Governor Raimondo's Task Force on Overdose Prevention and Intervention

June 12, 2019

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WELCOME & ANNOUNCEMENTS

Rhode Island's Naloxone Public Awareness Campaign

Rhode Island's Naloxone Public Awareness Campaign

YouTube

Drowning | Rhode Island Department of Health

Rhode Island's Naloxone Public Awareness Campaign

Rhode Island's Opioid Overdose Crisis and Co-Occurring Disorders

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WHAT ARE "CO-OCCURRING DISORDERS?"

- Aka "Dual Diagnosis" or "Comorbidity"
- Varied definitions
- Largely artificial
- Substance related disorder and another mental health disorder

DISORDERS THAT COMMONLY CO-OCCUR

- Anxiety disorders
- Mood disorders
- Psychotic disorders
- Certain personality disorders
- ADHD and impulse control disorders

ANXIETY DISORDERS

- Generalized anxiety disorder (GAD)
- Phobias
- Social anxiety disorder
- Post-Traumatic Stress Disorder (PTSD)
- Obsessive-Compulsive Disorder (OCD)

MOOD DISORDERS

- Depressive disorders
- Bipolar disorder
- Substance induced

PSYCHOTIC DISORDERS

- Schizophrenia
- Schizoaffective disorder
- Delusional disorder
- Severe depression
- Bipolar disorder

OTHERS

- Impulse control disorders
- Personality disorders
  - Borderline personality disorder
  - Antisocial personality disorder

SOME MENTAL HEALTH STATISTICS

from the National Alliance on Mental Illness (NAMI)

- 1 in 5 adults in U.S. (46.6 million) experiences mental illness in a given year. [1]
- 1 in 25 adults in the U.S. (11.2 million) experiences a serious mental illness in a given year.[2]
- 1 in 5 youth aged 13–18 experiences a severe mental disorder at some point during their life. [3]
- 1.1% of adults in the U.S. live with schizophrenia.[4]

MORE MENTAL HEALTH STATISTICS (NAMI)

- 2.6% of adults in the U.S. live with bipolar disorder.[5]
- 6.9% of adults in the U.S. (16 million) had at least one major depressive episode in the past year.[6]
- 18.1% of adults in the U.S. experienced an anxiety disorder (PTSD, OCD, GAD, etc.).[7]
- Among the 20.2 million adults in the U.S. who experienced a substance use disorder, 50.5%—10.2 million adults—had a co-occurring mental illness.[8]

HOW COMMON IS THE OVERLAP?

- "About half…" with mental illness have substance use disorder and vice versa (Substance Abuse Mental Health Services Administration)
- Depends somewhat on diagnostic standards and illness and substance
- Generally accepted = 50% adults and 60% adolescents

OVERLAP BY SOME SPECIFIC DISORDERS from NIDA

- Mood disorders – 22%
- Any anxiety disorder – 19%
- PTSD
  - Non-military = 22-43%
  - Military = up to 60% (when including binge drinking)
- Generalized Anxiety Disorder (GAD) – up to 50% (when binge drinking is included)
- Social Anxiety Disorder – 36%
- Schizophrenia – 47 – 59% (up to 90% use nicotine!)

HOW ABOUT THE OTHER WAY?

- People with Substance Use Disorders (SUDs) are at especially higher risk for:
  - Depressive disorders and bipolar disorder
  - Anxiety disorders and PTSD
  - Eating disorders
  - Schizophrenia
  - ADHD

THE OTHER WAY
(SUD Having Mental Health Disorders)

- 28% had an anxiety disorder
- 26% had a mood disorder
- 18% had antisocial personality disorder
- 7% had schizophrenia

WHY SO COMMON?

- Symptom control
- Symptoms of one can lead to another
- Inadequate treatment of medical illness
- Overlapping risk factors (genetics)
- Stigma of seeking psychiatric treatment

PROBLEMS WITH STATISTICS

- What came first?
- Diagnostic problems
- Billing and reimbursement
- Physician, institutional, culture biases
- Patient needs hierarchy

WHAT IT ALL MEANS FOR PEOPLE

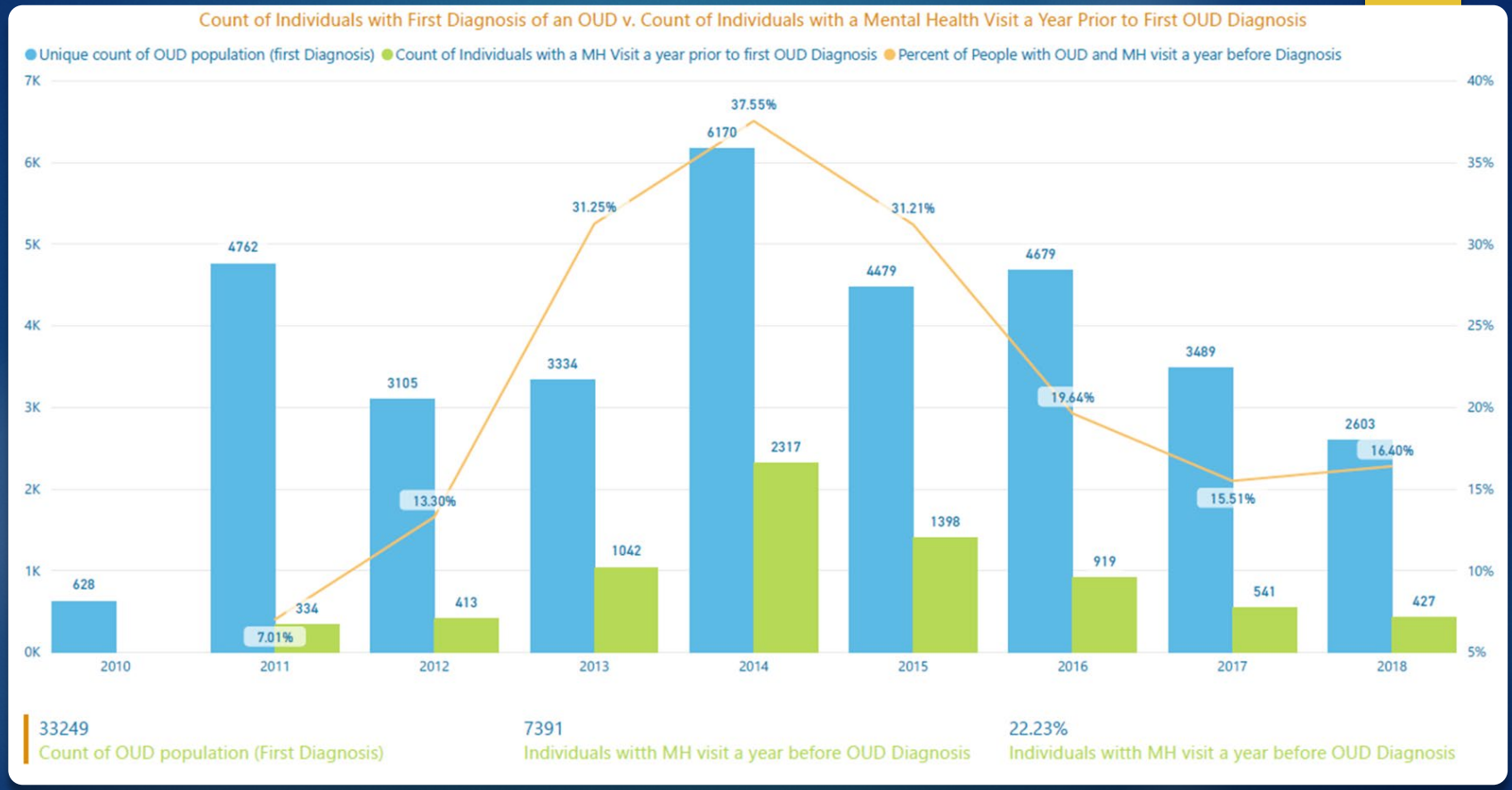
- 8.2 Million with co-occurring disorders (2016)
  - 48.1% received treatment for EITHER
  - So over 50% received treatment for NEITHER

- Guess how many received NEEDED (recommended) for both:

WHAT ABOUT OPIOIDS AND RHODE ISLAND?

