DELAWARE STATEWIDE BEHAVIORAL HEALTH NEEDS ASSESSMENT

JULY 2024

FOR: DELAWARE'S CCBHC CROSS AGENCY STEERING COMMITTEE

PREPARED BY: BOWLING BUSINESS STRATEGIES

TABLE OF CONTENTS

I. INTRODUCTION AND EXECUTIVE SUMMARY 3

Demographics and Service Area Description 4

II. DESCRIPTION OF DELAWARE'S BEHAVIORAL HEALTH SYSTEM 6

Elements of a high functioning system of care 7

III. DELAWARE'S BEHAVIORAL HEALTH PREVALANCE DATA 10

Prevalence rates in comparison to national trends 11
County-level highlights 17
Core Data Set, State required CCBHC Measures, and MCOs 20

IV. OTHER KEY STATEWIDE DATA 23

wellbeing, incarceration, graduation rates 23
Child & Family Wellbeing 24
School Settings 26
Staffing and Workforce 27

V. INPUT FROM THE STAKEHOLDER ADVISORY COMMITTEE AND PWLE 31

VI. SUMMARY OF FINDINGS - STRENGHTS, CHALLENGES, OBSERVATIONS AND OPPORTUNITIES 35

Strengths 35
Challenges 35
CCBHC Observations + Opportunities 36

VII. RECOMMENDATIONS AND NEXT STEPS 40

VIII. ADDENDUM FOLLOWING JUNE 21, 2024 CASC MEETING 42

VIII. APPENDICES 45

Appendix 1: Sources 45
Appendix 2: Additional Census Data 47
Appendix 3: Visual of current DE BH system 48
Appendix 4: DE Licensing and Performance Management of BH Services 50
Appendix 5: Number of Beneficiaries with SUD OR MH Conditions 51
Appendix 6: Provider Availability by County 2023 52
Appendix 7: sampling of core data set measures 55
Appendix 8: MCO Scorecard on behavioral health 60
Appendix 9: four-year graduation rates by student group class of 2022 61
Appendix 10: Projected national BH staff shortages 62
Appendix 11: behavioral health workforce shortages 63

I. INTRODUCTION AND EXECUTIVE SUMMARY

Bowling Business Strategies (BBS) developed this statewide behavioral health needs assessment for Delaware's Division of Substance Abuse and Mental Health (DSAMH), Division of Prevention and Behavioral Health Services (DPBHS), and Division of Medicaid and Medical Assistance (DMMA) to help inform implementation of the Certified Community Behavioral Health Clinic (CCBHC) model. BBS produced this report based largely on publicly available data, including: US Census, Model-Based Estimated Prevalence for States, America's Health Rankings, Mental Health America, ChildTrends, KFF, Health Plans NCQA, and Medicaid. See ***Appendix 1: Sources*** for full list of sources used for this report, as well as specific footnotes listed throughout.

This needs assessment intends to provide a statewide needs assessment to be used in furthering the design and implementation of the Delaware CCBHC model and that can also be used to support a county and provider level needs assessments. Delaware has produced several needs assessments that are primarily focused on one population or diagnostic category and do not look at the population as a whole or the system as a comprehensive provider of services; this needs assessment seeks to fill that gap. Furthermore, in order to meet CCBHC criteria, a CCBHC must complete a community needs assessment at least every three years. States can do their own needs assessment to complement the CCBHC's and to make sure they have a strong understanding of the state-wide needs in comparison to a specific community. Given the design of the current system, the proposed CCBHCs were challenged to consider their own community needs assessment and it was determined that a state-wide needs assessment would provide them with a solid foundation to start.

Section I of this needs assessment begins with general demographic information about Delaware and service-area information, followed by a description of Delaware's behavioral health system (*Section II*), which includes elements of a high functioning system of care. Ultimately, any system design should be supported if it is producing the desired outcomes. This needs assessment proposes to help Delaware decide if their current system does just that and, if not, what adjustments are needed. All systems have gaps, and this opportunity will allow Delaware to establish a vision to ensure the most successful outcomes possible are achieved.

Sections III, IV, and V focus on the data. *Section III*, specifically, focuses on Delaware's behavioral health prevalence compared to national trends for children, youth, families, and individuals as well as findings from Delaware's three counties – New Castle, Kent and Sussex. While *Section IV* looks at other key statewide data that relate to behavioral health measures, and *Section V* focuses on the input received by people with lived experience and specifically members of the CCBHC Demonstration Grant's Stakeholder Advisory Committee (SAG).

Section VI summarizes the findings with specific callouts to strengths, challenges, observations and opportunities within the CCBHC model. Finally, *Section VII* states BBS recommendations and next steps following these findings. *Section VIII* is a comprehensive appendix, with appendices referenced throughout the report.

Across all the data, some themes have emerged: Substance Use Disorder (SUD)-related measures have been improving for adults, while mental health measures for adults are not as strong. Among children and youth, data showed higher rates for children in several mental health categories, including Severe Depression, Suicidal Ideation, PTSD, Trauma, and Psychosis, as well as higher adolescent drug use than the national average.

There are a few notable gaps in this report: an update to the University of Delaware report on SUD prevalence in Delaware is in process and has not yet been released as of this publishing date; Delaware providers have not contributed provider-level data in this report, potential CCBHC providers will need to develop their own needs assessment during the CCBHC planning phase; and the SUD Needs Assessment for youth has been delayed is not included in this report.

DEMOGRAPHICS AND SERVICE AREA DESCRIPTION

This state-level needs assessment takes into account each of the three counties – New Castle, Kent and Sussex and to the degree there was county level data available. For the purpose of this needs assessment each county is considered a service area. Given the design of the Delaware system, there are no county level catchment areas: providers are located in areas where either they or the state have identified a need and provide services specific to that need. Providers are funded for a specific service or set of services but not necessarily for a comprehensive array of services as sometimes other states require through statutory or regulatory expectations, nor at this point, to provide the CCBHC nine required services within individual providers.

Please see *Appendix 2: Additional Census Data* for addition census information.

Overall population size	Delaware has 1,031,890 total residents, with 575,494 in New Castle County, 255,956 in Sussex County, and 186,946 in Kent County. All three counties in Delaware are considered a Medically Underserved Area (MUA).[1]
Race/ethnicity	Delaware's population is predominantly White (68%), followed by 23.8% Black/African American, 4.4% Asian, 0.7% American Indian and Alaska Native, 4.9% other race, and 3.0% two or more races. 10.3% reported Hispanic/Latino origin.
LGBTQ+	Delaware has a significant LGBTQ+ population, with 7.5% of adults identifying as LGBT. This is significantly higher than the national average of 5.5%.[2]
Language	13.9% of Delaware residents speak languages other than English at home, with the most common languages being Spanish, Chinese, and Haitian-Creole.
Age	5.3% are 0-5; 20.4% are 6-17; 53.5% 18-64 and 20.8% 65 and older.

[1] HRSA
[2] UCLA School of Law, Williams Institute. (2023). Adult LGBT Population in the United States.

Socioeconomic status	The median household income is $79,325, the per capita income is $42,180 and the poverty rate is 9.4%.
Without health insurance	6.9% of the population doesn't have health insurance.
Medicaid enrollment	In Jan 2024, a total of 285,691 individuals in Delaware were enrolled in Medicaid, with 227,140 enrolled in a managed care organization (MCO); 16,080 in an MCO-plus; 42,471 in fee-for-service; and 43,449 disenrolled due of unwinding[3]
Chronic conditions	Delaware ranks 28th as 11.4% of adults have had three or more of the following chronic health conditions: arthritis, asthma, chronic kidney disease, chronic obstructive pulmonary disease, cardiovascular disease (heart disease, heart attack or stroke), cancer (excluding non-melanoma skin cancer), depression or diabetes[4]

[3] Total Medicaid Enrollment by Month | Delaware Open Data Portal
[4] America's Health Rankings

II. DESCRIPTION OF DELAWARE'S BEHAVIORAL HEALTH SYSTEM

Delaware's system is multi-layered, with separate cabinet level positions for adult and child/youth services and their provisions, with a limited coordinated approach to family systems when the adults and children both have behavioral health needs. Please see *Appendix 3: Visual of current DE BH system*.

Additionally, Delaware's statutory structure does not reference a community mental health center (CMHC) system design to support the provision of mental health and substance use disorder services to a broad population (statute linked here). Typically, states use confirming statutory authority or department level policy that lays out a system of care design that has more readily lends itself to the CCBHC design as a natural next iteration of the system. In Delaware however, because the statutory authority does not support a provider network, DSAMH and DPBHS RFP all behavioral health services. This is a burdensome step to get funding to providers and ultimately services to people in need.

This approach - of multiple contractors providing an aspect of care, the use of independent behavioral health clinicians, and many grassroot organizations providing services - can be viewed as both a strength and a challenge. In theory, this allows for freedom of choice and the oversight entities can make decisions about whether to use providers or not based on their individual strengths. However, there are challenges: a lower amount of continuity of care, providers' inability to build ecosystem of care to address a need, providers limited resources to build necessary infrastructure to support quality and outcomes, and patients more likely to disengage in services due to increased transitions and hand offs that are required.

Delaware operates a system for community-based MH and SUD where more often, SUD and MH services are provided by different providers, and adults are in a different service system from children and youth. Adults who are Medicaid insured may receive care from providers who have DSAMH contracts or may receive service through MCO referrals, to those same or different providers depending on need. Many of the uninsured and underinsured receive service provided by DSAMH's contracted providers as well as paid for by DSAMH. DSAMH uses state and grant funding to support the uninsured and underinsured while DMMA funds Medicaid beneficiaries primarily through the MCOs. Children and youth are covered by service systems operated by DPBHS, either directly or through contracted providers and the MCOs for behavioral health therapy. DSAMH collaborates with DPBHS in the planning and implementation of behavioral health services, for prevention and transition age youth.

As previously stated, Delaware does not have a CMHC system design, where a continuum of required services and responsibilities radiate from. The state system is reliant on individual therapist and independent provider organizations that provide a piece of what is considered a full continuum of necessary services (and as defined by the CCBHC nine required services). Funding for services includes a combination of federal grants (including the Substance Abuse Prevention & Treatment and Community Mental Health Services Block Grants), state funding and Medicaid funds. In addition, Delaware currently has two behavioral health crisis systems serving children and youth, and adults.

These two systems provide statewide coverage across the lifespan and meet SAMHSA's requirements for responding within certain time frames. They do not fully meet federal requirements related to text and chat call center features; and the child and youth crisis system does not include walk-in/urgent care crisis stabilization or transportation services. The state is working to combine call center functions to serve the lifespan, including meeting requirements as part of the federal 988 Suicide & Crisis Lifeline but it is anticipated that crisis response services will remain separate. See *Appendix 4: DE Licensing and Performance Management of BH Services* for more information.

ELEMENTS OF A HIGH FUNCTIONING SYSTEM OF CARE

The elements present in a high functioning system of care should exist regardless of the design model or structure being used. Research highlights the key elements necessary to engage the most people seeking care, provide the most appropriate services that result in positive outcomes and to address the overall needs of the state. The table below summarizes the key elements that should be present in the state's system of care, with some variation among states to fit each state's unique system of care design.

*The table below highlights the key elements of a high functioning system of care with bulleted **examples** of how that element is operationalized. The actual functionality of each element will be dependent on the system design and the priorities of the state and from the community needs assessment.*

TIMELY AND EASY (LOW-BARRIER) ACCESS TO CARE
• Easy access through a defined provider system with either a no wrong-door, or centralized intake process. • Most common treatment and support options available either in a single setting or coordinated by that setting. • Assessments support triage of people to the most appropriate level of care prior to crisis driving that decision. • Same day access for emergent services including MOUD, and crisis stabilization • Standards for access to care, including for intake, time to first appointment and follow-up • Adjust access processes for vulnerable or hard to reach populations (pregnant/postpartum women, elderly, I/DD, transition age youth)
COMPREHENSIVE ASSESSMENT AND INDIVIDUALIZED CARE PLAN
• Develop assessment protocols that incorporate strengths and assess various aspects of an individual's life • Use standardized assessment tools that consider SDOH • Incorporate individual's priorities and voice in treatment and care plan • Develop measurable and achievable goals • Identify lead care manager to ensure plan includes all treatment options

COMMUNITY-BASED AND PREFERENCE FOR LOWER LEVELS OF CARE
• Reduce reliance on residential and inpatient care by building more robust community-based options • Use of effective tools to determine level of care and treatment needs • Use of a Medication First approach, wrap around, and person's strengths to provide care in the community • Consider natural supports as part of care plan • Develop proactive crisis plan to mitigate use of higher levels of care
EFFECTIVE TREATMENT
• Use evidence-based practices (EBP) that are monitored for fidelity, quality and outcomes • Ensure providers are trained in EPBs and use supervision to adhere to fidelity • Improve crisis response and suicide/overdose prevention. • Improve the availability and quality of peer-support services • Expand access to digital and telehealth service • Build capacity for prevention and early intervention • Use measurement-based care to gauge individual and system success • Trauma informed and resiliency building (add more hear not just catch phrase)
INTEGRATION OF BEHAVIORAL HEALTH, WITH PHYSICAL HEALTH, AND OTHER COMMUNITY AND SOCIAL SERVICES
• Promote building integrated physical health, mental health, and substance use services • Create systems to address holistic care • Implement care coordination to ensure the various providers involved in a person's life work collaboratively and not at cross-purposes including with SDOH, criminal justice, child welfare, health care, vocational rehab, education and employment, etc.
CARE TRANSITION SUPPORT AND PATHWAYS
• Build strong continuums of care to ensure maintenance of engagement as people navigate the system • Ensure access to peers, care coordination and community health workers are available to support care transitions • Develop discharge planning protocols to ensure warm handoffs • Develop pathways to connect with transition age youth
EQUITY
• Identify and address inequitable conditions for people with mental health and substance use conditions within the system • Build cultural competency training and expectations into the system

- Focus services based on preference – being person centered/driven and strength based
- Be aware of and where able to address, the social/political constructs and historical systemic injustices, such as racism and discriminatory structures and policies, that disproportionately impact the mental health of people of color

WORKFORCE ADEQUACY

- Expand scholarships and loan repayment programs to stimulate workforce growth
- Support ways to increase the number and diversity of mental health and substance use disorder workforce including people with lived experiences.
- Cross-train the workforce on co-occurring approaches
- Work with universities and colleges to influence curriculums to meet the state needs
- Establish policies and practices that encourage community-based providers to recruit, hire and train graduate level professionals

SUSTAINABILITY

- Reimburse evidence-based behavioral health treatments at their true cost
- Use a learning collaborative model to advance ways to address key needs
- Use finance tools (alternative payment models, deliverable based contracts, incentives)
- Fund infrastructure needs to ensure providers have the necessary tools to be high functioning

ACCOUNTABILITY

- Include patient-important outcomes in treatment planning and assessments of care quality
- Establish system, provider and population level measures
- Hold providers accountable to evidence-based standards of care that improve outcomes and quality of life.
- Use the data to understand what is impactful, improving or not improving including the use of a CQI process
- Achieve optimal outcomes through prevention, early identification and intervention, with a targeted focus on children, youth, and families

COVERAGE

- Strengthen mental health parity regulation and enforcement of equivalent coverage for mental health and substance use disorders
- Finance and implement early interventions for serious mental illness
- Maximized the use of Medicaid and Early, Periodic Screening, Diagnosis and Treatment (EPSDT)
- Use of Medicaid including use of waivers, alternative payment methods, and blending of funding and maximization

III. DELAWARE'S BEHAVIORAL HEALTH PREVALANCE DATA

This section documents the prevalence of different mental health or substance use conditions among adults and, where possible, separately for children and youth. This describes what is estimated to be present based on various data sources and reports. Specific challenges and strengths within the data are called out in each category. Looking at various data points and reports provides some insight into Delaware's strengths and challenges, but everyday experience of the state's leadership and providers should also be considered in the context of where to focus resources. The Mental Health American report used for several of the data points reflect positive numbers for Delaware overall and factors such as the number of people responding to questionnaires, prevalence calculations based on screening and access to care can impact data in either direction.

