New Mexico Behavioral Health
Collaborative Meeting

Thursday, October 8, 2015

Human Services Department
37 Plaza la Prensa
Santa Fe, NM

Video Conference Sites
Farmington CSED
Las Cruces CSED
Roswell CSED
Clovis CSED
Thursday, October 8, 2015
37 Plaza La Prensa
Santa Fe, New Mexico
1:00 p.m. – 4:00 p.m.

AGENDA

1. 1:00 – 1:15 p.m.  Call to Order
   • Introduction of Collaborative Member/Recognize Remote Sites
   • Review/Approval of Minutes from April 23, 2015

2. 1:15 – 1:30 p.m.  Dr. Wayne Lindstrom, CEO Report

3. 1:30 – 1:45 p.m.  Centennial Care Update
   Nancy Smith-Leslie - Medical Assistance Division
   Dauna Howerton, PhD - Behavioral Health Services Division

4. 1:45 – 3:15 p.m.  John Morris, MSW
   Executive Director, The Annapolis Coalition
   Presentation on BH Workforce Challenges and Solutions

5. 3:15 - 3:45 p.m.  Behavioral Health Planning Council (BHPC) Report
   Lisa Trujillo, Behavioral Health Planning Council

   Local Collaborative Alliance Update
   Rick Vigil, LCA Chair

6. 3:45-4:00 p.m.  Public Input

   Adjourn
July 9, 2015, Meeting Minutes

New Mexico Behavioral Health Collaborative
October 8, 2015 · 1:00–4:00 p.m. · 37 Plaza La Prensa, Santa Fe, New Mexico

Handouts: Copies of the NM Behavioral Health Purchasing Collaborative Meeting public hand-outs may be obtained from the website www.bhc.state.nm.us and www.newmexico.networkofcare.org/mh

<table>
<thead>
<tr>
<th>Topic</th>
<th>Discussion</th>
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<tr>
<td>Video Conferencing Sites</td>
<td>Albuquerque South CSED, Farmington CSED, Las Cruces CSED, Roswell CSED</td>
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<tr>
<td>Present were:</td>
<td>Brent Earnest/HSD, Daphne Rood- Hopkins/CYFD, Retta Ward/DOH, Dr. Wayne Lindstrom/BHSD, Karen Courtney-Peterson/GCD, Richard Blair/DFA, Miles Copeland/ALTSD, Carlos Moya/ALTSD, Loren Hatch/DOT, Annjenette Torres/PED, Nicole Adams/NMHED,</td>
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<tr>
<td>1. Call to Order</td>
<td>The meeting was called to order at 1:00 pm.</td>
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<td>Review/Approval of Minutes</td>
<td>Handout-DRAFT Meeting Minutes, New Mexico Behavioral Health Collaborative Meeting – January 8, 2015 and April 23, 2015</td>
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<td>Brent Earnest, HSD Secretary Designate</td>
<td>A MOTION was made Secretary Retta Ward and seconded by Secretary Miles Copeland to approve the minutes from January 8, 2015 and April 23, 2015, Behavioral Health Collaborative Meeting. The MOTION was PASSED unanimously.</td>
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<td>2. Behavioral Health Director and CEO Report</td>
<td>Brent Earnest called the meeting to order at 1:00 p.m.</td>
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<td>Dr. Wayne Lindstrom, CEO</td>
<td>- Agenda modifications were made to accommodate reaching a quorum before voting on action items.</td>
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<td>- Introduction of Behavioral Health Collaborative Members</td>
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<td>- Introduction of Community Member in Roswell</td>
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<td>➢ Strategic Plan</td>
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<td>- Two year initial planning initiative is planned for July 30, 2015</td>
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<td>- Focus on three critical domains: Regulations, Finance, and Workforce</td>
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<td>- Today’s meeting and the next two BH Collaborative Quarterly Meetings will be devoted to the three domains.</td>
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<td>➢ Major Service Transitions</td>
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<td>- Turquoise Health and Wellness ceased provided BH services in NM effective March 31, 2015</td>
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<td>- La Frontera announced terminating NM operations effective May 31, 2015. Transitions have been staggered with Otero and Lincoln Counties scheduled for June 30th, and Dona Ana County for July 31st.</td>
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<td>➢ Quality Service Review (QSR) Case Formulation and Clinical Documentation Training is being provided to the new “transitioning providers.”</td>
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UNM Consortium for Behavioral Health Training and Research (CBHTR): Workshops on Behavioral Health Clinical Practice-Free educational workshops for providers planning on expanding behavioral services into their current practices.

