Rhode Island's Adult Behavioral Health System of Care: A 2024 Snapshot

AUGUST 2024

State Agency Contributions

Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH)

Department of Children, Youth, and Families (DCYF)

Department of Corrections (DOC)

Department of Health (RIDOH)

Department of Human Services (DHS)
Office of Healthy Aging
Office of Veterans Services

Executive Office of Health and Human Services (EOHHS)
Medicaid Program

Office of the Health Insurance Commissioner (OHIC)

University of Rhode Island

Table of Contents

Executive Summary

As Rhode Island's health and human services system works to recover stronger from a pandemic and ongoing challenges such as the overdose epidemic, affordable housing shortage, workforce crisis, and demands for additional home and community-based services, this 2024 Snapshot of Rhode Island's Adult Behavioral Health System of Care aims to depict its current state and opportunities for strengthening it. This 2024 Snapshot demonstrates the interagency approach in the State of Rhode Island to addressing the RI 2030 Plan priority of "Enhancing Public Health and Wellness" for all Rhode Islanders.

Key actions identified throughout this document include the need to:

- Invest in supportive services availability for placement and retention in geographically appropriate, affordable, and low-barrier housing as units and subsidies are made available for priority populations.
- Enhance employment supports and targeted workforce initiatives for those in recovery and who need individual placement to ensure economic mobility.
- Produce public awareness campaigns to change stigma and attitudes towards homelessness, poverty, mental health and substance use disorder treatment and medications, and toward individuals and families with lived experience.
- Address the impacts of structural racism and ableism to achieve health equity for individuals with behavioral health conditions.
- Ensure efficient transitions between systems of care, for transition-aged youth entering the adult system and older adults who may transition to long-term services and supports.
- Review existing sustainable funding streams, as well as create new ones, to support services that will ensure robust prevention activities for the progression of serious mental illness and substance use disorders — including those with Intellectual and Developmental Disabilities (I/DD) and those that may result in suicide or overdose.
- Continue emphasis on universal screening across medical, mental health, substance use, social, and long-term care settings for physical and behavioral health conditions and risk factors.
- Maintain advances in harm reduction and rescue that saturate communities with naloxone, promote safer drug use behaviors, and reach community members before and after an overdose.
- Expand low-barrier access to all medications and supports that have proven to be successful in treating substance use disorders.
- Implement the Certified Community Behavioral Health Clinics (CCBHCs) federal demonstration program and continue to sustain the 988-crisis service continuum (including crisis lifeline, mobile response, and walk-in stabilization centers) with quality control measures.

- Improve residential treatment and temporary respite services through the identification of properties to be used for mental healthcare and substance use residential treatment and other community-based programs, as well as workforce recruitment efforts.
- Provide robust community supports for individuals in recovery — including housing, social and peer capital, basic needs, economic supports, and workforce opportunities.
- Develop the necessary resources to ensure discharges include home and community-based supports, placements into lower levels of care, and/or into long-term services or institutions that appropriately address the behavioral health needs of all individuals.
- Implement revised Medicaid rate changes and keep pace with inflation to address behavioral healthcare workforce shortages and afford wages that allow providers to implement evidence-based practices and sustain services.
- Coordinate with the community, State agencies, and across sectors to improve partnerships and planning with the goal of ensuring inclusion, equity in resource distribution, quality service delivery, and improved governance for behavioral health.

Failure to act will result in continued reactionary spending on expensive services that yield poor outcomes. Planned, proactive investments aimed at understanding root causes are the only way to secure a solid infrastructure for Rhode Island. This is being achieved through:

- The Health Care System Planning (HCSP) Cabinet and the Executive Office of Health and Human Services (EOHHS) Independent Advisory Council working to create a statewide health care system plan.
- The preparatory work that aided in Rhode Island's selection into a federal demonstration program that will help the State to implement a statewide Certified Community Behavioral Health Clinics (CCBHCs) program.
- The passage of Senate resolution 3167 to explore recommendations for establishing a unified system of care for children's and adult's behavioral health needs moving forward in Rhode Island and the continued work to create a strong Rhode Island Behavioral Health System of Care for Children and Youth.
- The creation of the Ladders to Licensure Program that will help to increase the capacity and diversity of the health professional workforce by funding partnerships.
- Full implementation of the Office of the Health Insurance Commissioner (OHIC) Rate Review and renegotiation of the Medicaid 1115 Waiver with the Centers for Medicare and Medicaid Services (CMS) to sustain and pilot necessary services.

- The issuance by Governor McKee of an executive order to establish an Olmstead Advisory Group that will work on drafting and issuing an Olmstead Plan by February 2025 for Rhode Island to ensure services are adequately available to those who need them in the safest, most-appropriate, and least restrictive setting possible.
- Continued changes in State policy such as through the OHIC Affordability Standards and federal policies such as those governing Medication for Opioid Use Disorders (MOUD) and 42 CFR Part 2 Re-Disclosures.

Introduction

The American Medical Association defines "behavioral health" as generally referring to mental health and substance use disorders, life stressors and crises, and stress-related physical symptoms. Behavioral healthcare refers to the prevention, diagnosis, and treatment of such conditions. Rhode Island has a history of providing the highest quality behavioral healthcare in the nation. However, over the past 30 years, investment in the system has declined significantly, resulting in an overreliance on federal grant funding and challenging our system to keep pace with inflation and other environmental changes. These challenges and changes impact the quality of care due to the inability to build network capacity to meet the needs of all members of the communities we serve.

RI 2030: Enhancing Public Health and Wellness

State agency partners have prepared this document to present a 2024 Snapshot of collective efforts being pursued to achieve the RI 2030 Plan priority of "Enhancing Public Health and Wellness" as outlined by Governor Dan McKee:

- *By the next decade, Rhode Island will have a healthcare system that supports affordable and accessible services to maximize good health outcomes for all Rhode Islanders, emphasizing preventive care, addressing social determinants of health, supporting our healthcare providers and increasing their diversity, and eliminating health disparities*.

Indeed, Rhode Island's health and human service agencies have been undertaking a broad range of collaborative healthcare planning and improvement efforts over the last four years. EOHHS received a grant that supported the creation of the *2020 Behavioral Health System Review* which was conducted in partnership with the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH); the Department of Children, Youth, and Families (DCYF); and the Rhode Island Department of Health (RIDOH). The review included a needs assessment and gap analysis, as well as two specific implementation plans for programs that would help fill those gaps: Certified Community Behavioral Health Clinics (CCBHCs) and mobile crisis programs. Then, also starting in 2020, the State's Interagency Team took on the creation of the Rhode Island Behavioral Health System of Care for Children and Youth, which began to be implemented in 2022, with enhanced home and community-based services funding.

This 2024 Snapshot pulls from lessons learned from these two historical documents and processes, and aligns the State's current state of system strengths, weaknesses, opportunities, and threats with the following additional interagency efforts and key sources of information:

- FY 2024-2025 Combined Block Grant Application-Behavioral Health Assessment and Plan.
- The 2020-2024 BHDDH Substance Misuse Prevention Strategic Plan.

- The Governor's Overdose Task Force's Strategic Roadmap.
- The Rhode Island Behavioral Health System of Care Plan for Children and Youth.
- The State Plan on Aging.
- Rhode Island Suicide Prevention Strategic Plan.
- OHIC Integrated Behavioral Health Work Group Report (August 2019).

Each of these, and other, planning efforts are more fully described in Appendix A.

2024 Snapshot-In-Brief

This 2024 Snapshot intends to document many of the efforts to improve the adult behavioral health system within, and in addition to, this existing array of planning documents. The 2024 Snapshot draws on known, existing efforts, State agency priorities, and the community input reflected in previously existing documents. State agency representatives provided input on any identified areas where the 2024 Snapshot was inconsistent with those planning documents — and no inconsistencies were identified. The 2024 Snapshot is intended to be a point-in-time review and will continue to be refined as progress is made and the environment in which the State operates changes. Feedback on this 2024 Snapshot from organizations and individuals with lived experience — as well as other key stakeholders — is welcome to help recommend improvements to this document and provide additional context and/or information.

This 2024 Snapshot, discusses adult behavioral health and healthcare in terms of the strengths, weaknesses, opportunities, and threats (SWOT) in the areas of:

- Socioeconomic and environmental determinants of health.
- Prevention and promotion.
- Early identification and referral.
- Overdose prevention and harm reduction.
- Crisis response and stabilization services (including 988).
- Community-based outpatient treatment, including opioid treatment programs.
- Community-based residential treatment and temporary respite.
- Community-based recovery services.
- Inpatient and institutional services.
- Accountability for quality services and community engagement and coordinated partnerships.

There are specific populations (i.e., young adults, older adults, adults with disabilities, prenatal and postnatal individuals, individuals experiencing homelessness, members of

the LGBTQ community, and justice-involved individuals) who are most reliant on the system and often require more specialized services and approaches. These approaches must include a focus on the socioeconomic determinants of health such as the creation of affordable, community-based housing with wraparound services to ensure all individuals can thrive.

Continuing conversations about, and conducting quality improvement to, addressing funding, access, equity, and quality concerns described in this document will realize the State's collective vision for a modern behavioral healthcare system where:

- *All Rhode Islanders, across the lifespan, will thrive in healthy communities in which they can achieve their personal goals for wellness, housing, and employment.*

Vision for Rhode Island's Behavioral Health Continuum of Care

Figure 1 depicts our shared vision for the behavioral health continuum of care in Rhode Island — inclusive of both mental health and substance use services. The continuum begins by centering transition-aged youth, adults, and older adults as end users of this continuum of care. The continuum starts broadly, with behavioral health promotion and prevention efforts, and then moves into less universal or overarching services with early identification and referrals to treatment and support services. The term "prevention" can mean different things to various audiences. For the purposes of this 2024 Snapshot, prevention is inclusive of the following components:

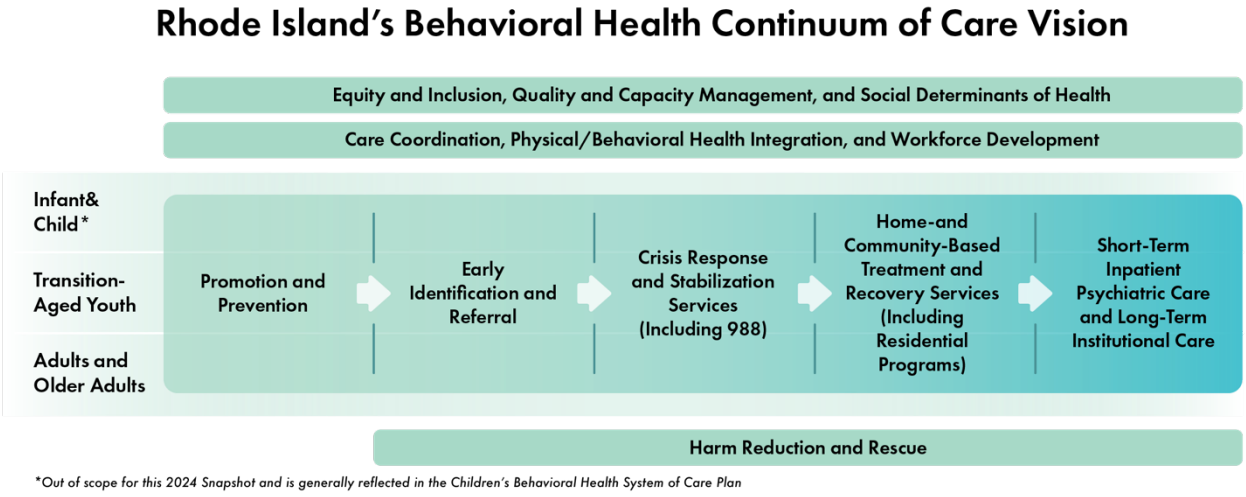
- Primary prevention, which focuses on reducing the onset of substance use disorder diagnoses, and can focus on universal, selective, or indicated populations.
- Overdose prevention, which focuses on reducing fatalities related to the use of opioids and occurs throughout most of the continuum after selective prevention.
- Relapse (or reoccurrence) prevention, which focuses on increasing the length of time that an individual is in active recovery and can occur while in treatment, aftercare, or recovery.