Of note among adults, Delaware has a much higher overdose rate than the national average although measures have been trending positive in substance use disorders (SUD) measures the last few years. Delaware's mental health measures, however, are not as strong as the SUD measures, which is understandable given the resources attributed to SUD the last several years.

Among children and youth, Delaware has a higher rate of children in all mental health categories, including Severe Depression, Suicidal Ideation, PTSD, Trauma, and Psychosis; as well as higher adolescent drug use than the national average.

As part of the unique structure for providing behavioral health services to children and youth, Medicaid oversees and reimburses the first 30 outpatient visits a child or youth has each plan year. DPBHS will then manage/reimburse for any outpatient visits over 30 visits in the same plan year or if a child requires specialty mental health services.

What is seen throughout the data, when it is viewed as not just a single data point but rather a grouping of data that tells a story, is a continuing increase in the number of people with an SUD or MH condition or both. This could be due to growing need and/or better identification. This chart from DSAMH's Mobile Crisis Intervention Services (MCIS) data shows calls for non-SUD related needs (anything other than SUD) far outnumbering SUD calls. Highlighting the need to focus on MH in the adult system more broadly.

	2020	2021	2022	2023
SUD	1,541	1,610	1,279	1,073
Non-SUD	21,792	19,003	18,971	17,630
Total	23,333	20,613	20,250	18,703
% of SUD	7%	8%	6%	6%
% of Non SUD	93%	92%	94%	94%

Additionally, state data shows a discrepancy between national averages related to co-occurring and the state data. This discrepancy in the context of providers primarily focusing on a single SUD or MH diagnosis for adults, and limited access to child/youth SUD treatment, the variance is likely due to lack of identification rather than co-occurring not common in the state.

The national average of co-occurring for youth is around 13.5% and for adults the data shows 37.9% of adults with an SUD diagnosis also have a MH diagnosis and that 18.2% of adults with a MH diagnosis also had an SUD diagnosis. Another data source indicates about 1 in 3 or 33% of adults with depression also have an SUD diagnosis. In the table below highlighting Delaware Medicaid claims data, only 2% of the total population served had a co-occurring claim for individuals with MI, SMI or SPMI while the national average is much higher. This likely is because individuals with co-occurring may not be receiving the appropriate diagnosis and therefore treatment.

Medicaid Claims Data % of Beneficiaries*	2016	2017	2018
Mental Illness	21%	22%	23%
Substance Use	4%	4%	4%
SPMI, SMI	9%	9%	10%
Co-Occurring SPMI, SMI, MI	2%	2%	2%

*Report on the State of Behavioral Health in Delaware

The Uniform Reporting System (URS) shows different numbers related to co-occurring for adults – 23% in 2022 and 18% in 2023, closer to the national average and may be reflective of different reporting structures. For children and youth it remains low with 2% in 2022 and 1% in 2023.

What is also highlighted in the state data is the significant drop off of youth receiving services into the transition age years and then people likely re-engaging (or newly identified) later in their late 20's and early 30's. This is likely because their needs resurface or they disengaged during the transition time period from child and youth services to adult services. The 2023 Block Grant report shows a drop from those served in the age group of 13 to 17 years old at 18.6% to a 3.2% for 18 to 20 years old and 5.5% for 21 to 24 years old and then rises again with a larger age spread of 25-44 and increase to 31.5%. While this does not tell the entire story – it is clear from the data and from reports by both DPBHS and DSAMH, transition age youth would be an important focus area.

PREVALENCE RATES IN COMPARISON TO NATIONAL TRENDS

SUBSTANCE USE- ADULTS (18+)

Adults with substance use disorders (SUD) for the most part aligns with the national averages other than opioid use which continues to be on the high side for usage, overdoses, and deaths. Although in the more recent years those numbers are trending downward: Delaware has moved from the second state with the most overdose deaths to the fifth state.

Per the Substance Use Disorder Among Delaware Medicaid Clients Annual Prevalence Report 2014-2019, 2022, Delaware Medicaid enrollees have a ***high rate of SUD prevalence***. Nearly ***one in five*** Delaware Medicaid clients (18.9%) had a SUD claim during at least one year. Opioid use disorder (OUD) was the most common type of SUD, followed by alcohol, cannabis, and cocaine or stimulant.

Strengths - Delaware vs. National	DE	USA
Drug Use Disorder in the Past Year	9.07%	9.41%
Individuals (18+) Reporting Needing but Not Receiving Treatment for Alcohol Use in the Past Year, 2019-2020	10.1%	10.7%
Percentage of adults who reported binge drinking	14.4%	Ranked 9th
Challenges - Delaware vs. National		
All Drug Overdose Death Rate (per 100,000 population) (CDC)	54	32.4
Opioid Overdose Deaths as a Percent of All Drug Overdose Deaths	89%	76%
Alcohol Use Disorder in the Past Year	12.26%	11.28%
Percentage of adults who reported using prescription drugs non-medically	13.5%	Ranked 23rd

Source: America's Health Ranking and SAMSHA

MENTAL HEALTH – ADULTS (18+)

There appears to be some Mental Health (MH) needs even though reporting about mental health and deaths by suicide are below the national average. Since Delaware has focused so much on SUD it may be more difficult to focus on other MH needs outside of suicidal ideation (SI). Additionally, Delaware has traditionally used private community therapists to address non-PROMISE levels of need.

Strengths - Delaware vs. National	DE	USA
Percentage of adults who reported their mental health was not good 14 or more days in the past 30 days	14.4%	Ranked 9th
Number of deaths due to intentional self-harm per 100,000 population	13.7%	Ranked 9th
Percentage of adults who reported binge drinking	15.2%	Ranked 8th
Challenges - Delaware vs. National		

Number of deaths due to drug injury (unintentional, suicide, homicide or undetermined) per 100,000 population (1-year)	52.4	Ranked 46th
Adults Reporting Unmet Need for Mental Health Treatment	8.1%	7.4%
Adults Ages 18+ Reporting a Major Depressive Episode in the Past Year	9.1%	8.1%

Source: America's Health Ranking and SAMSHA

Mental Health America data, in Figure 1, highlights different aspects of data. This is why it is important for a needs assessment to include several data resources and allow it to tell a story of what may be happening and in the context of providers and the state's experience to identify strengths and needs.

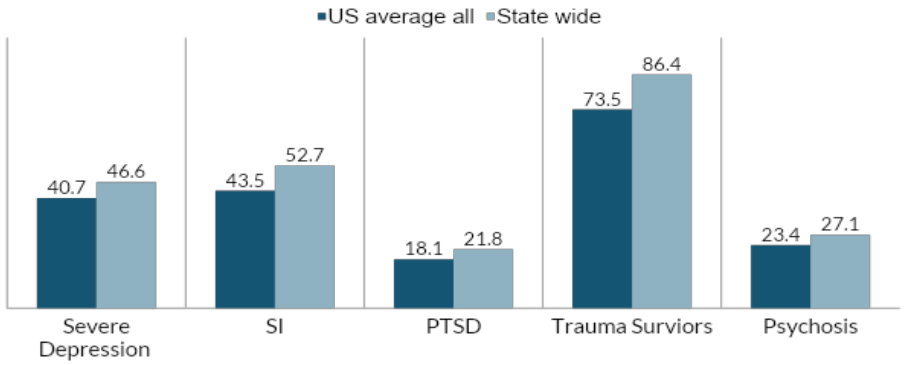


Figure 1: Percentage of adults who reported their mental health was not good 14 or more days in the past 30 days (Mental Health America)

BEHAVIORAL HEALTH – OLDER ADULTS (65+)

There is higher rate of binge drinking among older adults in Delaware compared to the national average. They also report more challenges getting access to primary care. There is limited information about older adults from the national data set but State data may provide more insight into this population.

Strengths - Delaware vs. National	DE	USA
Percentage of adults ages 65 and older who reported being told by a health professional that they have a depressive disorder, including depression, major depression, minor depression or dysthymia	9.4%	Ranked 2nd
Percentage of adults ages 65 and older who reported having physical, mental or emotional problems or difficulty remembering, concentrating or making decisions	5.9%	Ranked 3rd
Challenges - Delaware vs. National		

Number of deaths due to drug injury (unintentional, suicide, homicide or undetermined) per 100,000 adults ages 65 and older (3-year estimate)	10	Ranked 23rd
Percentage of adults ages 65 and older who reported binge drinking	8.9%	Ranked 44th
Percentage of adults ages 65 and older who reported a time in the past 12 months when they needed to visit a doctor but could not because of cost	3.4%	Ranked 32nd
Percentage of adults ages 65 and older who reported having a personal doctor or health care provider	13.5%	Ranked 23rd

Source: America's Health Ranking

SUBSTANCE USE – CHILDREN AND YOUTH (12-17)

There are higher rates of substance use disorders (SUD) in children and youth in Delaware compared to the national average, with the exception of alcohol. Relatedly, there are also higher rates of needing SUD treatment than the national average. As stated previously, there is an identified lack of SUD treatment services in Delaware, which could explain the SUD prevalence rates among children and youth.

Strengths - Delaware vs. National	DE	USA
Opioid Misuse in the Past Year Aged 12-17	1.69	1.85
Alcohol Use Disorder in the past year Aged 12-17	3.16	3.32
Challenges - Delaware vs. National		
Classified as Needing Substance Use Treatment in the Past Year Aged 12-17	14.22%	11.50%
Alcohol Use Disorder in the Past Year: Among People Aged 12 to 20	6.23%	5.72%
Substance Use Disorder in the past year Aged 12-17	9.09%	8.95%

Source: 2021-2022 NSDUH: Model-Based Estimated Prevalence for States | CBHSQ Data (samhsa.gov)

MENTAL HEALTH – CHILDREN AND YOUTH

There are higher rates of mental health diagnosis in Delaware's children and youth compared to the national average. In addition to diagnoses, there are also significantly higher rates of severe depression, suicidal ideation, and trauma. However, higher rates of diagnoses may be a result of better use of assessment tools and identification of children in need.

Strengths - Delaware vs. National	DE	USA
Children/Youth Reporting a Severe Depressive Episode in the Past Year	10.10%	11.5%
Had Serious Thoughts of Suicide in the Past Year Aged 12-17	13.06%	13.16%
Challenges - Delaware vs. National		
Youth with Major Depressive Episode who did not Receive Mental Health Services	9%	Ranked 27th
Made any Suicide Plans in the Past Year Aged 12-17	6.4%	6.35%
Other - Emotional Disturbance		
Students K+ with an emotional disturbance for an IEP	8.56%	7.18%

Source Mental Health America (2023); 2021-2022 NSDUH: Model-Based Estimated Prevalence for States | CBHSQ Data (samhsa.gov)

Ranking first in the nation is best and ranking 50th in the nation is worst.

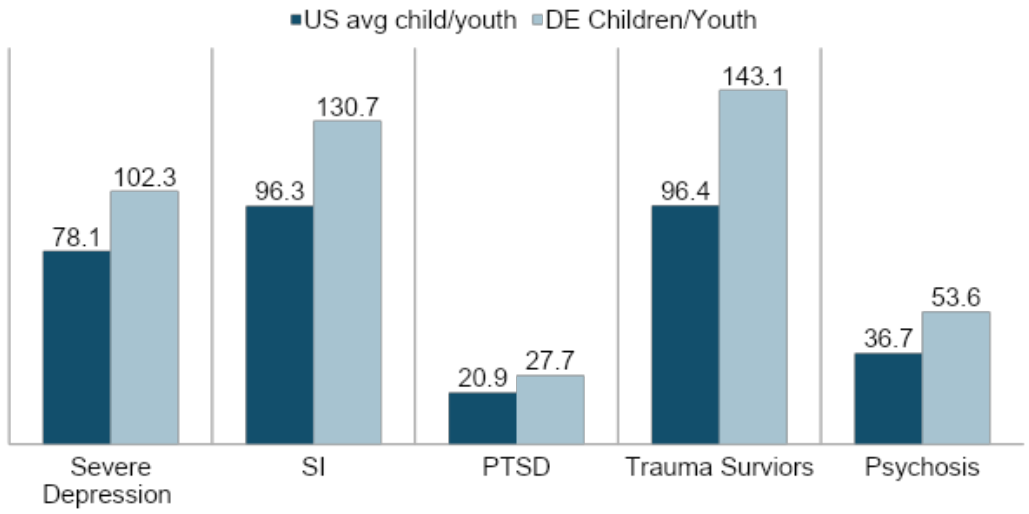


Figure 2: Summary of Kids Mental Health Data (Mental Health America Jan 2022-Dec 2023)

As stated previously, Delaware has a unique system and payment structure for providing services to children and youth, leading to complex processes for data collection. Among the services DPBHS directly oversees, there are identified gaps in certain specialty mental health services by county. This includes FFT and MST services in Sussex County and Wraparound services in Kent County. Youth in

need of SUD residential treatment must currently seek a provider out-of-state. *See Appendix 6: Provider Availability by County 2023 for a full list of specialty mental health services.*

It is also important to note that children with private health insurance do not have access to specialty mental health services overseen by DPBHS, except for Mobile Response and Crisis Stabilization (MRSS) services and in instances where children and youth qualify for co-insurance (private and Medicaid).

Within MRSS, Delaware does not include crisis stabilization (walk-in/urgent care) or transportation services as part of the crisis service continuum. If a child experiencing a behavioral health crisis requires transportation (i.e., school to hospital) and a parent or guardian is not able to provide it, crisis response will rely on law enforcement to transport the child, which is challenging to ensure a trauma-informed approach. In addition, the behavioral health crisis call center for children and youth does not include text or chat functions, and is not part of the Lifeline network as required by the federal CCBHC criteria. Call center features will be addressed in the coming year through Delaware's 988 implementation efforts to integrate adult and youth call centers functions.

