

New Mexico
Behavioral Health
Expert Panel

White
Paper

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Table of Contents

Purpose of This White Paper	2
Executive Summary	3
Introduction	6
The Process	7
Findings and Considerations	14
Conclusions	27
Next Steps	29
Appendices	30

Purpose of this White Paper

The purpose of this white paper is to present findings and recommendations about the next phase of implementation of New Mexico's behavioral health system. This paper presents information gathered from approximately 50 behavioral health experts who gathered in July and August of 2011 for three one-day meetings to discuss and define the evolution and future of behavioral health services and systems in New Mexico.

The information presented in this paper is to be used as a guide for State government leaders, policy makers, consumers, advocates, providers and others working together to ensure better and more integrated behavioral health services for all New Mexicans.

Executive Summary

The New Mexico Behavioral Health Collaborative convened a **Behavioral Health Expert Panel** to make recommendations related to the future of behavioral health services in New Mexico. This Expert Panel consisted of approximately 50 consumers, family members, adult and youth providers, advocates and state personnel, and met for three one-day meetings in July and August, 2011. The Expert Panel was asked to provide input to the State and stakeholders as New Mexico enters into a Medicaid modernization process and prepares to re-negotiate all Human Services Department-administered contracts for behavioral and physical health services. This Panel offered the following recommendations regarding structure, funding, governance, guiding principles and other aspects to improve the behavioral health system and ensure better integration of behavioral health and physical health services:

Structure

The critical need to increase integration of behavioral health with primary care was a strong and overarching recommendation. At the same time, there was not consensus regarding whether behavioral health should remain carved out, become carved in, or developed into a hybrid model. However:

- There was consensus that improvement in specific behavioral health outcomes for consumers and families is more critical than the specific model selected (carve in, carve out or a hybrid model)
- There is an interest in local/regional governance and administrative structures within any new model
- There was some thought that the next entity/entities that manage the behavioral health system should be a non-profit(s) and possibly a New Mexico agency(ies)

Funding

- There is a need to protect behavioral health funding
- Funding for behavioral health services must be tracked and administered separately
- A greater percent of behavioral health dollars should be spent on services and a smaller percent on administration

Governance

- There must be more consumer, family, and provider involvement in policy development and decision making related to behavioral health
- There must be transparency and accountability throughout the system to improve quality of care, with access to, and state ownership of, behavioral health data
- There must be continued real support for local and regional governance, involvement and decision making
- Governance must be “transparent” with the ability to make significant decisions and provide clearly understood rationales
- Mission, roles, expectations, and relationships for all components of the governance structure (Collaborative, local entities, Planning Council, etc.) must be clearly defined and delineated

Guiding Principles

- There must be more focus on children and youth and better integration with all systems that serve them (the school, juvenile justice, tribal and foster care systems)
- There must be an expanded focus on prevention, early detection and early intervention for the full range of behavioral health conditions in both primary care and behavioral health settings
- The system must take into account the diversity of the state in terms of geography, race/ethnicity, and culture and be flexible enough to respond to this diversity
- There must be an increased focus on strengthening peer and family support services
- The behavioral health system must maintain a focus on recovery and resiliency
- The behavioral health system must maintain a focus on wellness, prevention, and stigma reduction

Other Components

- There must be a thoughtful plan for any transition that takes into consideration the potential impacts of any changes and the appropriate timing to ensure a smooth and successful process for consumers and providers
- There must be better oversight of any entity(ies) that is(are) administering behavioral health

- There must be very detailed contracts with clear expectations and increased readiness reviews for any entity(ies) administering behavioral and/or physical health services
- There must be tighter contracting with any entity(ies) that is (are) overseeing behavioral health services
- Dollars saved through efficiencies must go back into the behavioral health system to build innovative services for consumers
- There should be an examination of the current payment system to determine if a transition from fee-for-service to a capitated or per-member-per-month or other payment system would lead to better services and outcomes
- Billing and paperwork must be simplified and reduced
- Integration between behavioral and physical health must also focus on links with the educational system and schools; the Tribes and Tribal systems; and corrections, the criminal and juvenile justice system and programs such as Jail Diversion
- There must be an expanded focus on developing the state's behavioral health workforce, including recruiting, retaining and training behavioral and physical health professionals throughout New Mexico, especially in frontier and rural regions

Introduction

For at least ten years there has been recognition of the need to improve and expand behavioral health services in New Mexico¹. In response, New Mexico has reconfigured behavioral health services and systems in an effort to improve these services.² With a changing federal landscape for healthcare, a new state administration, and the end of the current behavioral health contract on the horizon, the time has clearly come to assess the state's behavioral health system and determine what changes should be made to both improve services and assure better integration between behavioral health and physical health.

New Mexico is currently poised to assess and refine State-administered health-related contracts for Medicaid and managed care services and systems to align with Medicaid modernization that is currently underway. All significant New Mexico Human Services Department-administered contracts for the provision of health services are due to be re-bid or re-defined in the next 12 to 24 months. During the 2012/2013 fiscal years, these contracts will be re-bid. A Request for Proposals to identify a "Statewide Entity" or entities (a Managed Care Organization(s) to administer and provide all state-linked behavioral health services) is slated to be released during this same time period with a planned start up in July, 2013.³

Additionally, the State has contracted with Alicia Smith and Associates to gather stakeholder input related to "Medicaid modernization" and, with that input, assist the State in the development and submission of an application to the Centers for Medicare and Medicaid Services (CMS) for an 1115 Waiver. Application for this Waiver will be made in late 2012 or early 2013 with changes to the Medicaid program taking effect July 1, 2013. Furthermore, the Patient Protection and Affordable Care Act⁴ (PPACA, federal health care reform) is scheduled to go into effect in 2014, which, if fully enacted, will increase the number of people on the

¹ See the 2010 Strategic Plan, *Positioning Behavioral Health for Health Care Reform: A Framework for Action FY11 – FY14* at: <http://www.bhc.state.nm.us/pdf/Final%20Strategic%20Plan%209Dec2010.pdf>.

See also the *Gaps Analysis* at:

<https://docs.google.com/#folders/folder.0.0B5huooreWjxoOTNkOTIyZDQtMmM1Yi00NDEyLWIwM2MtZGE4YTBjODVINjc2>.

See the New Mexico Behavioral Health Collaborative website at: <http://www.bhc.state.nm.us/>.

² *Ibid.*

³ The nature and content of these re-bids and RFPs will depend, in part, on what is determined through this process.

⁴ At: <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>

Medicaid roles in New Mexico by several hundred thousand. Finally, the requirement for mental health parity approved through the federal Parity Act will dramatically increase the number of New Mexicans with behavioral health coverage, leading to a much larger number of citizens potentially requesting behavioral health service.

The Process

Through the leadership of the New Mexico Behavioral Health Collaborative, a process was developed and implemented to assess the current system and make recommendations for the future of behavioral health in New Mexico, taking into account the increasing number of people potentially accessing the system, the federal focus on integrating behavioral health and primary care, and the ongoing reality of limited funds to provide behavioral health services. A **Behavioral Health Task Force**, consisting of behavioral health experts and state personnel, was initially convened by Linda Roebuck Homer, Collaborative CEO, to recommend a process for re-examination of this system. (Please see Appendix A for a list of Task Force members and their affiliations.)