Next, sub-populations move through the continuum to receive various levels of services from least to most intensive, and oftentimes in the least to then the most restrictive setting. These are the services that support individuals and families experiencing a crisis, provide individuals with essential treatment and then recovery services and programming, and, at times, if necessary, individual and institutional stays. Additionally, harm reduction is a core component that works across several parts of the continuum. It is a strategy that helps people stay as safe and healthy as possible while they are still considering making changes in their lives to improve their behavioral health. Harm reduction and rescue can occur through engaging directly with people who use drugs to prevent overdose and infectious disease transmission; improve physical, mental, and social wellbeing; and offer

low-barrier options for accessing healthcare services, including substance use and mental health disorder treatment.

Lastly, reflected across the entire continuum are two essential components that must be considered for all people, places, and policies throughout the care continuum. The first pillar includes equity and inclusion, quality and capacity management, and social determinants of health (SDOH). The second pillar includes care coordination, physical and behavioral health integration, and workforce development.

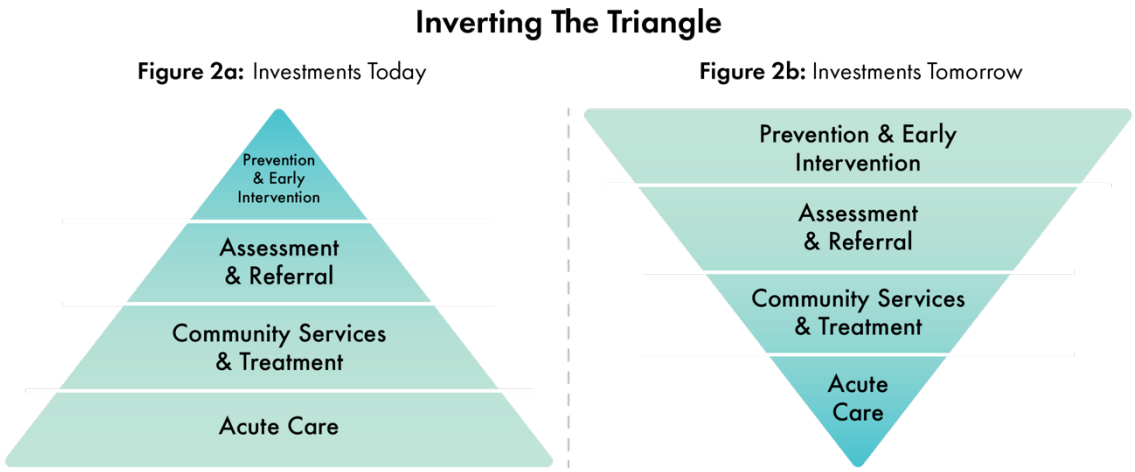
Figure 1.



Flipping the Investment Pyramid

The behavioral health system in Rhode Island once resembled the model described in Figure 2b and was looked at as a model for other states to emulate. Over the past three decades, shifts in State budgeting have reduced the foundational infrastructure of the community-based behavioral healthcare system, leading to a huge gap in services and a dramatic uptick in expensive institutional settings. Several reports commissioned to assist in establishing a roadmap to address the gaps in the behavioral healthcare system have identified similar conclusions. The 2015 Truven Report on Rhode Island's behavioral healthcare system stated, "Rhode Island has the scaffolding for a high-performance behavioral healthcare system, but the glue that allows this framework to produce high-quality, cost-effective results could be strengthened." The 2021 interagency Behavioral Healthcare System Review report stated that, "Payments for behavioral health services largely rely on a fee for service chassis that does not account for quality or outcomes."

Figure 2.



2021 Behavioral Health Action. Answering the Call to Action: A Vision for all Californian's Behavioral Health.

The Investments Triangle — which depicts California's approach to smarter spending in Figure 2b — represents the shift of investments needed to improve access to home and community-based services and prevent the need for higher-cost and institutionally-focused care in the behavioral health and healthcare systems. Rhode Island has opportunities to take the current spending patterns and change the paradigm by investing most of the funding on best practices rooted in prevention, early identification, and community services that yield better outcomes. If funding is focused on prevention, the need for acute care and crisis intervention lessens over time. Doing so prevents poor or worsening health outcomes for individuals, families, and communities, as well as also leading to economic benefits. Table 1 provides examples of investing in prevention as opposed to acute care.

Table 1. Prevention Versus Acute Care Investments

Proactive Prevention	Avoidable Reactive Response
Prescription drug takeback programs, providing locked bags to parents for medications.	Emergency response to a child overdose due to access to unprescribed medications.
Flexible funding to prevent homelessness and eviction, permanent supportive housing.	Homeless shelters and hotel programs, institutionalization, and hospitalization.
Implementing prescriber education to reduce reliance on opioid medications.	Responding to increasing demand for opioid use disorder treatment and/or harm reduction services.

988 Lifeline, community mobile crisis response and stabilization centers.	Hospital emergency services.
CCBHCs core services and residential community-based treatment and care settings.	Hospital inpatient services.
Recovery supports like the Recovery-Friendly Workplace Initiative that helps keep people in recovery in the workforce.	Reliance on public assistance programs like unemployment, SNAP benefits, TANF, etc.

Parity with Physical Healthcare

Rhode Island recognizes that behavioral healthcare (including both mental health and substance use) is equally as important as physical healthcare and demands the same attention, as dictated by the Mental Health Parity Act of 1996 (MHPA). The MHPA requires that large group health plans cannot impose annual or lifetime monetary limits on mental health benefits that are less favorable than any such limits imposed on medical or surgical benefits. Conversely, the State is working diligently to implement a behavioral healthcare system that incorporates and works to improve the underlying socio-economic and environmental determinants of health. The following list provides examples of these determinants of health[1], which can influence equity in health outcomes in both positive and negative ways:

- Housing and basic amenities.
- Natural and built environments.
- Food security and clean drinking water.
- Employment, job security, and income.
- Education and early childhood development.
- Social inclusion and capital, life conditions, and non-discrimination.
- Resolution of structural conflicts.

Current State: Strengths, Weaknesses, Opportunities, and Threats

The approach taken by State agency partners to produce an initial inventory of the adult behavioral health system in Rhode Island was guided by key source documents referenced previously and an interagency review of existing efforts. Using this information, State agencies reviewed SWOT across each part of the behavioral healthcare continuum to develop high-level matrices that depict each across State agencies. These matrices also draw upon input from BHDDH System Review (SR) meetings and data

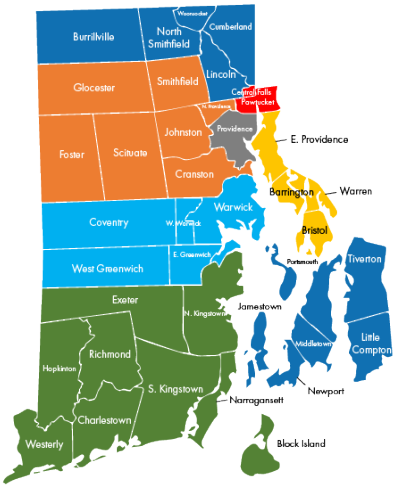
[1] Social determinants of health (who.int)

collected from the Substance Use and Mental Health Block Grant Needs Assessment (BGNA) to support current state claims.

System Review and Block Grant Needs Assessment

The SR takes place quarterly in each of the eight catchment areas throughout the State as shown below in Figure 3. This quarterly review was created to strengthen partnerships between the State and the full network of community providers for the purposes of enhancing communication between community partners and BHDDH. Each SR evaluates the services, individual flow, and gaps within the designated catchment area. The SR addresses the comprehensive behavioral health system, to include planning, prevention, early intervention, outpatient and residential treatment, and recovery efforts. Information, both qualitative and quantitative, is compiled by BHDDH to use for needs assessments, planning, and funding opportunities.

Figure 3: RI Catchment Areas



CCBHC Region 1: CCA
- Burrillville
- Cumberland
- Lincoln
- North Smithfield
- Woonsocket

CCBHC Region 2: Gateway
- Pawtucket
- Central Falls

CCBHC Region 3: Gateway
- Cranston
- Foster
- Glocester
- Johnston
- North Providence
- Scituate
- Smithfield

CCBHC Region 4 TPC, FSRI Amos House*
- Providence

CCBHC Region 5: East Bay*
- East Providence
- Barrington
- Warren
- Bristol

CCBHC Region 6: Thrive
- Coventry
- East Greenwich
- West Greenwich
- Warwick
- West Warwick

CCBHC Region 7: Newport MH
- Jamestown
- Little Compton
- Middletown
- Newport
- Portsmouth
- Tiverton

CCBHC Region 8: Gateway
- Block Island
- Charlestown
- Exeter
- Hopkinton
- Narragansett
- North Kingstown
- South Kingstown
- Richmond
- Westerly

**Represents CCBHC Application Still Under Review*

Below is a list of CCBHCs in the eight catchment areas. It should be noted that these programs are still under review to ensure all certification criteria is being met. Additionally, review of new CCBHC program applications is ongoing.

CCBHCs represented in Figure 3, listed in alphabetical order:

- Community Care Alliance (CCA) - CCBHC Catchment Area 1: Burrillville, Cumberland, Lincoln, North Smithfield, and Woonsocket
- Family Services of Rhode Island (FSRI) - CCBHC Catchment Area 4: Providence
- Gateway Healthcare – Pawtucket - CCBHC Catchment Area 2: Pawtucket and Central Falls

- Gateway Healthcare – Johnston - CCBHC Catchment Area 3: Cranston, Foster, Glocester, Johnston, North Providence, Scituate, and Smithfield
- Gateway Healthcare – South County - CCBHC Catchment Area 8: Block Island, Charlestown, Exeter, Hopkinton, Narragansett, North Kingstown, South Kingstown, Richmond, and Westerly
- Newport Mental Health (NMH) - CCBHC Catchment Area 7: Jamestown, Little Compton, Middletown, Newport, Portsmouth, and Tiverton
- The Providence Center (TPC) - CCBHC Catchment Area 4: Providence
- Thrive Behavioral Health - CCBHC Catchment Area 6: Coventry, East Greenwich, West Greenwich, Warwick, and West Warwick

The BGNA seeks to identify areas in which behavioral healthcare service needs are being adequately met and where services could be strengthened. The BGNA can be used to efficiently direct funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to meet Rhode Island's needs. Quantitative national datasets are analyzed to compare outcomes in Rhode Island to all other New England states and national data. Data for the BGNA are collected through a quantitative community survey and qualitative focus groups. Mental health and substance use providers are invited to participate in BGNA data collection alongside those who have received services or those who have had a family member who has received services. The most recent 2022 BGNA may be found in Appendix B.

Strengths, Weaknesses, Opportunities, and Threats (SWOT) Matrices

The following tables provide a summative SWOT analysis of the core components of Rhode Island's vision for a comprehensive behavioral healthcare continuum for adults. This summative review serves as the critical context in which to anchor current, and potentially future, State goals to address challenges outlined later in this 2024 Snapshot. For reference, a detailed description of the service continuum is provided in Appendix C. Please note that equity is a foundational principle across all aspects of the care continuum, and therefore a focus on equity is reflected within each of the SWOTs and not independently on its own.