See *Appendix 5: Number of Beneficiaries with SUD OR MH Conditions*

COUNTY-LEVEL HIGHLIGHTS

Consistently, Kent County data shows higher rates of behavioral health prevalence over New Castle and Sussex Counties. As indicated in Figure 3,[5] Kent County also has the higher average number of mentally unhealthy days reported in the past 30 days.

The data could be skewed, however, due to the demographics along the Sussex County Coast. As indicated in Figure 4, trauma prevalence is high across counties, which has so many ramifications including but not limited to: substance use, child protection, and increased number of chronic health conditions.

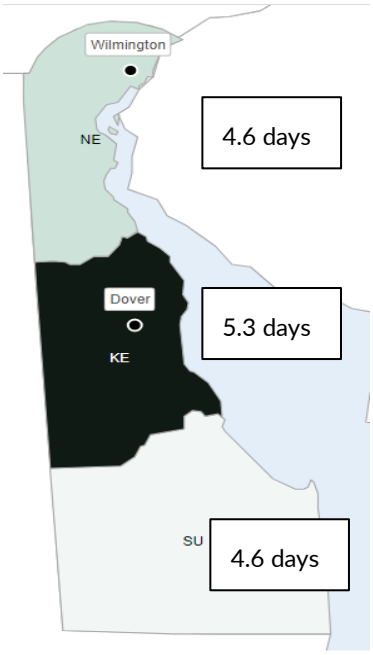


Figure 3 Average number of mentally unhealthy days reported in past 30 days (MHA County and State Data Map)

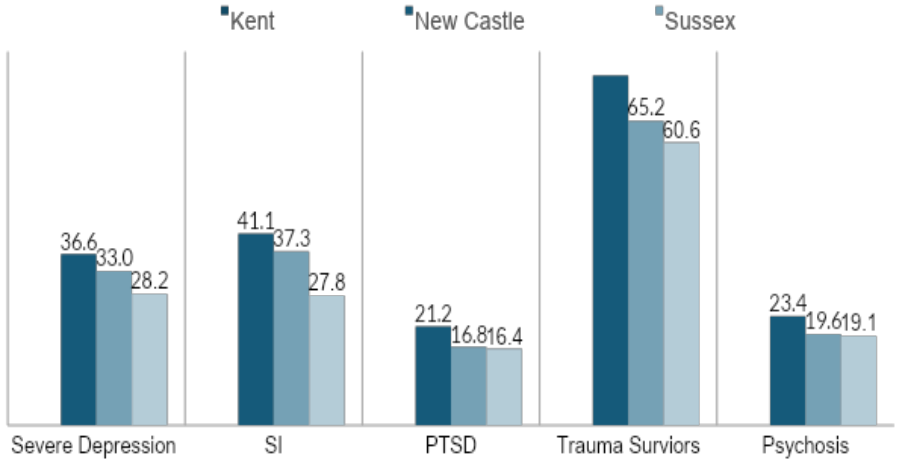


Figure 4 Delaware's Average of Various Mental Health Needs Compared to the US Average (County Health Rankings)

[5] Poor Mental Health Days County Health Rankings

New Castle County has the highest percentage of adults reporting binge or heavy drinking, as indicated in Figure 5, while Sussex County has the worst ratio of population to mental health providers, as shown in Figure 6.

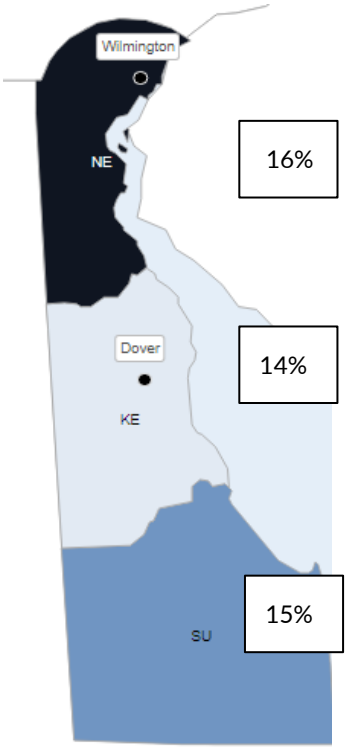


Figure 5: Percentage of adults reporting binge or heavy drinking (County Health Rankings)

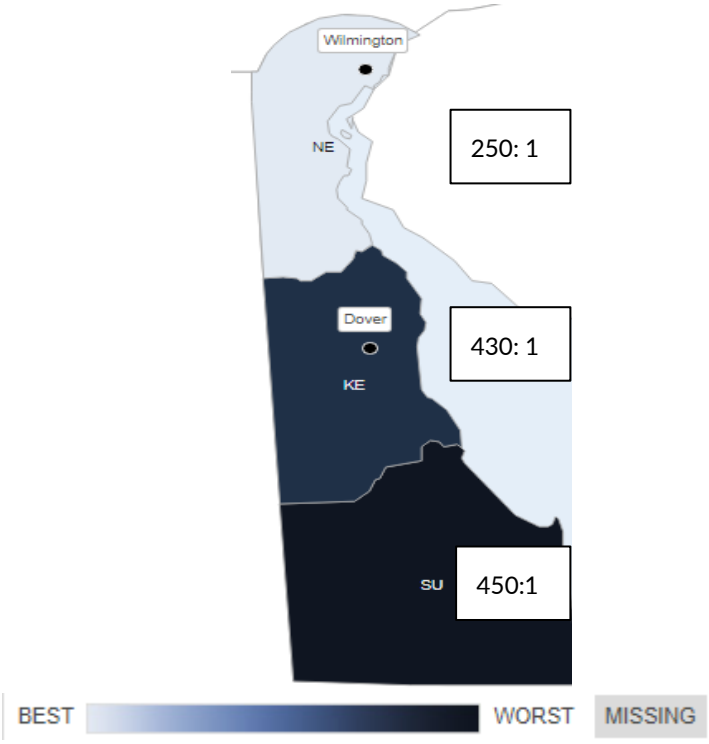


Figure 6 Ratio of population to MH providers (County Health Rankings)

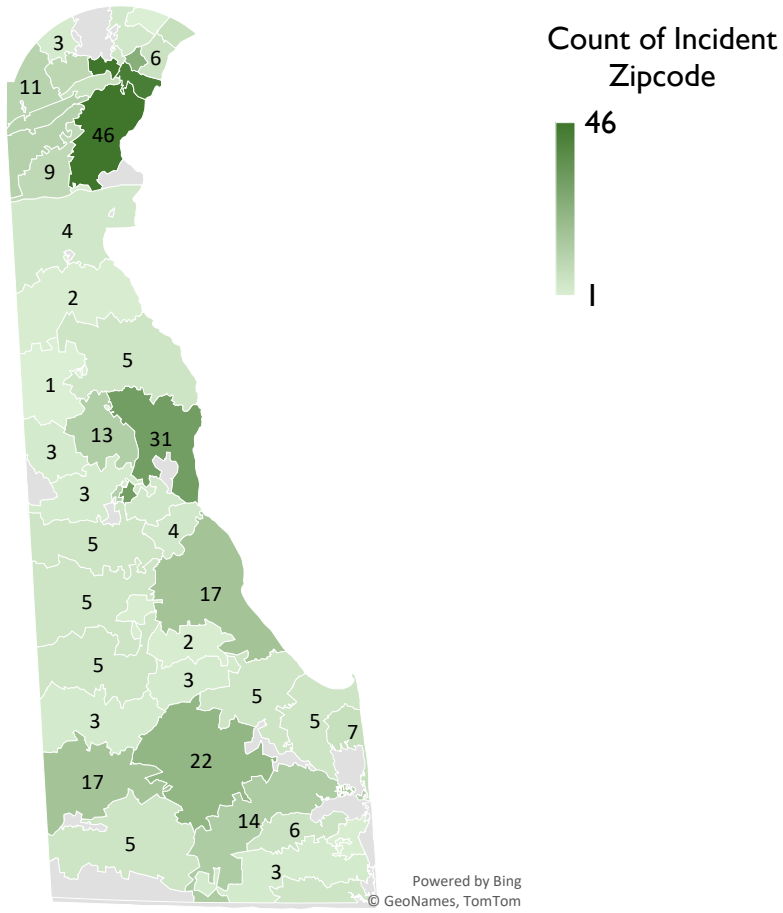


Figure 7 County Hotspots (DIA 2023)

The map in Figure 7 from the county level Death Investigation Alert (DIA), December 2023, shows additional hotspots for counties and again highlights the potential needs by zip code in all three counties. The ramifications of both the SUD that leads to overdoses can also be impacted by missing co-occurring treatment and impact what is identified as needs for children and youth, including child welfare involvement and higher reports of trauma for children.

Although not behavioral health measures, Health Outcomes tell us how long people live on average within a community, and how much physical and mental health need people experience in a community while they are alive. The connection between mental health and substance use on health outcomes is well known. Social and economic factors affect how well and how long we live as well. Social and economic factors include factors such as income, education, employment, community safety and social support. The choices that are available in a community are impacted by social and economic factors. These choices include our abilities to afford medical care and housing and to manage stress. The below table explains how Delaware Counties rank in these categories, from best (1) to worst (3).

	New Castle County	Kent County	Sussex county
Health Outcomes	2	3	1
Social and Economic Factors	1	3	2

Source: County Health Rankings – Health Outcomes and Social and Economic Factors

CORE DATA SET, STATE REQUIRED CCBHC MEASURES, AND MCOS

The Core Data Set is reported each year to CMS by DMMA. There is significant overlap of the Core Data Set and the CCBHC state required measures. CCBHC has a total of 17 possible measures: 13 broken down by child and adult, 2 for both children and adults, and 2 optional measures for children. [Optional measures include use of first-line psychosocial care for children and adolescents on antipsychotics (APP-CH) and Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH).]

As demonstrated in the pie charts Figure 7, of the 17 possible CCBHC measures, 2 are SAMSHA measures related to experience of care. Of the 15 required measures, 10 are adult specific and 5 are child specific.

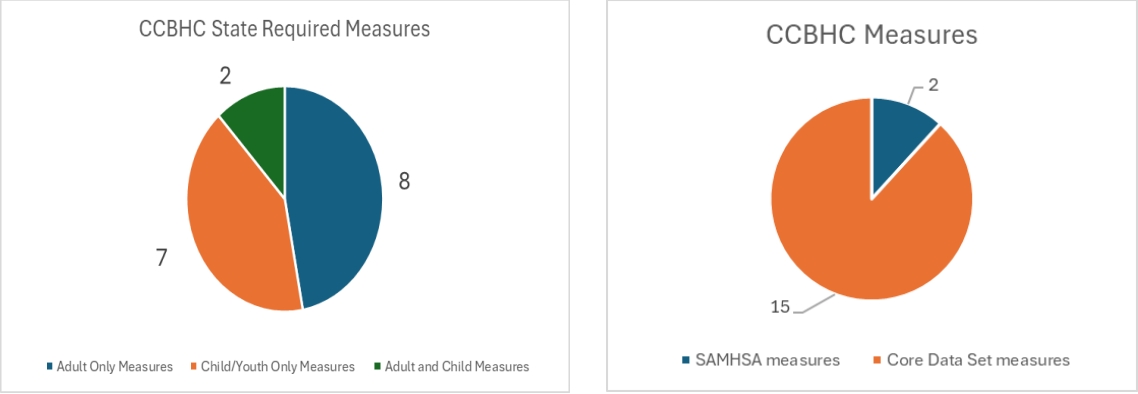


Figure 8: Core Data Set and CCBHC State Required Measures

Given the overlap in these measures, Delaware may want to identify ways to improve the data to get ready for the CCBHC expectations, including identifying where the CCBHC can influence the measures. See *Appendix 7: sampling of core data set measures* for more Core Data Set Measures.

In reviewing the data there are a few measures that appear to not be reported on such as "*follow up after hospitalization and emergency room visits for 6 to 17 year olds.*" Beginning to track that data will be

important. Also, the measures related to SUD tend to be more positive and the measures related to mental health less so. This continues to be evident throughout the various data sets. Lastly, the data sets related to primary care (development screenings, well child visits) are generally very positive. Because of this positive reflection of primary care being in contact with families for these two events, it could highlight an opportunity for the CCBHC and primary care to work collaboratively on increasing referrals and care coordination between the CCBHC and primary care especially since primary care integration is a part of the CCBHC model.

MANAGED CARE ORGANIZATIONS

There are three MCOS in Delaware: Highmark BCBSD Health Options, AmeriHealth Caritas Delaware, and Delaware First Health. Delaware First enrollment began in January 2023 and, as such, this report focuses on Highmark and AmeriHealth.

The MCO Scorecard measures outcomes from worst (1) to best (5) in the following categories for adults: care coordination; medication adherence; access, monitoring, and safety; risk adjusted utilization; and overuse of opioids.

As shown in the table below, of the 16 measures, MCOs scored well in only 25%. Coordination between the MCOs and a comprehensive provider, such as a CCBHC, could dramatically improve these outcomes. Also of note is measures related to MI or MH tend to do worse than those associated with SUD - showing again that Delaware has done a better job addressing SUD - and CCBHC could also be an opportunity to address the MH needs across the populations. See *Appendix 8: MCO Scorecard on behavioral health* for full the MCO Scorecard on Behavioral Health.

Scoring	Highmark		Amerihealth	
	#	%	#	%
Scored Well	4	25%	4	25%
Scored Average	3	19%	5	31%
Scored Poorly	9	56%	7	44%

Source: Health Plans - NCQA

IV. OTHER KEY STATEWIDE DATA

WELLBEING, INCARCERATION, GRADUATION RATES

ADULT WELLBEING

Data from the Delaware's Emergency COVID-19 Grant showed at intake, 45.8% self-reported poor to fair health. Additionally, 18.3% reported very poor to poor and 22.5% reported neither poor nor good. By contrast, 54.2% reported good, very good, or excellent health.

INPATIENT DISCHARGE

A 2021 review of the provision of SUD services, including MOUD, for patients at the Delaware Psychiatric Center (DPC) with co-occurring mental health and substance use disorders identified SUD service gaps both within DPC and in the community. During this review, DPC expressed a need to have a better process in place to identify SUD services in the community, including providers who can provide services for individuals with co-occurring diagnosis, including SPMI and co-occurring SUD.

Based on the service gaps identified by DPC during the discharge planning process, a recommendation was made to support mental health providers in adding SUD services for this population.

EMPLOYMENT

Data from the Delaware's Emergency COVID-19 Grant showed employment and school enrollment rates for participants at intake.

Employment & School Status	Clients Employed or Enrolled in School at Intake (%)[6]
Employed Full-Time	35.9%
Employed Part-Time	7.7%
School Full-Time	10%
School Part-Time	5%

INCARCERATION RATES

Delaware's Department of Corrections reports that nearly 53% of the State's total facility population has an identified behavioral health condition (see table below). In addition, of those identified to have a behavioral health condition, 23% have a mental illness, 23% have a serious mental illness (SMI), 25% have a substance use disorder, and 29% have a co-occurring disorder.

