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

OVERDOSE DOESN’T MEAN IT’S OVER
NALOXONE SAVES LIVES. GET IT AT ANY PHARMACY.
Rhode Island’s Naloxone Public Awareness Campaign
Rhode Island’s Naloxone Public Awareness Campaign

Rebecca Lerner shared a post.

Yes!!

Rhode Island Department of Health
Jun 5 at 2:17 PM

What if you could save a life? Would you?

If I were drowning

Rhode Island Department of Health
Jun 5 at 1:51 PM

An overdose can happen anywhere. Be prepared. Get naloxone at any pharmacy.

OVERDOSE DOESN’T MEAN IT’S OVER

PREVENTOVERDOSERI.ORG
Get Naloxone – Prevent Overdose RI
Naloxone (sometimes called Narcan®) is a medicine that...
Rhode Island’s Opioid Overdose Crisis and Co-Occurring Disorders

BRIAN DALY, MD
CHIEF MEDICAL OFFICER
Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals
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
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!)
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?
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.
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.
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.\textsuperscript{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.\textsuperscript{16}
- Individuals living with serious mental illness face an increased risk of having chronic medical conditions.\textsuperscript{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.\textsuperscript{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.\textsuperscript{19}
- Suicide is the 10\textsuperscript{th} leading cause of death in the U.S., and the 2\textsuperscript{nd} leading cause of death for people aged 10–34.\textsuperscript{20}
- More than 90\% of people who die by suicide show symptoms of a mental health condition.\textsuperscript{21}
- Each day an estimated 18-22 veterans die by suicide.\textsuperscript{22}
Appendix E – OUD, MH via other variables
References

- National Institute on Drug Abuse. (2018). *Why is there comorbidity between substance use disorders and mental illnesses*
- 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.*
References (continued)

- 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*.
References for NAMI Data


References for NAMI Data in Appendix D


Behavioral Health: Hospitalizations and Emergency Department Visits

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Chief, Center for Health Data and Analysis (CHDA)
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
• 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%)

- Mental Illness, No Substance Use: n = 40,745 (67.2%)
- Both Substance Use and Mental Illness: n = 19,905 (32.8%)
- Substance Use Only: n = 10,785 (35.1%)

*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%)

Mental Illness, No Substance Use  
n = 85,351  
59.3%

Substance Use Only  
n = 31,880  
35.2%

Both Substance Use and Mental Illness  
n = 58,671  
64.8%

*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
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.

Number

25,000

20,000

20,782

5,354

(25.8%)

20,828

5,921

(28.4%)

18,872

6,000

(31.8%)

2016

2017

2018

15,428

14,907

12,872

(74.2%)

(71.6%)

(68.2%)

Mental Illness

Substance Use

*Note: Hospitalizations among Rhode Island residents with primary diagnostic code related to behavioral health.
Source: Hospital Discharge Data, CHDA, Rhode Island Department of Health
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**
  - Female: 30.3%
  - Male: 69.7%

- **Mental Illness**
  - Female: 50.0%
  - Male: 50.0%

ED Visits*

- **Substance Use**
  - Female: 30.2%
  - Male: 69.8%

- **Mental Illness**
  - Female: 52.7%
  - Male: 47.3%

*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

*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
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.
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.
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.
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.
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)
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.
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)
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.
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.
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.
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!

Ryan Erickson

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