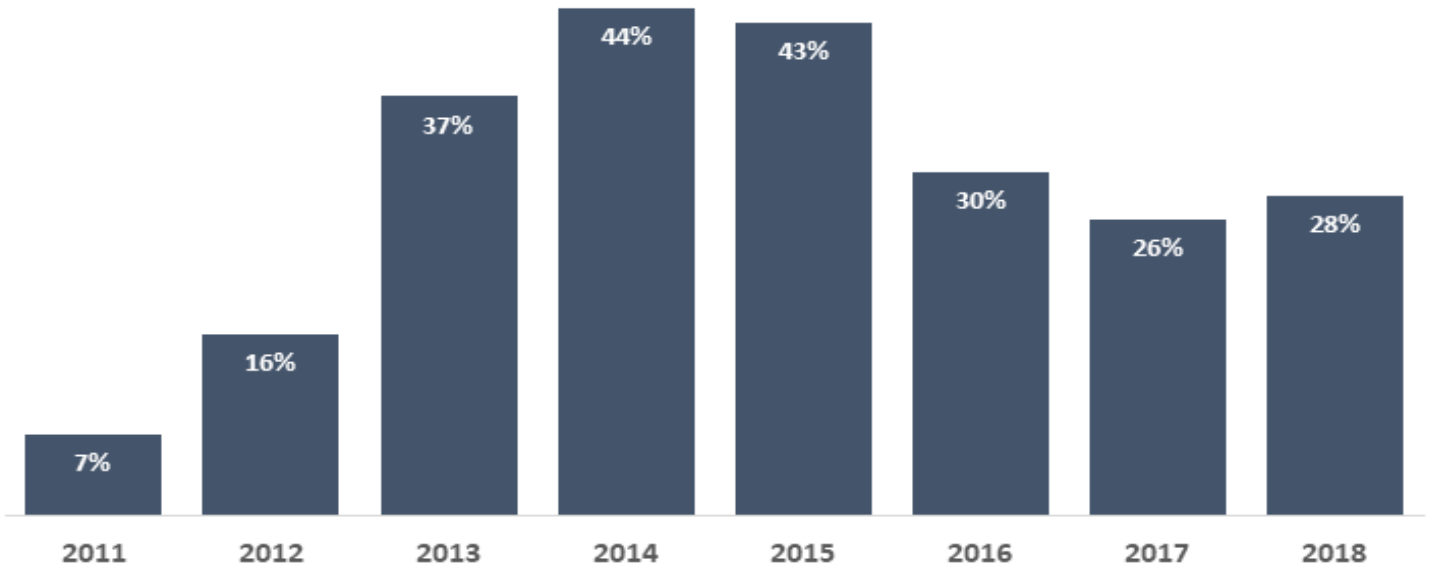
- **6.9%**

WHAT ABOUT OPIOIDS AND RHODE ISLAND?


Count of Individuals with First Diagnosis of an OUD v. Count of Individuals with a Mental Health Visit a Year Prior to First OUD Diagnosis
Unique count of OUD population (first Diagnosis)
Count of Individuals with a MH Visit a year prior to first OUD Diagnosis
Percent of People with OUD and MH visit a year before Diagnosis
7K
6K
5K
4K
3K
2K
1K
0K
40%
35%
30%
25%
20%
15%
10%
5%
628
4762
3105
3334
6170
4479
4679
3489
2603
334
413
1042
2317
1398
919
541
427
7.01%
13.30%
31.25%
37.55%
31.21%
19.64%
15.51%
16.40%
2010
2011
2012
2013
2014
2015
2016
2017
2018
33249
Count of OUD population (First Diagnosis)
7391
Individuals witth MH visit a year before OUD Diagnosis
22.23%
Individuals witth MH visit a year before OUD Diagnosis

Percent of People with a claim for Opioid Use Disorder (OUD) in given year who also had mental health treatment in the 12 months prior to the OUD claim

Data source: All Payer Claims Database



FUTURE CONCERNS

- Continued artificial separation – 6.9%!!
- Criminalization of mental illness
- Ageing population will increase demand
- Narrow focus will miss opportunities

KEY TAKE-HOME POINTS

- SUDs and Mental Health (MH) disorders commonly co-occur
- Each can lead to or cause symptoms of the other
- Most separation is artificial
- Separation can be damaging
- Treating more holistically is the key – 6.9%!!!!!!

QUESTIONS OR COMMENTS?

- Thank you!

Appendix A – Definitions

- NIH: Co-Occurring Disorders: Comorbidity describes two or more disorders or illnesses occurring in the same person. They can occur at the same time or one after the other. Comorbidity also implies interactions between the illnesses that can worsen the course of both.

- SAMHSA: Comorbidity describes two or more conditions appearing in a person. The conditions can occur at the same time or one right after the other.

Appendix B – Some wisdom from SAMHSA

- Substance use disorders and mental illnesses have many of the same risk factors. Additionally, having a mental illness may predispose someone to develop a substance use disorder and vice versa.
- Treatment for comorbid illnesses should focus on both mental illness and substance use disorders together, rather than one or the other.
- Effective behavioral treatments and medication exist to treat mental illnesses and addiction.
- Comorbid substance use disorder and mental illnesses are common, with about half of people who have one condition also having the other.

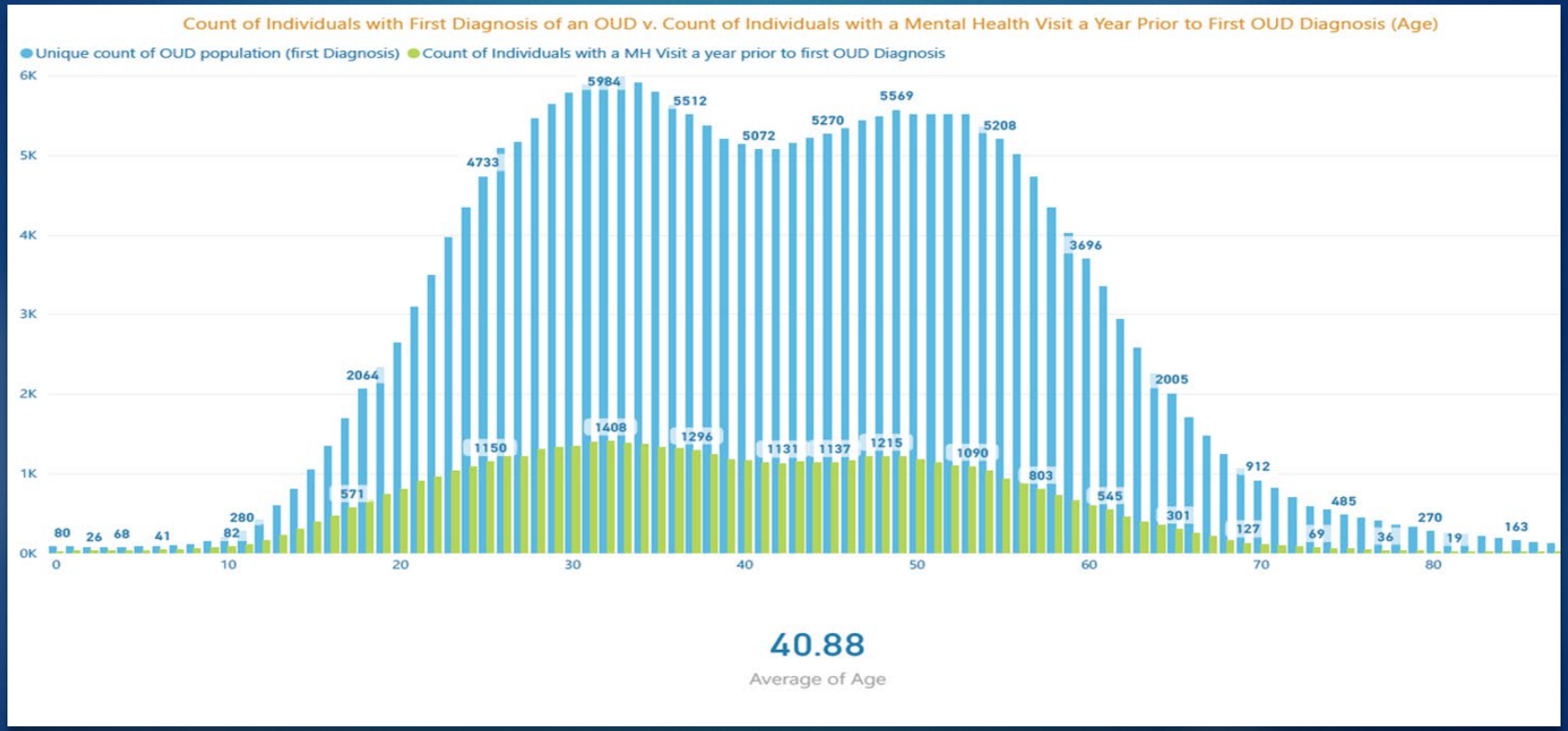
Appendix C – social statistics relating to mental illness (NAMI)

- An estimated 26% of homeless adults staying in shelters live with serious mental illness and an estimated 46% live with severe mental illness and/or substance use disorders.[9]
- Approximately 20% of state prisoners and 21% of local jail prisoners have “a recent history” of a mental health condition.[10]
- 70% of youth in juvenile justice systems have at least one mental health condition and at least 20% live with a serious mental illness.[11]
- Only 41% of adults in the U.S. with a mental health condition received mental health services in the past year. Among adults with a serious mental illness, 62.9% received mental health services in the past year.[8]
- Just over half (50.6%) of children with a mental health condition aged 8-15 received mental health services in the previous year.[12]
- African Americans and Hispanic Americans each use mental health services at about one-half the rate of Caucasian Americans and Asian Americans at about one-third the rate.[13]
- Half of all chronic mental illness begins by age 14; three-quarters by age 24. Despite effective treatment, there are long delays—sometimes decades—between the first appearance of symptoms and when people get help.[14]