[6] Delaware Emergency COVID-19 Grant Final Progress Report Summary (2023).

Facility	Mentally Ill (MI)	Seriously Mentally Ill (SMI)	SUD	Co-Occurring	Total	**% of Total Facility Population**
Baylor Women's Correctional Institution (BWCI)	27	48	12	105	192	**81.7%**
Howard R. Young Correctional Institution (HRYCI)	136	115	208	402	861	**68.9%**
James T. Vaughn Correctional Center (JTVCC)	257	331	48	81	717	**42.1%**
Sussex Correctional Institution (SCI)	102	34	305	60	501	**45.0%**
Total	**522**	**528**	**573**	**648**	**2,271**	**52.8%**

Sources: DE DOC Annual Report 2022

CHILD & FAMILY WELLBEING

CHILD PROTECTION - CHILD AND YOUTH

Delaware ranks in the bottom half of all Child and Family Wellbeing categories. Lower rates of overall child maltreatment but not enough post-response services. Additional data of child maltreatment does identify variation in physical abuse, psychological abuse, neglect, etc. The Annie E. Casey Foundation (AECF) ranks Delaware in the bottom half of all states in overall child wellbeing at 34th in the national [2023]. This is a drop from ranking 30th in the nation in 2022.

Among the 2023 indicators, Delaware ranked:

- 28th for Economic Wellbeing, with no change from 2022
- 41st in Education, down from 27th in 2022
- 31st in Health, down from 30th in 2022
- 28th in Family and Community, up from 30th in 2022

Strengths - Delaware vs. National	DE	USA
Children who were maltreated per 1,000	5.4	8.1
Percent of referrals that met the criteria for an investigation or an assessment	25%	51%
Percent of recurrence of maltreatment within 6 months	<1%	3%

Challenge - Delaware vs. National	DE	USA
Number of victims who received post-response services	28%	58%
Number of non-victims who received post-response services	9%	26%
Number of child fatalities per 100,000	3.4	2.4

Source: AECF 2023 Kids Count Data Book and AECF 2022 Kids Count Data Book

TAKE CARE DELAWARE

Take Care Delaware provides the school with a "heads up" by law enforcement when a child has been identified at the scene of a traumatic event. It could be a domestic violence situation, a shooting in the neighborhood, witnessing a malicious wounding, a drug raid at the home, etc. Police are trained to identify children at the scene, find out where they go to school and send the school or school agency a confidential email or fax that simply says . . . "Take care of [Child's Name]".[7]

Take Care Delaware notices include:



Figure 9: 2023-2024 School Year (Aug.-Dec. 2023); 1,063 notices were sent covering a total of 1,695 students

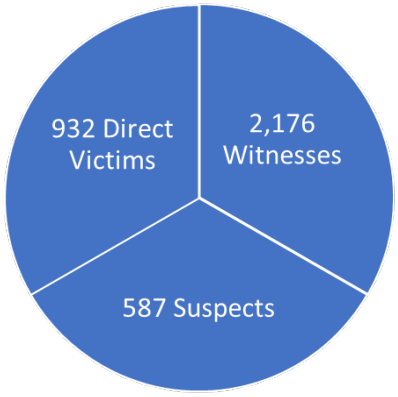


Figure 10: 2022-2023 School Year; 2, 253 notices were sent covering a total of 3,695 students

Source: Department of Services for Children, Youth and Families

[7] Take Care Delaware / Handle With Care: Overview

SCHOOL SETTINGS

SCHOOL-BASED SERVICES

Delaware has a school-based health care (SBHC) program that provide school-aged youth with comprehensive physical, behavioral, and preventive health services in school settings. As of 2021, there were 39 total SBHCs, with 32 SBHCs operating in high schools (all public/non-charter).[8] Seven of the SBHCs operating in high schools also serve attached middle schools. All SBHCs located in public, non-charter high schools include behavioral health providers as part of the state model and state law requires school-based health centers to provide behavioral health services and referrals.

In 2020, the Delaware General Assembly included language in the FY2020 Budget Epilogue to establish new SBHCs in high needs elementary schools across the state. In 2021, there were a total of seven elementary schools with SBHCs.

Delaware SBHCs are funded through a combination of state funds, Medicaid reimbursement, and reimbursement from commercial insurance. Additional support comes from community partnerships and in-kind support from schools and medical sponsors.

GRADUATION RATES

Youth involved in the child welfare system graduate at much lower rates than youth not involved in the child welfare system. Youth are often involved in the child welfare system either because they or their parents have a SUD or mental health disorder. CCBHCs are also required to have defined care coordination relationships with child welfare agencies.

As a result, BBS reviewed graduation rate information. The statewide graduation rate for the class of 2022 was 87.79%. This is a slight increase from the class of 2021 (87.02%). The graduation rate also increases slightly when accounting for five and six-year cohorts.[9]

Highlights from 2022 data shows the demographic groups that fall below the state average, including English language learners (69%); students with disabilities (72%); students in foster care (55%); students who are homeless (70%); and migrant students (33%). In addition, students of color fall below the state average with the exception of Asian American and multi-racial students. Please see *Appendix 9: four-year graduation rates by student group class of 2022* for four-year graduation rates by student group in class of 2022.

[8] Advancing the Health and Well-being of Delaware Students: A Strategic Plan for School-Based Health Centers in Delaware (2021)

[9] The graduation rate for the Class of 2021 was 87.02% at the end of four years, and 88.65% at the end of five years, increasing the graduating class by 175 students. The graduation rate for the Class of 2020 was 87.70% at the end of four years, 88.42% at the end of five years and 88.50% at the end of six years, increasing the graduating class by 78 students in the fifth year and 7 students in the sixth year.

STAFFING AND WORKFORCE

TYPE OF SERVICES

CCBHCs must enroll in SAMHSA's treatment locator, which helps people, their families and other treatment providers find available services. Additionally, CCBHCs must provide care coordination, ensuring access to and discharge planning for the individuals served when they receive services from outside service providers including emergency departments, hospitals, and residential settings. Below is a sampling of what can be found in the treatment locator related to number and types of services. However, because not all providers enroll in the treatment locator and may not accurately reflect their services to match treatment types this may not be particularly helpful to identify gaps in service provider types. Additionally, understanding how a program operates, their length of stay, number of beds or availability, step down available and how they manage utilization means it is hard to exactly know the number of each provider type needed. This needs a much deeper analysis to be more helpful in the context of this needs assessment.

Level of care	Mental Health Facilities (#)	Mental Health Facilities (%)	Substance Use Disorder Facilities (#)	Substance Use Disorder Facilities (%)
Total Facilities	**34**	**100%**	**53**	**100%**
Community-based and outpatient services	29	85%	38	72%
Crisis intervention	6	18%	43	81%
Intermediate care settings (e.g. intensive outpatient, partial hospitalization)	3	9%	3	7%
Residential care	1	3%	2	38%
Hospital inpatient	5	15%	3	6%
Case Management	25	74%	43	8%
Tailored program for Veterans	1	3%	1	2%

Source: Delaware's Mental Health and Substance Use Treatment Facilities

SERVICE GAPS

In 2022, a national survey showed that approximately 7.6 out of 29.3 million adults aged 18 and older with a mental illness (AMI) in the past year (2021) perceived an unmet need for mental health services.[10]

In addition, a recent national survey from the National Council for Mental Wellbeing showed 83% of behavioral health workers indicated that without public policy changes, provider organizations won't be able to meet the demand for mental health or substance use treatment and care.[11]

WORKFORCE SHORTAGES

CCBHCs are responsible for using their community needs assessment to make several decisions regarding staffing to address the needs of the population they serve. There are several CCBHC staffing related requirements. HRSA data on Delaware's behavioral health professionals illustrate existing shortages when compared to other states in the Mid-Atlantic and extended regions. The Behavioral Health Workforce of Delaware and neighboring states is listed in the table below.[12]

State	Psychiatrists (total #)	Psychiatrists (per 100,000 population)	Psychologists (total #)	Psychologists (per 100,00 population)	Social Workers (total #)	Social Workers (per 100,00 population)
Delaware	**95**	**9.47**	**729**	**74.24**	**1913**	**194.83**
District of Columbia	332	49.55	1765	258.36	2422	354.53
Maryland	1196	19.40	5602	91.11	9780	159.06
New Jersey	1223	13.20	9104	98.59	18532	200.69
New York	4777	24.08	26379	131.14	60526	300.90
Pennsylvania	1800	13.88	10209	78.71	30146	232.42
Virginia	1054	12.20	5678	66.16	13691	159.52
West Virginia	190	10.66	1060	58.85	2872	159.46

[10] Behavioral Health Workforce 2023 Brief (hrsa.gov)
[11] New Study: Behavioral Health Workforce Shortage Will Negatively Impact Society - National Council for Mental Wellbeing (thenationalcouncil.org) (2023)
[12] Area Health Resources Files (hrsa.gov)
Psychiatrist AMA Physician Masterfile 2021; Census County Pop. Estimates 2021
Psychologist American Community Survey PUMS 2017-21; American Community Survey PUMS 2017-21
Social Workers American Community Survey PUMS 2017-21; American Community Survey PUMS 2017-21

In addition, the table below shows that the number and rate of psychiatrists varies by county, with fewer in Kent and Sussex counties.[13]

County	Total Number	Rate per 100,000 population
Kent	13	7.06
New Castle	69	12.07
Sussex	13	5.25

HRSA is also projecting national shortages will increase between 27% and 93% for selected behavioral health providers by 2036. See *Appendix 10: Projected national bh staff shortages* for more information.

There are many factors related to workforce shortages, including high workload/caseloads, low wages, policies preventing practitioners from working at their full scope of practice, lack of organizational support, and many others. These combined lead to increasing burnout. The National Council for Mental Wellbeing's recent survey of behavioral health professionals showed 93% experiencing burnout, with 62% reporting moderate or severe levels of burnout. This same survey reported 48% saying the impact of workforce shortages have caused them to consider other employment options.[14]

WORKFORCE SHORTAGE SOLUTIONS

SAMHSA has identified several strategies to support and enhance the health care workforce such as expanding integrated care and telehealth, and leveraging health support workers, including peers and community health workers.[15]

Among behavioral health professionals surveyed by the National Council for Mental Wellbeing, more telehealth options (46%) was the highest ranked action to help reduce challenges in the mental health/substance use field. This was followed by apprenticeship programs (42%) and student loan forgiveness (37%). The same survey showed that 38% said less time spent on administrative tasks would help them better serve their clients.[16]

In addition to nationally identified solutions, there are many strategies adopted by states to expand and support their behavioral health workforces. These include:

[13] Area Health Resources Files (hrsa.gov)
Psychiatrist AMA Physician Masterfile 2021; Census County Pop. Estimates 2021
[14] New Study: Behavioral Health Workforce Shortage Will Negatively Impact Society - National Council for Mental Wellbeing (thenationalcouncil.org) (2023)
[15] Behavioral Health Workforce 2023 Brief (hrsa.gov)
[16] New Study: Behavioral Health Workforce Shortage Will Negatively Impact Society - National Council for Mental Wellbeing (thenationalcouncil.org) (2023)

- Entering into interstate licensing compacts to expanding the number of potential licensed professionals who can practice in Delaware, including psychiatrists, nurses, mental health counselors, psychologists, and social workers. As of March 2024, Delaware has:[17]
    - Entered and participating in interstate compacts for nurses, and psychologists
    - Passed legislation to enter in interstate compacts for mental counselors and physicians and enacting rules to participate in both
    - Has not introduced legislation to enter or participate in new interstate compact for social workers.
- Codifying expanded telehealth rules following the end of the Public Health Emergency, to include synchronous and asynchronous modalities, video and audio and audio-only, and to prescribe medications.
- Exposure of behavioral health professional scopes through mentorships and shadowing; and recruitment of high school students into higher education programs, including scholarship opportunities.
- Expanded use and scope of non-licensed and para-professional staff, with a focus on prevention strategies.

Please see *Appendix 11: behavioral health workforce shortages* for more information about behavioral health workforce shortages in nearby states.

[17] Compact State Map | Interstate Medical Licensure Compact (imlcc.org)
Home | NURSECOMPACT
PSYPACTMap - Psychology Interjurisdictional Compact (PSYPACT)
Compact Map – Counseling Compact
Compact Map – Social Work Licensure Compact (swcompact.org)

V. INPUT FROM THE STAKEHOLDER ADVISORY COMMITTEE AND PWLE

During the May 20, 2024 Stakeholder Advisory Community meeting, members of the CCBHC SAG discussed the following topics: Community Needs, Access and Barriers to Care, CCBHC Services, and Staffing and Workforce. SAG members were asked to answer additional questions about Partnership and Care Coordination via a survey sent after the meeting due to time constraints. To note – many of the suggestions made, such as accessing culturally appropriate services, seeking integrated care for dual diagnosis, or even a welcoming environment are requirements of the CCBHC and therefore would be addressed with the implementation of - and providers meeting - the certification requirements.

Community Needs	**When you need help or support, do you know where to go?** The participants provided mixed responses as some people know where to go based on their own experience and knowledge living and/or working in Delaware. People have utilized DSAMH and Help is Here websites. Several suggested it would be helpful to have an updated, online registry as individuals who utilize resource lines expressed that the resources lines do not have all of the information - what insurance is accepted, for example, or if any beds are available - and it can be difficult to help people navigate the systems. Several people also acknowledged Delaware's bifurcated system does not support individuals with a dual diagnosis, which is a real service gap. This treatment connection is specifically challenging to connect people to appropriate care. Lastly, members of the Latino community often don't know where to turn for help due to lack of culturally appropriate resources. **Do you feel like you have been able to get the help that you need in our community? If not, what has been missing?** Most participants do not feel they can get the help they need in Delaware. In addition to the dual diagnosis service gap previously stated, there was concern the connection is not quick and the lack of communication from the State is a problem. Participants expressed a lack of understanding and education on where community members need to call, who they should speak to, and in what order. Or, when there is a connection to be made there is a lot of red tape in order to make it happen. Additionally, participants expressed there are not enough treatment beds available for people living with addiction, which is often further limited by insurance type. Furthermore, Delaware lacks peer-led support groups, whether in person or virtual, that are accessible at no-or-low cost to the public, that are committed to preserving autonomy and informed consent for all participants that reject police

	and psychiatric interventions. Furthermore, Delaware specifically lacks peer-led services for autistic adults outside of assistance related to employment. Lastly, Latinos report that they have not been able to get the help they need due to the absence of Hispanic providers and bilingual therapists.

