New Mexico Behavioral Health Collaborative Meeting

Thursday, January 14, 2016

Human Services Department
37 Plaza la Prensa
Santa Fe, NM

Video Conference Sites

Farmington CSED
Las Cruces CSED
Roswell CSED
Clovis CSED

New Mexico Behavioral Health Collaborative

Monique Jacobson
Department of Children, Youth, and Families
Secretary – Collaborative Co-Chair

Brent Earnest
Human Services Department
Secretary – Collaborative Co-Chair

Thursday, January 14, 2016
37 Plaza La Prensa
Santa Fe, New Mexico
1:00 p.m. – 5:00 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 October 8, 2015
2. 1:15 – 1:30 p.m. **Dr. Wayne Lindstrom, CEO Report**
3. 1:30 – 3:15 p.m. **Barbara Coulter Edwards**
   Presentation on Regulations
4. 3:15 – 4:30 p.m. **MCO Quality Improvement Program Presentations**
5. 4:30-5:00 p.m. **Public Input**

   Adjourn

October 8, 2015, Meeting Minutes

New Mexico Behavioral Health Collaborative

January 14, 2016 · 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.newmexico.networkofcare.org/mh and www.bhc.state.nm.us

Topic	Discussion
Video Conferencing Sites	Farmington CSED, Las Cruces CSED, Roswell CSED, and Clovis CSED
Present were:	Brent Earnest/HSD, Daphne Rood- Hopkins/CYFD, Retta Ward/DOH, Dr. Wayne Lindstrom/BHSD, Richard Blair/DFA, Miles Copeland/ALTSD, Kelly Zuni/IAD, Marcos Trujillo/DOT, Mitchell Lawrence/DVS, Nicole Adams/NMHED,
1. Call to Order Review/Approval of Minutes	The meeting was called to order at 1:00 pm. Handout-DRAFT Meeting Minutes, New Mexico Behavioral Health Collaborative Meeting – October8, 2015. A **MOTION** was made Secretary Retta Ward and seconded by Secretary Miles Copeland to approve the minutes from October 8, 2015, Behavioral Health Collaborative Meeting. The **MOTION** was **PASSED** unanimously.
Brent Earnest, HSD Secretary Designate	Brent Earnest called the meeting to order at 1:00 p.m. • Agenda modifications were made to accommodate reaching a quorum before voting on action items. • Introduction of Behavioral Health Collaborative Members • Introduction of Community Member in Farmington
2. Behavioral Health Director and CEO Report	Dr. Wayne Lindstrom, CEO ➢ Strategic Plan • Two year strategic planning initiative was convened on July 30, 2015 • Focus on three critical domains: Regulations, Finance, and Workforce • A final summary of the July 30th session is included in my report. • A full Strategic Plan will be completed by December 14, 2015. • After presentation of the Plan to the Behavioral Health Collaborative agencies in January 2016, an Accountability Team will be created to monitor progress during the two-year implementation period. ➢ Certified Community Behavioral Health Clinics (CCBHC): SAMHSA has verbally communicated that NM has been selected as one of twenty (25) states as a recipient of the planning grant funds to establish CCBHCs. Expected funding was reduced by almost

50%, as a result, a revised budget and SOW was submitted to SAMHSA. We should be getting the official announcement in the next couple of weeks.

- PAX Good Behavior Games
  - Dr. Dennis Embry, President of the PAXIS Institute, presented two weeks ago to NM's Children's Cabinet on PAX GBG BHSD's Office of Substance Abuse Prevention (OSAP) has begun planning and coordination with necessary stakeholders to complete classroom selection, training, and monitoring processes to be completed by June, 2016
  - PAX Good Behavior Games: is an intervention at the elementary in the first grade level. It is a methodology that really works to enhance the competencies of children in the first grade to self-regulate. It gives them the skills and gives the teaching staff the skills to be able to regulate ones behavior.
  - I would like to invite Dr. Embry back to present to the Collaborative at some future date and show some of the videos of the before and the after and hear the testimonials of children and teachers.
  - We are going to have future follow-up with the Governor's office and the Public Education Department on how we can implement this in New Mexico schools. New Mexico under a national grant award is currently being practiced the Farmington schools and Ruidoso schools. It is showing the same kind of results as demonstrated in other parts of the country and internationally as well.

- Behavioral Health Services Division Promotional Pieces: Behavioral Health services division is displaying promotional pieces of more positive messaging between behavioral health and recovery. We are being more visible in the community with the back drop you see behind us, and we also have banners and other items that further reinforce this message.