At the first and subsequent meetings of the Task Force, a number of key decisions were made, including the development of a set of core commitments and preliminary guiding questions. A process and timeline for gathering input from relevant and representative stakeholders was outlined. It was agreed that there would be transparency throughout the process. And it was determined that all input would be analyzed and then articulated in a white paper that would serve as public input for the State and related stakeholders in the evolution of New Mexico's behavioral health system.

The Task Force initially affirmed the following core principles and commitments for the future system:

- Protecting and strengthening behavioral health
- Integrating behavioral and physical healthcare for the whole person
- Shaping our future behavioral health system using what we have learned from the past and our vision for the future

- Maintaining focus on recovery and resiliency
- Focusing on individual outcomes and wellness

Related to these principals and commitments were the following preliminary guiding questions⁵:

- How do we accomplish integrated care and ensure a strong behavioral health system?
- How will behavioral health fit within Medicaid modernization?
- What is unique to New Mexico that we must address in any structure, contract and RFP?
- What are the strengths and weakness of the current SE structure and contract? How should it be changed?
- What are the strengths and weaknesses of the current Behavioral Health Purchasing Collaborative model and operation? How should the Collaborative be changed?
- Should behavioral health continue to be carved out?
- Should behavioral health be carved in?
- If carved in, should there be special conditions specific to behavioral health?

At the Task Force's recommendation, it was determined to convene a **Behavioral Health Expert Panel** consisting of behavioral health experts from across the state, representing both the range of constituents and the demographics of the state, to participate in three one-day meetings in July and August, 2011. The participants would include consumer and family members, behavioral health providers serving youth and adults, and advocates. State representatives from the Behavioral Health Collaborative, the Human Services Department, the Department of Health, the Corrections Department, and the Children, Youth and Families Department would be on site to assist. It was also determined that local and national experts would be brought in to provide information on various New Mexico behavioral health models, models in other states, and an overview of the Patient Protection and Affordable Care Act and implications for behavioral health in New Mexico. In addition, information would be provided on the Medicaid Modernization process concurrently taking place in the state and how the Modernization process and behavioral health restructuring processes would synch and support one another.

⁵ These questions were refined as the process unfolded.

It was also determined that the State would contract with the Consortium for Behavioral Health Training and Research⁶ (CBHTR), based out of the University of New Mexico Health Sciences Center Department of Psychiatry's Center for Rural and Community Behavioral Health (CRCBH), to coordinate and facilitate this process. The Task Force would continue to meet regularly throughout the process to provide support, problem solve, and coordinate activities.

Each Expert Panel member was selected for her/his behavioral health expertise. Expert Panel members were representative of the population of the state, and included consumers and family members, advocates, and youth and adult providers. Attention was paid to ensure that Expert Panel members represented the racial/ethnic and geographic diversity of the state. Lastly, it was an expressed expectation of all Expert Panel members that they would act as liaisons and provide information to and solicit input from the constituency group(s) that they each represented.

At these meetings, the Expert Panel members were divided into four working groups that met together throughout the process. (Please see Appendix B for a list of Expert Panel members, their affiliations and the constituency group(s) they represent.)

Meetings took place July 7, July 29, and August 18, 2011.

The First Meeting^{7 8}

The first meeting, on July 7th, was designed to provide an overview of the process and information that could be used by Expert Panel members in subsequent meetings as they worked to answer the questions above and make recommendations for the future direction of behavioral health in New Mexico. As such, the following presentations by local and national experts were provided:

⁶ See: <http://www.cbhtr.org/>.

⁷ The agenda for the first meeting can be viewed at: https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWJxoZjUwNTgwNzQtZGVlYy00ZjI5LTk2MGQtNTEwYTc2NWRjODFl&hl=en_US.

⁸ Notes from the first meeting can be viewed at: <http://www.cbhtr.org/bhept>

- *Overview of the Process and What We are Trying to Accomplish*⁹
 - Linda Roebuck-Homer, CEO, NM Behavioral health Collaborative
- *Medicaid Modernization in NM and Implications for Behavioral Health*¹⁰
 - Alicia Smith, Alicia Smith and Associates
- *The Affordable Care Act: Implications for Behavioral Health*¹¹
 - Chuck Ingoglia, National Council for Community Behavioral Healthcare
- *Behavioral Health Models, Systems and Services: Lessons from Across the Country*¹²
 - Chuck Ingoglia, National Council for Community Behavioral Healthcare
- *Screening, Brief Intervention & Treatment in NM*¹³
 - Arturo Gonzales, Sangre de Cristo Community Health Partnership
- *NM Hope Accountable Care Collaborative*¹⁴
 - Patsy Romero, Romero and Associates
- *HB432 Behavioral Health Pilot Project*
 - Roque Garcia, CEO, Rio Grande Behavioral Health

Additionally, a significant number of relevant articles, briefs and papers were made available to Expert Panel members, both in hard copy and through a website developed specifically for this process at: www.cbhtr.org/bhept.¹⁵ With this information as a backdrop, Expert Panel members were asked to return to their communities and constituent groups and seek feedback on the questions provided. This information and responses to questions would then be brought back to the second meeting.

⁹https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWJxoY2ZiNjE5YmYtNjU3ZS00OWZiLWFlYTktMmQ4MGQxODU5MmMy&hl=en_US

¹⁰https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWJxoMzgyMDZmNzAtZDg2MC00ODlmLTliNzktZDU1MjcyNjZlNDQ4&hl=en_US

¹¹https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWJxoNjAyM2JlMTQ0NjUxZi00MGRmLTlkYjYtNWY5NzcyZDA5OWUx&hl=en_US

¹²https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWJxoZjQxZGVINGQtMTZjNy00ODkwLTlhNGItMTdkMzQwMTlmMDQ1&hl=en_US

¹³https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWJxoMjk1ZTA0MzktODY1Mi00YTktLWE2YjUtYjY2IwNTEyNzcx&hl=en_US

¹⁴https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWJxoNzlwYjA2N2YtOTBiZi00N2Y0LTlmNzMtN2JlMTRiYjU4NTgz&hl=en_US

¹⁵ For a complete list and links to these documents, visit: <http://www.cbhtr.org/bhept>.

The Second Meeting^{16 17}

The Second Meeting was held on July 29th. This meeting was structured to provide Expert Panel members almost an entire day to answer the following questions related to how New Mexico accomplishes integrated care and ensures a strong behavioral health system in the future:

1. Should behavioral health remain carved out, become carved in, or should a hybrid model be developed?
2. How should funding for behavioral health services be administered and/or tracked?
3. What governance structure(s) should be in place, given your answers to questions 1 and 2 above?

After a brief welcome and introduction, Expert Panel members were divided into four groups by color – yellow, green, blue and red- and provided a break out room. Each group included consumers, family members, providers and advocates. CBHTR staff facilitated group discussions and served as scribes to capture notes. State agency “experts” rotated through the groups to answer questions. At the end of the day, all Expert Panel members came together to report out and discuss their findings, which served to guide the development of the next set of questions for the process.