Crisis Triage and Stabilizations Centers: Established by HB 212 in the 2015 legislative session, $1.75 million was appropriated to establish HSD/BHSD Crisis Triage and Stabilization Centers. These Centers will be health facilities that are licensed by DOH with a planned sustainability funding through Medicaid.

BH Investment Zones: HB 2, the General Appropriation Act, included a $1 million appropriation to HSD/BHSD for additional behavioral health services to be allocated through Behavioral Health Investment Zones.

New Mexico Crisis and Access Line (NMCAL): is expanding to broaden access and utilization of the service:
- Peer-to-Peer Warm Line: The Warm Line was identified as a need by the House Joint Memorial 17 Task Force to provide telephonic support by Consumer Support Workers
- Core Service Agency (CSA) After-Hours Crisis Access Program: is a statewide CSA option in collaboration with ProtoCall under the NMCAL contract.
- Public Awareness Campaign: has been planned make New Mexicans aware of NMCAL.

Network of Care (NOC): the BH web portal is being customized to become the website for the BH Collaborative with an anticipated launch in July, 2015

Supportive Housing: BHSD is implementing the following:
- Project Rental Assistance (PRA),
- Social Innovation Fund Pay for Success,
- H2 Action Planning Session, Cooperative Agreements to Benefit Homeless Individuals for States (CABHI-States,
- Transitional and Supportive Housing Programs

Certified Community Behavioral Health Clinics (CCBHC): BHSD is applying for one of SAMHA’s planning grants. SAMHSA intends to select up to twenty-five states as recipients of the planning grant funds of up to 2 million for one year: eight of these planning grant recipients will be selected as demonstration states in year two.

Partnership for Success Grant: BHSD’s Office of Substance Abuse Prevention (OSAP) has been awarded this SAMHSA grant of $1.6 million annually for 5 years ($8 million total) to address underage drinking and youth prescription drug abuse.

National Strategy for Suicide Prevention (NSSP): This SAMHSA grant of $1.47 Million, three year grant awarded to BHSD continues in its 2nd year of implementation.

Dose of Reality Campaign: This research-based statewide campaign has been launched statewide by BHSD’s Office of Substance Abuse Prevention to raise awareness and to educate teens and parents about the serious risks for addiction and overdose from prescription painkillers.

Applied Behavioral Analysis (ABA):

Cognitive Enhancement Therapy (CET)

Community Engagement Teams (CET)

Administrative Improvement Projects:

Presentation will be posted on the Behavioral Health Collaborative Website and on the NM Network of Care.
3. Payment Reform & Performance Measurement

Dale Jarvis, CPA

  - Value based purchasing:
    - Moving from paying for volume to paying for value
      - Strategies to reduce inappropriate care and increase high value of care
    - 3 components of High Value Care: High Consumer Value, Clinically Effective, Cost Effective.
- Behavioral Health Payment Reform Road Map:
  - Project Plan Development
  - Service Delivery redesign
  - Identify Funding Pools

- Funding Pools and Service Delivery Redesign:
  - Key Question: What service improvements are needed to rebalance the funding pools?
    - Primary Care, Medical Specialty Care, Acute Care Hospital, Pharmacy, Behavioral Health and Other
- Utilization-Financial Modeling: Washington State Return on investment calculator
- Phased Implementation
  - Phase 1 - Payment Reform Preparation
  - Phase 2 - Begin Pay for Performance
  - Phase 3 - Full Value-Based Purchasing

Daphne Rood - Hopkins: We are interested in enhancing health care systems with children, protective services, children in the juvenile system, specifically protective services children, because the issue is there is not a stable place to live, are there any states that have initiatives that you know that focus specifically on improving the health and life outcomes for children? One of the things that we are blessed with is that we are under the national average of obesity and we don’t have the chronic conditions showing up in our young age population. Is there something out there that we can use?

