Alternate Visions of Rhode Island's Behavioral Health System		
"Their Vision"		**"Our Vision"**
Community-based CMHCs and Community Support Programs (Riverwood) are relics of the 1970's - 1980's deinstitutionalization movement and no longer relevant to new approaches to healthcare expansion.	**HISTORY**	Community mental health organizations (CMHCs and specialty providers like Riverwood) emerged out of the 1960's – 1970's civil rights and disability rights movement and are essential for the unfinished business of maximizing community-based care and clients' rights to the least restrictive care.
Consumers are best served by providing them advisory board and advocacy opportunities. The complex financing and organizational change issues require a high level of business and professional expertise on governing Boards. Consumers are ill/disabled and in need.	**CONSUMERS**	Clients and family members are key Board members and sometimes employees in community-based mental health organizations. Their "lived experience" is critical to the planning, design and delivery of effective local services. Consumers have strengths and resiliency; a compre-hensive, holistic plan can maximize quality of life and minimize health care utilization.
The Federally Qualified Community Health Center will be the primary point of care for the uninsured for both their primary care and their behavioral health care.	**CARE OF UNINSURED**	The current CMHOs have decades of experience providing acute and long term care for the most at-risk and most disabled. Our staff capacity makes us the logical point of care for mentally ill clients. Federal and state funding will recognize CMHCs as essential safety net providers. FQHCs do primary care; they are ill equipped to do acute and long term behavioral health care.
Colocation of primary and specialty care including mental health/substance abuse, with the expansion of health coverage, will enable large systems to meet all the needs of acute and long term clients. Integrating these office and hospital based services will achieve care coordination.	**COORDINATION OF CARE**	CMHOs already coordinate community care for high risk populations via numerous health and human services collaborations: Dept. of Corrections/Police Depts./Probation & Parole Dept. of Children, Youth & Families/Child serving organizations Dept. of Education/Public and private schools DBH/severely mentally ill Health Plans/MCOs/PCPs/Managed Medicaid clients

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Healthcare funding increases will lead to increasing the numbers of those that are insured; in turn this will lead to improved access and health outcomes for chronic diseases.	**MEDICAL MODEL OF CARE**	Funding increases for behavioral health and human services leads to improved access to social casework services. It is the psycho educational and psychosocial services we provide that build on client strengths and will result in better self-management of long term conditions.
Specialty healthcare, including mental health/substance abuse providers, drive up Medicaid and state costs because they are not sufficiently managed by HMOs/MCOs to incentivize less costly care.	**PUBLIC HEALTH COSTS**	CMHOs, by providing individualized home and community-based, scheduled and unscheduled services, have been successful in driving down institutional care costs. They are prime resources for the next generation of cost avoidance strategies.
Large, integrated health systems will become highly efficient because health plan reimbursements will incentivize them to reduce and prevent costly care (e.g., ERs and inpatient).	**EFFICIENCY**	CMHOs are highly efficient at reducing healthcare costs because of their leveraging of housing, jobs, peer support and their integrating of substance abuse, mental health and health promotion services.
The behavioral health system should be managed and directed by large national MCOs and Managed Medicaid HMOs (NHP) that will determine who the major providers should be. (State of RI is not competent to manage the system.)	**STEERING THE SYSTEM**	EOHHS and the Division of Behavioral Healthcare do not need to relinquish their roles. They know the licensed and accredited regional agencies that are credible providers for managed Medicaid/NHP. (The State can be a competent licensing and regulatory body; requires less focus on staffing and regulations and more focus on outcomes and cost containment.)
Any loss of local governance (e.g., nonprofit regional Board) and local accountability (e.g., local clinical management team/CEO) will have a minimal effect on how services are planned and delivered.	**LOCAL BOARDS**	Horizon Healthcare Partners believes strongly in the value of local Boards, local management teams, and regional/niche services. CMHO Boards gain value from donors, volunteers, local resources, and other agencies, when serving their clients.
The hospital, the health center, the PCPs can be incentivized to build local systems of care that divert from inpatient and Emergency Department utilization.	**LOCAL SYSTEMS OF CARE**	CMHOs represent local systems of care, coordinating with state and local public and nonprofit providers and health plans, to use all the community resources available (housing, employment, self-help, peer support.)

Opinion
Without Financial Support for CMHOs
Potential Results

- As in other states, a couple of violent acts by underserved adolescents or adults with behavioral health problems, will cause public outcry about the multiple years of declining state support. (But is the CMHO safety net still there?)

- Federally Qualified Health Centers, just as they are absorbing newly insured primary care patients, will become swamped by children and adults with moderate to severe mental health and/or substance abuse problems with virtually no capacity to serve them. (Will the CMHO safety net be there?)

- Substance abuse providers, swamped with opioid addicted clients, lack the MD and RN staff needed to serve "co-occurring clients without regard to their insurance coverage. (Is the CMHO safety net still there?)

- DCYF and its child welfare reform networks no longer have a stable CMHO to collaborate with to keep children out of inpatient and out of state care. (Can child serving agencies with limited experience with acute, community-based care recreate the CMHO?)

- The Department of Corrections reentry programs no longer have a network of strong partnering substance abuse and mental health agencies. (Are CMHOs still there to fill the void?)

- State and private nonprofit agencies begin to realize Lifespan and Care New England have no strong business interest in: homeless, underinsured, special need clients requiring home-based services. (Will the State of RI have to recreate the experience and capacity of CMHOs?)

- Like other states, police departments go from being the "off hours mental health provider" to dealing 24/7 with residents that cannot or will not engage in healthcare enrollment and office based care. (Without CMHOs, do our communities become less safe?)

- The net funding for direct services further decreases as HMOs/MCOs need to take administrative costs, reserves, and profits from their state funding. (Should out-of-state businesses and stock holders gain at the expense of RI CMHOs?)

- CMHOs are forced to reduce their workforce of supervised and credentialed caseworkers and service coordinators that work "in the field"; they are replaced by a smaller number of licensed practitioners that work primarily in the office. (Do high caseloads make home and community-based care less available?)