At the end of the second meeting, it was proposed that the Behavioral Health Expert Panel convene on August 18th to:

¹⁶ The agenda for the second meeting can be viewed at:

https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWJxoNTQxMjlxMzgtZmUzZS00ZjQzLWFjNDctN2JlYzU1OTM4Y2M0&hl=en_US.

¹⁷ Notes from the second meeting can be viewed at:

Green Group notes at:

https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWJxoOTYwMDZIYjItOTFhMy00YTl2LTk3NGEtZGQ2MzAzNTc0MGJh&hl=en_US

Red Group notes at:

https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWJxoY2Y3YWVmNjMtNjMxOC00MjY0LTgxMzktMzBhM2ZhZjE4YzVk&hl=en_US

Blue Group notes at:

https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWJxoMWQ2YjcxMDgtOTM4Ny00OWEzLTlhYWEtMDU2ZmEzZDkzMTJk&hl=en_US

Yellow Group notes at:

https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWJxoNTA1ZWY4M2Q0NWNhOS00NDhLTg0ZGYtMTBhZDczOTNjZTI2&hl=en_US

Notes from the ending group discussion at:

https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWJxoNjMyMwVhODAtZWQxZS00MzZjLWFjODAtNjU4ZGQ0NWQ1Mjgy&hl=en_US

- 1) Discuss, refine, and ensure the accuracy of the information presented in the initial draft of this white paper, which was based on the group discussion of July 29th;
- 2) Examine the recent history of behavioral health models in New Mexico and determine which model components have worked and not worked, in an effort to clearly identify those aspects that should be carried forward and those that should not; and
- 3) Using the National Council for Community Behavioral Health Care’s “Four Quadrant Clinical Intervention Model,”¹⁸ as a guide, explore and define various possible practice and financial models that would best support the integration of physical and behavioral health services for all consumers and populations regardless of the acuity of their behavioral and physical health needs.

The Third Meeting^{19 20}

The Third meeting was held on August 18th. The morning started with three half-hour long presentations on the following topics:

- *Overview of the [First Edition] White paper: Findings and Considerations to Date²¹*
 - Sam Howarth
- *Overview of Behavioral Health Models in New Mexico*
 - Rodney McNease and Karen Meador

¹⁸ A copy of Four Quadrant Clinical Intervention Model can be found at:

https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWjxoOGNkNWQ1ZDktYzdhMC00NTM3LWlhZmUtYmVIN2I2MmFmYmJk&hl=en_US.

¹⁹ The agenda for the third meeting can be viewed at:

https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWjxoYTdhMWViyzMtYTEzMC00NzlxLTg2ZGYtNmM5YmQxNGU3NmJl&hl=en_US.

²⁰ Notes from the third meeting can be viewed at:

Green group notes:

https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWjxoNzc1NzllZmItNzd mOC00ZDM5LTjhZmMtM2I4MjliM2JhNTQ5&hl=en_US

Red Group notes at:

https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWjxoNTQ5ZDU0Y2UtN DhkNy00YjU2LTk1NDUtZmI5MjdjNjFkNmM1&hl=en_US

Yellow Group notes at:

https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWjxoZmYxZGMxMjYtZ WlzM000DAYLThmZjgtNTU1OWI2YjMzOTg3&hl=en_US

Blue Group notes at:

https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWjxoNzhjNjBIMGQtMm FkZi00YTA1LTk1YWUtNzY2ZiNGZlOWE3&hl=en_US

²¹https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWjxoMzM4ZDNIMzMt NDA4MS00NjYyLWExZWItNzg0ZjBmYmRhMzhk&hl=en_US

- *Overview of Possible Practice Models that Support Integration of Physical Health and Behavioral Health Services*²²
 - Steven Adelsheim

These presentations were designed to provide background information for the facilitated breakout sessions that would follow. After the presentations, the panel members convened in their four small groups to:

- Discuss and refine the findings from the first draft of the white paper
- Discuss New Mexico’s experience with different behavioral health models and determine which things to carry forward and which not to do again
- Discuss possible practice models and implications for a future behavioral health model

Related to this last discussion, and using the National Council for Community Behavioral Health Care’s “Four Quadrant Clinical Intervention Model,”²³ as a guide, a number of sub-questions were considered:

- If one accepts the benefits of early detection and early intervention and the notion of prevention in behavioral health, where does funding come from for such programs? The primary care side? The behavioral health side? Partially from both? How would you track the money? Where would the cost savings go if/when you identify them?
- If you expect cost savings on the medical side when people with chronic medical conditions have fewer medical inpatient and emergency room visits due to effective treatment of depression, how do you link those funds back to behavioral health, especially in a carved out model?
- What is the role of the peer or family specialist in a more integrated model? How would they effectively link with care management in a primary care based setting?
- What do you see as the most critical components of a behavioral health medical home?

²²https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWJxoM2MwZTE0MTMtYmMzNS00NmMzLWE2MDAtNDYzjhjMWRhYmFh&hl=en_US

²³ A copy of Four Quadrant Clinical Intervention Model can be found at: https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWJxoOGNkNWQ1ZDktYzdhMC00NTM3LWJhZmUtYmVIN2I2MmFmYmJk&hl=en_US.

It was anticipated that these discussions would provide additional information, ideas and understandings to help shape decisions about the choice of the behavioral health model, improvements to the governance structure, and how funding and accountability for behavioral health services would be protected and assured in an integrated system.

At the end of the day, the groups came back together and a representative from each of the groups presented on his/her respective group's deliberations and findings.

Findings and Considerations

It is important to note that what follows are the findings of the authors of this white paper based on a review and analysis of meeting notes from the first, second and third meetings and includes corrections and additions to the first draft of The White Paper offered by Expert Panel members at the third meeting held on August 18th, 2011.

Three significant questions were asked at the second meeting of the Expert Panel:

1. Should behavioral health remain carved out, become carved in, or should a hybrid model be developed?
2. How should funding for behavioral health services be administered and/or tracked?
3. What governance structure(s) should be in place given your answers to questions 1 and 2 above?

The Expert Panel's answers to these questions from that meeting, as well as further clarification developed at the third meeting, are described below:

Regarding Model (carve in, carve out or hybrid)

There was not consensus across the groups regarding question 1 (Should behavioral health remain carved out, become carved in, or should a hybrid model be developed?). Rather several themes emerged. All groups supported their respective conclusion(s) by indicating that their model(s) would: 1) **best protect behavioral health funding**, and that their model(s) would, or could, 2) **support improved integration of behavioral health and physical health services**.

Three groups supported a “carved in” or “hybrid” model that would have behavioral health services administered by physical health Managed Care Organizations but with separate accounting for behavioral health dollars and accountability for behavioral health services. Presumably, this management arrangement for behavioral health services would also rely on existing behavioral health providers, provider networks and organizations. **Two groups supported a “carved out” model.** (While there were only four groups, there were five positions as one group was split.)

There was a difference of opinion, too, on the number of organizations needed/desired to administer behavioral health. One group that supported services remaining carved out felt that there should be three regional organizations (one north, one central, and one south) to administer these services. Another group that was leaning toward a carved in model was split as to whether there should be statewide or regional organizations.