Table 2. Socio-economic and Environmental Determinants of Health SWOT	
Strengths	• Availability of non-emergency medical transportation (NEMT) to behavioral healthcare services has improved. • Recognition from State agency leadership of the importance of employability to achieving recovery, social supports and integration, housing stability, and treatment cost moderation has occurred. • Creation of a statewide Supported Employment Taskforce and Work4Wellness with subcommittees focused on training needs, data collection, and outcome metrics. • Establishment of programs provided by DHS to achieve economic stability has included the needs of behavioral health individuals.
Weaknesses	• Limited availability of affordable and supportive housing. • Deficient amount of actionable data about the use of supported employment services and the employment of people with disabilities. • Limitations and reliability of NEMT and transportation for daily activities such as employment and errands can be challenging. • Complexity of SDOH-related referrals which can be siloed, time-consuming, a lack of feedback loop, and the need to strengthen a strong referral system.
Opportunities	• Develop a State-funded Bridge Subsidy Program for special populations (including severe and persistently mentally ill, justice-involved) to create pathways to community-based housing options through partnerships with the Department of Housing, Rhode Island Housing, and the healthcare sector. • Implement evidence-based practices such as the Housing First model to ensure individuals with behavioral health conditions can obtain and maintain housing. • Train case managers to assist individuals with applying for eligible benefits through the RIBridges system. • Capitalize upon employer engagement potential to hire individuals with disabilities based on interest and involvement in Work4Wellness Taskforce activities. • Create greater capacity and use of supported employment services to capitalize on collective interest across State agency partners. • Incorporate workforce diversity, equity and inclusion initiatives that address systemic oppression at different organizational levels to improve poor behavioral health outcomes in populations with marginalized identities through a workforce that reflects the cultural and demographic identities of individuals. • Offer education (not just employment) supports to youth and young adults.

	• Ensure facilities are located within public transportation routes and are accessible to individuals with disabilities through programs such as the R.A.M.P. Stamp.
Threats	• Individuals are likely to continue to cycle through the system and may become homeless without access to affordable housing in the community. • Individuals, families, and communities — particularly Black, Indigenous, and people of color (BIPOC) and those who identify as Latinx — continue to be impacted by overdoses from not only opioids, but also stimulants, alcohol, and counterfeit pills. • New and dangerous drugs like fentanyl and xylazine are infecting the Rhode Island drug supply, challenging the progress being made to reduce overdose deaths. • Three in four individuals receiving behavioral healthcare services are food insecure.[2] • Lack of a coordinated supported employment provider network can result in limited and competing resources. • Untreated behavioral health conditions obstruct available pathways to achieve economic stability and self-sufficiency. • Pregnant people, people who speak languages other than English, transition-aged youth, older adults, and unhoused individuals continue to experience great challenges when seeking behavioral healthcare services. • Unemployment rates among people with disabilities is high and lacks equity. • Systemic and institutional discrimination remains a perpetual concern. • Stigma and lack of social cohesion and acceptance remain challenges for specific populations, cultures, and geographies. • Since the pandemic began — impacting social and economic stability of households — rates of psychological distress among children, youth and young adults have increased. This includes symptoms of anxiety, depression, and other mental health disorders. (Protecting Youth Mental Health US Surgeon General's Advisory)

[2] Carvalho, O.D., Sternin, S., Aubin, S., Montague, K., Storti, C., Voyer, H., Borden, S., Elsing, R., Cottrill, S. & Stein, L.A.R. (2023). FY2023-2024 Rhode Island Substance Abuse Prevention Treatment and Community Mental Health Services Block Grant Needs Assessment Report. Training: Executing a Block Grant Needs Assessment," 500-2120-0000-09772), Principal Investigator-Stein, Project Director-S. Cottrill.

Table 3. Promotion and Prevention SWOT	
Strengths	• Data-driven planning and implementation of programs demonstrated positive outcomes, utilization of evidence-based programs, and experienced prevention professionals providing services in the community through Regional Prevention Coalitions and RI Student Assistance Services Program. • The Office of Healthy Aging (OHA) promotes community-based programs to prevent social isolation among older adults which can prevent loneliness, which is associated with higher rates of depression, anxiety, and suicide. • Two local hospitals, Kent and Westerly, have bronze level certification as geriatric emergency departments (EDs). Geriatric ED certification involves screening all older adults for depression, dementia, delirium, and a pharmacological review. • The work of Governor McKee's Challenge Team to Prevent Suicide Among Service Members, Veterans, and their Families, chaired by the Office of Veterans Services, in collaboration with BHDDH and RIDOH, is recognized by the National Veterans Administration Suicide Prevention Program for success in implementation.
Weaknesses	• Traffic violation fines earmarked for prevention through the Rhode Island Substance Abuse Prevention Act (RISAPA) are not currently available, requiring programs to seek additional Federal grants and other sources of funding for prevention efforts. • More public education is needed to reduce stigma associated with mental illness and substance use disorders. • Lack of gambling prevention in Rhode Island, especially among young adults, may result in a higher incidence of problem gambling and a higher need for treatment and support services.
Opportunities	• Identify additional resources and/or opportunities to collect funds to provide sustainable investments into prevention activities across key agencies. • Expand the State Epidemiological Outcomes Workgroup (SEOW) and Evidence-Based Practices Workgroup to increase data-driven behavioral healthcare programming. • Expand gatekeeper training for suicide prevention to identify and engage individuals at risk. • Expand opportunities to align public health and behavioral health efforts with the goal of promoting the integration of services across specific units, divisions, or workgroups and create a bridge between public health and behavioral health agencies.

Threats	• Risk of penalties to the Mental Health and Substance Use Block Grants due to insufficient State funding to support maintenance of efforts and tobacco enforcement of underage sales. • Attrition of advanced prevention professionals from the workforce with no clear succession planning. • Stigma continues to affect receivers and providers of behavioral healthcare services. Public perception associated with the cycle of addiction and mental illness is unfavorable and not understood. • Introduction of local casino online gambling may further impact youth and young adults.

Table 4. Early Identification and Referral	
Strengths	• Increased behavioral health screening in primary care as well as for maternal depression and substance use in prenatal care practices. • Transitions programs, e.g., Healthy Transitions, that include outreach and screening. • Case management services for children also identify needs of adult family members. • Crisis Intervention Training and Mental Health First Aid training are helping community responses to identified populations in need. • Past and current communications campaigns such as Know the 5 Signs and Campaign to Change Direction.
Weaknesses	• Screening, Brief Intervention, and Referral to Treatment (SBIRT) billing is complicated and utilization may likely be underreported. • Long wait times may exist for referrals to general outpatient services upon screening and early identification.
Opportunities	• Utilize certified Community Health Workers (CHW) to conduct SBIRT screening. • Develop opportunities to incentivize SBIRT through value-based care or fee-for-service billing in public and private insurance markets. • Use the Global Behavioral Health Screener (GloBHS) tool in shelters, housing authorities and during outreach, conflict free case management (CFCM), Family Care Community Partnerships (FCCPs), adult day programs, Community Action Programs, United Way 211, home stabilization providers, urgent care, and programs that support caregivers and older adults (e.g., The Point, OHA programs, chronic disease self-management and prevention workshops, Meals on Wheels). • Maintain screening by visiting nurses after childbirth and increasing well-child visits.

	• Distribute copies of *Take Charge of Your Behavioral Health* within primary care settings, senior centers, and behavioral health providers. • Distribute copies of *Wellness Coping Statement Cards* with behavioral health providers.
Threats	• Services, particularly culturally appropriate and multi-lingual, are limited after screening identifies a need requiring referrals. • Communication between electronic health records and social service referral platforms continues to be partially or fully siloed across providers and systems. • Lack of resources for non-profit social service organizations to fulfill social service referrals appropriately and manage such requests.

Table 5. Harm Reduction and Rescue	
Strengths	• RI has a history of strong community participation in the Governor's Overdose Task Force, including the harm reduction and rescue workgroups. • Promising harm reduction activities such as the establishment of an overdose prevention center, harm reduction vending machines, and use of harm reduction outreach efforts in high-burdened communities show progress in the State's commitment to reduce overdoses and stigma. • Receipt of 50,000 naloxone kits annually for 10 years through opioid settlements allows for availability of life-saving treatments through community-based harm reduction programs, staffed by peers with lived experiences, which enhances individual engagement that saves lives and may lead to treatment and recovery. • Multiple departments (BHDDH, EOHHS, RIDOH, DCYF) have a vested interest in reducing opioid-related fatalities and have been recognized nationally for stewardship of opioid settlement dollars and have also received grant or other funding to continue making progress. • The Seven Challenges outpatient treatment program for youth and young adults to address substance use and co-occurring treatment has been sustained and is being implemented statewide.
Weaknesses	• Extent of time needed to ensure safe opening of the overdose prevention center. • Low wages for the peer workforce can often result in staff turnover, particularly given the high-demand of harm reduction-related positions such as outreach. • Inability to bill for harm reduction services for reimbursement locally or nationally.

Opportunities	• An abundance of time-limited funding has been invested nationally in combatting the opioid epidemic, including settlements with several pharmaceutical companies. • Outreach efforts may be sustained through the CCBHCs perspective payment system. • Integration of chronic disease screenings, management, and prevention within CCBHCs (e.g., prediabetes, diabetes, hypertension, dementia, cancers, physical activity). • The exploration of investment options for settlement funding may result in a continued sustainability of harm reduction and other non-billable activities.
Threats	• Lack of sustainability of settlement funding, including Teva Pharmaceutical products, to pay for harm reduction peer work and naloxone supply in the long term. • Lack of coordination and consensus among State agencies regarding what outreach activities are, how they should be delivered, and why they are not billable.

Table 6. Crisis Response and Stabilization Services	
Strengths	• Rhode Island's 988 Lifeline has consistently ranked among the top three local answer rates in the country. • Lessons learned from children's mobile crisis response and stabilization services implementation — as well as from adult-oriented pilots — can be leveraged to inform the implementation of crisis response best practices within the CCBHC program. • Continued availability of BH Link — a 24-hour crisis receiving and stabilization facility that connects individuals experiencing behavioral health (BH) crises with treatment and recovery supports. Services are provided in a community-based setting by a team of nurses, peers, counselors, and psychiatrists. • In the first six months of 2024 BH Link has conducted over 1,000 assessments (serving 726 unique individuals) • On demand access to medications for opioid use disorders through the Opioid Treatment Programs (OTP) mobile van, 24/7 buprenorphine hotline, and bridge clinics remains high. • Medications to treat opioid use disorder and SUD residential services are available for all Rhode Islanders including services for the uninsured/undocumented.
Weaknesses	• BH Link, the State's walk-in crisis triage and stabilization facility, is not serving the anticipated number of individuals in the state due, in part, to its location. • Workforce availability for crisis response and stabilization services.
Opportunities	• Fill in gaps in the crisis system by opening new places for people in crisis to go, such as peer-run respite facilities.

	• The State is in the process of funding a Management Information System that will help to coordinate crisis response and referrals. • Federal legislation allows states to collect fees from phone bills to fund the crisis system. • Continue to braid federal grant funding with State settlement dollars to maximize impacts and to reduce and duplication of services. • Continued evaluation and exploration of post-overdose alternatives including the HOPE (Heroin – Opioid Prevention Effort) Initiative to ensure support and the offering of resources for everyone affected by an overdose can be leveraged to build community crisis response services and follow-up. • Work with Lifespan hospitals to implement a new Drug Enforcement Agency (DEA) rule allowing them to dispense methadone, along with care coordination with local methadone clinics, is in process.
Threats	• Continued challenges with law enforcement responses and behavioral health stigma. • The Safe Landings overdose crisis stabilization and care coordination program had more than a year delay due to building issues and will now need to be re-bid.