Access to Care	**Have you or anyone you know faced any barriers to getting the care you need? If so, what were they?**
	
	All participants stated yes – they have personally witnessed barriers to care or have seen others experience barriers to care. The barriers expressed were:
	
	• Medical issues are not addressed in recovery providers and wounds/wound care is a big issue. Additionally, individuals being discharged prior to stabilization is a real barrier to care, especially as there are rarely to none in-house connections to future appointment following discharge – there is little support to ensure the connection to care happens after the referral is made.
	• Lack of transportation is a big barrier to care, as well as a big cost of care.
	• Lack of housing and housing support is a huge barrier to care and one participant stated they have never been able to successfully connect someone to the Hope Center.
	• Cost of services can be a barrier to care
	• General lack of culturally-competent services
	  ○ Members of the Hispanic community face behavioral health stigma, as well as lack of Spanish-speaking providers (including therapists, receptionists, community health workers, and peer specialists)
	  ○ Majority of mental health professionals in Delaware are white, cisgender, heterosexual, and non-disabled with some considerable disparities in age and class
	• State agencies not helpful in support participants to get connected to MAT, Inpatient Care, or medical providers
	
	How could it be easier for you to get the care and support you need in the future?
	
	Participants had several suggestions to improve care:
	
	• Establish integrated medical care into behavioral health care
	• Facilitate support groups and utilizing peers/CHWs to connect people to treatment
	• Individuals staffing the resources lines should be more informed on available resources and the specificity of those resources, e.g. know where beds are available or how to access housing vouchers.
	• Services should be provided by trust Latino organizations and/or Latino providers for the Latino community ensuring bilingual and culturally competent services.

	• More treatment beds and transportation to/from treatment and appointments • More comprehensive trainings and education surrounding systems of oppression for providers • More non-white providers, perhaps through increased scholarships and other incentives for students from marginalized groups looking to start a career in behavioral health

CCBHC Services	**Among the services that are currently provided, which ones are most important to you and why?**
	
	• Crisis services that are staffed appropriately and can respond to calls 24/7 and do not need to engage Law Enforcement.
	• Housing for families
	• Behavioral health services for Latinos (adults and children)
	• High quality, available treatment, specifically MAT providers
	• Telehealth services due to lack of accessible transportation
	
	What mental health or substance use services do you feel are lacking in your community?
	
	• Adequate providers
	  ○ Dual diagnosis providers
	  ○ Child psychiatrists
	  ○ Bilingual providers (English and Spanish)
	• General coordination across all systems, including integrating BH and medical care
	• Services supporting transition-age youth
	• Respite centers
	• Alternative to Suicide peer-led support groups
	• MAT/MOUD services
	• Culturally Inclusive Outpatient Treatment (CODs)

Staffing and Workforce	**How do you feel when you walk into a place you are getting services?** • People living with addiction often feel judged and lack of respect • Many Latinos feel alienated or uncomfortable in mainstream services due to lack of culturally competent and bilingual staff • Lack of trauma informed practices and unwelcoming environments as walking into a mental health space that feels cold and clinical - like in a medical hospital - can feel alienating and even intimidating **How could services be made more welcoming and engaging for you?** • Increasing wages and workplace wellness could contribute to increasing welcoming environments in the provider offices • Enacting trauma informed principles in the physical space - using warmer colors, for example – and intentionally trying to make the environment as

	hospitable as possible would be helpful to make it feel like a place participants would willingly go • Providers trained on trauma informed care • Bilingual and culturally competent services • Hiring and training community health workers and peer specialists • The State can be more involved in communication, follow up, and overall support for provider services and support in communication amongst providers
Partnership and Care Coordination	**What other organizations in your community are doing good work?** • Face the Facts DE • Phoenix Family Resources • Impact Life • Oxford House • Hispanic American Association of Delaware (HAAD) • Banyan Treatment • Kirkwood Detox • Sean's House • Eclipse Wellness • AVH Group • On Demand Healthcare **Can you share any other services or programs that you really rely on?** • Endless requests for housing assistance • School-based services • HAAD • Help is Here **Have you ever had any difficult experiences trying to navigate services across different providers to get what you need?** All respondents answered yes: • It's often impossible as providers do not communicate • The lack of Spanish-speaking providers makes it challenging for Latinos to navigate multiple providers

VI. SUMMARY OF FINDINGS - STRENGHTS, CHALLENGES, OBSERVATIONS AND OPPORTUNITIES

STRENGTHS

Delaware has put a lot of effort and resources into supporting people with SUD the last several years and all of the data – behavioral health prevalence data, the Core Data Set, and MCO data – support that SUD-related measures are improving among adult Delawareans.

Regarding SUD workforce and access there are now multiple types of providers serving adults with behavioral health needs expanding beyond just contracted providers to include primary care settings and other community providers, so people have more choice and access.

It should be noted that the availability of specialty mental health services overseen by DPBHS has increased over the last year, with some exceptions. This includes availability in all counties of Therapeutic Support for Families (TSF) and Family Based Services (FBS).

Delaware's call center and mobile crisis response services for children and youth are available seven days a week, 24 hours a day across the state.

School-based health centers are required by state law to provide mental health and substance use disorder assessments, crisis intervention, individual counseling, and referrals and connections to community behavioral health care.

CHALLENGES

Overall, the behavioral health providers are designed more as "specialty providers" service a specific diagnostic criterion/single population rather than "comprehensive providers". This prevents individual providers and the system as a whole in building the necessary infrastructure to support the key elements of a high functioning system of care.

PROVIDER-SPECIFIC CHALLENGES RELATED TO CCBHC:

BBS provided technical assistance to prospective CCBHC providers in Delaware in 2023 and early 2024 via the CCBHC Planning Grant. During this process, BBS learned of several challenges facing providers who want to become CCBHCs: missing or not meeting several of the CCBHC requirements, providers had competing demands and could not dedicate time or resources to tasks related to their Individualized Action Plan; and providers tended to be single population focus and therefore did not have required services, staff, or policies/procedures across the lifespan, as required by a CCBHC. Some of these challenges are related to state parameters and policy decisions and some related to provider decisions or limitations.

Regarding resources, no provider completed a community needs assessment (CNA). Many of the certification requirements depend on the CNA driving program design, staffing, care coordination relationships, etc. Providers also lacked EHR and infrastructure requirements, as well staff trainings and supervisions needs would need to be enhanced to adhere to CCBHC criteria and enhanced service

array. Providers also demonstrated limited ways to establish meaningful participation by people with lived experiences in their governing board.

Regarding services, no one provider served the lifespan across mental health and substance use needs. Some providers are not licensed SUD providers and would need to complete the process in order to become a CCBHC. There are no veterans service relationship established. Relatedly, many providers saw the DCOs as a way to meet the needs of the population but have not yet started discussions to create a plan to ensure 51% of the encounters are provided by the CCBHC and not the DCO. While DCO relationships can help augment the provision of required services by the CCBHC, certain services drive encounters and that should be understood prior to DCO relationships being established. Establishing these DCO relationships will also be challenging as there are limited-to-no care coordination agreements in place.

SAMHSA CCBHC planning grant opportunity is often seen as foundational for providers to make progress towards certification and support them with these challenges. No provider in DE has received this grant or additional funding to support CCBHC implementation.

And finally, crisis services for both adults and children do not currently meet the CCBHC criteria. That either needs to be addressed or an exception request to HHS needs to be made. Either way because Delaware wants to provide crisis services outside of the CCBHC an exception request is needed.

CCBHC OBSERVATIONS + OPPORTUNITIES

OBSERVATION 1

Delaware's child and adult behavioral health system is currently designed and divided both diagnostically (mental health and substance use disorder) and by ages (children/youth and adults).

CCBHC Opportunity: *Full integration* of the mental health and substance use disorder system to address co-occurring conditions, provide a full family continuum of services, and provide treatment to transition aged youth. Children and youth are part of families and often addressing parental or caregiver needs supports the success of children and youth and additionally while addressing children and youth behavioral needs parents' and caregivers' own needs are more manageable. While this is a big change for the Delaware system, it is part of the CCBHC design and Delaware could consider an incremental approach to achieve a more integrated design.

OBSERVATION 2

There are no identified catchment areas or defined provider network leading providers to respond to an RFP based on where they are located and what they would like to provide. When systems lack identified catchment areas and with identified responsible providers it can lead to inconsistent coverage of services across all locations of the state thus making it difficult for the state to hold providers accountable and challenging to ensure people's needs are addressed timely and effectively.

CCBHC Opportunity: Using CCBHC locations as hubs by establishing *catchment areas* will create a centralized intake, a core set of available services, access to DCO services with a care coordination model, accountability for services being provided and outcomes being achieved for all Delawareans. No one provider is currently designed to move from the current state to this described future state. Again, an incremental approach could help design and then build this infrastructure.

OBSERVATION 3

There is currently no "common Delawarean experience". If there appears to be a need to address or a service needed, a fund source is identified, an RFP is published, and contract established without necessarily determining the extent of the need. While data is used to view trends and identify needs, engagement with stakeholders (constituents, providers) with no formal review of a needs assessment is also used. Identification of proposed desired outcomes or consideration of a core defined set of services would support better development of new ways to address needs. The current process of contracting for services may be helpful in the moment but may not address needs in the long-term, or produce the desired outcomes.

CCBHC Opportunity: *A core set of services*, such as those in the CCBHC model, should be available to everyone in the state. Many of the services are available but not always in a coordinated or integrated manner. This can create gaps in care and transitions from one service system to another, creating an opportunity for people to disengage or their needs not being fully assessed and addressed by the providers.

OBSERVATION 4

Oversight of the DSAMH providers is based on certification to bill Medicaid, licensing for SUD services and contract expectations. Oversight for DPBHS includes monitoring visits, chart reviews, review of the environment of care, review of human resource files all feeding into a report that includes strengths and areas for improvement. DPBHS oversees and approves corrective action plans developed by providers If areas of improvement warrant corrective action. DSAMH is in the process of developing additional licensing requirements. While oversight has components of quality the lens tends to be more compliance focused and not comprehensive in populations served or diagnostic categories since service delivery is not designed that way.

CCBHC Opportunity: Using the CCBHC requirements to create a provider oversight process that focuses on 1. "Does the CCBHC meet the requirements?" through a compliance lens; and 2. "Are the providers delivering high quality services that achieve the required and desired outcomes?" through a quality and outcome lens. The state also has the discretion to add additional requirements and outcomes based on their priorities. Additionally, this could lend itself to more family focused services – treating the adults and children – in a way that drives better overall outcomes in the short and long-term.

OBSERVATION 5

For DSAMH, substance use is the driver of services and mental health services are primarily focused on the Promise program for the SMI population (an 1115 waiver). DSAMH funds un/underinsured individuals using state general funds, block grant and other grant funding.

For DPBHS the services are primarily mental health focused. Several other departments have a role in child/youth behavioral health (DPH, DOE). Coordinating these services with a structured oversight for the children's system of care will produce improved outcomes. DPBHS uses a combination of funding sources including block grant funding and Medicaid.

For DMMA, the MCOs play a role in contracting for and paying for SUD or MH state plan services for individuals with Medicaid.

CCBHC Opportunity: Viewing the behavioral health system through a *collective lens* should lead to improved outcomes and *maximization of the funding*, including maximization of Medicaid therefore freeing up other resources for services and supports that either don't have or have limited funding (i.e. housing, transportation, other social drivers).

The CCBHC model will provide an understanding and focus on the needs of the *entire population*, not just the most severe. The CCBHC model is designed to address needs across the severity spectrum and build in more supports at the front end of need, including screening and early identification, to help mitigate more severe and chronic needs. The CCBHC model does not reduce the focus on the most vulnerable but provides a balance that focuses on increasing upstream services, building additional outpatient support in a way that increases access, engagement and treatment completion.

DMMA has secured resources through the HCBS Waiver to support CCBHC implementation and could be used to augment these efforts.

OBSERVATION 6

Crisis services are provided through various pathways and are being addressed through the 988 planning to respond to crises more effectively. It has been identified that the crisis services do not meet all the CCBHC requirements and as noted previously will require either changes to the design or request to HHS for an exception allowance.

CCBHC Opportunity: Use the current work for 988 and mobile crisis to ensure the required *crisis services* of the CCBHC criteria are addressed.

OBSERVATION 7

Funding for services appears to happen through multiple funding streams and doesn't always appropriately enhance the use of Medicaid funds. By using Medicaid funds more judicially other funds such as state general fund could be used for services that are typically not Medicaid billable yet impact behavioral health outcomes (i.e. housing, transportation, concrete needs).

CCBHC Opportunity: The PPS funding model creates some additional flexibility and covers more real costs than traditional payment models. Mapping the funding streams, what the funds pay for and the mechanisms used (i.e. MCO vs. non MCO; Fee-for-Service, direct contract, pay for performance, cost based contracting, administrative Medicaid) could highlight additional opportunities to extend the use of all funds earmarked for behavioral health.

VII. RECOMMENDATIONS AND NEXT STEPS

The intention of this needs assessment is to reflect back to DSAMH, DMMA, and DPBHS Leadership the state of Delaware's behavioral health system. Using this information, leadership has an opportunity to refine their CCBHC vision and make design decisions that address what has been highlighted as strengths, challenges, observations and opportunities. Moving from where the Delaware system design is today to where the state may want to move and within the CCBHC framework will require decisions and changes at the state level to influence what is happening at the provider level. It will be important for the state to review how some of their expectations or policies influence what providers are able to do (how flexible, bold or risky they can be in taking on the CCBHC design), what might be provider TA and resource support needs and what may simply be part of the iterative change process that will need to be managed and guided along the way.

REFLECT ON THE NEEDS ASSESSMENT

BBS recommends leadership considers the following questions:

1. Does the data and information in this needs assessment provide you with a strong foundation of what is currently happening in Delaware and what might need to change to ensure CCBHC implementation? What else do you need to know?
2. What would need to change to address key elements you think don't currently exist in the Delaware system but CCBHC could help address?
3. How could the CCBHC model support Delaware in addressing or improving the key elements of a system to create better outcomes for identified measures?
4. Based on this data and information are their additional design elements or outcomes you would want to consider?

COMMITMENT TO CCBHC AS A SYSTEMS CHANGE PROJECT

BBS recommends Delaware's CASC consider the following and take action where appropriate:

1. Based on divisional commitment to CCBHC implementation, determining how CCBHCs fit into the system will be key. Are CCBHCs hubs that other services (DCOs, MOUs, Care Coordination) radiate from or are CCBHCs simply another options of providers in a service area?
2. What current state policies/procedures or system design elements need to be considered for the purpose of CCBHC design and its role?
3. Are the counties considered the recommended CCBHC Service Area?
4. Are there other providers you want to consider engaging that are new or re-engagements?
5. Operational considerations:
    - Finalize and approve Delaware's CCBHC criteria.
    - Identify any target Medicaid population.
    - Identify any targeted case management populations (a required service).

    - Finalize the billing code list.
    - Begin work on data and outcome requirements based on the current Demonstration Application.
6. Determine the MCOs' role (payment, oversight) and engage the MCOs in the implementation.
7. Determine any changes to crisis services to meet the CCBHC requirements and/or make exception request to HHS. This includes crisis services as a Medicaid billable service, a non-payment DCO or some other relationship with the CCBHCs.
8. There are currently no SAMHSA forecasted CCBHC provider planning grants. Does the CASC want to provide additional funding to providers to support their development to become provisionally certified?