Lastly, there was a concern, (sometimes a strong concern) with for-profit entities administering behavioral health services, and a desire to have services administered by a local non-profit organization(s).

It is clear that the priority for all groups is improved and additional services for consumers and improved integration and coordination of all services between behavioral health and physical health. Without any evidence that one model will necessarily lend itself to these outcomes,²⁴ it is not surprising that there was not consensus across the groups on a model.

²⁴ See Ingoglia presentations at:

https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWJxoNjAyM2JlMTQ0tNGUxZi00MGRmLThkYjYtNWY5NzcyZDA5OWUx&hl=en_US

and

https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B5huooreWJxoZjQxZGVlNGQ0tMTZjNy00ODkwLTlhNGItMTdkMzQwMTlmMDQ1&hl=en_US

There also seemed to be agreement across the groups on the following components related to a possible model:

- Improvement in specific behavioral health outcomes for consumers and families is more critical than the specific model selected
- It is more important to determine the desired outcomes and then conduct an analysis to determine if carved in versus carved out (or hybrid), and a statewide model versus a regional model will best achieve these outcomes
- While it is not known if there was a full consensus on this item, there is a strong preference that any entity(ies) administering behavioral health services be not-for-profit.

Regarding essential aspects of any new model:

- Regardless of model, we still need to directly address and improve collaboration between physical and behavioral health (integration)
- There must be transparency and accountability for quality of care
- The model should support consumer-driven services
- Behavioral health services and funding must be protected while allowing flexibility and interface with physical health
- The behavioral health system must focus on wellness, prevention and early intervention
- There must flexibility within the behavioral health system itself
- Specific behavioral health needs must be prioritized within any given model and resourced accordingly
- There must be better data collection, and reporting, including the assurance of the state's ability to maintain behavioral health data longitudinally.

A significant number of Panel Members articulated a desire for local administration of the model arguing that New Mexicans have developed enough expertise at this point to build and implement an effective behavioral health system, without needing to rely on outside (out-of-state) expertise. In the event that expertise in a particular domain might not exist in the state, these Panelists suggested that we should build our own expertise in these areas rather than outsourcing.

Regarding Funding

- In respect to question 2 (How should funding for behavioral health services be administered and/or tracked?), there appeared to be an overall consensus that **behavioral health funding and accountability for this funding must be tracked separately and not co-mingled with funding for physical health** and that any **model implemented must maximize dollars to consumers (services) and minimize dollars for administration. In addition, there was a sense that, regardless of structure, dollars saved through efficiencies need to go back into the system to build additional services for consumers and families.**

Other significant issues related to the question of how to track/administer funding that emerged from the groups, but without full consensus included:

- Need to incentivize integration, perhaps through pay-for-performance or case rates for behavioral health providers to communicate and collaborate with physical health providers (and vice versa)
- Need to incentivize care management, perhaps through per member per month payments
- Need to support services that promote coordination between emergency rooms and outpatient services
- Need to protect specific services including psycho-social, transportation, supportive housing and employment, respite, infant mental health, school mental health, and peer supports
- Need to incentivize services provided in rural/frontier areas, perhaps through sub-capitation and/or enhanced rates and/or the use of different, rural area-specific service definitions
- There is an interest in performance contracting
- There is an interest in money following the individual
- There is an interest in using capitation rather than fee-for-service
- Cost savings in any system could be earmarked for prevention and early intervention, perhaps funding community-based efforts that have been demonstrated to be effective

- Savings could happen at the plan level and then go back into the pool, thus providing more money for more behavioral health services in both primary care and behavioral health settings
- Could place behavioral health providers (perhaps peer specialists) in emergency rooms and jails to provide rapid intervention, referrals and linkages to other community behavioral health services. Provide increased care coordination and case management to those who are known to make frequent and expensive visits to ER and urgent care services
- Savings could go to demonstrated prevention and support programs, as well as community-based programs/services to decrease the number of consumers requiring higher end services
- May want to consider differentiated funding that specifically provides additional funding as needed to rural and frontier parts of the state, but with an appreciation for rate equalization efforts

Regarding Governance

There was no consensus across the groups regarding question 3 (What governance structure(s) should be in place given your answers to questions 1 and 2 above?). This is likely the case because all groups were interested in a governance structure(s) that would best support improved and additional behavioral health services and improved integration of behavioral health and physical health services. At present, there is no clear evidence that one governance structure will better ensure these outcomes than another. In spite of this, several themes emerged related to governance:

- Some concern was shared that the Behavioral Health Collaborative has too many voting state agency representatives. One recommendation was that possibly only those agencies and commissions with direct and significant financial responsibility and oversight of behavioral health services might have votes. This would presumably include agencies such as the Human Services Department, the Department of Health; Aging and Long Term Service Department; Children, Youth and Families Department; Public Education Department; Department of Indian Affairs, and the Corrections Department might have votes

- Interest was raised about possibly having consumers, families, providers and representatives from business and the legislature as part of the governance structure with voting authority
- There must be continued real support for local and regional governance, involvement and decision making
- Local governance entities must be financially supported (e.g., paid local coordinator/administration)
- Governance must be “transparent”, defined here as the ability to get information used to support or change policy or make significant decisions such that the rationale for changes are clearly understood
- Mission, roles, expectations, and relationships for all components of the governance structure (Collaborative, local entities, Planning Council, any others) must be clearly defined and delineated.
- The revised governance structure must more effectively allow for, structure, and respond to consumer input than the current model
- The Planning Council should have more power; its relationship to local entities should be strengthened and clarified; and the planning council should provide critical recommendations for the use of reinvestment funds
- There must be better technical assistance from the Collaborative to regional providers and regional administrations

Other Findings

Over the course of the meetings, a number of other, related, key areas emerged. Each of these areas should inform decisions related to the structure, funding, governance, and implementation of New Mexico’s behavioral health system.

Regarding Integration and Coordination

During the first and second meetings, there was uniform agreement among Panel Members that improved integration between behavioral health and physical health must occur. During the third meeting, the very idea of integration expanded beyond the connection between physical health and behavioral health to also recognize the need for links (integration) with the educational

system and schools, the Tribes and Tribal systems, corrections, the criminal and juvenile justice systems and programs such as the Jail Diversion Program.

It was suggested that this broader understanding of integration, and better coordination across these various systems and entities, would support a stronger continuum of care from prevention and wellness to recovery and resiliency. Additionally, it would support a system of care that is responsive across all ages, cultures, and geographic regions throughout New Mexico.

Regarding Regionalization and Cultural Sensitivity:

Expert Panel members are clear that an improved behavioral health system will need to do a better job of representing and responding to regional differences in the state. It was suggested by one group that “transitioning to the regional structure would allow for consideration of the cultural needs of the region [and] expand access [to services] beyond the community to [the] region.” Another group offered that the “language of carve in needs to require governance at the local community level (leadership, ownership and risk residing at the local level).”

Several of the groups pointed out that the current Local Collaborative structure is advisory and that this structure is not adequate; these groups suggest, as evidenced by the quote above, that an improved behavioral health system would have a more meaningful regional presence that would include, at a minimum, a role in governance and, at a maximum, function as “Regional Entities” (as opposed to a “Statewide Entity”).