Table 7. Home and Community-Based Treatment and Recovery Services (Outpatient Treatment)	
Strengths	• Implementing the CCBHC model will help to fill current gaps in access to crisis services, improve reimbursement rates for outpatient behavioral health services, and improve access to behavioral healthcare for all Rhode Islanders regardless of their ability to pay. • The RI CCBHC certification standards include supported employment as a required psychiatric rehabilitation service with Individual Placement and Support (IPS) services as an evidence-based supported employment practice. • Historic provision of evidence-based practices including Assertive Community Treatment (ACT) and lessons learned from Integrated Health Homes (IHH). • Rhode Island has a robust network of providers that offer FDA approved medications to treat opioid use disorders. Low barrier access has improved via increased mobile services and agencies are implementing the new DEA/SAMSHA approved "take home" rules, schedules, and patient centered decision-making processes. • Some outpatient SUD services are allowable under the CCBHC model and are included in the CCBHC payment rate, which will help to improve reimbursement rates. • New approved increases in Medicaid rates for SUD services will go in affect in 2024-2025, improving reimbursement rates across a broad set of services.

	• A pilot program and a Medicaid 1115 Waiver proposal to implement contingency management statewide has started. • RI has added 70 new SUD residential beds utilizing opioid settlement funding. • RI has 16 locations where individuals can receive treatment for problem gambling throughout the state and a local problem gambling hotline. • The Rhode Island Certification Board (RICB) offers a certificate program in problem gambling for counselors to build competency in treating individuals with gambling disorders. • Seven Coordinated Specialty Care (CSC), also referred to as Healthy Transitions, Programs have been established. CCBHCs must provide Healthy Transitions as a required service.
Weaknesses	• Lack of access to/availability of outpatient appointments and behavioral health counselors especially for those with cooccurring I/DD. • Lack of known evidence-based practices beyond contingency management for those with stimulant use disorder. • Community Mental Health Centers (CMHCs) have several vacancies for supported employment specialists. • Most service agencies either do not offer supported employment services or do so with low fidelity to evidence-based models. • Current Medicaid rates are not adequate to incentivize provider agencies to prioritize the use of supported employment services and non-face to face work with employees is not reimbursable.
Opportunities	• Support routine rate review across the behavioral health system to increase access to community-based services across all payors. • Incorporate a zero-suicide approach in hospital and healthcare systems. • Offer supported employment and education support for youth and young adults in the Healthy Transition Programs. • Establish Mental Health Court Diversion programs across the State. • Review Medicaid 1115 Waiver for opportunities to provide non-traditional services such as those that support individuals with cooccurring I/DD and sustain programs including contingency management. • Integration of chronic disease screenings, management, and prevention (e.g., prediabetes, diabetes, hypertension, dementia, cancers, physical activity) in outpatient offices. • Leverage findings from upcoming RIDOH Statewide Health Inventory, specifically the integration of primary care in behavioral health as well as others (including co-location). • Explore opportunities to strengthen behavioral health in remote or designated mental health professional shortage areas as well as rural or isolated communities.

	• Ensure out-patient services to treat DUI/Refusals at all licensed BH/BHDDH facilities provided are evidence-based by adding to certification and regulation standards.
Threats	• Inadequate commitment and/or prioritization by providers to focus on employability as an essential outcome of treatment. • Lack of resolution to administrative burden and challenges related to behavioral health in primary care for on-demand treatment and billable services and vice versa for physical health services in behavioral health settings. • Challenges can arise with providers understanding presenting symptoms within the I/DD population and inappropriately attributing the systems to a disability and not an underlying medical and behavioral health issue. • Continued stigma around mental health and SUD, particularly in less urban areas of the state, for which seeking behavioral health in a primary care setting is preferred. • Sustainability needs as funding shortages may arise for non-traditional provider support programs such as MomsPRN.

Table 8. Home and Community-Based Treatment and Recovery Services
(Residential Treatment and Temporary Respite)

Strengths	• EOHHS is successfully piloting two medical respite community-based settings and has requested medical respite as part of a Recuperative and Restorative Care Service through the Medicaid 1115 Waiver for sustainability. • EOHHS is piloting a third medical respite site focused primarily on behavioral health respite with secondary physical health needs, including a focus on those who are ready for transition into the community from correctional facilities. • Settlement dollars are supporting SUD residential treatment and medications for individuals who are uninsured/undocumented. • SUD respite beds are now available for individuals experiencing homelessness and SUD • Mobile van treatment services and community-based programs like the Imani Community Recovery Program are meeting people where they live in lieu of waiting for people to find their way into treatment.
Weaknesses	• SUD residential facilities continue to be underfunded with low Medicaid rates that have resulted in past closures. • The lack of on-demand detox or residential treatment for adults and adolescents. • No specific clinical track to address increasing stimulant use in the state.

	• Implement appropriate screening tools to ensure individuals are placed in the appropriate American Society of Addiction Medicine (ASAM) levels of care. • Lack of residential treatment beds available for individuals who need criminogenic supports. • Singular option for residential treatment for pregnant and parenting women and their babies as SStarbirth is the only option in the state. • Care settings such as enhanced Mental Health Psychiatric Rehabilitative Residences (MHPRRs) and Assisted Living Facilities, are needed for individuals with criminal justice involvement and also for individuals with serious and persistent mental illness (SPMI) and co-occurring disorders, who are living in shelters or are unsheltered. • MHPRRs continue to be underfunded and lack pathways to less restrictive housing settings, long-term care supports, and end of life care.
Opportunities	• Build capacity of MHPRRs and pathways to additional care. • Incorporate discharge planning from the Department of Corrections and forensic and criminogenic expertise into CCBHCs and/or medical respite. • Sustainability of pilot programs through insurance and other sustainable funding options. • Integration of chronic disease screenings, management, and prevention (e.g., prediabetes, diabetes, hypertension, dementia, cancers, physical activity) across settings. • Explore group home options in the I/DD and/or BH system to serve people with cooccurring disorders who are at risk for hospitalization, arrest, or homelessness. • Ensure inclusivity of individuals with I/DD in medical respite programs and develop options for anyone who requires assistance with activities of daily living. • Explore centralized screening for appropriate ASAM levels of care. • Utilize new settlement dollars to address SUD service needs for adolescents, pregnant women, and other identified needs.
Threats	• Lack of prioritization for the funding needed to address critical systems gaps. • Continued funding and programmatic silos in the I/DD and BH systems of care.

Table 9. Home and Community-Based Treatment and Recovery Services (Recovery Services)	
Strengths	• Rhode Island has built up a cadre of Certified Peer Recovery Specialists (CPRS) and introduced several peer programs that are being replicated in other states. • Services provided by CPRS are Medicaid billable when provided through a Medicaid-approved organization. • Brown University, with the Long-Term Care Ombudsman, implements the Diamond Fund project to educate nursing home administrators about accepting individuals on suboxone.
Weaknesses	• There are challenges to billing for recovery services, which creates an overreliance on grant funding. • Pay for CPRS is very low and there are CPRS who leave the field shortly after entering it because the wages are not livable. • There is not a pathway from recovery housing into affordable or supportive housing. • Medicaid-covered transportation does not include transport to and from some recovery settings and/or recovery plan meetings.
Opportunities	• Grow the Recovery-Friendly Workplace Initiative to include a case management approach to different kinds of businesses and organizations, including state government offices. • Expand the state-funded recovery housing program to include different levels of support as defined by the National Association of Recovery Residences (NARR) levels and incorporate as a component of Restorative and Recuperative Care long-term. • Incorporate housing navigation into recovery housing through Medicaid Home Stabilization Services. • Clarify role and billing differences for certified peer recovery specialists, case managers, and certified community healthcare workers in different workplace settings, especially integrated care teams. • Integration of chronic disease screenings, management, and prevention within recovery centers (e.g., prediabetes, diabetes, hypertension, dementia, cancers, physical activity) • Explore options for peer supports and peer professionals for individuals with cooccurring BH and I/DD. • Continue to ensure braided funding supports for families and the prevention of overdose deaths and reoccurrence in recovery.

Threats	• When grant funding decreases, some programs may be in jeopardy due to lack of coverage as a billable service. • Lack of a pathway to CPRS access for individuals leaving institutions. • The lack of affordable housing options available for individuals leaving recovery housing combined with 3-10 year waiting lists for federal subsidies. • Skilled nursing facilities are reluctant to admit, and often decline admission to, individuals in recovery who are prescribed suboxone.

Table 10. Inpatient and Institutional Services: Short-Term Inpatient Psychiatric Care (Community Hospitals with Locked Units, Unlocked Crisis Stabilization Units)	
Strengths	• RI has three unlocked stabilization units, one provides services to individuals with co-occurring intellectual and/or developmental disability and behavioral health concerns, and two provide care to individuals with behavioral health concerns.
Weaknesses	• Inappropriate discharges from hospitals, long-term care, and criminal justice facilities—including to homelessness—that occur to high-need and complex individuals who need a specific level of care (including step-downs for I/DD co-occurrence) for which there are limited options. • Individuals who are not approved for hospital level of psychiatric care but are holding in facilities or at inpatient units due to a lack of other available options, at a given point in time where the facility only receives administrative rate (or no rate) instead of psychiatric care rates.
Opportunities	• Investments in home and community-based services to ensure continuity of care upon discharge and/or safe placement in lower level of care that is less restrictive.
Threats	• Inpatient units becoming long-term care for individuals with no other options.

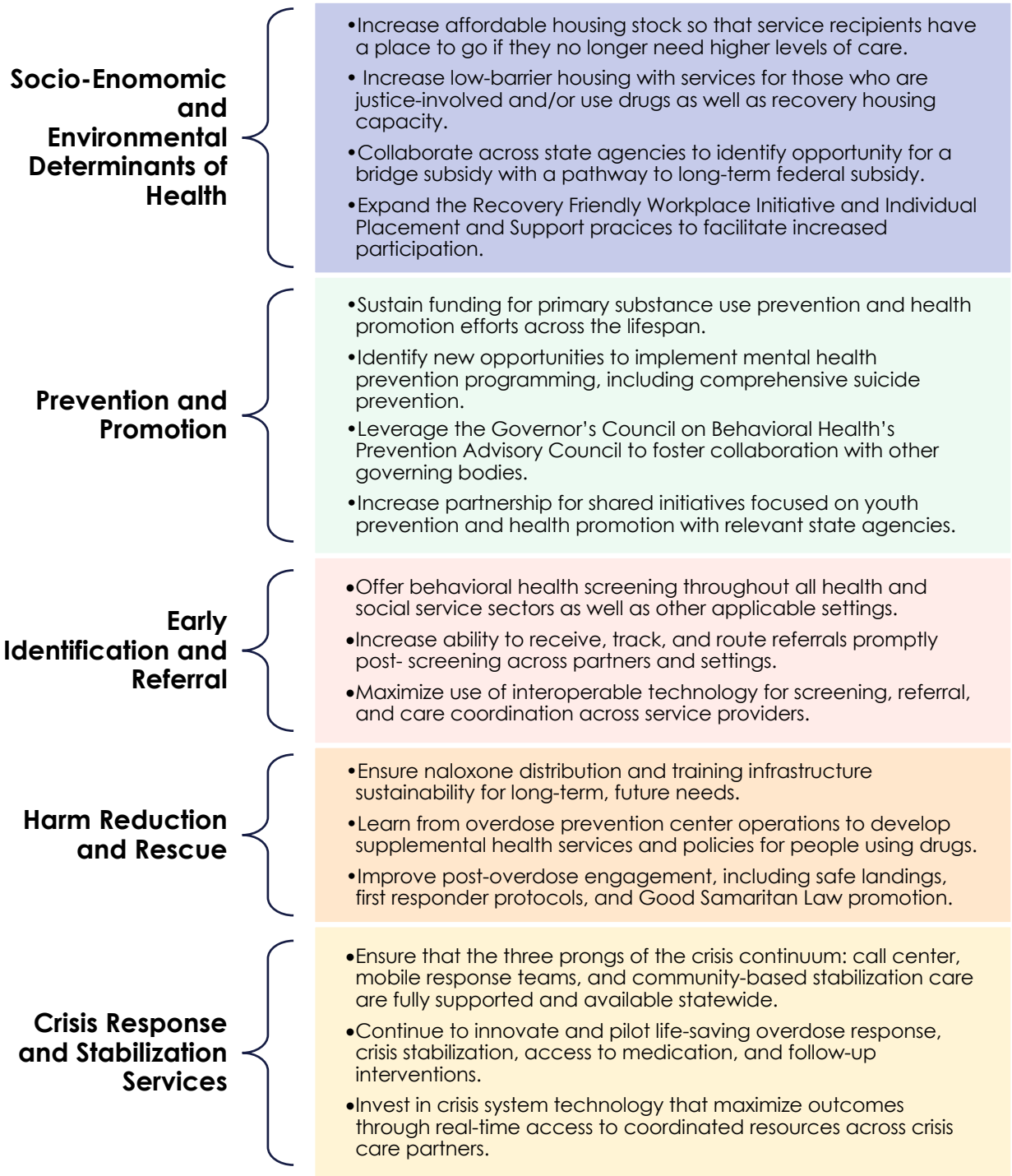
Table 11. Inpatient and Institutional Services: Long-Term Institutional Care (Behavioral Health Nursing Home Units, Traumatic Brain Injury Nursing Homes, Intermediate Care Facilities, and State Hospitals)	
Strengths	• RI has a State Psychiatric Hospital.
Weaknesses	• No specialized facilities, with a current one-size-fits-all approach tied to existing Medicaid/Medicare rate bundle. • Current system is resistant to taking people who utilize methadone or other FDA approved medications to treat SUD needs. • Staffing ratios in existing nursing homes do not meet the needs of individuals with significant behavioral health needs.
Opportunities	• In 2025, the long-term care population is anticipated to go into Managed Care Organizations (MCOs) contracts. • Investments in new levels of care may lessen the risk of being discharged to homelessness when individuals do not meet hospital level of care. • Reinforce the use of Preadmission Screening and Residential Review (PASRR) to identify needs and treatment recommendations for those entering long-term care. • Maximize ability to provide end of life care for individuals with behavioral health and cooccurring I/DD.
Threats	• Hospitalized individuals who need Long-Term Services and Supports (LTSS) but cannot access appropriate level of care due to chronic behavioral health diagnoses and treatment needs. • Persistent challenges with maintaining accountability within the system to ensure continued level of care placements for complex individuals. • Lack of adequate facility capacity for individuals with significant behavioral health challenges to live out their lives. • Growing elderly population with reduced nursing home/assisted living services. • Potential for additional, younger individuals requiring long-term care because of the prolonged overdose epidemic.