Dale Jarvis: Nothing in the BH Integration Toolkit addresses this now.

Daphne Rood-Hopkins: I will pull measures from CYFD and send them to Wayne.

- Performance Measurement System Foundation
  - National Behavioral Health Performance Measurements
    - System Outcomes: Quality Measures and Federal Quality Programs
    - Individual Outcomes: Treatment to Targets
- Value-Based Purchasing Design
  - Element One-Accountable Payment Models: Capacity-Based, Fee for Service, Case Rate/Bundled Payment, and Sub-Capitation.
  - Element Two- Pay performance: Providers are directly rewarded for efforts to successfully provide patient centered,
clinically effective, and cost effective care.

- **Payment Mechanisms**
  - Capacity Funded-Identify staffing requirements and buy capacity
  - Fee for Service-Payment for all authorized visits or days, paid at an agreed rate
  - Stratified Case Rate/Bundled Payment-Payment of a flat fee per patient
  - Sub-Capitation-Payment of a fixed fee per eligible (per member per month) to provide all medically necessary services.

- **CCBHC Prospective Payment System**
  - Bundled Payments
    - Daily Bundled Rate and a Monthly Bundled Rate
  - Quality Bonus Payment Layer
    - Optional for Daily PPS
    - Required for Monthly PPS

- **Pay for Performance**: Common Health home example
  - Fee For Service-payments for series provided by Primary Care Providers
  - Case Rate-prevention, early intervention, care management for chronic health conditions
  - Bonus-performance bonus or share of savings from reduced total healthcare expenditures

- **Four Phases of Pay for Performance**
  - Pay for participation-agree to participate in developing a quality contract that describes the design and measures
  - Pay for Reporting-additional payments to support the cost of moving to a P4P including implementation and use of health information technology
  - Pay for Performance-pay for hitting process targets
  - Pay for Outcomes-paying for care where P4P is working

- **The Pay for Performance Process**
  - Develop the benchmark metric for each measure (goal)
  - Identify the baseline metrics for each measure for each provider (where are you now)
  - Measure frequently
  - Earn your bonus-Show improvement or hit the benchmark

- **Performance Metrics**: Follow-up after hospitalization for mental illness (seven days of being discharged from the hospital for mental illness)
  - Set your baseline to a reasonable benchmark. If you set your benchmark too high then no one will receive the bonuses.
  - Show improvement to receive the bonus or meet your benchmark and automatically receive your bonus.

**Presentation will be posted on the Behavioral Health Collaborative Website and on the NM Network of Care**

### 4. Action Items

Community Engagement Teams Guidelines (CET):
A **MOTION** was made by Secretary Miles Copeland to approve the Community Engagement Teams Guidelines; and was seconded by Secretary Retta Ward to approve the Pilot Community Engagement Teams Guidelines. The **MOTION** was **PASSED** unanimously.
Revisions are proposed to the Severe Emotional Disturbance (SED) Criteria:
- Diagnoses: Changes were made to the current SED criteria to make it compliant with the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM). DSM will be generally referenced in the Criteria so that any updates to the DSM edition number will not require a revision to the criteria.
- Functional Impairment: The requirement to report on the Global Assessment of Functioning (GAF) was removed since this is no longer a requirement within DSM V. The wording “The disturbance is excessive and causes clinically significant distress or impairment in social, occupational, or other important areas of functioning,” was retained however.
- Personality Disorders (must require clinical or medical intervention) and Borderline Personality Disorder were added.
- Changes are proposed to Symptom Severity and Other Risk Factors.

