral Health Clinics (CCBHC). This application proposes a particular Prospective Payment model that is population based. The two unknowns going

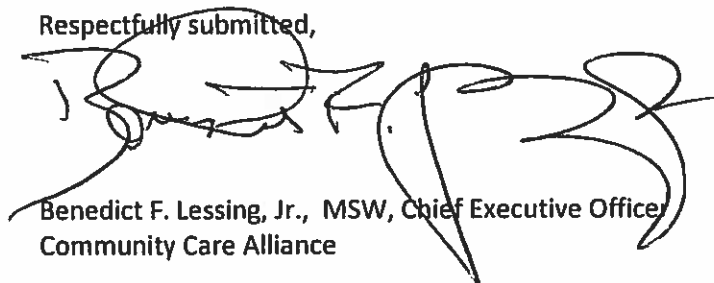
forward is whether Rhode Island will be selected as well as whether the incoming administration will adopt this approach. That being said, hundreds of hours of work have been expended in this process to analyze costs, capacity and program development needs and the viability of individual organizations to meet rigorous standards to address the mental health concerns in local communities. This work could and should be used as a foundation on which the state should move forward relative to planning.

**Summary:**

Over the past 11 months the state's infrastructure for the delivery of community based mental health services has been weakened. Community based organizations that have been the safety net for persons with severe and persistent mental illness have struggled to make payroll due to inconsistent payment and at times overly complex and different claiming systems by Managed Care Organizations. While improvement in payments has occurred, due in part to intensive advocacy and engaged legislators, the system remains fragile and not sustainable using the current funding methodology. It is my hope that the Senate will play a leadership role in moving the state's funding of mental health services for vulnerable populations to one that is more rational, accounts for the true cost in service delivery and affords the retention of a workforce capable of meeting the needs of the people we serve.

Thank you for the opportunity to offer this testimony.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Benedict F. Lessing, Jr.", written over a circular stamp or seal.

Benedict F. Lessing, Jr., MSW, Chief Executive Officer  
Community Care Alliance