The SWOT analysis identifies several areas where the State should continue interagency efforts and engage in strategic partnerships with non-State agencies to explore areas of growth across all parts of the service continuum — and the community factors that influence health. Continued prioritization of opportunities to strengthen the comprehensive array of services and supports — including promotion and prevention — are essential to inverting the Investment Triangle, as noted previously, to lessen the use of institutional and inpatient programs.

SWOT Priorities

Figure 4.

The following charts reflect the interagency priorities for quality improvement that have been identified and summarized as part of the 2024 Snapshot development process:



Home and Community-Based Treatment and Recovery Services

Outpatient Treatment

1. Implement, quality monitor, and sustain safety net providers through Certified Community Behavioral Health Clinics (CCBHCs).
2. Continue statewide efforts to integrate physical and behavioral healthcare in various settings to achieve value-based care.
3. Prioritze supports to ensure comprehensive outpatient care — including substance use treatment — that leverage Designated Collaborating Organizations (DCO), justice system supports, effective outreach, and Medication for Opioid Use Disorders (MOUD) provider networks.

Residental Treatment and Temporary Respite

- Implement, evaluate and resource recommendations from rate reviews and a changing environment to bolster access to residential services.
- Implement new 2024 ASAM levels of care screening tools to ensure individuals are placed in the appropriate ASAM levels of care.
- Ensure residential and community-based providers are able to develop a treatment track to address the increase in stimulant use disorders.
- Continue to train on the importance of implementing evidence based practices.
- Explore the ability of licensed providers to have the right of first refusal to purchase the state-owned properties that they occupy.

Recovery Services

- Ensure that peer-based recovery support services meet the quality standard set through the Medicaid program with quality audits.
- Enhance workforce supports (including training and professional organizations) with input from those with lived recovery experience.
- Leverage SAMHSA Recovery from Substance Use and Mental Health Problems Among Adults Report to expand into new environments.
- Maintain a sustained focus on special populations with specialized programming to reduce and eliminate disparities in recovery.

Short-Term Inpatient Psychatric Care and Long-Term Institutional Services

1. Continue investments in home and community-based services to ensure continuity of care upon discharge and safe placement in lower levels of care, when appropriate.
2. Increase community capacity to support long-term behavioral health needs and substance use medications and recovery within long-term services and supports systems.

Success Factors for Inclusive Services and Strong Community Engagement

In addition to the recommendations provided above, the identification of overarching issues that span the continuum should be considered to foster more cohesive and inclusive statewide planning, community-driven solutioning, quality-based resourcing, and system sustainability. To this end, these recommendations include:

Table 9.

Accountability for Quality Services	
1.	Address the impacts of structural racism, as well as ableism, and achieve health equity when it comes to accessing treatment and other mental healthcare services, where we know there are disparities using the following tactics: • Addressing Root Causes**:** Enhancing our strategies around social determinants of health, early intervention, and integration with primary healthcare to improve behavioral health outcomes. • Monitoring Progress for Communities of Color: Implementing robust data collection, assessing service location and accessibility, enhancing cultural competency, and engaging communities for feedback. • Utilizing Race Equity Councils: Entrusting the Race Equity Councils to lead these reviews and develop a comprehensive framework that includes key performance indicators and methods for data collection and analysis. • Training: Funding is needed to guarantee the availability of and access to the Groundwater Institute training for all health and human service agencies.
2.	Make Rhode Island healthcare workforce wages competitive with those being offered in nearby states, such as Connecticut and Massachusetts.
3.	Bilingual clinicians and Certified Peer Recovery Specialists are needed and when not available, a system must be in place to assist limited or non-English speaking individuals (including those who speak American Sign Language) across various health literacy levels.
4.	Hold MCOs accountable for having adequate network capacity and work with them to develop new landing spots.
5.	Work with regulators, legal staff, and the Division of Capital Asset Management & Maintenance (DCAMM) to determine ways to release state properties into the hands of providers so that they can access funding to make the necessary repairs and maintain the properties.

6.	Conduct quality monitoring of all behavioral healthcare contracts in the following way by the respective unit: 1) actively monitor contracts (contracts) to ensure the vendor is doing what they have agreed to contractually; 2) monitor fidelity (programs) so that we can document that the vendor is programmatically and clinically meeting best practices and standards of care; 3) monitor outcomes (data/evaluation) so that we can prove contracts have a purpose; and 4) regularly review system wide contracts (contracts) to determine if there is duplicative overlap that could be redirected to new programming.
7.	Consider developing a team with the Office of Management and Budget (OMB) to document cost avoidance that can be achieved across the State through implementation of existing strategies that can be leveraged, and the additional strategies and opportunities noted in this document.
8.	State employees do not receive temporary disability insurance, and insurance policies through Aflac and Colonial Life do not cover mental health related absences.
9.	Review this Snapshot document annually and provide updates to the Governor's Office.

Community Engagement and Coordinated Partnerships	
1.	Improve collaboration across state agencies and community partners, like Lifespan's transitional clinics, to coordinate a multitude of support services for our prison re-entry populations to address their physical, behavioral health, housing and employment needs, and reduce recidivism.
2.	Establish working definitions and protocols, based on best practices for the various types of recovery-based, harm reduction, and homelessness outreach services and coordinate funding across state agencies to avoid duplication of services.
3.	Employ strategies at all sequential intercept points where individuals with mental and substance use disorders encounter and move through the criminal justice system.
4.	Capitalize upon/encourage use of the Veterans Treatment, and Adult Drug Courts to change the course of many lives, that may otherwise be lost, through alternative judicial intervention.
5.	Provide supportive services at physical healthcare safety net providers, like Federally Qualified Health Centers (FQHCs), that can support people's behavioral health needs as well as their physical health needs, particularly individuals with less severe behavioral health conditions.
6.	Work with Eleanor Slater Hospital and the RI State Psychiatric Hospital to ensure that the admission, discharge, and transfer policies and procedures are clear to community partners.

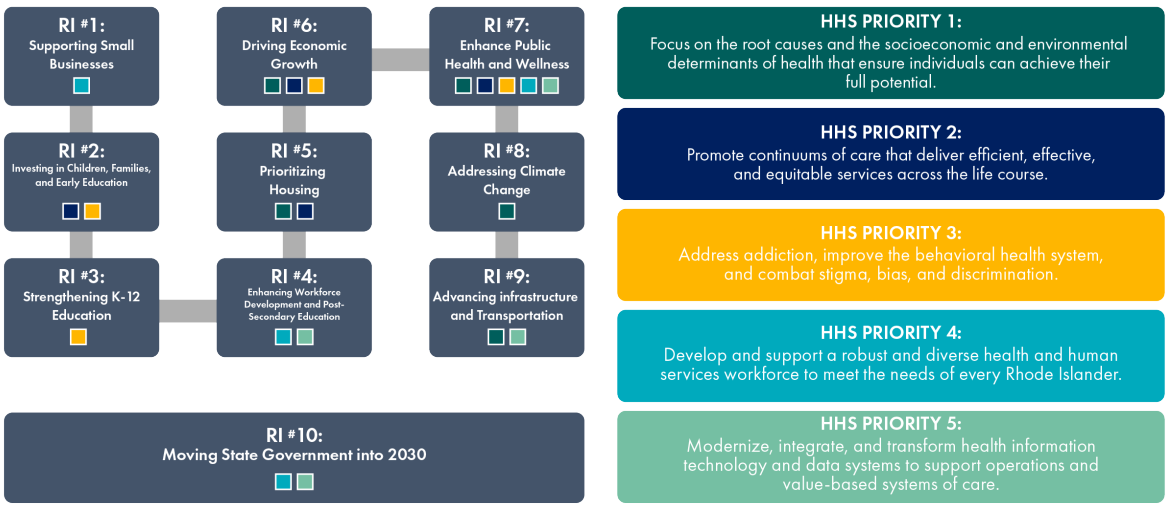
7.	Train staff across the care continuum on conflict-free case management, housing navigation, and housing retention services to ensure housing stability.
8.	Create a Recovery Advisory Committee of the Governor's Council on Behavioral Health.
9.	Establish a governance structure within the Governor's Council on Behavioral Health for suicide prevention planning that is coordinated with the Prevention Advisory Committee.

Conclusions

This 2024 Snapshot is intended to document the current system transformation efforts and opportunities to meet Rhode Island's vision for the adult behavioral health system continuum of care. This document also serves to recommend and prioritize additional opportunities for growth that include proactive investments in prevention, early identification, and community-based treatment over reactive acute institutional care.

Rhode Island has a substantial body of interagency work currently underway to improve its system of behavioral healthcare and meet the needs of all Rhode Islanders. With support from the community, Rhode Island is making strides to meet RI 2030 Plan by modernizing the structure, reimbursement for, and accountability of the adult behavioral health system of care. The figure below reflects the five Health and Human Services (HHS) strategies for Rhode Island, as aligned with the RI 2030 Plan. Opportunities moving forward as depicted in this 2024 Snapshot reflect HHS Priorities 1-4.