BBS will support the CASC in this reflection, as well as making these decisions and identifying next steps. The workplan for the CCBHC Planning Grant No-Cost Extension submitted to SAMHSA can be found at the end of this report and should be used to guide the timeline for decisions.

VIII. ADDENDUM FOLLOWING JUNE 21, 2024 CASC MEETING

This Needs Assessment was discussed at the June 21, 2024 CASC Meeting. The CASC requested a few pieces of updated data information, including: poverty data (lifespan and children), child welfare data, and overdose data.

POVERTY DATA

POVERTY – LIFESPAN

The United States Census Bureau's 2022 American Community Survey 1-Year Estimates report that Delaware has a higher median household income ($82,174) than the national average ($74,755). Delaware also has a lower percentage of people living in poverty at 9.4% compared to the national average of 12.6%. People in Delaware have a greater chance of living in poverty the younger they are.

Poverty by Age	DE
Under 18 Years	12.9%
18 to 64 Years	8.7%
65 Years and Over	7.7%

Source: Delaware - Census Bureau Profile

POVERTY – CHILDREN

Most recent data from the 2024 Kids Count Data Profile shows 26,000 children living in poverty. The table below shows how this compares over time and to national averages.

Children in Poverty	DE	USA
2019	16%	17%
2022	13%	16%

Source: 2024-KCDB-profile-DE.pdf (aecf.org)

CHILD WELFARE

The CASC requested additional information on child placement and reunification. This supplements existing data in the Needs Assessment under the Child Wellbeing (Child Protection - Child and Youth) section (Page 24-25).

Overview	DE
Child Maltreatment Victims (does not include children with dispositions of alternative response)	1,131
Foster Care Entry Rate (per 1,000 children in the state population)	1.4%
Children in Foster Care on 9/30	444
Children Adopted	88

Children in Foster Care by Race/Ethnicity	
Child Maltreatment Victims (does not include children with dispositions of alternative response)	1,131

Children in Foster Care by Race/Ethnicity			
	Entering Foster Care in FY 2021	In Foster Care on 9/30 (2021)	Exiting Foster Care in FY 2021
Alaskan Native / American Indian	0	0.2	0
Asian	0	0	0
Black	44.6	47.7	41.8
Native Hawaiian / Other Pacific Islanders	0	0	0
Hispanic (of any race)	9.2	8.1	15
White	42.9	38.5	37.9
Two or more races	3.4	5.4	5.4

Exits of Children from Foster Care (%) in 2021	DE
Adoption	30.7
Guardian	22.9
Reunification	27.9
Other	18.6
Total Number	280

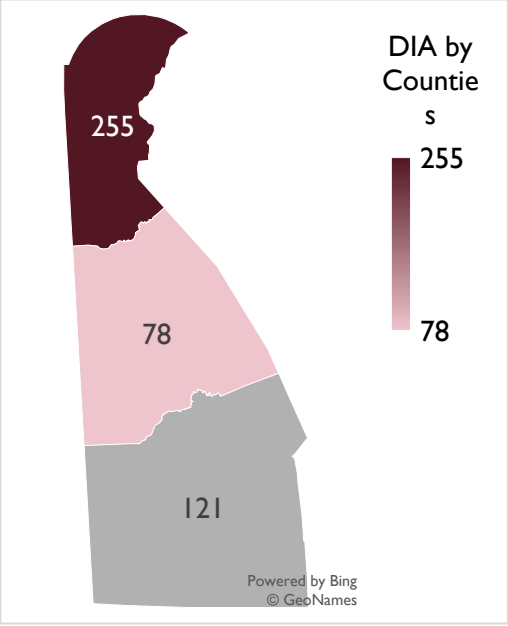
Source: Child Welfare Outcomes Report Data. Children's Bureau. Administration for Children & Families. U.S. Department of Health & Human Services.

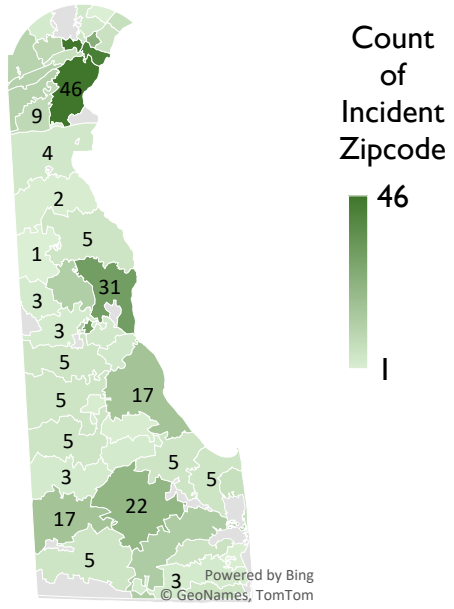
OVERDOSE DATA

DEATH INVESTIGATION ALERT (DIA) DATA FROM 2023

The Division of Substance Abuse and Mental Health (DSAMH) receives a Death Investigation Alert (DIA) when the cause of death of a Delawarean adult (18+) is suspected to be caused by a drug overdose. These deaths are classified as suspected overdose deaths because the alerts are obtained before the medical examiner confirms the cause of death. The purpose of analyzing suspected overdose deaths is to: identify notable trends, patterns, and hotspots; and inform potential interventions.

The following maps highlight the areas of the state with the highest number of overdose deaths. (n=454)





VIII. APPENDICES

APPENDIX 1: SOURCES

REPORTS AND RESOURCES INVENTORY (USED AND/OR REVIEWED)

Author	Title	Date
Annie E. Casey Foundation	Kids Count	2022 2023
Center for Disease Control	CDC WONDER Youth Risk Behavior Survey Behavioral Health Risk Factor Survey	Ongoing 2021 2022
CMS	Children's core set measures Adult core set measures Medicaid and CHIP scorecard Medicaid and CHIP total enrollment data Managed care enrollment data Data.Medicaid.gov	Ongoing
County Health Rankings	2024 Annual Data Release	2024
Delaware Department of Education	*2021-2022 Delaware Graduation Summary Statistics (2023)*	2022
Delaware Environmental Public Health Tracking Network	My Healthy Community	Ongoing
Division of Prevention and Behavioral Health Service	Take Care Delaware/Handle with Care Presentation to the Behavioral Health Consortium	Ongoing April 2021
Division of Public Health	Advancing the Health and Well-being of Delaware Students: A Strategic Plan for School-Based Health Centers in Delaware (2021) Release of Information on 2020 Delaware's Unintentional Drug Overdose Deaths	2021 August 2022
Division of Substance Abuse and Mental Health	DE Mental Health NOMS (2023) DIA Report (Dec 2023) DSAMH Dashboard at a Glance DTRN Monthly Dashboard Joint Finance Committee FY 2022 Annual Update MCIS Dashboard Multi-Year URS Output Tables SAMHSA URS Output Tables	Various years

	State of Behavioral Health in DE Initiation and Engagement Report 2016-2019 Substance Use Service Report – Daily Available Beds Report	
HMA Institute on Addiction	Delaware Substance Use Disorder Treatment System Needs Assessment	June 2022
Mental Health America	Policy Issues and Statements State and County Dashboard	2024 2022 2023
Mid-Atlantic Association of Community Health Centers	Community Needs Assessment Delaware 2021	2021
NAMI	NAMI_2022_State_Legislation_Report.pdf	2022
RAND	How_to_Transform_the_U.S._Mental_Health System	2021
SAMSHA	Certified Community Behavioral Health Clinic - criteria March 2023 NSDUH: Model-Based Estimated Prevalence for States | CBHSQ Data (samhsa.gov)	2023 2022 2021
University of Delaware, Biden School of Public Policy & Administration, Center for Community Research & Service	Substance Use Disorder Among Delaware Medicaid Clients - Annual Prevalence Report 2014-2019	February 2022 (currently being updated)
University of Delaware	Mental Health Professionals in Delaware	2019
U.S. Department of Health and Human Services	T-MSIS Substance Use Disorder Data Book	December 2022

APPENDIX 2: ADDITIONAL CENSUS DATA

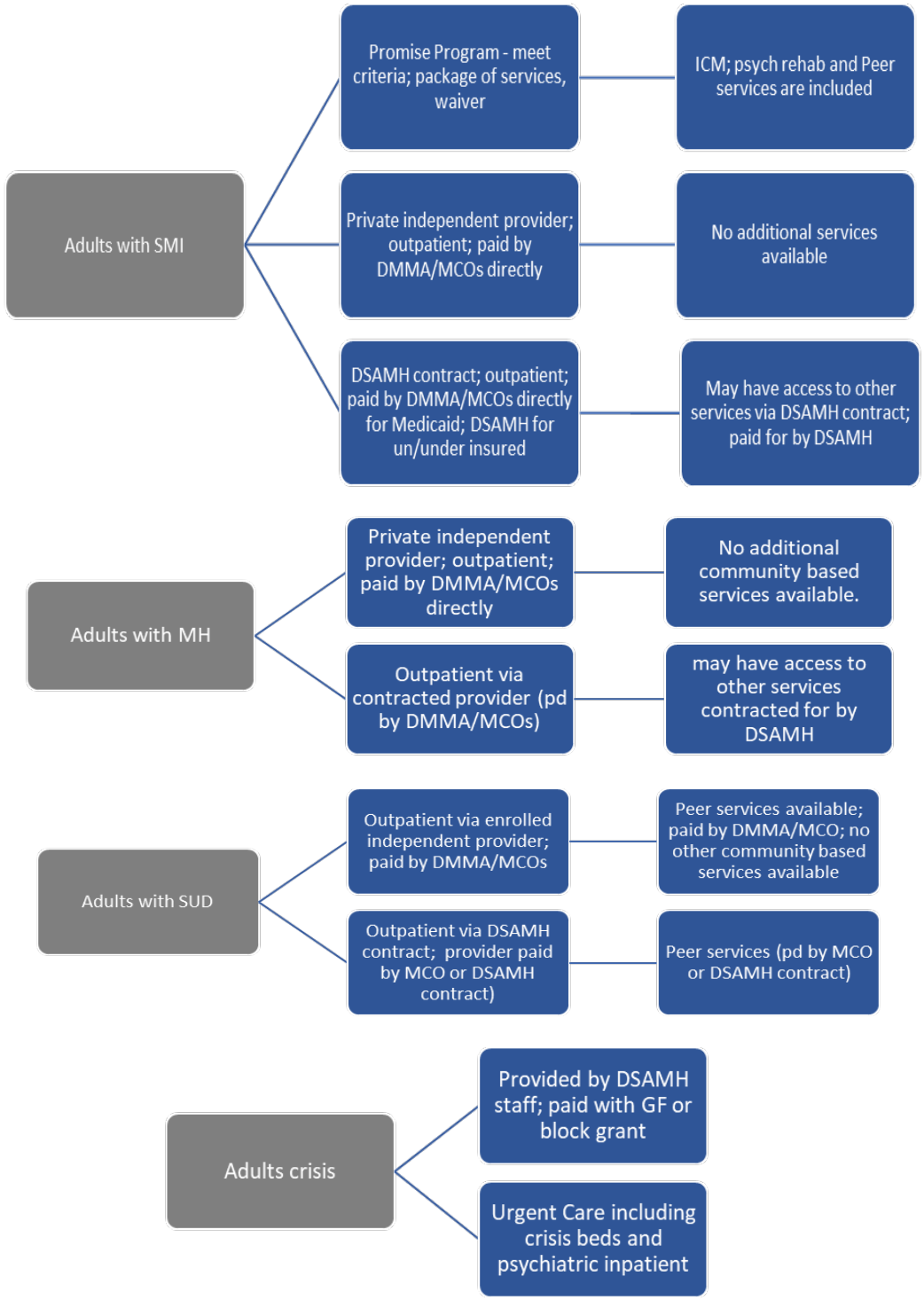
Data reflects July 2023 and some data points from 2018-2022 when updated data not available.

