

**MEETING MINUTES FOR THE
GOVERNOR’S COUNCIL ON BEHAVIORAL HEALTH
THURSDAY, APRIL 14, 2016**

Members present: Rich Leclerc, Linda Bryan, Anne Mulready, Ruth Feder, Wendy Looker, Maxine Heywood

Appointed members present: David Spencer (Leadership Council) and Megan Clingham (Mental Health Advocate)

Statutory members present: none

Ex-officio members present: Denise Achin, (DOE); Colleen Polselli (DOH); Sharon Kernan (EOHHS); Becky Boss, Linda Barovier, Dan Fitzgerald, Michele Brophy (BHDDH), Chris Strnad, Ranny Dougherty, Susan Lindberg (DCYF)

Guests: Christian Delacruz (PSNRI); Dana Parker (NAMI); Melissa Worcester (Beacon Health Options); Lisa Tomasso (TPC); Ted Long (DOH); and Narine Amroyan (BCBSRI)

Staff: Jim Dealy

1. Review Minutes (Rich Leclerc): The Minutes for the meeting of March 8, 2016 were reviewed. David Spencer pointed out that a Motion had been made and seconded at the March 8th meeting that DCYF “have a report presented to the Governor’s Council at this (4/15/16) meeting on the out-of-state referrals, the costs, and reason for the out-of-state referrals with non-patient identifying information.” The wording in the minutes did not accurately reflect the Motion as made. A Motion was made and seconded to amend the Minutes as discussed above but to otherwise accept as presented. The Motion carried.

2. Committee Reports (Anne Mulready): The Youth Transition Committee has been looking at two issues identified by the Healthy Transition Lab sites; housing/homelessness and transportation. There are gaps in terms of what housing options youth and young adults can access. One is that many of them do not meet HUD definitions for chronic homelessness because they are able to move between temporary living arrangements, rather than remain continuously homeless. Another problem is that youth are legally unable to sign leases, or, if able to, don’t have enough steady income to afford housing. Another is that types of housing that fit their needs (for example, congregate, age-specific housing) isn’t available. It was noted that a relatively high proportion of homeless

youth and young adults are LGBT, for whom appropriate housing is scarce. Chris Strnad added that DCYF has become aware that there may be some youth in the homeless population who are involved in sex trafficking and suggested that we might want someone to come and address the Council on this issue.

The next meeting is June 14th from 3:00 – 4:30 PM in Conference Room 126, in Barry Hall, 14 Harrington Road, Cranston, Rhode Island 02920.

Prevention Advisory Committee: Elizabeth Kretchman presented on behalf of Sandra DelSesto. Stakeholders were brought together at the PAC’s last meeting to give feedback on the BHDDH Prevention Strategic Plan. The Plan is being finalized and will be presented to the Governor’s Council. There are a couple of legislative updates. A letter from the Governor’s Council was sent to the Governor asking for reinstatement of general revenue dollars that were taken out of the state budget several years ago. Unfortunately, that letter went out after the Governor had submitted her budget to the legislature. There has not been a response to date. The PAC’s next meeting time is to be determined, probably sometime in June.

The Evidence-based Work Group, which is a subcommittee of the Prevention Advisory Committee, met on April 7, 2016. It is currently developing a draft application and set of standards that would allow a program that is not on a national Evidence Based Practice registry to be recognized as an evidence-based, locally developed innovative program.

3. RIDOH 2015 Statewide Health Inventory (Theodore Long): Dr. Ted Long Ted is Medical Director of the Department of Health’s Division of Policy, Information and Communications, and he also practices medicine part time. He introduced the RI DOH’s 2015 Statewide Health Inventory. The link to the full survey is:

<http://www.health.ri.gov/publications/reports/2015HealthInventory.pdf>

Dr. Long’s Power Point presentation is attached with these minutes.

He introduced the Inventory, which is part of a legislatively-mandated survey of all the state’s healthcare facilities and services, a study of healthcare utilization and capacity and a statewide health plan. The Inventory was produced for 11/1/15, but ongoing work is required to refine it further. Dr. Long presented an overall review of the Inventory findings, highlighted key findings and discussed links between the findings and overall population health goals. He noted the overarching goal to “positively demonstrate for Rhode Islanders the purpose and importance of public health.” and the three leading priorities, to: “address the social and environmental determinants of health in RI,” “eliminate disparities of health in RI and promote health equity, and “ensure access to quality health services for Rhode Islanders, including our vulnerable populations.” Each priority was broken down into five population strategies, with a specific health population goal. For example, reducing the incidence of chronic diabetes requires a strategy of increasing access to primary care. He

noted that the Inventory addressed three aspects of access to healthcare: financial access, geographic access and cultural access.

The Inventory divided health care providers into six categories, one of which was behavioral health clinics. He also detailed the methodological complexity of determining how much medical care in each of the categories is really available in the state. For example, national surveys determine, based on the number of primary care physicians, that Rhode Island has more than the required proportion of PCPs. However, the Inventory's survey, which counts actual FTEs of PCP time, showed that there is actually a shortage compared to national norms.