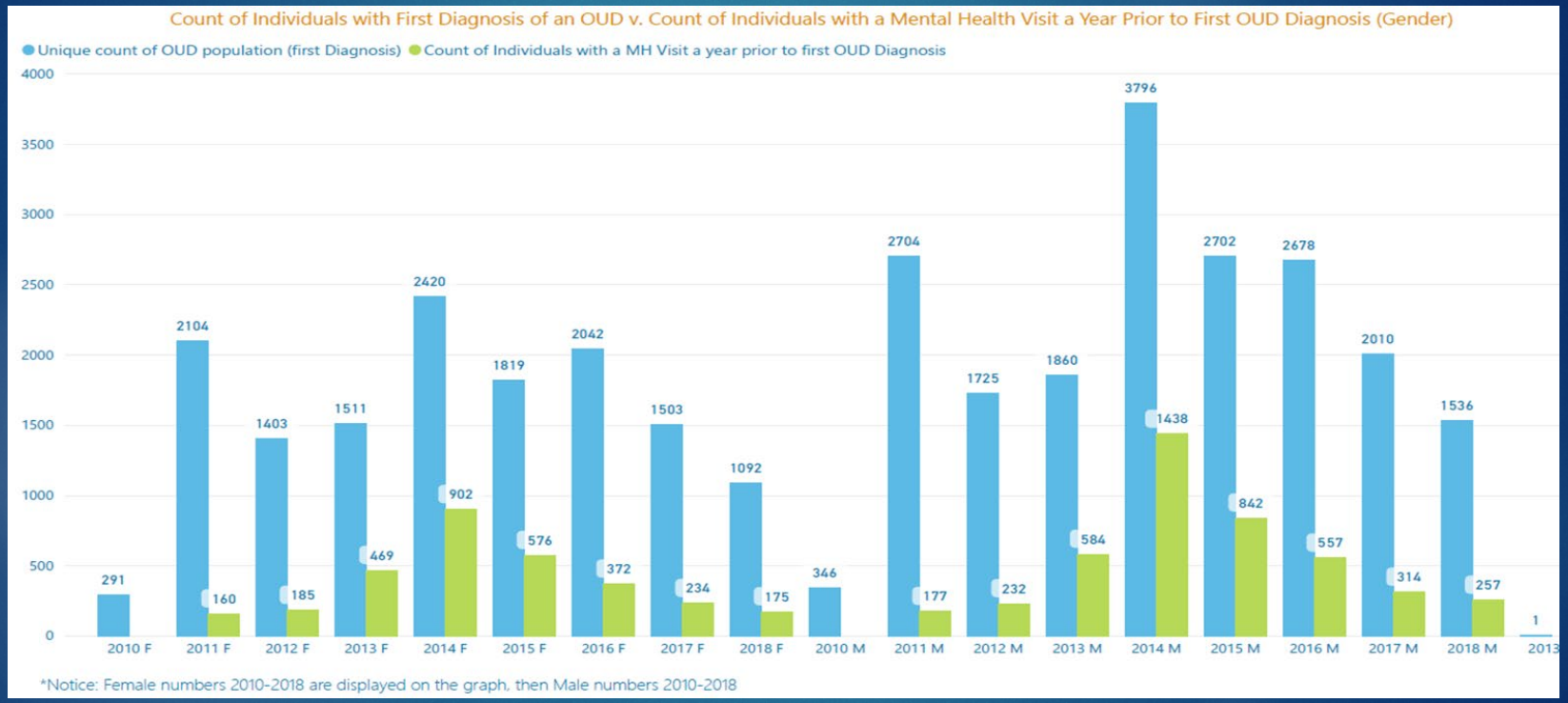
Appendix D – Consequences of lack of treatment of mental illness (NAMI)

- Serious mental illness costs America $193.2 billion in lost earnings per year.[15]
- Mood disorders, including major depression, dysthymic disorder and bipolar disorder, are the third most common cause of hospitalization in the U.S. for both youth and adults aged 18–44.[16]
- Individuals living with serious mental illness face an increased risk of having chronic medical conditions.[17] Adults in the U.S. living with serious mental illness die on average 25 years earlier than others, largely due to treatable medical conditions.[18]
- Over one-third (37%) of students with a mental health condition age 14–21 and older who are served by special education drop out—the highest dropout rate of any disability group.[19]
- Suicide is the 10th leading cause of death in the U.S., and the 2nd leading cause of death for people aged 10–34.[20]
- More than 90% of people who die by suicide show symptoms of a mental health condition.[21]
- Each day an estimated 18-22 veterans die by suicide.[22]

Appendix E – OUD, MH via other variables



Appendix E - Continued



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- Substance Abuse and Mental Health Services Administration. (2017). ***Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health.***
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Behavioral Health: Hospitalizations and Emergency Department Visits

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Governor Raimondo's Overdose Prevention and Intervention Task Force
June 12, 2019

Outline

- Brief Overview of Hospital Discharge Data

- Hospitalizations and Emergency Department (ED) Visits Related to Substance Use and Mental Illness
  - Trends 2016-2018
  - Counts
  - Selected Characteristics
  - Primary and Secondary+ Diagnoses

- Questions/Discussion

Acknowledgements

- Tracy Jackson, PhD
  Senior Public Health Epidemiologist, CHDA

- Kathy Taylor
  Hospital Discharge Data Manager, CHDA

Hospital Data: Overview

- Include all individuals, regardless of age or residency, admitted as inpatients or treated in an ED in an acute care or specialty hospital in Rhode Island.

- Based on administrative data; data are extracted from hospital billing systems.

- Contain encounter-level, clinical, and nonclinical information.

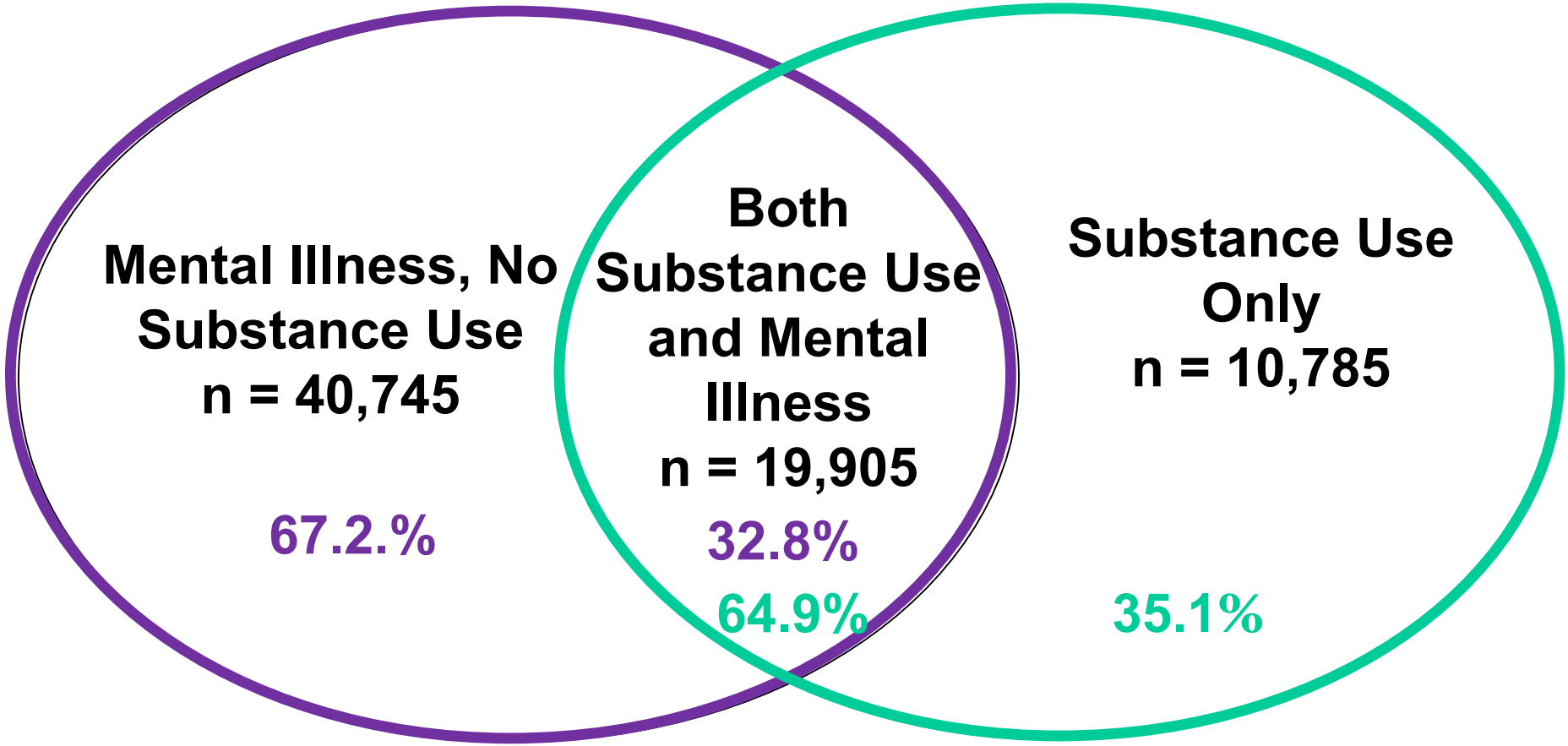
Hospital Data: Overview

- Include all-listed diagnoses and procedures, discharge status, patient demographics, and charges for all patients and payers.

- Coding change: International Classification of Diseases (ICD)-9 to ICD-10 (10/1/15).