Whatever regional authorities/governance structures would be created, Panel Members are clear that there needs to be distinct articulations and understandings of the roles and responsibilities of these structures, their make-up (who participates), and how they communicate with any Statewide Entity(ies) and statewide governance structure.

Across the groups there was recognition that a strong, regional presence is good for consumers and providers. The groups felt that a truly regional system would support more collaboration and better relationships between providers that, in turn, would support better services to consumers. The groups suggested that this was the strength of the Regional Care Coordination system

(RCCs) that was in place prior to the State-wide Entity. Panel Members identified positive aspects of the RCC structure that should be considered as we move forward. These positive aspects include:

- More local control and better community-based and community-responsive services
- Better understanding and use of non-Medicaid monies and services
- Better centralized support (from the Human Services Department)
- The ability to respond to local needs while not allowing for too much distinction from what was occurring in other regions
- Local control and responsibility, ownership and flexibility
- Better consumer involvement
- Expanded access within a region

Expert panel members also pointed to the need for strong quality improvement, monitoring and accountability systems.

The groups were uniform in their acknowledgement that the RCC system also had its failings/challenges and that these should not be brought forward. First among these is an inefficient, cumbersome, duplicative, and multi-layered administration. There was also agreement that there was difficulty getting services across regions and the groups clearly felt that any regional boundaries must be porous and allow consumers to receive services across regions and throughout the state.

Clearly, the groups believe, regardless of model, that there must be a regionalized structure and presence that brings forward the positive aspects described here. The groups recognize a significant difference between the RCC regional system and the current Local Collaborative system in this respect and are supportive of a regional system that has more than an advisory capacity; rather it should have a role in governance, oversight, monitoring and accountability.

There is also a clear recognition across the groups that an evolved behavioral health system must be more responsive to the cultural diversity in the state. One group offered that we must “include more emphasis on cultural considerations.” Amongst Panel Members there is an

awareness of the diversity within the state by region and by race/ethnicity and recognition that all behavioral health services must be culturally appropriate. Panel Members agree that:

- Any given model must recognize this diversity and be flexible enough to support culturally appropriate services for each region and specific population across the state
- There must be improved access for consumers regardless of where they are within the state, especially for Native Americans

Regarding Consumers and Family Members:

Panel Members were clear that consumers must be involved in every aspect of the behavioral health system including its design, implementation, governance and provision of services. One group offered, “Need to emphasize more strongly that consumers and providers need to be at the table together to help problem solve/address barriers and gaps with whatever entity is in charge.” Additionally, there was support for:

- More consumer, family, and provider involvement in policy development related to behavioral health
- Stronger mechanisms in place to ensure that consumers have the ability to provide meaningful input

Panel Members offered the following related to stigma and inclusion, things that must be considered and attended to as the behavioral health system and services in New Mexico evolve:

- Stigma has a huge impact on access to and advocacy for behavioral health services
- Ongoing efforts must continue to reduce stigma across all groups
- All involved in the behavioral health community must be careful about the language we use to insure that we don’t create an “us and them” - especially when speaking about consumer and family issues

Regarding Children and Youth, Early Intervention and Schools:

The expanded understanding of “integration” described above recognizes the importance of linking with other systems beyond behavioral and physical health. Some of the more significant systems that must also be integrated into an improved model must include those that serve children and youth. Panel Members articulated that:

- Our behavioral health system must prioritize our children, ensure age appropriate models, and ensure we don't push children's needs into an adult model
- There needs to be more coordination with the school system as a critical children's mental health partner as we move forward; we must consider the importance of cuts in school funding and the impact on the behavioral health services for children in schools
- The education system needs to be consistently involved in these behavioral health restructuring discussions and the development of a new behavioral health model
- Behavioral health services must be integrated with the educational system at all ages across the lifespan
- There must be an expanded focus on services for children and youth
- Schools and primary care providers must play a much stronger role in prevention, wellness and the early identification of behavioral health needs and linking to and with providers. One group put it this way, "[School-based services] need to be the 'backbone' and a central place for launching integrated services."
- Transition services for youth (ages 15-21 and 18 to 24) must be improved so children and youth move seamlessly to adult services
- Public schools and the Public Education Department must be more involved in screening and early identification, with quality services which prevent the misdiagnosis of children based on available funding

Regarding Native American Behavioral Health System Support

At the second and third meetings, Panel Members expressed a need to convene an additional group process to directly address the specific needs of Native Americans and the coordination of services between the Indian Health Service, tribal 638 programs, other tribal systems and behavioral and physical health providers who serve Native American populations.

There was agreement that, especially due to Native-American-specific provisions of the Patient Protection and Affordable Care Act, the voices of more Native Americans must be included in this process. It was suggested that the selection of a given model (carve in, carve out or a hybrid model) should be based on which model "will work best to serve [tribal systems]" and support the integration of these systems and behavioral health services. Another group offered, "rather

than [come to] consensus on a model, we agree that we choose the best model to achieve the best outcomes for tribal and rural communities and consumers.”

Regarding Wellness, Prevention, and Early Intervention

Panel Members demonstrated a firm commitment to wellness, prevention, and early intervention, indicating that there must be more attention to and support for these in an evolved behavioral health system. Panel Members offered:

- There is a need for the revised behavioral health system to exhibit more flexibility in the use of funding to better support expanded wellness, prevention, and early intervention activities
- There is a need for improved involvement of, and integration with, the public schools and primary care providers to allow for a stronger focus on wellness, prevention, and early intervention services
- Money must be identified for wellness, prevention, and early intervention services through both the behavioral health and physical health system(s)
- There is a call for more “creativity” in thinking about how we fund and support wellness and prevention that suggest using resources outside of the medical system and might include community-based initiatives, population-based efforts, reliance on the public schools and others

Regarding Peer Support

Panel Members felt that an improved behavioral health system will include the training, employment and use of peer specialists. Across the groups some of the key themes that emerged related to the role of the peer or family specialist in a more integrated model include the following:

- Peer and family specialists are critical to the system and we must increase their presence and roles
- Some suggested that peer and family support specialists should be more involved in consumer transition planning and services
- Peer support and family specialists should be reimbursed at reasonable rates

- It was suggested that we look at the community health worker model to see if there are lessons to be learned that could be extended to the peer and family support specialist model
- Focus must be on determining ways to better reimburse peer and family support specialists
- Peer and family support specialists could play a role in training primary care providers, including primary care case managers
- Peer and family support specialists could work in emergency rooms and jails and provide information, support and referrals

Regarding Workforce and Primary Care

Panel members recognize that if integration is to be improved, there must be a more robust health professional workforce and better communication and collaboration between all health providers. Panel Members recognize that there is a shortage of behavioral health providers in New Mexico (especially in rural and frontier parts of the state) and efforts must be made to increase the recruitment, retention and training of more providers (behavioral health providers, primary care providers and others).

