New Mexico Behavioral Health Collaborative

Strengthening New Mexico's Behavioral Health Service Delivery System

Executive Summary

The Behavioral Health Collaborative kicked-off its "Strategic Initiative to Strengthen New Mexico's Behavioral Health Service Delivery System" with a day-long strategic planning session on July 30, 2015. The Strategic Action Plan that ultimately results from this process will enhance the sustainability of the publicly-funded behavioral health service system in New Mexico.

Three workgroups were formed to focus on the following areas: Finance, Regulation, and Workforce. These three domains have been consistently cited as crucial to meaningful system improvement. Workgroup members were personally invited to participate in their particular workgroup because of their specific expertise and responsibility, their decision-making role, or to represent the perspective of their constituency. They were asked to remain with their assigned workgroup all day and to contribute from their deep knowledge and experience within each area. Each workgroup was given the same task: develop a practical, achievable, set of tasks, objectives, and priorities that can be accomplished within a two-year timeframe that will create sustainable improvements.

In advance of the strategic planning session, invited participants were asked to review a summary of current Behavioral Health Collaborative Initiatives. Participants were also provided a "white paper" -- a seven page overview of the most significant issues facing the state's behavioral health service system, and examples of possible actions formed from numerous reports, advisory group recommendations, and department studies of possible action steps. These were described as a starting point, but not a final list, of what each workgroup might consider and propose as priority actions. In addition, the concept of mutually complementary actions across several domains, i.e., an issue that is to be addressed by the Workforce group might also require developmental progress in the Regulatory or the Finance area to make change possible and practical.

A very diverse range of stakeholders and decision makers actively engaged in the full day planning session, which included:

- Senior managers from Behavioral Health Collaborative agencies;
- Two cabinet secretaries (Indian Affairs Department and Veteran Services Department);
- Three deputy secretaries (Departments of Human Services, Public Education, and Children, Youth, and Families);
- County Commissioners from two of New Mexico's most populous counties (Bernalillo and Dona Ana);
- Members of the Behavioral Health Planning Council;
- Representatives of the Local Collaboratives;
- Representatives of all four Managed Care Organizations (MCO);
- Members of the Behavioral Health Providers Association;
- Members of other BH professional associations;
- Partners from the University of New Mexico;
- Peer and family members;
- Representative of The Legislative Finance Committee; and
- The Association of Counties.

Fifty-nine individuals from a broad range of organizations, perspectives, experiences, and values committed to work together to recommend ways to improve the behavioral health service delivery system. All participants worked with their respective workgroups for the entire day. The Workforce Workgroup had 27 participants, the Finance Workgroup had 16, and the Regulatory Workgroup had 17 participants.

WORKGROUP OUTCOMES

The Workforce Workgroup

Twenty-seven decision makers and their representatives worked together on Workforce issues for the day. Members represented perspectives from prevention, treatment, and recovery. At the end of the day, all but five participants volunteered to attend the fall implementation planning meetings and continue their work on these issues. Facilitated by Jean Block, a noted group leader in New Mexico, the workgroup affirmed five areas of focus: training, recruitment and retention, sustainability, infrastructure, and image and messaging.

Training Implementation Team

1. Increase the use of registered nurses who could be employed by behavioral health services.
2. Increase the number of Certified Community Health workers through NMDOH certification program.
3. For Credentialing Boards:
   a. Require approved providers to submit training opportunities to a centralized site, e.g. NMCAL, NM Network of Care, in advance;
   b. Allow behavioral health-related prevention trainings to be recognized as meeting continuing education requirements for re-licensure; and
   c. Assure that behavioral health-related licensure reciprocity is facilitated with other states rather than serving as a barrier to recruitment of BH professionals to NM.
4. Provide tele-health consultation, training, and supervision across all behavioral health service disciplines, especially in rural areas.
5. Provide and/or promote training opportunities on the Network of Care.
6. Mandate that cultural humility and sensitivity training be required at every level in the state from Secretaries to Community Providers.
7. Expand functionality of NMCAL to serve as a BH training clearinghouse.
8. Provide training on organization and system development to assist in strengthening overall behavioral health system.
9. Certified Peer Support Workers:
   a. Improve training, certification and stature.
   b. Increase workforce.
   c. Integrate support into care planning;
   d. Align support training to meet service needs;
   e. Build job opportunities;
   f. Align Medicaid payment to support individual support, not just group support service; and
   g. Align Medicaid payment to offer peer operated respite services for adults.

Recruitment/Retention Implementation Team

1. Create clearinghouse of internship opportunities.
2. Establish legislative funding for K-12 outreach to support BH career interest and literacy.
3. Identify access needs for Intake Assessments versus the capacity for this service.
4. Reimburse for the services provided by interns.

Sustainability Implementation Team

1. Improve access to information across the Behavioral Health/Mental Health sector to enhance collaboration and cooperation.

2. Provide wellness and support system for providers:
    a. Remove barriers to effective and efficient practice;
    b. Increase collaboration;
    c. Minimize isolation;
    d. Increase peer support groups for clinicians; and
    e. Implement interventions to reduce practitioner burnout.

Infrastructure Implementation Team

1. Integrate Behavioral Health into Collaborate Care Model:
    a. Team based approach;
    b. Community-based systems; and
    c. Include professional and non-licensed workers.
2. Enhance Clinical Supervision.
    a. Integrate BH and other health services.
    b. Address medical/behavioral health overlap.
3. Develop ways to reduce administrative burden on providers.
4. Achieve advances in integrating best practices and build on our individual and collective strengths.