Supporting Rhode Island 2030



Moving Forward

Moving forward, continued State and community leadership as well as legislative champions will be needed to sustain commitment on these critical transformative actions for the benefit of all Rhode Islanders. As of June 2024, the following additional assets have been identified for implementation in the next year:

- Governor McKee established the Health Care System Planning (HCSP) Cabinet and the EOHHS Independent Advisory Council in February 2024 to evaluate and propose specific recommendations concerning the implementation of a statewide health care system plan, including potential legislation to implement such a plan.
- Rhode Island has been selected as one of 10 states to participate in the newest cohort of the federal CCBHC demonstration program. This offers the State an enhanced federal match rate for four years to support its implementation of the CCBHC program in October 2024 and further development and expansion of the program in subsequent years, reducing the costs borne to the State. The CCBHC program will help the State transition to a new delivery model for behavioral healthcare that expands access to coordinated and comprehensive services and supports to people of all ages, regardless of their ability to pay.
- Passage of Senate resolution 3167 to explore recommendations for establishing a unified system of care for children's and adult behavioral health moving forward in Rhode Island.
- Creation of the Ladders to Licensure Program that will help to increase the capacity and diversity of the health professional workforce by funding partnerships between health care providers and institutions of higher education to support staff who aspire to advance from paraprofessionals to licensed clinicians.
- Full implementation of the OHIC Rate Review increases for selected Medicaid services and continued evaluation of rates on a periodic schedule moving forward.
- Renegotiation of the Medicaid 1115 Waiver with the Centers for Medicare and Medicaid Services (CMS) to pilot and evaluate innovative healthcare strategies, including but not limited to: restorative and recuperative care, home stabilization services enhancements, and health equity.
- Issuance of an executive order for an Olmstead Plan for Rhode Island to ensure services are adequately available to those who need them in the safest, most-appropriate, and least restrictive setting as possible.
- Passage of FY25 State Budget that includes a proposal on the next election ballot that would provide $120 million dollars for affordable housing bonds.

- Creation of the Medical Examiners Working Group to inform the Comprehensive Suicide Prevention Advisory Council moving forward.
- Implement a pilot for a third medical respite site that has a focus on behavioral health and criminal justice populations who need recuperative and restorative care.
- Additional advances in housing-related policy, including changes to promote Accessory Dwelling Units (ADU) in Rhode Island.
- Continued changes in State policy such as the OHIC Affordability Standards and federal policy such as those governing Medication-Assisted Treatment.

Appendix A – Rhode Island's Health Care System Planning Processes

(As of December 2023)

EOHHS, along with State and community partners, has been implementing a broad range of vibrant planning activities over the last five years, many of which have led to important program implementation activities. Moving forward, the health care planning process will include cross walking and aligning these existing planning efforts in an overarching interagency and public/private process.

Health Planning Across the Life Course

- **Behavioral Health System Review (EOHHS)**
  The Behavioral Health System Review was created as a result of a grant from the Centers for Medicare and Medicaid Services (CMS) in 2019. The review identified key gaps and opportunities for Rhode Island's behavioral health system of care and resulted in two implementation plans for Certified Community Behavioral Health Clinics (CCBHCs) and mobile crisis. Those two plans are now being implemented by an interagency team of EOHHS/Medicaid, BHDDH, and DCYF**.** This includes the implementation of CCBHCs and mobile crisis.

- **Block Grant Planning (BHDDH)**
  Substance Use and Mental Health Block Grants | SAMHSA are used to fund programs for prevention, treatment, recovery support, and other services to supplement Medicaid, Medicare, and private insurance services. The Governor's Council on Behavioral Health was established by both federal and State law to review and evaluate the needs and problems associated with Rhode Island's services for individuals with mental health and SUD and is responsible for approving annual Block Grant plans. FY2024-2025 Combined MHBG and SUPTRS BG Application-Behavioral Health Assessment and Plan-FINAL.pdf (ri.gov)

- **Strategic Plan for Substance Misuse Prevention (BHDDH)**
  This plan reflects ongoing efforts to use data and key stakeholder and community participation to set goals and objectives; prioritize evidence-based programs, practices, and policies; coordinate activities; measure outcomes; identify target populations to improve health equity and reduce disparities related to substance use and mental illness; and plan for the sustainability of infrastructures and activities. The aim of this plan is to provide a roadmap to:
  - Increase the capacity of the State's prevention workforce.
  - Support key stakeholders, prevention providers, and policy makers to understand, promote, and work towards preventing and reducing substance use among young people.
  - Create an integrated prevention service delivery system which incorporates a broader behavioral healthcare approach.

- **Governor's Overdose Task Force (Interagency)**
  The Governor's Overdose Task Force is a statewide coalition of professionals and community members with the goal of preventing overdoses and saving lives. The Task Force is the center of all drug overdose prevention and intervention activities in the state, often bringing together more than 150 people to its monthly meetings. The multi-disciplinary composition of the Task Force, with the perspectives of individual members and expert advisors, brings cross-learning to the sectors around the table. The Governor's Overdose Task Force's Strategic Roadmap was completed in 2022. It is being implemented by the interagency team of EOHHS, BHDDH, RIDOH, RIDOC, and others. This includes programs funded by Opioid Settlement Funds, which are recommended to the EOHHS Secretary by the Opioid Settlement Advisory Committee. The programs are funded in key strategic pillars, as identified by the Task Force, including Prevention, Harm Reduction/Rescue, Treatment, Recovery, Social Determinants of Health, Racial Equity, Data, and Governance.

- **Workforce Planning Process**
  EOHHS, in partnership with the Department of Labor and Training (DLT), the Office of the Postsecondary Commissioner (RIOPC), RIDOH, the Department of Education (RIDE), and many other partners, developed a comprehensive strategy to address our state's health and human services workforce challenges. This has been an 18-month, interagency, public-private process that has engaged over 400 stakeholders from more than 160 partner organizations. The combined efforts of private and public partners resulted in significant progress in less than one year and the development of a "Rhode Map" to attract, train, and retain the future healthcare workforce through further collaboration, investment, and innovation.

- **Olmstead Planning (EOHHS)** – EOHHS has initiated an Olmstead review processes to gather key pieces of information to inform the Olmstead Plan process and begin community engagement. This includes asset mapping, a data review, and developing a proposed community-engaged approach to the work. This work is ongoing.

- **Health Information Technology Roadmap and Steering Committee (EOHHS)**
  The Health Information Technology (HIT) Roadmap was created by EOHHS in 2020 and led to the creation of the Rhode Island HIT Steering Committee. The Steering Committee brings together experts from healthcare organizations, community agencies, and state departments to address health information technology proposals and policy issues aimed at reaching the state's healthcare transformation goals, including behavioral health transformation. EOHHS is currently implementing the HIT Roadmap, along with RIDOH and BHDDH. Current priorities for the HIT Steering Committee include implementation and adoption of the opt-out consent model for the statewide Health Information Exchange, improving demographic data collection and standardization, and increasing access to behavioral health records.

- **OHIC Rate Review**
  In the FY23 State Budget, OHIC was directed to conduct comprehensive reviews of all social and human service programs (including multiple behavioral health programs) having a contract with or licensed by the State, inclusive of EOHHS and the agencies under its purview (RIGL § 42-14.5-3(t)). OHIC established an advisory council to oversee this process, which EOHHS and its member agencies attended, as well as an internal interagency collaboration meeting. OHIC submitted its final report in September, and EOHHS/Medicaid used the report in the preparation of its FY25 budget proposal.

- **OHIC Cost Trends**
  Beginning in August 2018, OHIC has led an interagency, public/private Cost Trend Steering Committee, with the vision of providing Rhode Islanders with high-quality, affordable healthcare through greater transparency of healthcare performance and increased accountability by key stakeholders. The initial goals were to reduce growth in healthcare costs by developing a cost growth target and providing transparent healthcare performance data to influence purchasing decisions and care delivery reforms for all health components; develop a deeper understanding of cost drivers and cost variation in Rhode Island; and determine what investments were needed to sustain ongoing analysis.

Specific Planning Focused on Children's Health

- **Rhode Island's Children's Cabinet (Governor's Office)**
  Pursuant to R.I.G.L. §42-72.5 (1-3), the Rhode Island Children's Cabinet is authorized to engage in interagency agreements and appropriate data-sharing to improve services and outcomes for children and youth, discuss all issues related to children and youth across state agencies, prepare a shared strategic plan, and develop a coordinated budget.

- **Behavioral Health System of Care for Children & Youth Steering Committee (EOHHS)**
  The Steering Committee is responsible for a long-term view of the Children and Youth Behavioral Health System of Care, by using the foundational components of the framework to drive efforts to establish better cohesion between the connector and program components. The Rhode Island Behavioral Health System of Care for Children and Youth Plan was completed in March 2022. The plan is currently being implemented by an interagency team including EOHHS, RIDOH, DCYF, RIDE, and others. This includes the implementation of mobile response and stabilization services for children and youth. The program has seen success in the first year, with 92% of the children participating in the stabilization remaining in the community, without having to visit an emergency room or having an interaction with law enforcement during the program's time period.

- **Infant and Early Childhood Mental Health Task Force (EOHHS)**
  In the 2022 Rhode Island legislative session, the General Assembly passed legislation directing EOHHS to establish a task force to develop a plan to improve promotion of social and emotional well-being of young children, as well as

screening, assessment, diagnosis, and treatment of mental health challenges for children from birth through age five with Medicaid coverage. The Rhode Island Infant and Early Childhood Mental Health Plan-2023 was completed in June 2023. The plan is being implemented by the EOHHS, RIDOH, DCYF, and RIDE interagency team. Implementation includes creation of an infant/early childhood mental health training program for home and community-based providers who serve children and youth, and investment in the multiple learning collaboratives and supportive services, including the DULCE (Developmental Understanding and Legal Collaboration for Everyone) Community Health Worker Program and the PediPRN and MomsPRN teleconsultation services for primary care providers needing help providing behavioral healthcare.

Other Major Activities in Process Focused on Health Across the Life Course

- OHIC Affordability Standards, including primary care spend and hospital rate caps and affordability standards 2.0, focused on behavioral health.
- RIDOH core equity metrics and OHIC equity quality measures.
- Health Equity Zones expansion and sustainability planning.
- RIDOH health promotion planning: e.g., suicide prevention, chronic disease, Alzheimer's disease plan, among others.
- Medicaid MCO re-procurement.
- Potential Medicaid hospital prospective payment implementation (AHEAD Model).

Appendix B – 2022 Block Grant Needs Assessment

Main Findings

The Block Grant Needs Assessment (BGNA) has four goals:

- To determine substance use and mental health services that are available in Rhode Island.
- To determine substance use and mental health needs in Rhode Island.
- To identify gaps and barriers to accessing substance use and mental healthcare services.
- To determine the quality of substance use and mental healthcare services in Rhode Island.

Five data sources were used in this BGNA: an epidemiological profile of the state, analysis of a national data set, focus groups with providers and receivers of behavioral healthcare services, key informant interviews, and a survey of providers and receivers of behavioral healthcare services, as well as community members whose family members have received behavioral healthcare services. These data were used in accordance with the BGNA goals described to outline strengths in the current services offered and needs identified by the Rhode Island community.

Strengths:

- Availability of transportation services to behavioral healthcare services has improved, although the reliability of such services shows room for improvements.
- Innovations such as the State's harm reduction center show progress in the State's commitment to reduce overdoses and stigma.

Needs:

- Individuals with substance use and mental health challenges are struggling to meet their basic needs, including having safe shelter and access to enough food. Basic needs insecurity is preventing individuals from accessing services and, when they can access services, it prevents them from fully benefiting from behavioral healthcare services.
    - Approximately 75% of individuals receiving behavioral healthcare services are food insecure.
- Healthcare organizations are having trouble retaining staff due to low wages and more competitive rates being offered in nearby states, such as Connecticut and Massachusetts.

- Need for long-term care settings were also reported, for both individuals in need of substance use services and mental healthcare services.
- Detoxification facilities were described as an urgent need.
- Pregnant people, people who speak languages other than English, youth, older adults, and unhoused individuals continue to experience great challenges when seeking behavioral healthcare.
- Stigma continues to affect receivers and providers of behavioral healthcare services.