Additionally, there is recognition that primary care providers need training to be able to identify behavioral health needs

Related to Medical/Behavioral Health Homes

Expert Panel Members offered the following related to medical/behavioral health homes:

- Medical home models would be helpful in providing screening and early intervention opportunities for behavioral health issues in public health and primary care settings, like the previous Screening, Brief Intervention and Referral to Treatment (SBIRT) model
- A behavioral health/medical home would provide the ability to support a system of care model while ensuring access to critical primary care services to consumers with high levels of both behavioral health and primary care needs
- This model would further integration by working to link across behavioral health and physical health systems

- One group suggested that there should be consistent administrative processes that support integration of behavioral health staff at primary care clinics
- It was recommended that there be more care coordination, case management, and peer support services to coordinate client care across systems

Regarding a Transition from the Current System to the Next System

Panel Members were clear that the transition to a new system must be well thought out and planned. For instance:

- There must be clearly written requests for proposals that articulate precise expectations of respondents
- There must be better oversight of any entity(ies) that is(are) administering behavioral health
- There must be very detailed contracts with very clear expectations and increased readiness reviews
- There must be the ability to readily and easily sanction for non-compliance with the contract(s)

Conclusions

Although there was not consensus about the structure or governance for behavioral health in New Mexico, the following themes emerged over the course of the entire Behavioral Health Expert Panel process:

- Improvement in specific behavioral health outcomes for consumers and families is more critical than the specific model selected
- Regardless of model, we still need to address and improve integration of physical and behavioral health
- There must be transparency and accountability throughout the system to improve quality of care, with access to and state ownership of behavioral health data over time
- Regardless of model, there needs to be some mechanism for meaningful local and regional input into all aspects of the system
- There must be more consumer, family, and provider involvement in policy development and decision making related to behavioral health
- Funding for behavioral health must be protected regardless of the model
- A greater percentage of dollars should be spent on services and a smaller percent on administration
- There is a strong preference that the next entity/entities that manage the behavioral health system be non-profit and possibly a New Mexico agency
- Regardless of structure, dollars saved through efficiencies need to go back into the behavioral health system to build innovative services for consumers. The system must take into account the diversity of the state in terms of geography, race/ethnicity, and culture and be flexible enough to respond to this diversity
- There is a need for local/regional governance and administrative structures within any new model
- We must shape the future of behavioral health by using what we have learned from the past to inform our vision for the future
- The behavioral health system must maintain a focus on recovery and resiliency
- The behavioral health system must maintain a focus on wellness and prevention
- We must work to reduce stigma related to behavioral health across all groups

- While improved integration between behavioral and physical health is fundamental to any redesigned system, the definition of integration should be extended to recognize the necessary links with the educational system and schools; the Tribes and Tribal systems; and corrections, the criminal and juvenile justice system and programs such as Jail Diversion
- There must be more focus on children and youth and better integration with all of the systems that serve them
- There must be an expanded focus on prevention, early detection and early intervention for the full range of behavioral health conditions in both primary care and behavioral health settings
- More must be done to include Native Americans in this process and a behavioral health system must be better able to integrate with the tribes, the Indian Health Service, Bureau of Indian Affairs and other tribal systems to better serve Native Americans
- An expanded focus on development of the full continuum of the state's behavioral health workforce must be undertaken, including expanding behavioral health training and support for primary care providers statewide
- There is a strong interest in strengthening peer and family support services
- There should be an examination of the current payment system to determine if a transition from fee-for-service to a capitated or per-member-per-month or other payment system would lead to better services and outcomes
- There must be much tighter contracting with any entity(ies) that is (are) overseeing behavioral health (and physical health) services. Expectations, requirements and consequences must be very clearly defined and readiness reviews must be more comprehensive. Agreements about management and ownership of behavioral health data must be clarified so that all data ultimately remains with the state system
- Attention must be paid to recruiting, retaining and training behavioral health (and physical health) professionals throughout New Mexico, especially in frontier and rural regions
- Billing and paperwork must be simplified and reduced

- There must be a very thoughtful plan for any transition, one that takes into consideration the potential impacts of any changes (positive and negative) and the appropriate timing to ensure a smooth and successful process for consumers and providers

Next Steps

This white paper will be sent out statewide.

Comments related to this White Paper can be sent to: bhept@cbhtr.org.

Please continue to check the Consortium for Behavioral Health Training and Research/Behavioral Health Expert Panel website for updates: www.cbhtr.org/bhept.

As recommended by the Expert Panel, a meeting of the Native American Subcommittee of the Behavioral Health Planning Council will be convened to discuss this White Paper in order to gather further Native American-specific input.

The Human Services Department and the Behavioral Health Purchasing Collaborative will reconvene the Expert Panel again in October to discuss additional elements of the Request For Proposals development process and alignment of behavioral health with Medicaid modernization. As requested by the Expert Panel, individuals representing Native American communities, education and primary care will also be invited.

Appendices

A) Behavioral Health Task Force Members and Affiliations

- **Steven Adelsheim**, M.D., Interim Director, CBHTR; Director, Center for Rural and Community Behavioral Health, UNM Dept. of Psychiatry
- **Deborah Altschul**, Ph.D, Assistant Professor of Psychiatry, Consortium for Behavioral Health Training and Research at the University of New Mexico
- **Geri Cassidy**, Medical Assistance Division, New Mexico Humans Services Department
- **David J. Ley**, Ph.D, Co-Chair, New Mexico Youth Provider Alliance and Executive Director, New Mexico Solutions
- **Brent Earnest**, Deputy Secretary, NM Human Services Department
- **Sam Howarth**, Ph.D, Senior Policy Analyst, Robert Wood Johnson Foundation for Health Policy at the University of New Mexico.
- **Harrison Kinney**, Director, Behavioral Health Services Division, NM Human Services Department
- **Rodney McNease**, Executive Director, Behavioral Health Finance, University of New Mexico Hospitals and President, New Mexico Providers Association
- **Diana McWilliams**, Deputy CEO, New Mexico Behavioral Health Collaborative
- **Karen Meador**, Policy Director, NM Behavioral Health Collaborative
- **Cathy Rocke**, Medical Assistance Division, New Mexico Human Services Division
- **Linda Roebuck-Homer**, CEO, NM Behavioral Health Collaborative
- **Shereen Shantz**, Program Manager for Consumer Affairs, New Mexico Behavioral Health Collaborative
- **Craig Sparks**, New Mexico Children, Youth and Families Department
- **Christine Wendel**, Chair, New Mexico Behavioral Health Planning Council

B) Behavioral Health Expert Panel Members, Titles and Constituency Groups(s) each

Represents (as reported by participants)

Blue Group (12)

Name	Title	Constituency Group(s) Representing
Kathy Bruaw-Sutherland	Inside Out	Individuals and family members affected by substance abuse, people with developmental disabilities, serious mental illness and DV-Post Traumatic Stress Syndrome
Roque Garcia	Southwest Counseling	Consumers and providers of behavioral health
Arturo Gonzales	Sangre de Cristo - CHP	Program integration of primary care and behavioral health; SBIRT
Adam Graff	Chief Fellow, Child & Adolescent Psychiatry at UNM	Young/future Behavioral health providers, psychiatrists – general, adult, child and adolescents
Pamela Holland	Behavioral Health Planning Council, Co-Chair of the BHPC Adult & Substance Abuse Subcommittee. I am a consumer and the President of the Interagency Forensic Network	Consumers, adults and people with co-occurring disorders; jail diversion program participants and people in the frontier and rural parts of New Mexico
Donald Hume	OCA, Recovery-Based Solutions	Consumers, family members, providers and advocates
Claire Leonard	Consumer – SMI, Catron County Grassroots Behavioral Health Group	Frontier consumers, children and youth
Beverly Nomberg	La Familia Inc.	Children and NMYPA
Craig Sparks	CYFD	State
Reuben Sutter		
Cari Washburn Chavez	Five Sandoval Behavioral Health Services, consumer and family member	Consumers
Ana Whitmore	Co-Chair of LC1, Advocate,	Families and consumers