Revisions are proposed to the Severe Serious Mental Illness (SMI) Criteria:
- Use the new diagnostic coding within DSM-5 for all disorders in the Criteria.
- Symptoms: Mood and anxiety symptoms have been added.

These are the only changes made to the SED and SMI that have been previously reviewed and approved by staff.

A MOTION to adopt the amended SED and SMI Criteria was made by Secretary Retta Ward and seconded by Daphne Rood-Hopkins to approve the amended SED and SMI documents. The MOTION was PASSED unanimously.

Documents will be posted on the BH Collaborative Website and on the NM Network of Care

5. Behavioral Health Planning Council (BHPC) Report and Local Collaborative Alliance

Lisa Trujillo, Chair, Behavioral Health Planning Council (BHPC)
- Quarterly Meeting and Long range Scenario Planning: We held our quarterly meeting on June 17, 2015. Mr. John Ross facilitated a BHPC workshop. The takeaways from the workshop include:
  - Focus on community-led prevention efforts.
  - Eliminate stigma culturally
  - Develop a Systems of Care including team coordination of services, a wraparound model
  - System should involve peer networks
  - Embrace full range of spiritual practices as recovery tools
  - Goal to have healthy communities that are prepared to embrace all members.
- Membership - Quarterly meeting was attended by consumers who were considering applying to become members of BHPC
- Collaborative Initiatives - BHPC continues to be informed about initiatives that involve cooperative efforts between the Collaborative agencies including Health Homes and Healthy Transitions, Communities of Care and the State Innovation Mode (SIM).
- Transitions – BHPC has been kept informed about current transition efforts
- ICSS and MCO Ombudsmen – BHPC has been informed about the development of a formal grievance process in the Medicaid system and look forward to having our members contributing to its development.
- Subcommittees - Reports from BHPC statutory subcommittees appear within the BHPC Reports:
• Adult Substance Abuse and Medicaid & Children and Adolescent Subcommittee report

Patricia Gallegos, Department Of Health, representing the Local Collaborative Alliance (LCA)
• LCA meets monthly on the 4th Tuesday of every month in the Collaborative Conference Room
• 18 Active Local collaborative-each collaborative has 2 members per local collaborative
• Local Collaborative End of Year Report 2015-End of year report from 13 Local Collaborative attached to report.
  o Business Conducted, Ongoing concerns and Issues, Special Projects and Accomplishments, Collaborative Partners, Goals for next Quarter, Presentation and Trainings.

BHPC and LCA Packet will be posted on the Behavioral Health Collaborative Website and on the NM Network of Care

6. Public Input

Chris Wendel, Recovery Santa Fe
• Recovery Santa Fe-movement happening locally and nationally around bringing forth the Face of Recovery. September is recovery month and we have on September 20th, Recovery Santa Fe Celebration at the Friendship Club. There will be a cookout, exhibitors, art show, movie-Anonymous People,

Tom Starke, Santa Fe Behavioral Health Alliance
• Goal is to help people, with mental illness caught in the criminal justice system, get out and prevent people with mental illness from getting caught in that system. They require support to avoid going into crisis.
• Cellphones for those with low income only get a few minutes a month and those minutes are precious. Many of the places they need to call like SNAP, Medicaid, Income Support, or other types of administrative support services, have long waiting times. Many commercial organizations have established telephone management systems that will actually take your name and number and will call you back. By doing this we can help individuals help preserve their minutes which are so valuable. I would like to ask you to look at your numbers that are heavily called, to provide assistance and see if you could provide this kind of call-back system.
• NM has a number of very effective crisis lines. There is poison control, rape crisis, suicide hotlines, NMCAL etc. Unfortunately if you’re calling these numbers you are burning up your minutes. When we talk to the clients they don’t use those lines, they go to the emergency room or call 911, and get their questions answered. This is very expensive and very ineffective so people don’t call these lines until they are desperate. The state could work with the different services to try to make these calls free. We have great services but the people that need them the most aren’t using them because they see it as putting their minutes at risk.