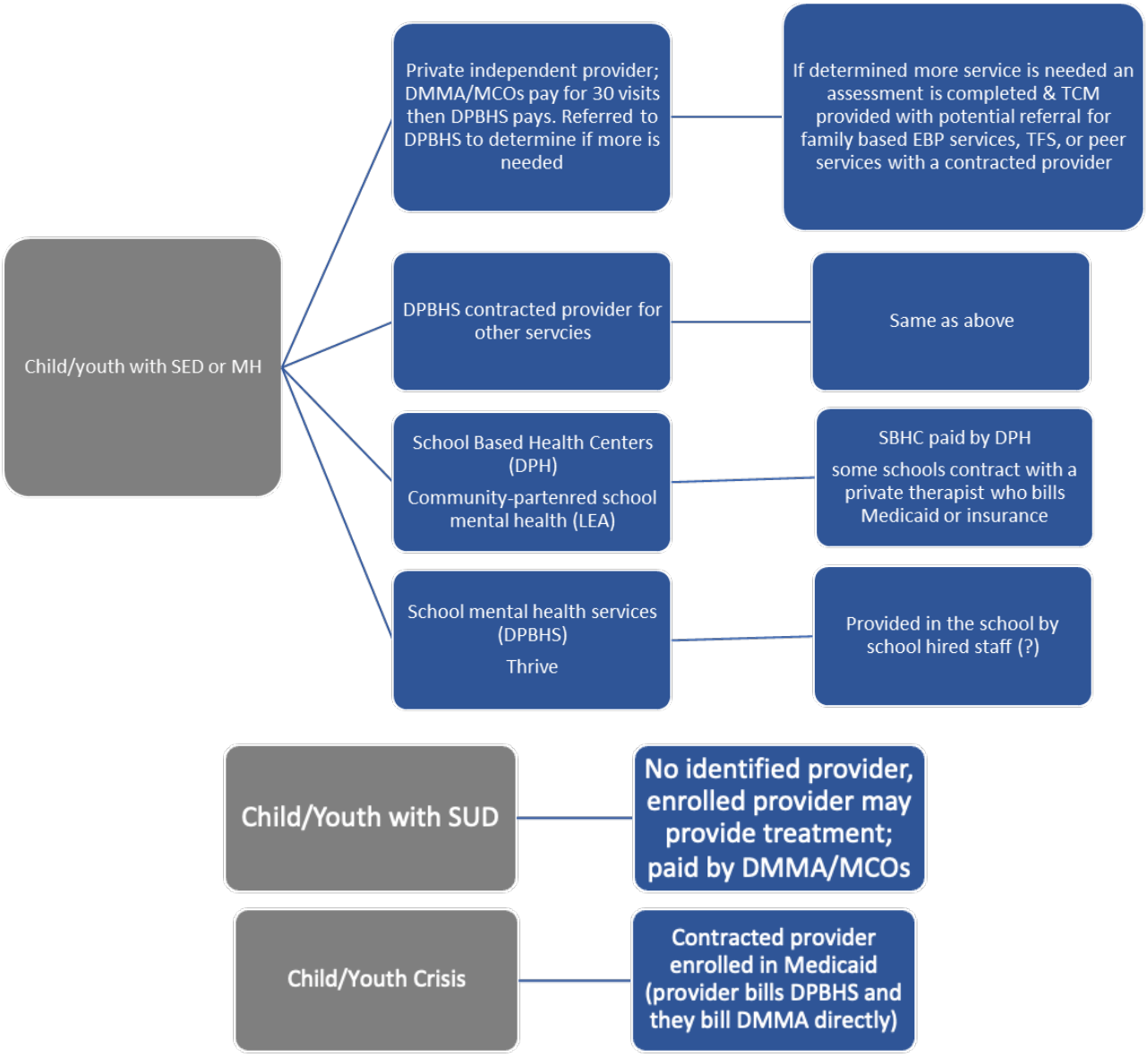
Demographic (*of state)	State #	State % (of total)	New Castle #	New Castle %	Kent #	Kent %	Sussex #	Sussex %	US Avg *if applicable*
Total Pop.*	1,031,890	100%	575,494	55.8%	186,946	18.1%	255,956	24.8%	
Children 0-5	54,690	5.3%	31,077	5.4%	10,843	5.8%	11,518	4.5%	5.6%
Children 6-17	210,506	20.4%	120,854	21.0%	42,437	22.7%	44,536	17.4%	21.7%
Adults 26-64	552,061	53.5%	324,579	56.4%	99,268	53.1%	121,067	47.3%	
Adults 65+	214,633	20.8%	98,985	17.2%	34,398	18.4%	78,834	30.8%	17.3%
White, alone	143,144	68.0%	360,259	62.6%	118,898	63.6%	213,467	83.4%	75.5%
Black or African American	131,391	23.8%	158,836	27.6%	54,027	28.9%	29,691	11.6%	13.6%
Hispanic or Latino	22,107	10.3%	65,031	11.3%	15,143	8.1%	24,828	9.7%	19.1%
Two or more races	4,294	3.0%	16,689	2.9%	7,852	4.2%	6,143	2.4%	3.0%
American Indian or Alaska Native	7,223	0.7%	2,877	0.5%	1,496	0.8%	2,816	1.1%	1.3%
Asian	45,403	4.4%	36,256	6.3%	4,487	2.4%	3,583	1.4%	6.3%
Native Hawaiian/Other Pacific Islander	1,032	0.1%	575	0.1%	187	0.1%	256	0.1%	0.3%
Veterans	63,088	6.1%	28,398	4.9%	16,734	9.0%	17,956	7.0%	5%
Housing Units*	465,787	100.0%	236,626	50.8%	76,899	16.5%	152,262	32.7%	
Households*	389,000	100.0%	220,437	56.7%	68,705	17.7%	99,858	25.7%	
Language other than English spoken at home	54,071	13.9%	91,504	15.9%	20,751	11.1%	28,923	11.3%	21.7%
H.S. graduate or higher	941,084	91.2%	532,332	92.5%	166,195	88.9%	230,616	90.1%	89.1%
With a disability (under 65)	97,274	9.7%	41,933	8.8%	23,929	12.8%	24,572	9.6%	8.9%
Persons without health insurance (under 65)	56,391	6.9%	28,114	5.9%	14,395	7.7%	22,268	8.7%	9.3%
Person in Poverty	96,998	9.4%	58,125	10.1%	19,629	10.5%	24,316	9.5%	11.5%
Population per sq mile	508	N/A	1,338.70	N/A	310.3	N/A	253.6	N/A	

Source: U.S. Census Bureau QuickFacts: Delaware

APPENDIX 3: VISUAL OF CURRENT DE BH SYSTEM

These visuals should be considered draft in representing the current system and can be updated to reflect more accurately the current system flow.




Child/youth with SED or MH
Private independent provider; DMMA/MCOs pay for 30 visits then DPBHS pays. Referred to DPBHS to determine if more is needed
If determined more service is needed an assessment is completed & TCM provided with potential referral for family based EBP services, TFS, or peer services with a contracted provider
DPBHS contracted provider for other servcies
Same as above
School Based Health Centers (DPH)
Community-partenred school mental health (LEA)
SBHC paid by DPH
some schools contract with a private therapist who bills Medicaid or insurance
School mental health services (DPBHS)
Thrive
Provided in the school by school hired staff (?)
Child/Youth with SUD
No identified provider, enrolled provider may provide treatment; paid by DMMA/MCOs
Child/Youth Crisis
Contracted provider enrolled in Medicaid (provider bills DPBHS and they bill DMMA directly)

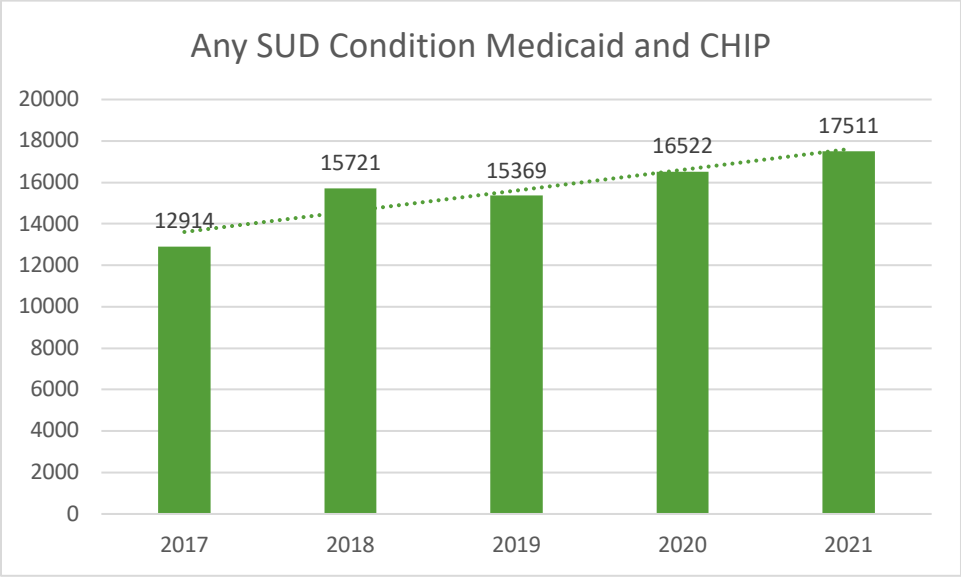
APPENDIX 4: DE LICENSING AND PERFORMANCE MANAGEMENT OF BH SERVICES

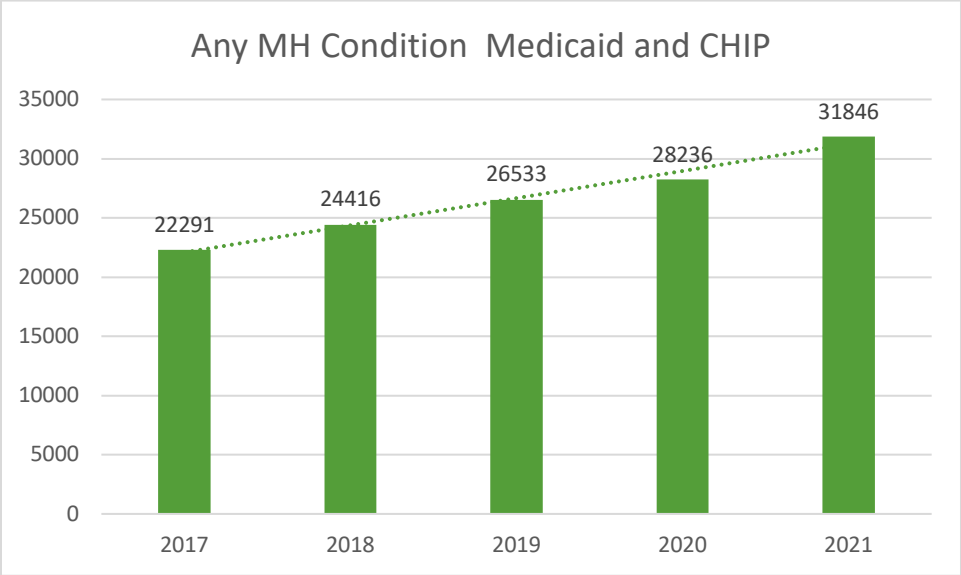
Licensing and performance management of behavioral health services is also divided for providers of Medicaid services and payments for uninsured or underinsured with each division addressing the needs of uninsured or underinsured slightly differently. CCBHC expectations include serving those populations.

Not including independent mental health counselors, DSAMH provides Medicaid certification to all other contracted providers (i.e. community mental health treatment, independent living and community integration; mobile crisis intervention services; inpatient psychiatric evaluation, diagnosis and treatment; substance abuse treatment and prevention services; assessment and case management services for clients sentenced by the Drug Court; and problem gambling services.

Service or Provider Type	Certification (to bill Medicaid)	Licensing	Payment	Part of CCBHC
Licensed independent counselors	Directly enroll in Medicaid	Licensing Board	Medicaid and private insurance	No other than in coordination with a CCBHC
Community based providers with contracts with DSAMH or DPBHS system	Certified by DSAMH	SUD licensed by DSAMH; no other license at this time	Direct contracts or Medicaid	Yes
Crisis services adults	Adult not certified.		Adult – state or other funding	Yes
Crisis services children/youth	Call center services are not certified. Mobile crisis services are certified		Direct contracts or Medicaid	Yes
Residential programs		Children's residential services are licensed by the DE DOE-Office of Childcare Licensing	For children's services, Medicaid and co-insurance (Medicaid and private)	No other than in coordination with a CCBHC
Inpatient hospitals				No other than in Coordination with a CCBHC

APPENDIX 5: NUMBER OF BENEFICIARIES WITH SUD OR MH CONDITIONS





Source: Medicaid

APPENDIX 6: PROVIDER AVAILABILITY BY COUNTY 2023

NEW CASTLE COUNTY

Week ending	Mobile Outpatien	TSF	FBS	MST	FFT	Wrap
1/20/23	26	5	9	9	20	0
1/27/23	16	13	0	0	15	2
2/3/23	14	13	4	0	5	2
2/10/23	15	17	0	1	15	0
2/17/23	11	14	0	2	15	2
2/24/23	12	12	0	3	14	3
3/3/23	13	15	0	3	11	4
3/10/23	9	20	0	1	11	5
3/17/23	12	17	0	0	8	3
3/24/23	15	19	2	0	10	3
3/31/23	16	14	2	0	7	3
4/14/23	16	15	3	0	3	4
4/21/23	8	13	5	0	2	3
4/28/23	19	17	0	0	6	4
5/5/23	14	8	1	0	4	4
5/12/23	26	9	1	0	4	2
5/19/23	16	21	1	8	1	2
5/26/23	30	23	0	5	2	2
6/2/23	33	25	0	5	2	1
6/9/23	28	24	0	0	3	1
6/16/23	35	24	1	0	1	1
6/23/23	26	20	0	0	3	1
6/30/23	32	25	2	2	4	0
7/7/23	32	24	2	1	2	0
7/21/23	31	26	1	4	0	0
7/28/23	27	21	2	1	1	1
8/4/23	32	29	1	1	2	1
8/11/23	30	29	1	1	4	1
8/18/23	37	22	0	5	7	1
8/25/23	31	25	4	6	6	1
9/1/23	32	30	1	5	4	2
9/8/23	32	30	2	5	5	2
9/15/23	33	30	1	5	5	1
9/22/23	35	28	2	3	2	1
9/29/23	32	30	3	1	1	1
10/6/23	35	26	7	2	3	2
10/20/23	34	35	7	4	3	1
10/27/23	31	32	6	4	6	1
11/3/23	37	34	4	4	6	1
11/10/23	43	36	8	4	7	0
11/17/23	43	21	11	6	7	0
12/1/23	55	23	14	3	7	0
12/8/23	37	26	12	3	6	1
12/15/23	38	21	12	12	5	1
12/22/23	41	25	9	19	5	1

KENT COUNTY

Week ending	Mobile Outpatient	TSF	FBS	MST	FFT	Wrap
1/20/23	0	1	0	3	6	12
1/27/23	1	3	0	0	5	2
2/3/23	1	3	0		5	2
2/10/23	3	3	1	1	7	3
2/17/23	3	2	0	2	5	2
2/24/23	3	4	0	3	5	1
3/3/23	3	4	1	3	5	2
3/10/23	5	4	0	3	3	2
3/17/23	4	2	0	3	4	3
3/24/23	2	1	2	1	3	2
3/31/23	1	1	1	1	2	4
4/14/23	8	4	1	4	1	6
4/21/23	8	2	1	3	0	5
4/28/23	5	2	3	3	0	6
5/5/23	3	6	0	0	1	6
5/12/23	3	4	0	0	1	10
5/19/23	1	8	0	0	7	8
5/26/23	5	4	7	4	6	8
6/2/23	10	4	0	6	0	7
6/9/23	11	0	0	4	5	10
6/16/23	10	2	2	2	2	10
6/23/23	19	4	6	1	5	10
6/30/23	18	7	2	0	4	10
7/7/23	23	12	2	3	7	10
7/21/23	25	21	6	6	4	8
7/28/23	20	15	4	6	3	7
8/4/23	20	11	2	3	2	10
8/11/23	21	20	6	0	6	8
8/18/23	22	15	5	5	4	8
8/25/23	17	10	5	5	3	8
9/1/23	14	9	0	3	5	9
9/8/23	13	6	3	5	5	9
9/15/23	15	7	2	6	1	6
9/22/23	14	7	6	6	4	8
9/29/23	13	8	6	4	6	5
10/6/23	18	12	2	2	4	5
10/20/23	20	20	2	4	2	2
10/27/23	16	20	2	5	1	0
11/3/23	13	17	2	5	4	0
11/10/23	15	17	2	5	3	0
11/17/23	17	22	3	8	4	0
12/1/23	19	17	6	8	4	0
12/8/23	14	15	2	2	2	0
12/15/23	17	18	6	6	2	0
12/22/23	15	18	6	5	2	0