	Family Member, Consumer	
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Red Group (9)

Name	Title	Constituency Group(s) Representing
Becky Beckett		
Noel Clark	Carlsbad MHC & Partners in Wellness	Youth Alliance and Adult Provider Association; consumers in Bernalillo, Valencia and Eddy Counties
Cindy Collyer		
Ann Jennings		
Norman Joe	Consumer	Navajo and other Native American consumers
Harrison Kinney		
Nancy Koenigsburg	Disability Rights New Mexico, Legal Director	People with disabilities throughout New Mexico
Mark Simpson	BHPC-Executive Committee & LC1, Board Member of La Familia Medical Center, Clubhouse Santa Fe, Oversight Committee	Consumers of mental health and physical health services
Dottie Tiger		

Green Group (13)

Name	Title	Constituency Group(s) Representing
Bill Belzner	Director of Behavioral Health with Presbyterian Medical Services	Providers
Bette Betts	Family member	Families and Consumers
Deborah Clark	Peer	DBSA – Albuquerque, LC2
Mickey Curtis	Clinical Director of Families & Youth Incorporated	NMYPA (Alliance)
Dolores Donihi	Office of Consumer Affairs at the Human Services Department, Behavioral Services Division	Family members
Gordon Eagleheart	CADC, CSW, IPSS, consumer and service provider	Local Collaborative-2, consumers and counselors
Kayt Gutierrez	Executive Director, Hozho Center	Local Collaborative-11, consumers in rural and

		frontier parts of the state, adult consumers, BHSD
David Graeber		
Diana McWilliams	Deputy CEO, Behavioral Health Collaborative	State of New Mexico all
Beaver Northcloud	Office of Consumer Affairs	Advocate for Native Americans in Region Six, statewide, and member of Local Collaborative-17 and Local Collaborative-16
Patsy Romero	Primary Care NM Model, National Alliance of the Mentally Ill	NAMI – families and consumers; NM Hope Accountable Care Coalition
Andrea Shije	Local Collaborative-16, Chair	Local Collaborative-16 and Native Americans
Holly Spanks		

Yellow Group (12)

Name	Title	Constituency Group(s) Representing
Nancy Jo Archer	CEO of Hogares Inc.	Alliance (youth providers) and CSA groups and advocates
Susan Casias		
Vincent D'Aloia	Family member	DBSA – Albuquerque, Local Collaborative-2,
George Davis		
Linda Mondy Diaz	Consumer and family member	Consumers and family members
Mike Estrada		
Gail Falconer	Office of Consumer Affairs at the Human Services Department, Behavioral Services Division	Families and consumers
David Ley	New Mexico Solutions	Providers
Maggie McCowan	Director of Government and Legislative Relations, Mesilla Valley Hospital	New Mexico Hospital Association
Rodney McNease	University of New Mexico Hospital	Providers
Lisa Sena	Local Collaborative-10,	Local Collaborative-10

	family member	
Shela Silverman	Director of the Mental Health Association of NM, Consumer	Consumers

**OVERVIEW OF THE
BEHAVIORAL
HEALTH EXPERT
PANEL WHITE
PAPER: FINDINGS
AND CONCLUSIONS
TO DATE**



A Health Care System in Transition

- Medicaid Modernization
- Pending re-bid or re-definition of NM HSD administered health related contracts, including the contracts for the Statewide Entity and Saluds
- Implementation of federal health care reform in 2014
- Movement towards health home models of integrated health care

Current health care realities for people with chronic mental illness, addiction issues, or chronic medical conditions

- Shortened lifespan for people with serious mental illness, up to 25 years,
- Shortened lifespan up to 37 years for people with both addiction and mental illness
- Increasing rates of diabetes, HTN, cholesterol, etc. with 2nd generation ant-psychotic medications. How is medical care and oversight being provided?
- Higher rates of ER visits, medical complications tied to addiction related issues.
- Higher medical costs associated with untreated depression for people with chronic illnesses such as diabetes, chronic pain, etc.

- **Half of all lifetime cases of mental illness start by age 14**
- **Three fourths start by age 24**

Early Detection and Intervention is Cost-Effective!

Patients in early detection program were treated at 1/3rd the cost over an 8 year period:

- Fewer symptoms
- Twice as many with jobs

The Behavioral Health Restructuring Process

- **A Behavioral Health Steering Team** formed to develop a process to gather input
- **A Behavioral Health Expert Panel** of 50 behavioral health state experts representing:
 - Consumers and family members
 - Advocates
 - Providers (youth and adult)
 - With support from state agency personnel and national experts

Guiding Principles for Behavioral Health System Restructuring

- Protecting and strengthening behavioral health
- Integrating behavioral health and physical health for the whole person
- Shaping our future using what we have learned from the past and our vision for the future
- Maintaining focus on recovery and resilience
- Focusing on individual outcomes and wellness

The Questions

- How do we build a statewide model of integrated care that supports a strong behavioral health system?
- Should behavioral health be carved out, carved in, or should a hybrid model be developed?
- What is unique to New Mexico that must be addressed in the development of any structure, contract or RFP?
- What works and also what needs to change in the current Behavioral Health Collaborative and SE structure?

The Meetings

The First Meeting (July 7, 2011)

- Introductions, education, and overview of the process

The Second Meeting (July 29, 2011)

- Addressed questions of carve in/out
- Models for tracking funding
- Governance structure

The Third Meeting (August 18, 2011)

- Review white paper initial draft
- Review state history with different BH models
- Discuss integrative care practice models

Question 1

How do we build a statewide model of integrated care that supports a strong behavioral health system?

Given the Intent of BH-PC Integration, How Do We:

- Develop and ensure a continuum of care for behavioral health, including prevention, early recognition and early intervention?
- Link behavioral health services to medical homes, be they in primary care or behavioral health settings?
- Ensure effective medical care for people with behavioral health conditions?
- Ensure effective behavioral health care for people with medical conditions?
- How do we identify and re-invest any cost saving tied to effective early medical treatment for people with behavioral health conditions or early behavioral treatment back into the appropriate health system?

TABLE 1: FOUR QUADRANTS OF CLINICAL INTEGRATION BASED ON PATIENT NEEDS

	QUADRANT II	QUADRANT IV
LOW ← BEHAVIORAL HEALTH RISK/COMPLEXITY → HIGH	Patients with high behavioral health and low physical health needs Served in primary care and specialty mental health settings (Example: patients with bipolar disorder and chronic pain) Note: when mental health needs are stable, often mental health care can be transitioned back to primary care.	Patients with high behavioral health and high physical health needs Served in primary care and specialty mental health settings (Example: patients with schizophrenia and metabolic syndrome or hepatitis C)
	QUADRANT I	QUADRANT III
	Patients with low behavioral health and low physical health needs Served in primary care setting (Example: patients with moderate alcohol abuse and fibromyalgia)	Patients with low behavioral health and high physical health needs Served in primary care setting (Example: patients with moderate depression and uncontrolled diabetes)
	LOW ← ————— PHYSICAL HEALTH RISK/COMPLEXITY ————— → HIGH	

Source: Adapted from Mauer 2006.