In the Department of Health, one of the key goals is to look at behavioral health. Although 92% of the BHDDH-licensed behavioral health organizations responded to the survey, he noted that the researchers were unable to survey many BH providers who are not affiliated with BHOs or are not licensed psychiatrist and psychologists. Dr. Long asked the Council's help in accessing these other providers, so that the Inventory fully reflects what is available. The researchers looked at insurance acceptance as a measure of access to behavioral healthcare. They noted that, while there are a very high portion of Medicaid behavioral health patients, many independent psychiatrists, and even more independent psychologists, will not take Medicaid.

A critical question that needs to be measured is coordination of care. The data available doesn't contain anything that can address this.

4. Update from EOHHS (Sharon Kernan): OHHS is about to begin the process for contracting with the Accountable Care Entities. It is anticipating that the procurement cycle will start on January 1st, 2017. Five ACE's have been approved. United Healthcare has completed contracting with one of them, Integra.

David Spencer thanked OHHS for working closely with the Council over the last several months on some issues that were brought to their attention around managed care organizations and some individual issues.

5. Update from DCYF (Chris Strnad): DCYF is providing an RFP for the bulk of its service array. It cannot comment on the RFP, but anyone interested can go to its website.

DCYF is now making the referrals for placement and home-based services that were formerly managed through the networks of care. This going well. It has been averaging about 40-50 requests for placement per week and about 30-40 home-based service referrals. Because this is a transition period, it will take a few months for the numbers to even out.

The question was raised as to whether DCYF can isolate which placement referrals are for child welfare issues as opposed to disability (including behavioral) issues. Chris responded that the bulk of them are child welfare or juvenile probation placements. Chris stated that, for every 40 requests for these services that come through, probably less than 1 is voluntary.

6. Update from BHDDH (Becky Boss): Becky described the Child Access Psychiatry Program, which is part of the State Integration Model Grant - creating a Child Access Psychiatry Program such as the one currently in Massachusetts. The model is to provide information to primary care physicians around children with a psychiatric presentation. A consultant was brought in to help do the mapping of child behavioral healthcare services – across department levels, across physical levels-making sure that the services that are provided are not duplicating efforts.

BHDDH finally received a purchase order for the management group that is going to oversee the CCBHC (Certified Community Behavioral Health Clinics) design. They will be working to understand the needs in the communities, helping the community behavioral health centers identify what their needs are, what their service needs are, what kind of services are needed.

The SBIRT proposal has been submitted. BHDDH will be applying for three new SAMHSA grants that focus on opiate use disorder and overdose. BHDDH has been working with the Leadership Council and Medicaid around the Opioid Treatment Provider Health Homes, which will be contracted for on July 1.

The Department took fair criticism at recent SAMHSA site visits for its ability to get input from consumers of behavioral healthcare. It was noted that the Governor's Council does not necessarily provide a place for consumer input – that consumers don't feel like they have input here. It is recommended that the Council take a look at what the function of the Council is with regard to consumers and then question whether or not it is doing enough to engage the active voice of the consumer in the Council and its business. Becky suggested that that as a discussion item for next month's topic.

David Spencer raised the question as to whether there are slots on the Council for consumer representatives. Richard Leclerc responded that, by State and Federal regulations, no more than 49% of the Council members can be service providers or state agency representatives, so a majority of the Council members are consumers, other community members or family members of consumers. The question is whether they are attending regularly. Have we designed a system whereby they can easily be replaced if not attending? Getting through these issues could easily take us a couple of hours so we open up the Sub-Committees to non-Council members. That's another opportunity for consumer participation.

It was requested that Jim look to see if there is a trend of the consumers on the Council not attending without reason. If so, the Council needs to address that.

7. Update on Block Grant Planning (Michelle Brophy): Michelle will report at the next meeting.

8. Old/New Business (Rich Leclerc): Rich noted that Council input into the SIM grant plan has to be contributed sometime within the next 30-45 days, otherwise the Plan is going to run out the door without our input.

The request for a change in the enabling legislation for this Council that was submitted to the Governor's Office has not moved on to the Legislature, so we will have to try to get it heard next year. The proposed changes consist mostly of updating requirements around membership which are out of date and have created compliance problems for the Council.

Joseph Le, a long-standing member of this Council, has resigned. He indicated that he did so for personal reasons. We will have one opening that we will need to fill. David Spencer recommended that we fill Joseph Le's position with a consumer if that is possible.

Please note that has been a change in one meeting date due to the November elections. we The November, 2016 meeting date has been moved to **Thursday, November 10, at 1:00 PM.**

David also noted that as of January 1, 2017, there was a cut in the Mental Health Incentives. It appears that this was unintentional. David made a Motion that this Council send a letter to the Secretary requesting that those funds of approximately \$5,000,000.00 (five million dollars) be reinstated to the Mental Health Centers. The Motion was seconded and carried with one abstention.

Adjourn - The meeting was adjourned by vote of the members.

Next Meeting: TUESDAY, MAY 10, 1:00 P.M.

Barry Hall

Conference Room 126

14 Harrington Road, Cranston, RI 02920

Statutory and Public members, please let Jim Dealy know if you cannot attend

This meeting is open to the public.

If you plan to attend and you require special accommodations to ensure equal participation, please contact Jim Dealy at the Division of Behavioral Healthcare Services at 462-0118.