Hospitalizations Related to Behavioral Health* Rhode Island, 2018

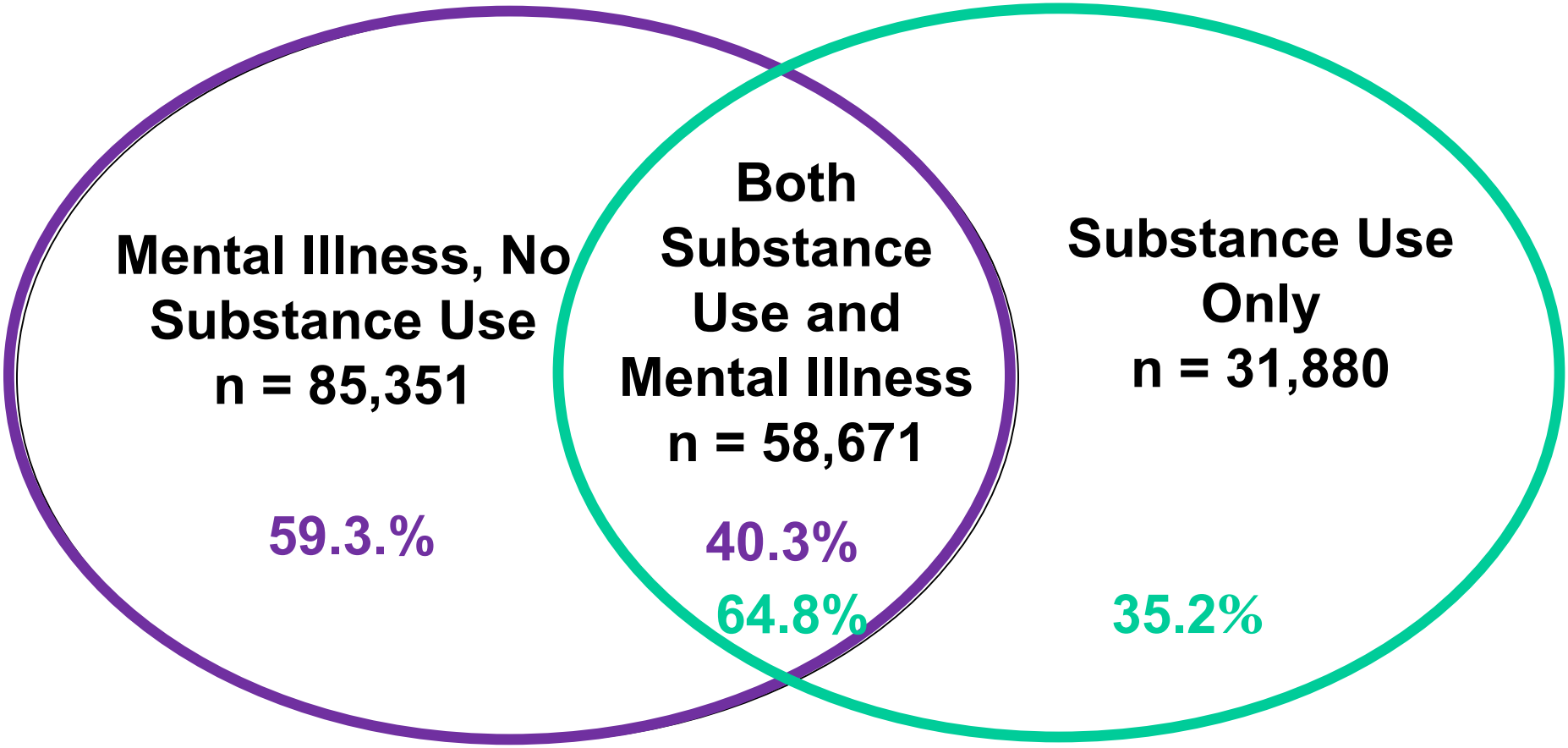
All Behavioral Health Hospitalizations = 71,435 (58.4%)



*Note: Hospitalizations among Rhode Island residents with any diagnostic code related to behavioral health.
Source: Hospital Discharge Data, CHDA, Rhode Island Department of Health

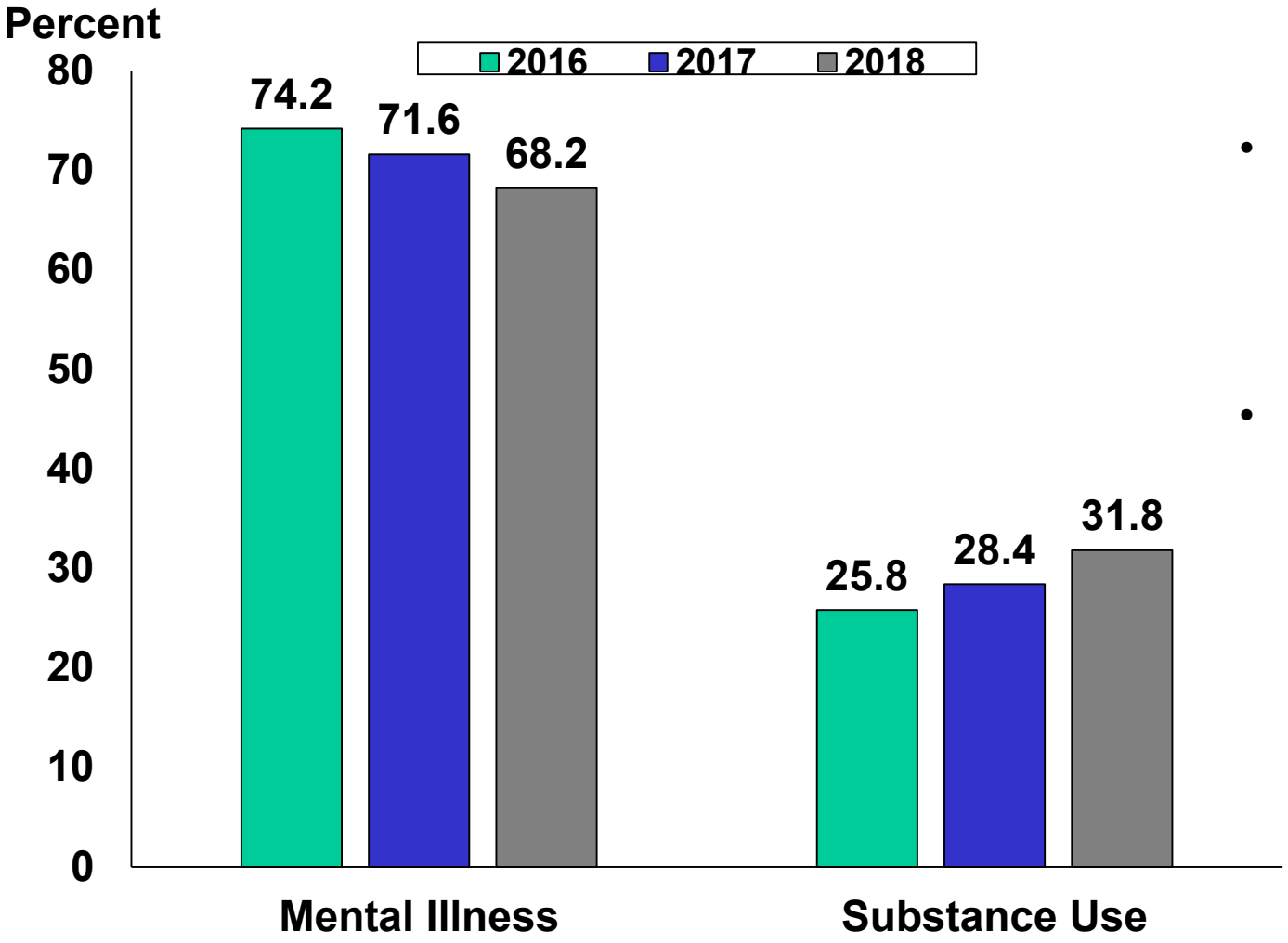
ED Visits Related to Behavioral Health* Rhode Island, 2018

All Behavioral Health ED Visits = 175,902 (39.2%)



*Note: ED visits among Rhode Island residents with any diagnostic code related to behavioral health.
Source: Hospital Discharge Data, CHDA, Rhode Island Department of Health