Quadrant I
BH ↓ PH ↓

- PCP (with standard screening tools and BH practice guidelines)
- PCP-based BH*

- Screening and early detection, early intervention as priority
- Potential SBIRT site
- Wellness and education support
- Cost- Savings from early detection, early treatment, prevention of movement to high end behavioral health/ medical conditions

Quadrant III

BH ↓ PH ↑

- PCP (with standard screening tools and BH practice guidelines)
- Care/Disease Manager
- Specialty medical/surgical
- PCP-based BH (or in specific specialties)*
- ER
- Medical/surgical IP
- SNF/home based care
- Other community supports

- Primary health site with strong behavioral health consultation
- Early screening of people with medical conditions for behavioral health problems
- Savings come when people with chronic illness get depression treatment, leading to better self-care, less time in ER, hospital, and with less BH treatment needs.
- Cost savings mostly seen on medical side

Quadrant II

BH ↑ **PH** ↓

- BH Case Manager w/ responsibility for coordination w/ PCP
- PCP (with standard screening tools and BH practice guidelines)
- Specialty BH
- Residential BH
- Crisis/ER
- Behavioral Health IP
- Other community supports

- BH side of system, with community based & Core Service Agency (CSA) services for people with SED and SMI
- Physical health is done as a potential consult or with warm handoff to primary care
- Cost-savings come from effective early intervention and treatment for BH, leading to decreased inpatient and RTC services
- Later cost savings after several years with successful community care

Quadrant IV

BH ↑ PH ↑

- PCP (with standard screening tools and BH practice guidelines)
- BH Case Manager w/ responsibility for coordination w/ PCP and Disease Mgr
- Care/Disease Manager
- Specialty medical/surgical
- Specialty BH
- Residential BH
- Crisis/ ER
- BH and medical/surgical IP
- Other community supports

- Strongest Integration quadrant for people with chronic or severe behavioral health and medical conditions
- BH medical home in CSAs
- Easy access to both BH and PC services, working side-by-side to ensure quality care
- Cost savings come from both effective community-based BH care, minimizing IP and RTC, and effective medical care, minimizing ER and medical IP visits.

Question 2

Carve In, Carve Out, or Hybrid of Carve In
with Protections of Behavioral Health
Funds?

Carve In-Minimal BHEP Support

- Physical health and behavioral health funds and services are managed together
- Historically in New Mexico, Managed Care Organizations (MCOs) have subcontracted for management of the behavioral health benefit with a behavioral health Managed Care Organization, which then pays providers
- Sometimes done with a regional component
- No clear way to track and manage the specific behavioral health dollars

Carve Out-Our Current Model in New Mexico- Some BHEP Support

- BH funds and services are managed by a behavioral health managed care organization(s), “carved out” from the physical health managed care organization(s)
- All behavioral health funds (general, federal, & Medicaid) are pooled and managed under one contract, which could be more than 1 Statewide Entity (SE)
- The SE focuses exclusively on behavioral health and the development of the behavioral health system
- A rigid separation exists between behavioral and physical health dollars, so funds cannot easily cross from one side to the other
- Makes integrated BH and PC more difficult to implement or manage
- Provides the strongest protection for BH funds

Hybrid-Carve In with Protection of Behavioral Health Funds-Strong BHEP Support

- MCO(s) manage both behavioral health and physical health funds, with special condition in place to protect and promote the development of behavioral healthcare and the integration of behavioral healthcare and physical healthcare
- A more permeable line that allows tracked funds to flow between BH and PC to support health needs of people with mental illness and BH needs of people with medical conditions
- Funds for behavioral health services would be tracked and accounted for separately from funding for physical health
- Could have multiple MCOs, as well as regional components
- The Behavioral Health Collaborative would still sign the contract and have oversight of the implementation of the Behavioral Health components of the contract(s), as well as track outcomes, integration, efficiencies, etc.

Examples of Protections for Hybrid Model

- Separate per member per month rate for behavioral health
- Requirement that MCO(s) contract directly with New Mexico providers/provider networks
- Requirement that behavioral health savings be tracked and reinvested into BH system

Question 3

Overarching Conclusions and unique aspects of New Mexico that must be addressed in the development of any structure, contract, or RFP

Overarching Conclusions- Structure

- Consensus that improvement in specific behavioral health outcomes for consumers and families is more critical than the specific model selected (carve in, carve out, or a hybrid model)
- Critical need to increase integration of behavioral health with primary care
- Interest in local/regional governance and administrative structures within any new model
- Some strong voices that the next entity/entities that manage the behavioral health system should be a non-profit(s) and possibly a New Mexico agency(ies)

Overarching Conclusions-Funding

- The need to protect behavioral health funding
- Funding for behavioral health services should be tracked and administered separately
- A greater percent of behavioral health dollars should be spent on services and a smaller percent on administration

Overarching Conclusions-Governance

- Increased consumer, family, and provider involvement in policy development and decision making related to behavioral health care and services
- Greater transparency and accountability throughout the BH system to improve quality of care, with access to, and state ownership of, behavioral health data
- Continued active support for local and regional governance, involvement, and decision making
- Governance must be “transparent”, with the ability to make significant decisions and provide clearly understood rationales
- Mission, roles, expectations, and relationships for all components of the governance structure (Collaborative, local entities, Planning Council, etc.) must be clearly defined and delineated

Overarching Conclusions-Focus Areas

- Increased focus on children and youth, with better integration with all systems that serve them (the school, juvenile justice, tribal and foster care systems)
- Expanded focus on prevention, early detection and early intervention for the full range of behavioral health conditions
- Greater attention and flexibility to the diversity of the state in terms of geography, race/ethnicity
- There must be an increased focus on strengthening peer and family support services
- Ongoing focus on recovery and resiliency
- Focus on wellness, prevention, and stigma reduction

Overarching Conclusions- Other Components

- A thoughtful plan for any transition, to ensure a smooth and successful process for consumers and providers
- Dollars saved through efficiencies must go back into the behavioral health system to build additional innovative services for consumers
- Billing and paperwork must be simplified and reduced
- Integration between behavioral and physical health must also focus on links with the educational system and schools; the Tribes and Tribal systems; Corrections, the criminal and juvenile justice system and programs such as Jail Diversion
- An expanded focus on developing the state's behavioral health workforce must begin, including recruiting, retaining, and training behavioral and physical health professionals statewide, especially in frontier and rural regions

For more information

- Please visit the Center for Behavioral Health Training and Research (CBHTR) website at:
www.cbhtr.org\bhept
- At this site you will find meeting minutes, notes, BHEP presentations, relevant articles and a copy of the white paper
- Email responses\comments to: bhept@cbhtr.org



Questions