Delfy Roach, Families ASAP
• It appalled me visiting a children’s psychiatric hospital, that it was more like a detention center than a hospital. If there is
anything we can do to begin to change that culture it wouldn't be as devastating to our kids to go there and for families to go to that level to seek that kind of care. Families are left to wait in the waiting room, nobody is friendly or welcoming, the environment is not welcoming, and so something needs to change. Doctors are not taking the time to listen to families, they are referring families to services that don’t exist or have such a long waiting list that it’s pointless to even do the referral. CSWs have a huge caseload and can’t really help families or when they leave, families are being dropped from service until another CSW can be hired.

- Discharge Planning - families leave with no real appointment, no information about what services is readily accessible and advising that this child was ever in crisis. Collaboration would go a long way if we would be available not only to the family and the child but to providers who work with them.
- I wanted to thank Secretary Jacobson for coming to our family summit meeting and listening to family stories. Understanding that our voice is important to the system of care.

Jean Howden-Families ASAP

- Residential Treatment - we have numerous initiatives in the state designed to increase access to mental and behavioral health services in our community. Despite receiving millions of dollars, we face the same barriers for the last 25 years. There are huge discrepancies in quality of services between the provider agencies. The agencies that do provide quality services are so over-booked, the waiting lists are months long, even for Systems of Care families who should only experience a 24 hour turnaround time. What families experience in our acute mental health hospitals is a long wait only to be told their children don’t qualify for stabilization stay because they are not suicidal or homicidal threats at that precise moment. There is a Medicaid rule that parents must place their children in in-state facility regardless of the appropriateness of services provided or get denial letters from each of the facilities. In-state facilities do not communicate with parents and do not include them in treatment decisions. By this time the child is 17-18 years old and going through the transitional service, which transitional grant monies are so limited and the entry so narrow. We aren’t putting money in the right place where it would solve the problems. My point is why do we keep throwing money in the same programs, expecting results? We do not want to waste the child’s time, having to return to the same program again and again.

Monica Miura, Families ASAP

- Residential Treatment - Many of our children would not need Residential Treatment if supportive services were available to help families within their communities. Residential treatment is one of the most expensive treatment options available at a minimum cost to Medicaid of $8,000 per month per youth. We submitted our proposal for the 1115 Waiver, our state agreed to provide respite and family support services for families with children with Serious Emotional Disorder (SED) diagnosis. There is a current Respite definition for certification. Certification has not been required previously, so why now? The family support service definition needs to be reconsidered to align with national guidelines and be reimbursed at a rate that is comparable to successful community programs in other states. Families ASAP have been collaborating with CYFD to create an updated comprehensive Respite Manual and Universal Job Description for family support. It is our hope that we could further broaden the partnership to include Human Services Department, Behavioral Health Services Division and Medicaid so that we can
create the best possible outcomes for families seeking services.

Kendra Morrison - Families ASAP
- Medicaid billing in the schools. The Medicaid billing in the schools is for children with IEP. Billing services are for occupational, speech, and language therapies, social work, anything that our children need to support their IEP program. At this time, schools are coercing families to sign off on Medicaid billing. It is allowable under IDEA that schools can get reimbursed for these types of services. The issue is that the schools are already getting monies to implement IDEA for those particular services. Right now schools are getting paid twice for the same services. Students with ADHD are also receiving services for behavioral health so the schools are actually double dipping.

Valerie Quintana, Clinical and Community Linkages Coordinator
- I am here to recognize and congratulate the work of the BHPC and LCA. The work they have done over the years has really been heard as we see that behavioral health has been integrated into the health care system through Centennial Care and now through the SIM planning. I would like to encourage and invite members of the LCA and BHPC to participate in the planning discussions for the SIM. You can do that via your Health Councils and the monthly SIM Summits. It is crucial because there are few behavioral health voices at these meetings.

7. Adjourn

A MOTION to adjourn meeting was made by Brent Earnest, Secretary and seconded by Secretary Ward. The meeting was adjourned at 4:15 p.m.