SUSSEX COUNTY

Week ending	Mobile Outpatient	TSF	FBS	MST	FFT	Wrap
1/20/23	1	1	0	3	0	6
1/27/23	1	6	0	0	0	6
2/3/23	0	4	0	0	0	6
2/10/23	0	2	0	1	1	6
2/17/23	1	6	0	2	0	4
2/24/23	0	6	0	2	0	6
3/3/23	2	6	0	2	0	5
3/10/23	2	14	0	2	0	8
3/17/23	4	11	0	0	2	6
3/24/23	2	10	0	0	1	6
3/31/23	1	11	0	0	0	7
4/14/23	2	6	0	3	0	6
4/21/23	1	11	0	3	0	10
4/28/23	1	6	0	3	0	10
5/5/23	1	4	0	0	1	10
5/12/23	1	2	0	0	0	10
5/19/23	4	2	0	0	0	10
5/26/23	8	0	0	4	0	9
6/2/23	4	0	0	4	0	11
6/9/23	6	2	0	4	3	11
6/16/23	9	1	0	2	2	10
6/23/23	9	8	0	1	3	11
6/30/23	9	7	0	0	4	11
7/7/23	19	6	0	0	3	11
7/21/23	8	11	0	0	2	10
7/28/23	5	9	0	0	2	9
8/4/23	5	8	0	0	2	10
8/11/23	1	2	0	0	0	10
8/18/23	5	3	0	0	0	10
8/25/23	5	4	0	0	0	11
9/1/23	3	10	0	0	0	10
9/8/23	3	12	0	0	0	10
9/15/23	4	8	0	0	2	10
9/22/23	4	10	0	3	0	10
9/29/23	7	6	3	0	2	10
10/6/23	15	6	5	0	0	11
10/20/23	20	17	5	0	0	10
10/27/23	15	20	6	1	0	9
11/3/23	9	16	6	1	0	9
11/10/23	11	16	6	2	0	8
11/17/23	11	6	6	0	0	7
12/1/23	12	12	6	2	0	7
12/8/23	11	14	6	0	0	10
12/15/23	10	12	6	0	0	10
12/22/23	10	14	6	0	0	9

APPENDIX 7: SAMPLING OF CORE DATA SET MEASURES

Cells highlighted in red indicate Delaware scored in the bottom quartile of the associated measure when compared to all states nationally. Cells highlighted in green indicate Delaware scored in the top quartile of the associated measure

1: higher is better; 2: lower is better; 3: is a CCBHC state required measure:

Measure (Age 18 and older)	Delaware State Rate	U.S. Median
Adherence to Antipsychotic Medications for Individuals with Schizophrenia[1;3]	60.9	62.2
Antidepressant Medication Management (at 12 weeks)[1;3]	56.9	58.8
Antidepressant Medication Management (at 6 months)[1;3]	40.8	41.8
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications: Ages 18 to 64[1]	70.1	77.1
Concurrent Use of Opioids and Benzodiazepines[2]	10.7	13.3
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence within 7 Days[1;3]	11	15.5
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence within 7 Days[1;3]	20.9	23.8
Follow-Up After Emergency Department Visit for Mental Illness or with Intentional Self-Harm within 7 days[1;3]	30.2	38.9
Follow-Up After Emergency Department Visit for Mental Illness or with Intentional Self-Harm within 30 Days[1;3]	41.8	52.5
Follow-Up After Hospitalization for Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 7 Days of the ED Visit[1;3]	28.8	33.9
Follow-Up After Hospitalization for Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 30 Days of the ED Visit[1;3]	45.9	54.5
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Percentage with a New Episode of Alcohol Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Ages 18 to 64[1;3]	45.5	42.1
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Percentage with a New Episode of Alcohol Abuse or Dependence who	15.4	12.2

Measure (Age 18 and older)	Delaware State Rate	U.S. Median
Initiated and Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation Visit: Ages 18 to 64[1;3]		
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Percentage with a New Episode of Opioid Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Ages 18 to 64[1;3]	62.3	56.6
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Percentage with a New Episode of Opioid Abuse or Dependence who Initiated and Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation Visit: Ages 18 to 64[1;3]	39.1	29.5
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Percentage with a New Episode of Other Drug Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Ages 18 to 64[1;3]	44.4	41.3
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Percentage with a New Episode of Other Drug Abuse or Dependence who Initiated and Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation Visit: Ages 18 to 64[1;3]	13.7	11
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Percentage with a New Episode of Alcohol or Other Drug Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Ages 18 to 64[1;3]	49	43.4
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Percentage with a New Episode of Alcohol or Other Drug Abuse or Dependence who Initiated and Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation Visit: Ages 18 to 64[1;3]	23	15.8
Use of Opioids at High Dosage in Persons Without Cancer[2]	7.1	6.7
Use of Pharmacotherapy for Opioid Use Disorder: Ages 18 to 64[1]	65.5	56.0
Prenatal and Postpartum Care: Postpartum Care: Percentage of Women Delivering a Live Birth who had a Postpartum Care Visit on or Between 7 and 84 Days after Delivery[1]	79.3	75

Core Data Set Measures Sampling - Adults *higher number is better*	DE Medicaid Rate	USA Median
Antidepressant Medication Management (at 12 weeks)	56.9	58.8
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence within 7 Days	11	15.5
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Percentage with a New Episode of **Alcohol Abuse or Dependence** who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis: Ages 18 to 64	45.5	42.1
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Percentage with a New Episode of **Opioid Abuse or Dependence** who Initiated and Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation Visit: Ages 18 to 64	39.1	29.5

Core Data Set Measures Sampling – Children and Youth *higher number is better*	DE Medicaid Rate	USA Median
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: Ages 1 to 17	54.4	62.6
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication: Ages 6 to 12 Percentage Newly Prescribed ADHD Medication with 1 Follow-Up Visit During the 30-Day Initiation Phase	33.5	43
Metabolic Monitoring for Children and Adolescents on Antipsychotics: Ages 1 to 17 Percentage on Antipsychotics Percentage on Antipsychotics who Received Cholesterol Testing: Ages 1 to 17	53.9	35.3
Delaware did not report on these three measures: 1. Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 (DE does not report on this measure) 2. Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (DE does not report on this measure) and 3. Follow up after Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-CH and FUA-AD)	n/a	1. 54.6 2. 47.9 3. 10.6

Source: Child and Adult Health Care Quality Measures Quality 2022

Core Data Set Measures Sampling – Children and Youth *higher number is better*	DE Medicaid Rate	USA Median
Percentage with at Least 1 Well-Care Visit with a Primary Care Practitioner or Obstetrician/Gynecologist: Ages 3 to 21	57.5	47.6
Developmental Screening in the First Three Years of Life: Ages 0 to 3	82.5	34.7
Well-Child Visits in the First 30 Months of Life: Percentage of Children who had 6 or More Well-Child Visits with a Primary Care Practitioner during the First 15 Months of Life	61.8	57.5
Well-Child Visits in the First 30 Months of Life: Percentage of Children who had 2 or More Well-Child Visits with a Primary Care Practitioner during the 15th to 30th Months of Life	74.1	65.1

Source: Child and Adult Health Care Quality Measures Quality 2022

Measure (see age description in each measure)	Delaware Medicaid Rate	U.S. Median
Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 (DE does not report on this measure)[3]	N/A	54.6
Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (DE does not report on this measure)[3]	N/A	47.9
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication: Ages 6 to 12 Percentage Newly Prescribed ADHD Medication with 1 Follow-Up Visit During the 30-Day Initiation Phase[1;3]	33.5	43
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication: Ages 6 to 12, Percentage Newly Prescribed ADHD Medication with at Least 2 Follow-Up Visits in the 9 Months Following the Initiation Phase: Ages 6 to 12[1;3]	42.2	54.1
Metabolic Monitoring for Children and Adolescents on Antipsychotics: Ages 1 to 17 Percentage on Antipsychotics who Received Blood Glucose Testing[1;3]	61.5	52.4

Measure (see age description in each measure)	Delaware Medicaid Rate	U.S. Median
Metabolic Monitoring for Children and Adolescents on Antipsychotics: Ages 1 to 17 Percentage on Antipsychotics Percentage on Antipsychotics who Received Cholesterol Testing: Ages 1 to 17[1;3]	53.9	35.3
Metabolic Monitoring for Children and Adolescents on Antipsychotics: Ages 1 to 17 Percentage on Antipsychotics who Percentage on Antipsychotics who Received Blood Glucose and Cholesterol Testing: Ages 1 to 17[1;3]	49.9	33.2
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: Ages 1 to 17[1;3]	54.4	62.6
Percentage with at Least 1 Well-Care Visit with a Primary Care Practitioner or Obstetrician/Gynecologist: Ages 3 to 21[1]	57.5	47.6
Developmental Screening in the First Three Years of Life: Ages 0 to 3[1]	82.5	34.7
Well-Child Visits in the First 30 Months of Life: Percentage of Children who had 6 or More Well-Child Visits with a Primary Care Practitioner during the First 15 Months of Life[1]	61.8	57.5
Well-Child Visits in the First 30 Months of Life: Percentage of Children who had 2 or More Well-Child Visits with a Primary Care Practitioner during the 15th to 30th Months of Life[1]	74.1	65.1

Source: *2022 Child and Adult Health Care Quality Measures Quality (medicaid.gov)*

APPENDIX 8: MCO SCORECARD ON BEHAVIORAL HEALTH

Ranking 1-5 (1 worse - 5 best)	Highmark	Amerihealth
Care Coordination		
Follow-up after hospitalization for MI	2	2
Follow-up after ED for MI	2	2
Follow-up after ED for SUD	3	3
Follow-up after high-intensity care for SUD	4	4
Medication Adherence		
Adherence to antipsychotic medications for individuals with schizophrenia	3	3
Patients with a new episode of depression—medication adherence for 6 months	2	3
Patients with opioid use disorder—medication adherence for 6 months	4	4
Access, Monitoring and Safety		
Cholesterol and blood sugar testing for youth on antipsychotic medications	4	4
Continued follow-up after ADHD diagnosis	2	3
Diabetes screening for individuals with schizophrenia or bipolar disorder	1	1
First-line psychosocial care for youth on antipsychotic medications	3	2
Substance use disorder treatment engagement	4	5
Risk Adjusted Utilization		
Plan all-cause readmissions For members ages 18 to 64,	1	1
Overuse of Opioids		
Avoiding opioids at high dosage	2	3
Avoiding opioids from multiple prescribers and multiple pharmacies	2	2
Avoiding potentially risky continued opioid use	2	2

APPENDIX 9: FOUR-YEAR GRADUATION RATES BY STUDENT GROUP CLASS OF 2022

The Delaware Department of Education's Graduation Summary includes additional rates by school district and individual school, which can be utilized to inform CCBHCs in conducting community needs assessments.

Student Group	Students in Cohort	Graduates	Graduation Rate
All Students	10,987	9,645	87.79%
Race/Ethnicity			
African American	3,548	3,023	85.20%
Asian American	456	432	94.74%
Hispanic or Latino	1,913	1,568	81.97%
Multi-Racial	330	291	88.18%
Native American	75	63	84.00%
Native Hawaiian/Pacific Islander	22	18	81.82%
White	4,643	4,250	91.54%
By Other Characteristics			
English Learner	727	504	69.33%
Low Income	2,836	2,289	80.71%
Students with Disabilities	1,836	1,323	72.06%
By Residence			
Foster Care	88	48	54.55%
Homeless	459	322	70.15%
Migrant	*	*	33.33%
Military Family	403	379	94.04%

Source: *2021-2022 Delaware Graduation Summary Statistics (2023)*

APPENDIX 10: PROJECTED NATIONAL BH STAFF SHORTAGES

HRSA is also projecting national shortages will increase between 27% and 93% for selected behavioral health providers by 2036.

Profession	Status Quo	Unmet Need	Elevated Need
Addiction counselors	-87,630 (53%)	-125,0101 (45%)	-153,190 (40%)
Adult psychiatrists	-37,980 (45%)	-51,680 (38%)	-82,920 (27%)
Child and Adolescent psychiatrists	-4,150 (75%)	-7,470 (63%)	-20,050 (39%)
Child, family, and school social workers	25,270 (112%)	-15,250 (94%)	-15,920 (93%)
Healthcare social workers	-3,920 (98%)	-26, 080 (80%)	-31,640 (77%)
Marriage and family therapists	-27, 450 (64%)	-42,840 (54%)	-51,140 (49%)
Mental health and substance use disorder social workers	-8,250 (93%)	-32,350 (78%)	-61,120 (65%)
Mental health counselors	-69,610 (62%)	-105,950 (52%)	-138,670 (45%)
Psychiatric physician assistants/associates	530 (111%)	-490 (92%)	-2,190 (71%)
Psychologists	-62,490 (63%)	-95,970 (52%)	-110,600 (49%)

Source: Health Resources and Services Administration

Note: Data are expressed in full-time equivalents (FTEs). Negative values indicate a projected shortage. Positive values indicate a projected surplus. Percent adequacy is calculated by dividing supply by demand. Unmet Need assumes increased demand and Elevated Need assumes both increased demand and improved access. Full descriptions of scenarios are found on the HRSA Workforce Projections Dashboard.

APPENDIX 11: BEHAVIORAL HEALTH WORKFORCE SHORTAGES

State	Points of Note
Maryland	• There is currently a Commission to Study the Health Care Workforce Crisis in Maryland to study the extent of healthcare workforce shortage in the State including the extent of shortages in community-based behavioral health treatment programs, examine the short-term solutions to address the immediate needs for identified shortages, and examine future health care workforce needs. A final report from the Commission was completed in December 31, 2023 • In recent years, the telehealth rules have been revised multiple times to allow behavioral health practitioners to provide services via synchronous and asynchronous modalities, by video and audio-only, and to prescribe • In 2020, Maryland passed legislation to join a new interstate. licensing compact for professional counselors.
New York	• Through the Office of Strategic Workforce Development state and city universities have increased funds for educational opportunities and some unrestricted funds for the equity population to use how they need to during their education and to make up for lost income. This approach will allow people to gain the education needed to enter the workforce in a needed field and not further enter into debt due to their inability to work full-time while learning. • With a $2M investment the City University of New York (CUNY) will train individuals to become the qualified mental health professionals that are needed. This includes a focus on minority and multilingual students. • The healthcare workforce including human services has been impacted by the COVID-19 pandemic and investing in this needed workforce is a priority of the administration. This will include loan repayment beyond just prescribers in the hopes of maintaining the current workforce and attracting new employees through bonuses and the educational supports reference above.
Washington, DC	The District of Columbia identified this as one of their top focus areas, with focus on short and long-term solutions. Among the strategies are: • Expose high school and college students of workforce opportunities through different tactics, including information sessions at colleges and universities

	• Have developed a repository of upcoming graduates who are interested in working in education settings to share with CBOs who can potentially hire them upon graduation • Review different strategies to maximize licensed and non-licensed staff based on need and equity including how licensed staff are allocated to each school instead of assigning 1 FTE to each school regardless of need; and determining what Tier 1 and 2 services can be provided by non-licensed staff to maximize licensed staff's availability providing Tier 3 services The District's Primary Project also utilizes by "child associates" who are para professionals. This prevention and early intervention program is designed to reduce mild adjustment difficulties of identified children in pre-kindergarten/ through third grade through one-to-one, non-directive play sessions to young children
National Center for School-based Mental Health	The Center has issued a recent brief - *Partnering With Colleges and Universities to Improve Your K–12 School Mental Health System* - with strategies for enhancing K–12 school mental health programming. Some of these strategies include: developing partnerships with colleges and universities to expand the workforce pipeline, conducting outreach to and engagement of students early in their career decision-making process, developing shadow and mentorship opportunities for new undergraduate and graduate students to spark interest and investment in school mental health professions, and building in externship and other practicum opportunities beyond initial engagement can lead to full-time positions and dedicated careers in school mental health.