Image/Messaging Implementation Team

1. Create and promote a re-branding campaign for Behavioral Health.
2. Get it on t-shirts and bumper stickers!
3. *"Good Health Demands Positive Behavioral Health"* (as a springboard).

The Finance Workgroup

Sixteen stakeholders participated in the Finance Workgroup. All members worked for the entire day with this group. Facilitated by Judith Bailie, a noted group leader and trainer from Santa Fe, the Finance Workgroup established the following priorities.

1) Establish Standardization, Collection & Sharing of Client Data
    a. Identify and engage all stakeholders/partners;
    b. Assessment of resources/needs, including:
        i. Local government, community;
        ii. Regional;
        iii. State; and
        iv. Human Services and Criminal Justice.
    c. Define common data elements/needs on forms and reports; and
    d. Identify interoperable technical solutions and standards.

2) Incentivize Payments for Outcomes
    a. Outcomes on system and consumer level;
    b. Move away from a "fee for service" and/or "unit of care" system that includes an outcome-based system of reimbursement;
    c. Develop and implement quality mechanisms tied to outcome measurement, such as:
        i. Pay for performance;
        ii. Risk-based funding; and
        iii. Payment for participation initially → move to pay for performance "goal."

3) Evaluate Care Coordination System to Ensure Effectiveness
   a. Transition from incarceration or high level BH services; and
   b. Evaluate potential benefits of integrating MCO Coordinated Care Systems with case management, CCSS, JPO, CSA, and community health workers to improve efficiency and outcomes.
   c. Minimize duplication and inefficiencies

4) Create Standard Definition of Crisis Triage and Stabilization Centers (CTSC) and establish multiple working NM CTSCs
   a. Operationalize CTSCs;
   b. Establish Medicaid reimbursement;
   c. Establish licensing standards;
   d. Examine related State Statutes (43-1);
   e. Integrate law enforcement requirements; and
   f. Assure Civil Liberties.

5) Incentivize State, Local Government, Tribal Collaboration
   a. Regionalize services and funding;
   b. Identify redundancy and gaps;
   c. Incentivize collaboration;
   d. Coordinate funding streams; and
   e. Ensure community participation

6) Develop Program Incentives
   a. Peer support;
   b. Wrap Around Teams;
   c. Open Access (including evening & weekend access to care/treatment;
   d. Consumer/member; and
   e. Group Therapy.

The Regulatory Workgroup

Seventeen individuals participated in the Regulatory Workgroup, including representatives from the MCOs, Medicaid Assistance Division, the Behavioral Health Provider Association, the Behavioral Health Planning Council, Disability Rights New Mexico, Indian Affairs Department, and consumer advocates. Facilitated by John Ross, a highly skilled consultant based in Albuquerque, the Regulatory Workgroup established the following results and priorities.

1. Integrated Care: create a ***Task Force*** that will focus on the complete NM Behavioral Health Statute, Regulatory and Policies framework with a goal of Untangling, Revising, adding New, and then Training/Communicating these changes. It was suggested that the following constituencies be represented on the Task Force: Consumers, Providers, MCOs, relevant State Agencies, Native American community. To be included in this process are both the Prevention and Intervention Behavioral Health domains. Finally, this Task Force will also develop and recommend a *Change Control Process* so that future Statutes/Regulations will be thoughtfully and intentionally layered onto existing Statutes/Regulations.
2. Integrated Care: develop and implement a *Grievance Process* for Providers. HSD can accomplish this through an Administrative process.
3. Administrative Burden: need an Implementation Team to focus on the following issues: within the continuum of care, focus on creating a consolidated audit process, review Deemed Status, define

positions such as Care Coordinator, better define the certification/licensing processes, and monitor the outliers.

4. Administrative Burden: need an Implementation Team to develop a set of recommendations to reverse the patient service flow process: goal is to engage and effectively intervene first, then focus on the Assessment/Treatment Plan. Also review the current 90 day reassessment rule. This process should include Prevention and Intervention domains.
5. Access & Availability of Treatment: explore Standards of Care and a potential regulatory framework for Adult Residential Treatment Centers. Additionally, review the current quality of children's Residential Treatment in New Mexico.
6. Workforce: when developing the future Behavioral Health workforce, focus on the Recovery population.

NEXT STEPS: IMPLEMENTATION PLANNING TEAMS and DELIVERABLES

Each of the three Implementation Planning Teams will meet three times during fall 2015. Of the participants on July 30th, 85% volunteered to continue their participation in this planning process by committing to attend and develop the specifics of the proposed implementation steps. Since then, other stakeholders have asked to be included. The priorities from July 30th will be clarified, developed, and supplemented with additional inputs as a detailed series of steps that lead to the desired actions, many of which require multiple parties to achieve results. As these priorities and their action steps encompass actions by the broad behavioral health stakeholder community, implementation will often be a complex set of interrelated negotiations, decisions and activities.

Workgroup	Participants July 30	Volunteers For Fall 2015
Workforce	27	22
Finance	16	14
Regulatory	17	14

A full Strategic Action Plan will be completed by December 14, 2015. After presentation of the Plan to the Behavioral Health Collaborative agencies in January 2016, an Accountability Team will be created to monitor progress during the two-year implementation period. This Team will have representatives both internal and external to state government. Its role is to recommend any needed course corrections and ensure accountability of the Plan.