- New Mexico Crisis and Access Line (NMCAL)
  - Peer-to-Peer Warm Line: has been activated. Peers are now employed by protocol and are co-located with the clinical staff. Protocol will be announcing soon on the open house relative to the Warm Line and will be wide invitation to us all to be a part of that.
  - The Peer-to-Peer Warm Line is staffed with Certified Peer Support Specialists between 3:30 p.m. to 11:30 p.m. seven days a week, 365 days a year.
  - Warm Line staff responded to 81 total calls the first week, 51 were calls directly to the new Warm Line phone number (855-466-7100). The remaining callers reached the Warm Line through the established NMCAL number (855-662-7474). The average length of a Warm Line call was 23.6 minutes.

- Behavioral Health Investment Zones
  - BHSD received a $1 million allocation during the last legislative session to create Behavioral Health Investment Zones. A request to epidemiology in the Department of Health to do a composite portrayal across three variables. Death due to drugs, death due to alcohol, and deaths due to suicide and where are the hotspots.
  - The two counties identified are Rio Arriba and McKinley Counties. BHSD has established an application process for these two counties to be designated as BH Investment Zones which will qualify them each for $500,000 to implement a plan that will best address the needs these priority zones.

Questions:
Richard Blair: Is Network of Care up and running with personal records active?
Wayne Lindstrom: NOC is active and the reality is that someone in recovery can in fact load their patient health information on the domain within the network of care itself. It is password protected and encrypted.
Richard: is this based on the model that was presented six months ago?
Wayne: Yes.
Secretary Zuni Comment: After the presentation with Dr. Embry I had our staff pull a list of just tribal schools on the reservations that have the elementary grades. We are going to move forward and try to figure out how to put it through procurement, to really bring the Good Behavior Games into those tribes that choose to do this. It was an excellent, excellent presentation, we were really excited about it and just looking at the statistics and their PAX is already working with First Nations in Canada. That is where Dr. Embrey is now and we are communicating on how we want to implement that for the tribal schools as well. I just wanted to let you know that the presentation really had a huge impact on the way that we want to really focus on our children through Indian Affairs Department.
Wayne: Thank you. It is no secret that how much of our resources go to dealing with these problems very late and if we want to do a better job of making an impact, we need to start dealing with the problems at a very young age.

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

3. Centennial Care Update

Nancy Smith-Leslie, Director Medical Assistance Division
Dauna Howerton, Ph.D., Behavioral Health Services Division

Centennial Care update-Nancy Smith-Leslie

- Enrollment numbers as of August 2015:
  - Total in Medicaid-822,428 (largest numbers in the Medicaid program)
  - Total in Adult Expansion-226,783 (more than originally projected)
  - Total in Centennial Care-642,047
  - Total in Long Term Care-46,359
  - MCO are working hard to complete the health risk assessments and are now at about 67% which is about 400,000 of people who now have a health risk assessment. There is still work to be done, but it is definitely getting better.
- Increasing Coordination of services: Total Members Accessing Community Benefit– 22,331
- Supporting Provider Capacity
  - Continuation of the PCP increase which was started in 2014– 1,982 providers receiving increased payments
  - MCO's are expanding use of telehealth office visits. Members can actually pick up their phone see their physician. They can download the app on their phone. This also includes the behavioral health providers.
  - Increasing use of Community Health Workers:
    - 100 community health workers are directly employed by or contracted with MCOs;
    - MCOs partnering with UNM to expand role of CHWs – care coordination, health education, health literacy, translation and community supports linkages.

- Implementing Payment Reform Projects
  - HSD approved 10 payment reform projects that launched in July 2015
    - Accountable Care Like Models-with UNM hospital
    - Bundled Payments for Episodes of Care – bariatric surgery, diabetes and maternity;
    - Patient-Centered Medical Home Share Savings – built upon Patient Center Medical Homes model by adding shared savings targets that reward achievement of utilization and quality targets,

- State Innovation Model Grant
  - NM received $2 million from CMS
  - Partnering with DOH to test innovative health delivery and payment models.
  - As part of the grant, HSD is leading planning efforts for an All Payer Claims Database (APCD)
  - We are still on track to launch two health home sites on January 1, 2016. We are working with the Farmington and Clovis communities. That program is called CareLink New Mexico.

- Engaging Members in their Care
  - 40,000 members actively participating in the Centennial Rewards Program.
    - Visiting dentist annually;
    - Participating in a walking program
    - Completing a Health Risk Assessment;
    - Adhering to their medications

- Continue to Build Upon Early Successes
  - MCOs reported an average of 39 ER visits per 1,000 member months in 2013 compared to an average of 35 ER visits in 2014
  - Two of the MCOs reduced non-emergent ER visits by 10% in 2014. ER visits is one way to measure care coordination.
  - Centennial Rewards program reported a 29% reduction in total hospital events for individuals with diabetes in 2014. This program is continuing to do measures as well.
  - All MCOs increased telehealth visits statewide with specialist by at least 15% in 2014. It literally went from zero to all the way up to 5000%. This is a very big accomplishment in telehealth.