Appendix C – Behavioral Health Continuum Background

Promotion

Behavioral health promotion is the process of informing the public about the importance of behavioral health and healthcare. Messaging can help them understand the importance of behavioral healthcare to the whole person and the importance of addressing the eight dimensions of wellness which include mental, physical, social, emotional, financial, spiritual, environmental, and vocational. These dimensions are interdependent and influence each other. When one dimension of our well-being is out of balance, the other dimensions are affected. To keep ourselves in balance we do things like engaging in the community in which we live, finding meaning in life through spirituality, working, seeking educational opportunities, and exercising. Also, we must address our basic needs for things like housing and nourishment. BHDDH currently works with a statewide communications group seated in EOHHS that assists with promotional communications.

Prevention — including Enforcement

As the earlier diagram shows, there are three categories of prevention services in behavioral healthcare: universal which provides education to the whole population; selective which addresses the needs of individuals perceived to be at risk for behavioral health conditions due to their life situations; and indicated which is when a person has shown evidence of having a behavioral health condition. The Center for Substance Abuse Prevention (CSAP) identifies Six Strategy Categories that comprise a comprehensive approach to prevention:

- Information dissemination
- Prevention education
- Alternative activities
- Community-based processes
- Environmental approaches
- Problem identification and referral

Rhode Island has been successful in managing a high quality, data-driven, grant-funded prevention system throughout the state. It focuses primarily on school-age youth but has invested in some programming for adults. As the strengths, weaknesses, opportunities, and threats (SWOT) analysis earlier in this document shows, the biggest gap in this system is the funding stream.

In 1987, the legislature recognized the need for municipal-level, community-based solutions to address the growing problem of substance use. The RI Substance Abuse Prevention Act (RISAPA), established through R.I. Gen. Laws § 16-21.2-1, created a financial mechanism through penalties on speeding violations for the planning and operation of comprehensive programs in every community. Over the years, the financial assistance to support these programs was drastically reduced in various budget cycles and altogether eliminated from the state budget at the end of fiscal year 2014. This resulted in the absorption of these costs by the Substance Abuse Treatment and Prevention Block Grant, discretionary and formula grants, and other funding from legal actions, but none from the State general revenue. Further, in 2016, the 35 municipal-level substance abuse prevention task forces were regionalized into seven prevention coalitions. The intention of the regionalization was to achieve economies of scale, reduce operating costs, streamline operations, and improve outcomes on State-identified priorities using evidence-based and best practices covering five of six prevention strategies as described above. Funding for prevention services in Rhode Island is now primarily allocated to seven regional coalitions and one provider of student assistance services statewide.

Enforcement in Prevention — An Example

Rhode Island has had in place a statute prohibiting the sale or distribution of tobacco products to underage individuals since 1896 (R.I. Gen. Law § 11-9-13). Prior to an amendment passed by the General Assembly in 1996, the statute was seen to be unenforceable due to the absence of an identified enforcement component. The 1996 amendment established a positive duty to enforce the statute, identified the State and local entities responsible for enforcement actions, and established the parameters within which underage individuals could participate in compliance checks. R.I. Gen. Law § 11-9-13.5 *et seq.* identifies BHDDH as the entity responsible for the administration of the statute, specifically as it relates to implementing required checks to determine retailer compliance with the prohibition on the sale or distribution of tobacco products to minors.

Section 1926 of the federal Public Health Act (P.L. 102-321), known as the "Synar Amendment," and subsequent federal reenactments requires each state to have in place and to enforce a statute preventing the sale or distribution of tobacco products to individuals under the age of 18 as a condition for receipt of federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funding. Currently, states are not required to raise their legal tobacco sales age to 21 by statute but are required to enforce a ban on such sales consistent with federal law. Each state is required to conduct an annual statewide random survey of over the counter and vending machine retail tobacco license holders and to engage in on-going enforcement efforts to limit the extent to which individuals under the age of 21 have access to tobacco products. Further, states must maintain a violation rate under 20% and document effective enforcement efforts or be *subject to a 10% reduction in their SAPT Block Grant award or other negotiated penalty.*

Screening, Early Identification and Referral

ASAM identifies one level of screening and early identification referral:

- **ASAM Level 0.5 Early Intervention**. Early intervention can consist of assessment and education for people at risk of developing a substance use disorder, or programs like DUI classes for people arrested for driving under the influence. The goal of .5 services is to intervene before a person develops a substance use disorder.

Examples of screening include SBIRT in primary care practices and healthcare centers using a variety of validated screening tools. Student assistance counselors may also conduct screenings in school settings to make referrals to treatment.

BHDDH is working to implement use of a standardized GloBHS in other non-medical and healthcare settings. Having a standardized tool to determine level of care (LOC) used throughout the State can provide a rich data set of the behavioral services needed by individuals encountered through street outreach, public housing, transitioning from prison, and those receiving a variety of non-clinical supportive services.

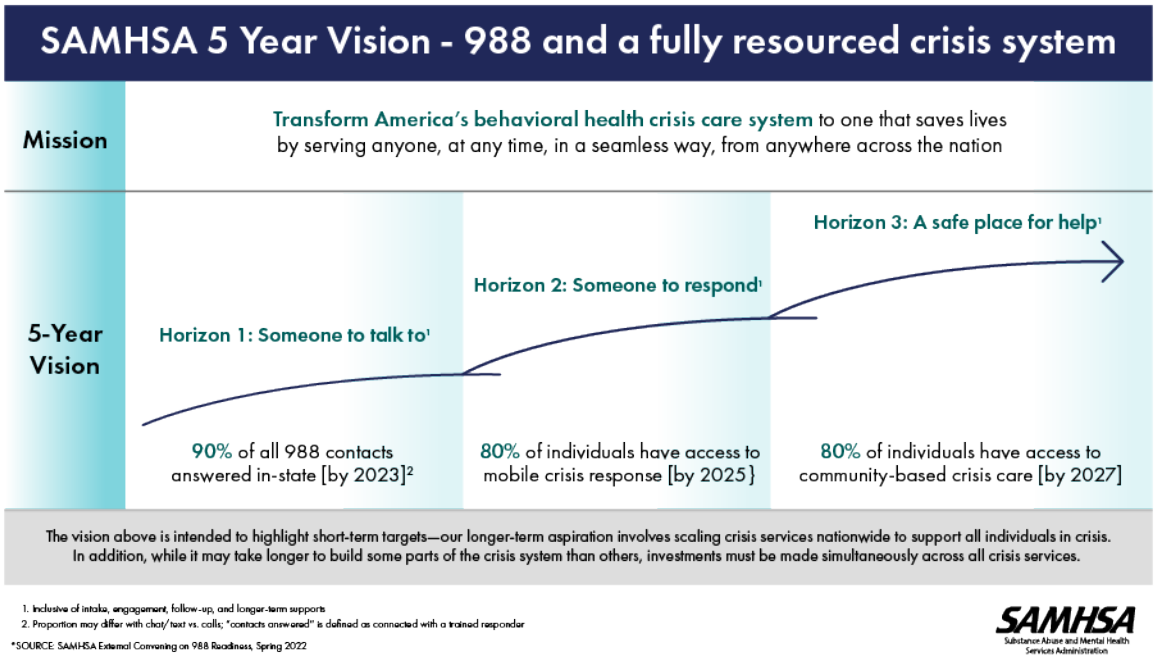
GloBHS is a brief screening tool (meant for non-clinicians to be able to use in about 10 to 15 minutes) that results in a preliminary substance use disorder placement as well as alerting the screener to other mental and physical health needs for follow-up care. The LOC that is recommended by the tool should be verified with a full clinical assessment at intake with a clinical professional. To be clear, the only level of care placement the GloBHS recommends is for SUD services in that the tool will provide a recommendation for a modality such as residential placement, but not the specific ASAM level of residential (e.g., 3.1). A full clinical assessment will be required to make that determination. The tool can also determine if an individual qualifies for a referral to Coordinated Entry services based upon the federal definition of homelessness.

Screeners will use the GloBHS to facilitate the referral process, once it is established that:

- There are no emergency issues.
- No BH Link walk-in appointment is recommended/needed.
- No home/community visit by BH Link staff is recommended/needed.
- No home-based assessment by EMS/Police is recommended/needed.

Crisis Response and Stabilization Services (Including 988)

As the chart below shows, SAMHSA has a five-year vision for improving crisis response nationwide.



Three Components of the Crisis Continuum

- **Someone To Talk To - 988**
  A single point of access through the 988 Lifeline.
- **Someone to Respond – Mobile Crisis Response Teams**
  A cadre of mobile crisis response teams dispatched by 988. Teams may have different configurations, specialty areas and geographic locations, some of which will be operated by CCBHCs.
- **A Safe Place for Help – Walk in/Drop Off Triage and Stabilization Center**
  BH Link is a statewide 24/7/365 triage and receiving center for adults that has capacity for 23-hour observation.

<u>Community-Based Treatment</u>

While many people struggle with both mental health and substance use conditions, there are also many that struggle with just one of these conditions. Therefore, we will discuss them separately as well as discussing co-occurring mental health and substance use conditions. BHDDH-licensed providers, which are the safety net providers for the public healthcare system for behavioral healthcare, rely very heavily on Medicaid to pay for services. Rhode Island's EOHHS was established in 2007 to strengthen the publicly funded healthcare system; increase efficiency, transparency, and accountability of EOHHS and its departments; promote data-driven and evidence-based strategic decision making, analytical orientation, and EOHHS-wide training in data analysis; improve the customer experience; and integrate budget and finance. Under state law, EOHHS serves as "the principal agency of the executive branch of state government" (R.I.G.L. §42-7.2-2) responsible for managing the departments of: Health (RIDOH); Human Services (DHS);

Children, Youth and Families (DCYF); and Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH).

BHDDH provides direct services to nearly 45,000 Rhode Islanders across the lifespan as well as an array of regulatory, protective, and health promotion services to our communities. Health and human services benefits represent $4.1 billion spending per year, approximately 40% of the entire State budget. In 2014, the State consolidated behavioral health Medicaid funding under EOHHS, therefore; the State has requested that BHDDH and EOHHS be co-designated as the State Single Agency, per the provisions established in 42 U.S.C § 300x30(a), solely for the purposes of calculating the Substance Use Prevention and Treatment Block Grant (SABG) maintenance of effort (MOE). Specifically, the designees, BHDDH and EOHHS, are to be jointly designated as administering agencies for federal aid purposes; BHDDH remains the substance use authority with sole responsibility for the activities outlined in the pertinent federal substance abuse laws and regulations, including 42 U.S.C § 300x-21 et seq. The General Assembly created this language for the 2017 legislative session, which became R.I. Gen. Law § 40.1-1-13. Powers and duties of the office pertaining to behavioral healthcare, developmental disabilities, and hospitals.

Mental Health Treatment

BHDDH's mental health treatment continuum has levels of treatment that are consistent with an individual's level of need or acuity. The individuals served by BHDDH-licensed facilities are those with any mental health condition, serious mental illness (SMI), or serious and persistent mental illness (SPMI). Children or youth under the age of 21 who have mental illness may be diagnosed with a serious emotional disturbance (SED). They are also served in our system of care as well as receiving services funded through DCYF. The levels of treatment available to adults include crisis stabilization, residential services, supportive housing services, partial hospital and intensive outpatient programs, assertive community treatment, integrated health homes, and other community-based treatment. Hospitalizations and inpatient services of care are also accessed by some of these individuals, but these services are overseen by RIDOH. Individuals with SMI and SPMI that require a nursing home level of care will be assessed by the preadmission screening and residential review (PASRR) program for their behavioral health needs. The services BHDDH oversees are described below.