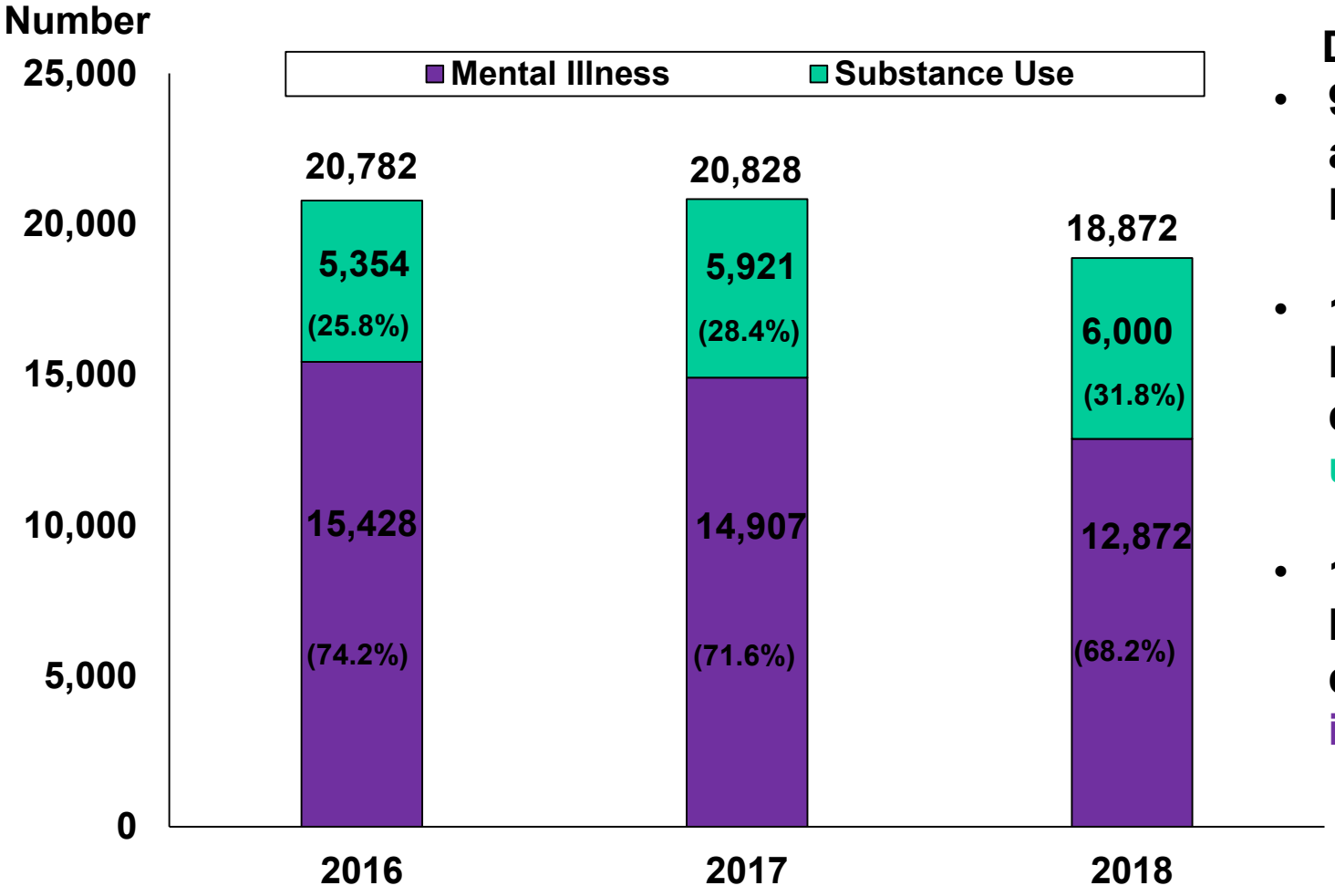
Hospitalizations with Behavioral Health As A Primary Diagnosis Rhode Island, 2016-2018



- **8.0% decrease in mental illness-related hospitalizations during 2016-2018.**
- **23% increase in proportion of BH hospitalizations due to substance use (2016-2018).**

**Note: Hospitalizations among Rhode Island residents with primary diagnostic code related to behavioral health.*
Source: Hospital Discharge Data, CHDA, Rhode Island Department of Health

Hospitalizations with Behavioral Health As A Primary Diagnosis Rhode Island, 2016-2018

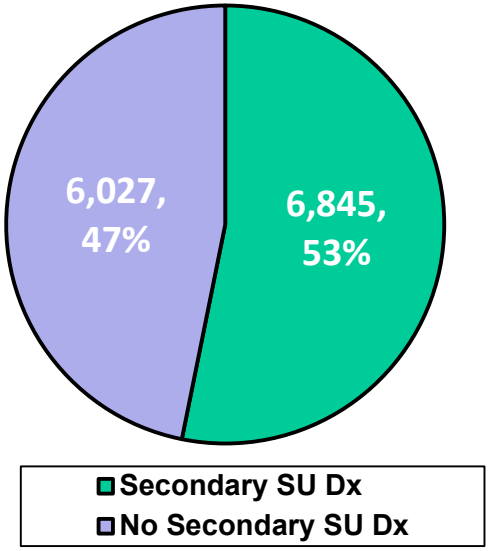


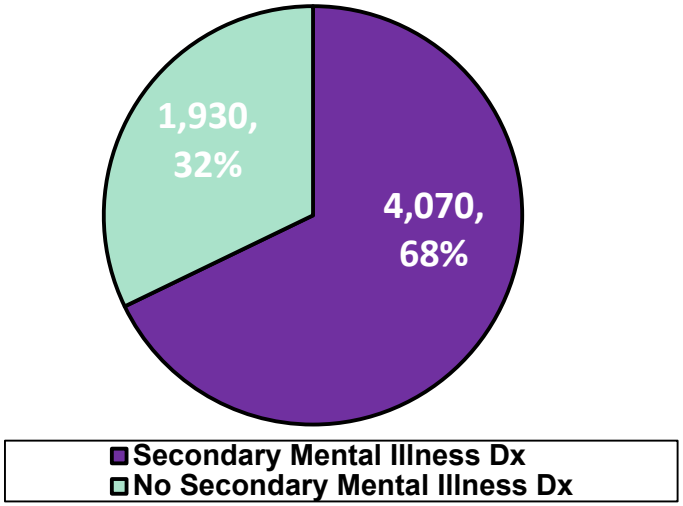
During 2016-2018:

- **9.2% decrease in all BH-related hospitalizations**
- **12% increase in hospitalizations due to substance use.**
- **16.6% decrease in hospitalizations due to mental illness.**

**Note: Hospitalizations among Rhode Island residents with primary diagnostic code related to behavioral health.*
Source: Hospital Discharge Data, CHDA, Rhode Island Department of Health

Secondary Diagnoses Among Behavioral Health Hospitalizations Rhode Island, 2018



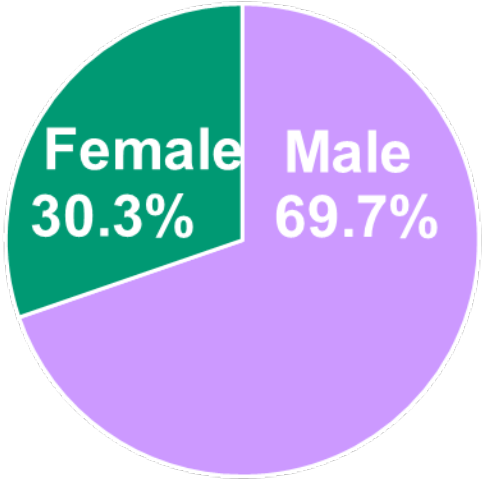


- More than half (53%) of hospitalizations with a primary diagnosis of mental illness had a secondary diagnosis of substance use.
- More than two-thirds (68%) of hospitalizations with a primary diagnosis of substance use had a secondary diagnosis of mental illness.

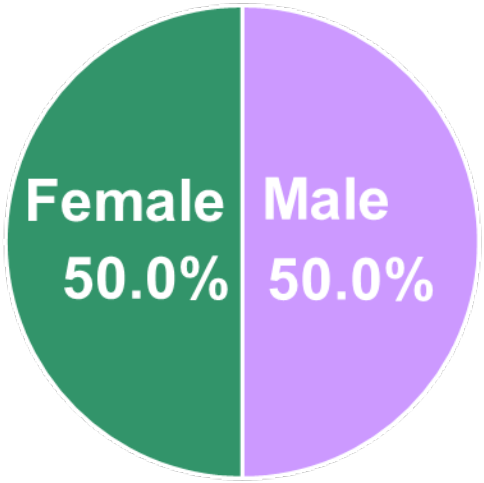
Characteristics of Behavioral Health Related Hospitalizations and ED Visits

Behavioral Health Hospitalizations and ED Visits by Gender Rhode Island, 2018

Hospitalizations*

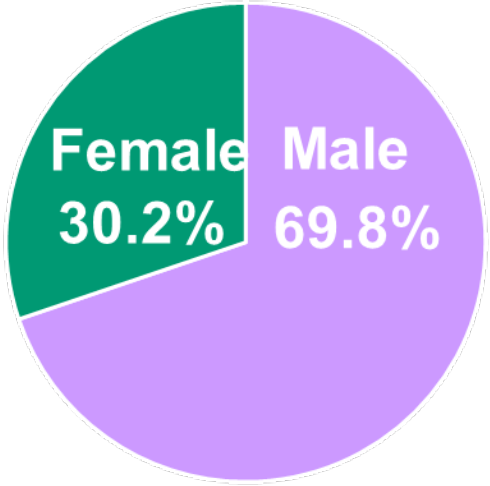


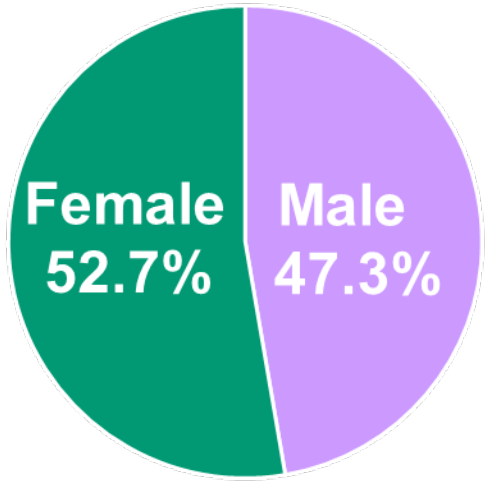
Substance Use



Mental Illness

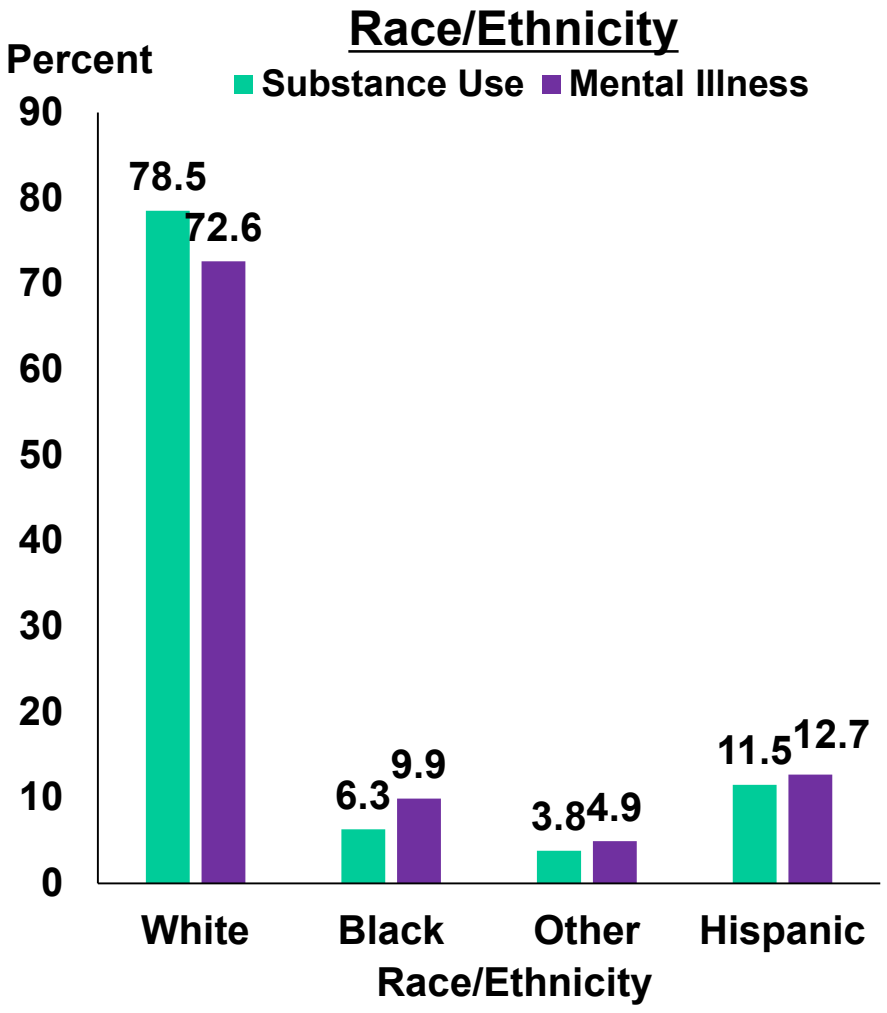
ED Visits*

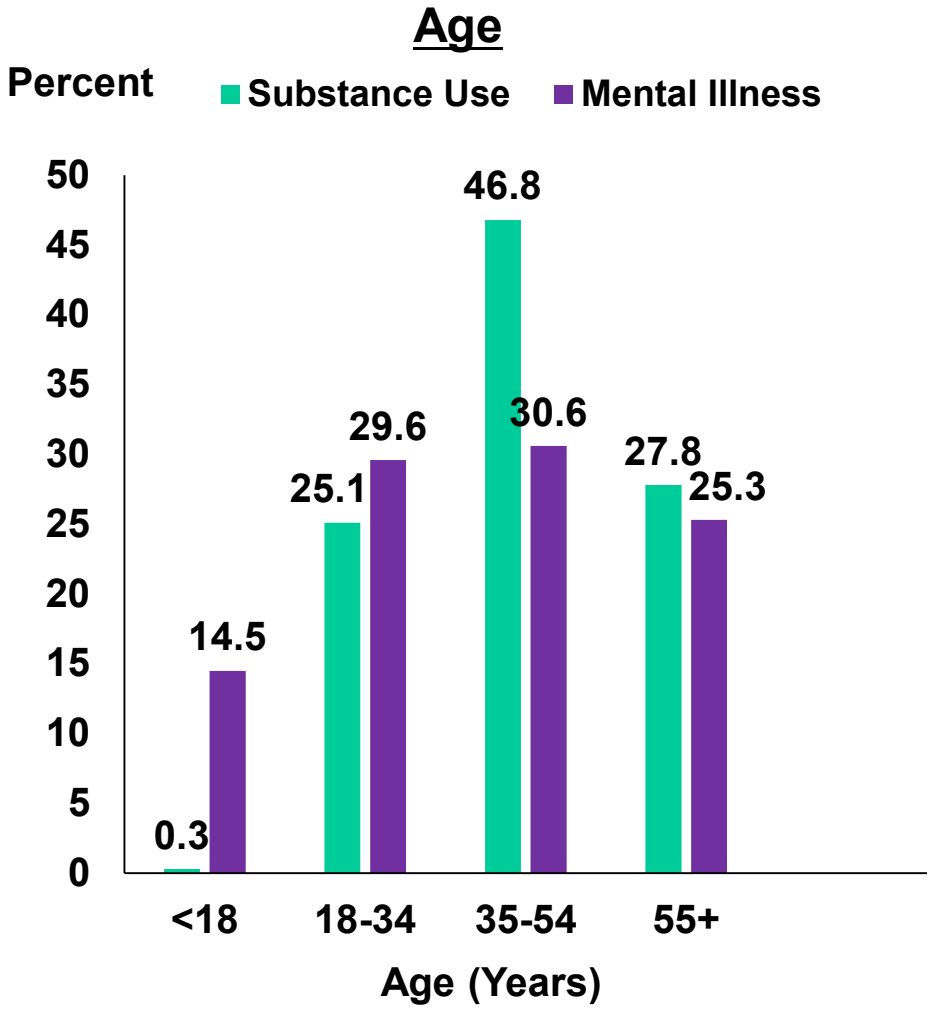




**Note: among Rhode Island residents with primary diagnostic code related to behavioral health.*
Source: Hospital Discharge Data, CHDA, Rhode Island Department of Health

Selected Characteristics of Behavioral Health Hospitalizations Rhode Island, 2018