Community-Based Mental Health Treatment

Community-based services have been provided by BHDDH-licensed community mental health centers (CMHCs) since the deinstitutionalization of mental hospitals. These CMHCs are regulated by BHDDH and are qualified Medicaid providers. BHDDH, DCYF and EOHHS are in the process of transforming our system of care by implementing the CCBHC model. This model ensures access to a sustainably financed model of integrated, evidence-based SUD and mental health services, including 24/7 mobile crisis response and some forms of Medication for Opioid Use Disorders (MOUD). These specially designated clinics serve anyone who walks through the door, regardless of their age, diagnosis, or insurance status.

Also, the CCBHCs function as a fixed point of responsibility for ensuring a quality community tenure of persons with serious conditions, and as the "least restrictive setting." The CCBHCs collectively would assume function as the organizational entity for portal of entry and gatekeeping functions on a range of "deep end" services. Currently most service dollars go to support high levels of inpatient care, criminal justice beds, or nursing home beds. CCBHCs are required by SAMHSA to provide nine core services, which they can provide directly. Some of these core services may be provided via formal relationships with designated collaborating organizations (DCOs):

1. Crisis services
2. Treatment planning
3. Screening, assessment, diagnosis & risk assessment
4. Outpatient mental health & substance use services
5. Targeted case management
6. Outpatient primary care screening and monitoring
7. Community-based mental health care for veterans
8. Peer, family support & counselor services
9. Psychiatric rehabilitation services

At the time of this writing, eight providers have met the RI CCBHC Certification criteria. The State is working closely with each provider to ensure full operational readiness for go-live by the program launch date of October 1, 2024. CCBHCs will have the ability to provide all nine required CCBHC services throughout their designated catchment area. CCBHCs are expected to enter into partnerships with DCOs sufficient to meet the behavioral prevention, treatment, and outreach needs in their catchment area consistent with the cultural composition of the area. Other collaborative arrangements will also be necessary, including coordination with the 988 call center, schools, and other stakeholders.

RI has selected the Prospective Payment System (PPS-2) rate structure, which, in addition to the monthly tiered, site-specific rates, has a required structure of outlier payments and quality bonus payments. The PPS-2 rate structure will include four population rate categories:

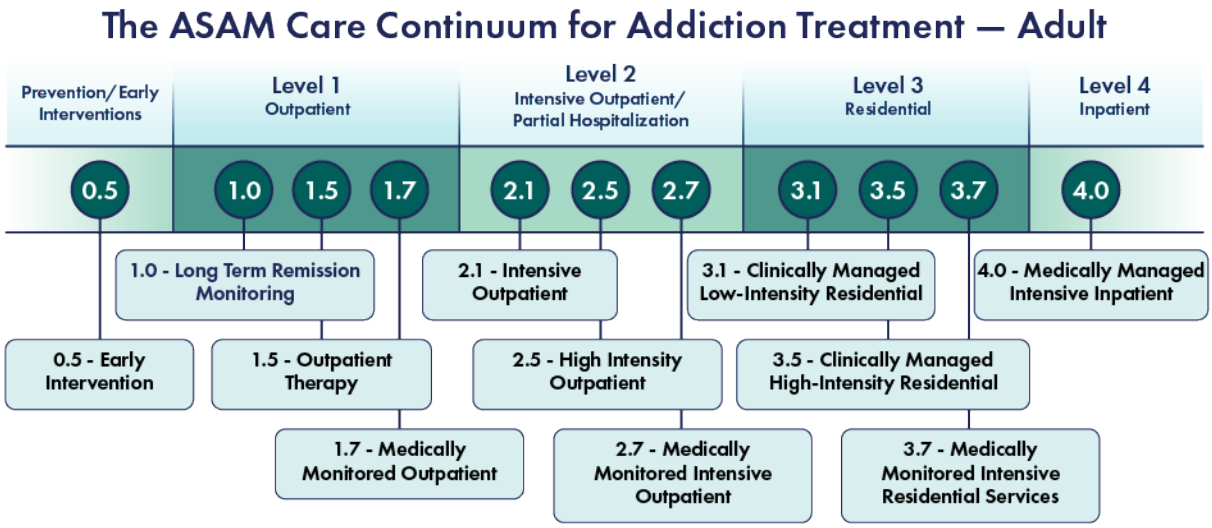
1. High-acuity adult
2. High-acuity children and youth
3. Substance use disorder
4. Standard population

Mental Health Psychiatric Rehabilitative Residences

BHDDH licenses several levels of MHPRRs ranging from supported apartments that have staff available to residents, fully staffed MHPRRs, specialized MHPRRs for higher acuity individuals or those with co-occurring mental health and substance use conditions, and the newest enhanced MHPRR that serves high-acuity individuals with co-morbid health conditions.

Substance Use Treatment

The American Society of Addiction Medicine (ASAM) establishes criteria to assess the appropriate level of care for addressing a person's substance use and mental health at the time of assessment. The ASAM levels of care include early intervention, outpatient treatment, intensive outpatient/partial hospitalization, residential care, and inpatient treatment. While the State, like the nation, is in the middle of an opioid epidemic, RI also has a high incidence of alcohol misuse and must also address the misuse of stimulants and other drugs including cannabis, which recently became legal for use by adults.



Outpatient Services

There are three levels of outpatient services identified by ASAM that are provided by BHDDH-licensed providers as well as some private practitioners that are not licensed by BHDDH. These levels are as follows:

- **ASAM Level 1.0 Long-Term Remission Monitoring** Consistent with the chronic care model of treatment, this level would provide on-going monitoring for patients who have achieved long-term remission.
- **ASAM Level 1.5 Outpatient Therapy** Appropriate for individuals with less severe disorders or as a step down for more intensive services.

- **ASAM Level 1.7 Medically Monitored Outpatient Care** This level includes specialty office based opioid treatment, opioid treatment program, as well as low intensity, medically monitored, ambulatory withdrawal management services.
- **ASAM Level 2.1 Intensive Outpatient Services (IOP)** Consisting of at least nine and no more than 19 hours per week of structured programming to address addiction, relapse prevention and cooccurring disorders. These programs typically offer medical care 24 hours a day by phone or within 72 hours in person.
- **ASAM Level 2.5 High-Intensity Outpatient Program** This is at least 20 hours a week but is less than 24-hour care. This level of care provides structure, and daily oversight for people who need daily monitoring, but not 24/7 care. Clinical and peer staff impart the importance of peer support, builds pro-recovery attitudes and improved coping strategies and behaviors.
- **ASAM Level 2.7 Medically Managed Intensive Outpatient Treatment** Provides services for individuals who are experiencing intoxication, withdrawal, biomedical and/or psychiatric concerns requiring medication management on-site.

In addition to the previous outpatient levels of care, BHDDH licenses and works closely with our federal DEA and SAMSHA partners to ensure compliance and to provide local oversite via the State Opioid Treatment Authorities (SOTA) position who is designated by BHDDH to monitor all opioid treatment programs (OTP). The OTPs provide medications for opioids use disorders with medications such as methadone, buprenorphine, and naltrexone. Additionally, OTPs offer support services such as HIV/HEP C and TB screening, relapse prevention counseling, and services. Service recipients may also access OTP health home services to address physical health and other social determinants of health. BHDDH is working to incorporate as many of these outpatient services as possible into the new CCBHC model.

Residential Services

ASAM identifies – and BHDDH-licensed providers offer – three levels of residential services for individuals with an alcohol or a substance use disorder. They are as follows:

- **ASAM Level 3.1** Clinically Managed Low-Intensity Residential Treatment. At this level, treatment consists of a setting where people reside and receive counseling services. Structured treatment is required for 9-19 hours per week of structured clinical services and recovery supports such as 12 steps, etc. Focus is primarily on relapse prevention, building coping skills and strategies. This level promotes prosocial skills, personal responsibility, and reintegration of the individual into systems of work, education, and family, with a well thought out effort towards discharge planning.
- **ASAM Level 3.5 Clinically Managed High-Intensity Residential Services** for adults. This level of care provides 24-hour care with trained counselors with at least 20 hours of structured clinical services per week. Services should be designed to support recovery from SUD and co-occurring conditions and include daily activities that allow individuals to learn and practice prosocial behaviors.

The Medicaid fee-for-service rates for these services have historically been a big challenge for providers. Because there is a need for room and board at a residential facility, it requires providers to find other sources of funding for the room and board. They may seek some reimbursement from service recipients, but many of them do not have the funds to pay for it. Medicaid is unable to pay for room and board and unlike some other states, Rhode Island does not invest in any general revenue to pay for room and board. This is a gap in our continuum that will be addressed later in the strategic plan.

Community-Based Recovery Services

SAMHSA's working definition of recovery defines recovery as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

Hope, the belief that these challenges and conditions can be overcome, is the foundation of recovery. A person's recovery is built on his or her strengths, talents, coping abilities, resources, and inherent values. It is holistic, addresses the whole person and their community, and is supported by peers, friends, and family members.

The process of recovery is highly personal and occurs via many pathways. It may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care, and other approaches. Recovery is characterized by continual growth and improvement in one's health and wellness and managing setbacks. Because setbacks are a natural part of life, resilience becomes a key component of recovery.

According to SAMHSA, there are four major dimensions of recovery:

- **Health** - overcoming or managing one's disease(s) or symptoms, and making informed, healthy choices that support physical and emotional well-being.
- **Home** - having a stable and safe place to live.
- **Purpose** - conducting meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.
- **Community** - having relationships and social networks that provide support, friendship, love, and hope.

Certified Peer Recovery Specialists

Rhode Island was the first state to institute a joint certification for peer recovery specialists (PRS) that encompasses addressing both mental health and substance use. PRS are individuals with lived experience of a behavioral health condition. This could be experience with their own condition or experience supporting a loved one with these conditions. PRS work in a variety of settings including on treatment teams, as crisis responders, as individuals conducting outreach, and in recovery community centers.

Agencies that wish to receive Medicaid reimbursement for services provided by certified peer recovery specialists must demonstrate their compliance with minimum standards set by Medicaid and BHDDH through submission of an application to BHDDH to become a certified provider.

Recovery Community Centers

Recovery community centers (RCCs) are peer-operated centers that serve as local resource hubs of community-based recovery support. RCCs help people build recovery capital at the community level by providing mutual aid support, resource navigation, advocacy training, social activities, employment and education support, and other community-based services. They help facilitate supportive relationships among people in recovery, as well as community and family members. BHDDH funds four agencies that operate six RCCs across the state. A list of locations may be found here.

Recovery Housing

Recovery residences offer a substance free living environment for individuals recovering from SUD. Recovery residences function as a supportive dwelling and are not halfway houses or programs that are required to be licensed by any state agency, in that they do not provide rehabilitation, treatment, supervision, or dispensing or management of medications. While recovery residences are not required to be licensed, R.I. Gen. Law § 40.1-1-13 requires that all referrals made from state agencies or state-funded facilities must be to certified residences that meet national standards outlined by the National Alliance of Recovery Residence (NARR).

NARR's certification standards are organized across four domain areas: administrative operations, physical environment, recovery support, and good neighbor. Standards are tailored to each of NARR's four levels of support that are distinguished by the level of services and support offered at a residence.

BHDDH supports over 40 recovery houses in different parts of the state, with more than 500 certified level two beds. Some locations focus on special populations, like women and veterans. They play an instrumental role in helping people recover in a safe environment. More information about certified recovery houses can be found here.

Inpatient Services

ASAM identifies two levels of inpatient services which are as follows:

- **ASAM Level 3.7 Medically Monitored High Intensity Inpatient Treatment** These services are for people who need intensive medical or psychological monitoring in a 24-hour setting but do not need daily physician interaction.
- **ASAM Level 4 Medically Managed Inpatient Services** These services offer 24-hour nursing care and daily physician visits. People in this level of care need daily physician monitoring, along with 24-hour oversight and are usually hospitalized.

BHDDH-licensed providers offer level 3.7 services. Level 4 services are provided in hospitals licensed by the Rhode Island Department of Health. BHDDH has struggled to ensure that there is enough capacity within level 3.7. Once again, this is a concern related to rates coming from Medicaid fee-for-service.