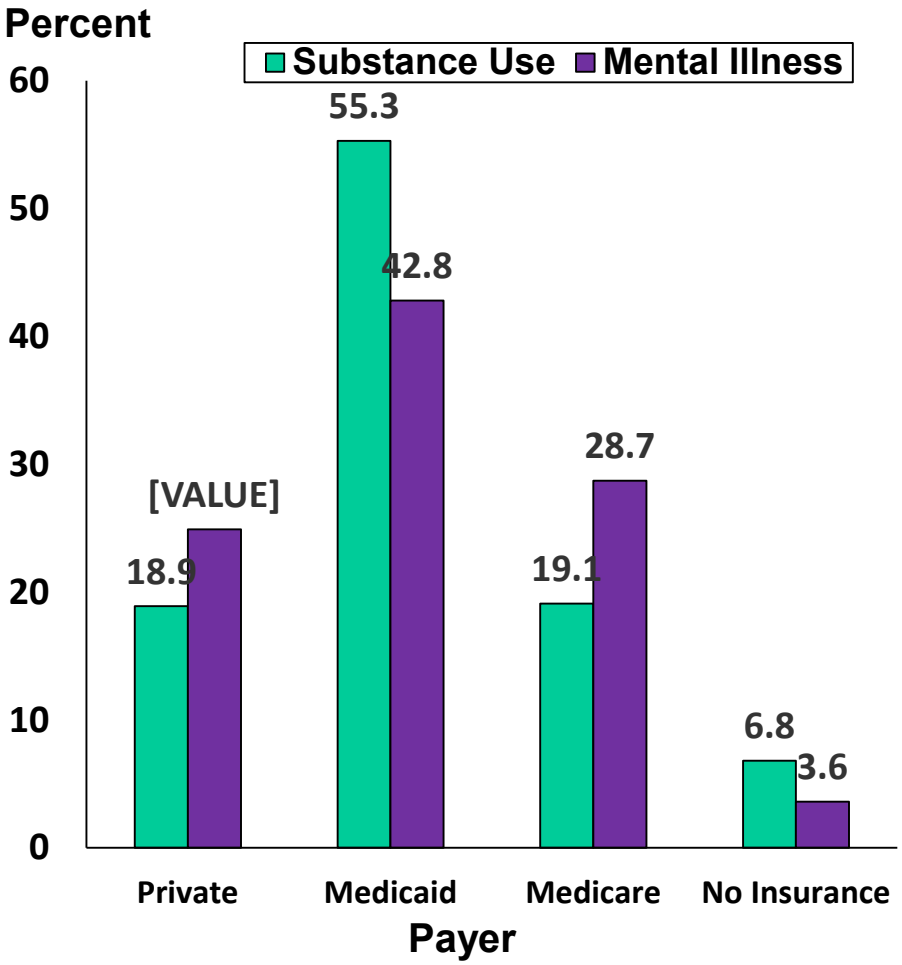




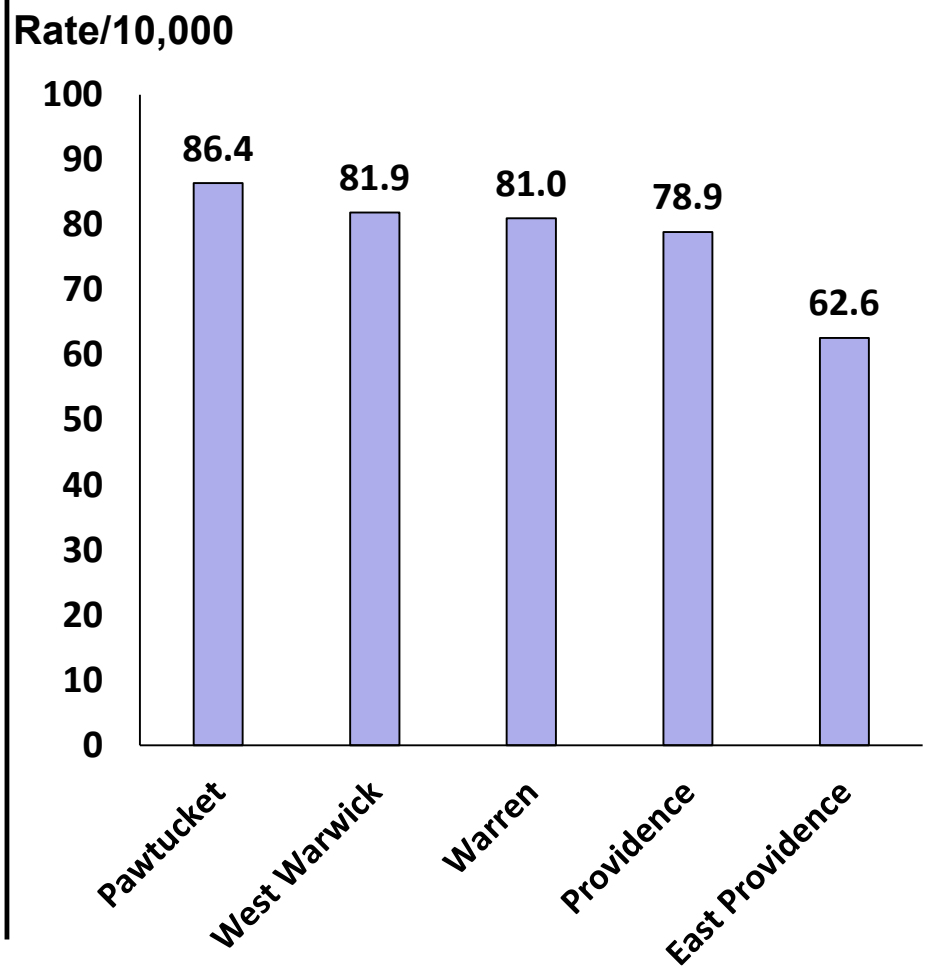
Note: Hospitalizations among Rhode Island residents with primary diagnostic code related to behavioral health
Source: Hospital Discharge Data, CHDA, Rhode Island Department of Health

Selected Characteristics of Behavioral Health Hospitalizations Rhode Island, 2018

Insurance Coverage

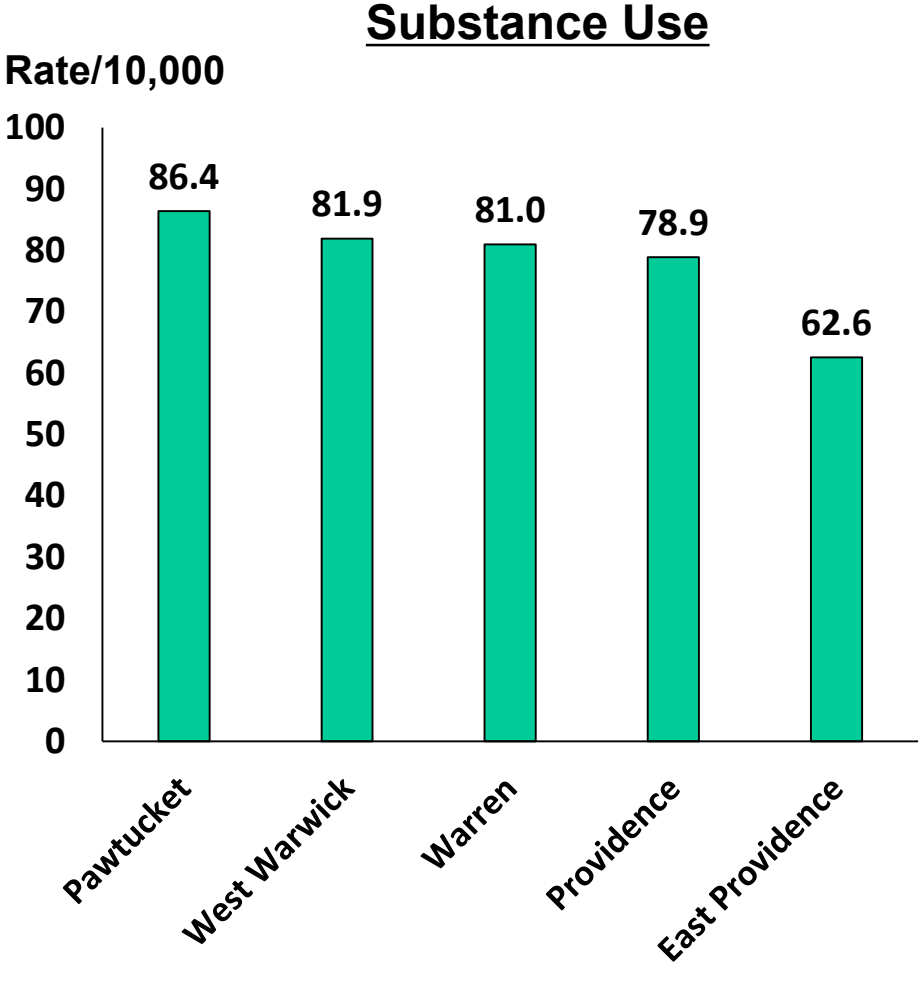


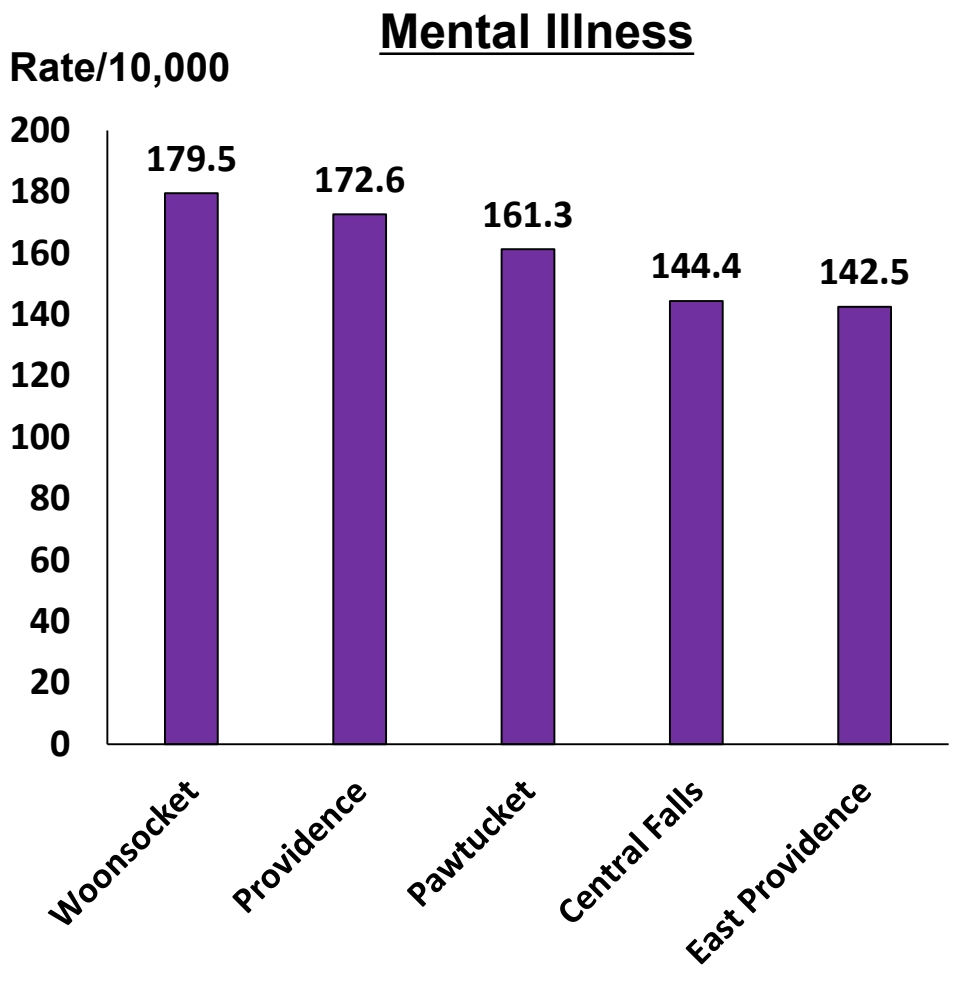
City/Town- Highest Rates



*Note: Hospitalizations among Rhode Island residents with primary diagnostic code related to behavioral health
Source: Hospital Discharge Data, CHDA, Rhode Island Department of Health

Substance Use and Other Behavioral Health Hospitalizations by Municipality Rhode Island, 2018





**Note: Hospitalizations among Rhode Island residents with primary diagnostic code related to behavioral health*
Source: Hospital Discharge Data, CHDA, Rhode Island Department of Health

Top Reasons for Substance Use and Other Behavioral Health Hospitalizations Rhode Island, 2018

Substance Use

- Alcohol-related disorders
- Opioid-related disorders
- Alcoholic liver disease
- Sedative, hypnotic, or anxiolytic related disorders
- Other psychoactive substance related disorders
- Poisoning by, adverse effect of and under-dosing of narcotics and hallucinogens
- Cocaine-related disorders
- Alcoholic gastritis
- Cannabis-related disorders

Mental Illness

- Major depressive disorders
- Bipolar disorder
- Schizoaffective disorders
- Schizophrenia
- Reaction to severe stress
- Alzheimer's disease
- Vascular dementia
- Unspecified psychosis
- Persistent mood disorders
- Anxiety disorders

**Notes: Hospitalizations among Rhode Island residents at all acute care and specialty hospitals; based on primary diagnosis.*

Most Common Secondary Diagnosis among Substance Use Hospitalizations Rhode Island, 2018

- Alcohol-related disorders
- Major depressive disorder, single episode
- Opioid-related disorders
- Cocaine-related disorders
- Nicotine dependence
- Major depressive disorder, recurrent
- Non-phobic anxiety disorders
- Purpura and other hemorrhagic conditions
- Sedative, hypnotic, or anxiolytic related disorders
- Essential (primary) hypertension
- Cannabis-related disorders

**Notes: Hospitalizations among Rhode Island residents among all acute care and specialty hospitals; secondary diagnosis among those with primary diagnosis of substance use.*
Source: Rhode Island Hospital Discharge Data, Rhode Island Department of Health

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STRENGTHENING BEHAVIORAL HEALTHCARE IN RHODE ISLAND

Governor's Overdose Prevention and Intervention Task Force

Ryan Erickson, Policy Advisor to Governor Gina M. Raimondo

June 12, 2019

Strengthening Behavioral Healthcare in Rhode Island
Governor Raimondo's Executive Order

In May 2018, Governor Raimondo signed Executive Order 18-03, which tasked several State agencies with improving behavioral healthcare in Rhode Island.

- The Executive Order directed actions in three core areas:
  - ***Enforcement of State Parity Requirements***
  - ***Statewide Plan for Behavioral Healthcare***
  - ***Statewide Conversation on Behavioral Health***
- The Executive Order resulted from Governor Raimondo's conversations with teachers across the state following the Parkland Shooting.
  - Teachers repeatedly stressed the need to more fully address students' mental health needs.

Strengthening Behavioral Healthcare in Rhode Island
Executive Order Actions: Parity

Key Actions to Enforce State Parity Laws

- The Rhode Island Office of Health Insurance Commissioner (OHIC) completed/will complete market conduct exams (MCEs) of Rhode Island's four commercial insurers.
  - The MCE with Blue Cross Blue Shield of Rhode Island resulted in substantial changes to its utilization review practices.
  - Blue Cross also committed to investing $5 million over five years to support behavioral health prevention.
  - MCEs with United Healthcare, Neighborhood Health Plan of Rhode Island, and Tufts Health Plan are ongoing and will be completed later in 2019.
- The Executive Office of Health and Human Services (EOHHS) has undertaken a concurrent parity review process with Medicaid—also to be completed in 2019.

Strengthening Behavioral Healthcare in Rhode Island
Executive Order Actions: Statewide Plan

Key Actions on Statewide Behavioral Health Plan

- From May-November 2018, the Governor's Office convened two internal, State working groups to assess the current behavioral health (BH) landscape in Rhode Island and pose opportunities for improving the behavioral healthcare system in the short- and long-term
  - One group focused on children and youth; the other on adults.
  - Agencies involved: EOHHS, BHDDH, DCYF, RIDOH, OHIC, RIDE, SIM, RIOVA, and DHS.

Governor Raimondo signs EO 18-03 at Thundermist Health Center in Woonsocket on May 4, 2018. (Photo courtesy of ABC6)

Strengthening Behavioral Healthcare in Rhode Island
Executive Order Actions: Statewide Plan

Key Actions on Statewide Behavioral Health Plan (continued)

- Beginning in September 2018, representatives from the Governor's Office began to share findings of the internal assessment with key stakeholders in the BH system.
  - Stakeholders involved: Service providers, experts in child/youth/adult behavioral health, insurers, advocates, medical services providers, and users of the BH system including people with lived-experience and their families.
  - Feedback from community partners was directly integrated into the review.
- A final report of the findings and suggested opportunities was delivered to Governor Raimondo on November 30, 2018.
  - Final report details are featured later in this presentation.

Strengthening Behavioral Healthcare in Rhode Island
Executive Order Actions: Statewide Conversation

Key Actions on Starting a "Statewide Conversation"

- Convened six "Let's Talk Mental Health" town halls in different areas of the state.
  - Featured stories of people with lived experience, providers, and advocates.
- Complemented many (15+) private sit-down meetings between State officials and people who access BH services.

Directors Yarn, Alexander-Scott, Jones, and Boss and Senior Advisor Coderre at a "Let's Talk Mental Health" event in September 2018. (Photo courtesy of EOHHS)

Strengthening Behavioral Healthcare in Rhode Island
State Working Groups on Behavioral Health

Challenges Identified by Statewide Planning Groups

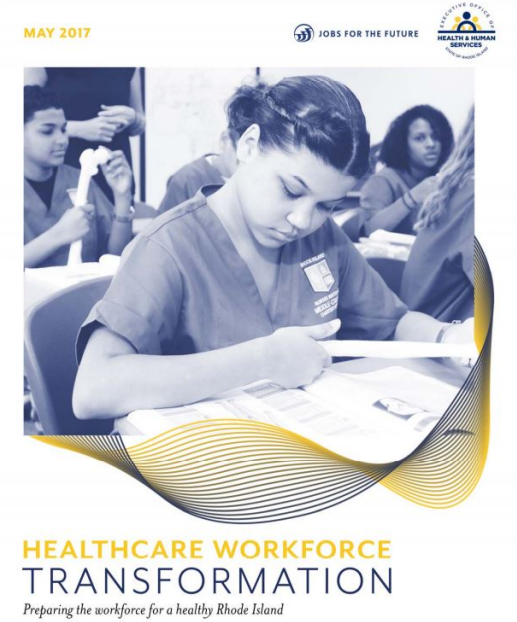
- Available services not always in sync with the needs of Rhode Island residents.
  - Among others: Few non-English-speaking clinicians, limited prevention programs, community-based services, and whole-family approaches.
- In-demand services are unavailable in some areas of the state:
  - Youth Substance Use Disorder (SUD) residential services, child psychiatry, specialists in eating disorders, brain injury treatment, specialists in dual-diagnosed populations, and others.
- Overreliance on Emergency Department (ED) and inpatient hospital care.
- Primary care is underutilized as a platform for BH care.
- Negative perceptions inhibit access to BH care.

Strengthening Behavioral Healthcare in Rhode Island
State Working Groups on Behavioral Health

Challenges Identified by Statewide Planning Groups (continued)

Medical billing challenges limit reimbursement frequency and potential for BH providers.

- Reimbursements may not be adequate for some needed services or populations.
- Compensation for BH workers are too low to attract and retain a stable BH workforce.
- Limited information on the positive outcomes of BH care prevents people from understanding the effectiveness of BH interventions.
- Fragmented authority inhibits functional BH planning.



EOHHS's 2017 report on Healthcare Workforce Transformation, which notes challenges in building the behavioral health workforce the state needs (Photo courtesy of EOHHS)

Strengthening Behavioral Healthcare in Rhode Island
State Activities Following the Executive Order

Continuing on Progress Built through the Executive Order

- BH "PULSE" Process
  - Umbrella structure for BH system improvements.
  - Four-part strategy to drive short-term and long-term improvements to the behavioral healthcare system.
  - PULSE is a performance management strategy the State employs to bring unity and strategic alignment in State systems by addressing challenges and goals.

Strengthening Behavioral Healthcare in Rhode Island
State Activities Following the Executive Order

Continuing on Progress Built through the Executive Order (continued)

- Four initial core PULSE areas:
  - Fiscal Stabilization of Behavioral Health Providers
  - Development of Community Alternatives for Key Populations
  - Statewide Conversation on Behavioral Health
  - Development of a Population Health Plan for Behavioral Health
- All have or will have formal channels for external stakeholder engagement.

Strengthening Behavioral Healthcare in Rhode Island
Behavioral Health PULSE and Plans for the Future

Fiscal Stabilization of Behavioral Health Providers

- Support to BH providers by Medicaid to ease cash flow challenges.
- Consider appropriate service, process, and rate changes (including rate review).
- Engage actively with CMHCs, OTPs, and residential services providers, and MCOs.

Statewide Conversation on Behavioral Health

- Continue “Let’s Talk Mental Health” events.
- Launch of BH-related public awareness/media campaigns across the state under one umbrella for consistent messaging with the goal of reducing negative perceptions.
- Plan new events and campaigns with feedback from community partners and people with lived experience.

Strengthening Behavioral Healthcare in Rhode Island
Behavioral Health PULSE and Plans for the Future

Development of Community Alternatives for Key Populations

- Focused on developing new or reconfiguring existing services to help key populations avoid hospitalization and rehospitalization
- Two key focus populations: children/youth with a BH crisis and less-restrictive settings for patients at Eleanor Slater Hospital

Development of a Population Health Plan for Behavioral Health

- Will set a small set of ambitious goals to drive transformative long-term change in the behavioral health system
- Focus is the whole system
- Will robustly engage external stakeholders

Thank you!

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PUBLIC COMMENT