Applied Behavioral Analysis-Dauna Howerton, Ph.D., BHSD

- What is Applied Behavior Analysis?
  - Service delivered to members identified with Autism Spectrum Disorder (ASD) or identified as At-Risk for developing ASD. There were services prior to May 1, 2015 but ended at age five. This service went into effect May 1, 2015 to provide services up to the age of 21.
  - If diagnosed with Autism there are three domains where you see deficits. They are areas of communication, social interaction, and repetitive behavior.
  - The best intervention is to start when children are very young. If you are in the age group preschool before the age of five

you can receive up to 40 hours per week, if over the age of five you can receive up to 20 hours per week of these services. Providers predominately will do in home services.

- Certification of providers: have to be board certified Behavior Analyst
- There are three stages:
  - Stage one-Screening to confirm the presence of Autism and provider develops an Individualized Service Plan.
  - Stage two-Referral for services. Bases on assessment results a treatment plan is developed for stage three.
  - Stage three-ABA provider implements treatment plan. Treatment is data driven and assessed to measure success.
- Providers: Services started with only six providers. One provider is only a stage one provider. There are two pending approval. Behavior Health Works in Las Cruces and UNM CDD. UNM is going to be a stage one provider, which is really great because a team that travels around the state, this way they don't have to travel to Albuquerque to get that stage one service.

Questions:
Richard: What are the basic requirements for the providers to become board certified for these services?
Dauna: Stage 1 provider qualifications - licensed, doctoral-level clinical psychologist or a physician who is board-certified or board-eligible in developmental behavioral pediatrics, pediatric neurology, or child psychiatry. Stage 2 provider qualifications – Behavioral Analyst with documented certification by the Behavior Analyst Certification Board (BACB) and there are some provisions made for providers who are working on board certification. Stage 3 provider qualifications – Behavioral Analysts and Behavioral Technician with documented certification by the Behavior Analyst Certification Board (BACB).
Brent: significant change for the Medicaid program. After the age of 5 families were relying on some state funded programs through the Department of Health and their DDSD program. This has been a great benefit and overall better coordination with state programs. It is a significant change and will take a while. We have gone from four to six providers and more coming on board.
Wayne: Would like to take the opportunity to acknowledge Dr. Howerton as being out project lead. She has gotten amazing amount done in a relatively short period of time in developing a responsive service for a tremendous need, so thank you and thank you to your advisory group.

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

4. <u>Behavioral Health Workforce Challenges and Solutions</u>

John Morris: Executive Director, Annapolis Coalition on the Behavioral Health Workforce

- What is the Annapolis Coalition: a small not-for-profit
- Workforce: how we think it should be but what is the reality?
  - Workforce issues are complex, creating "wicked" challenges.
  - Issues of diversity (race, ethnicity, language and workplace culture) further complicate workforce development strategies
  - First-a focus on workforce development in behavioral health specialty settings
  - Second-a focus on behavioral health in integrated settings
  - Third-a focus on direct support workforce in a variety of settings.
  - Workforce development-For decades we have underinvested and wasted resources.
- The paradoxes of workforce development in behavioral
  - We train graduate behavioral health professionals for a world that no longer exists
  - Those who spend the most time with consumers/families receive the least training.

- Training programs persist in utilizing ineffective teaching strategies. We train only where willing crowds gather
- Consumers and families receive little educational support and lived experience doesn't inform the rest of the workforce. We don't use their experience in a teaching role
- Diversity of the current workforce doesn't match the diversity of those served.
- Students are rewarded for "doing time" in our educational systems.
- We do not systematically retain our recruit staff and once hired, little supervision or mentoring is provided.
- Career ladders and leadership development are haphazard
- Incompetent service systems thwart the competent performance of individuals.

➢ There is some light at the end of the tunnel
- For behavioral health specialty settings: A national action plan—with relevance for NM
- For integrated settings: The Center for Integrated Health Solutions
- For the high volume category of direct support workers two initiatives

➢ The Action Plan for Behavioral Health Workforce Development
- General findings: Widespread concerns about the current and future workforce, high levels of dissatisfaction

➢ Strategic goals
- Expand the roles of persons in recovery; Increased educational supports, shared-decision making, and expand peer and family support.
- Enhance community capacity to support behavioral health and wellness; Competency development with communities, in behavioral health workforce, and strengthening connections between behavioral health organizations and their communities.
- Implement systematic retention and recruitment strategies; Implement and evaluate interventions, develop career ladders, and grow your own workforce.
- Increase the relevance, effectiveness, and accessibility of training; Competency and curriculum development, evidence-based training methods, technology-assisted instruction, and systematic support to sustain newly acquired skills.
- Effective Teaching Strategies: Interactive sessions, Academic detailing / outreach visits, Reminders, Audit and feedback, Opinion leaders, Patient mediated interventions, and Social marketing
- Actively foster leadership development; Identify leadership competencies tailored to behavioral health, competency based curricula, formal-continuous leadership development beginning with supervision and succession planning
- Enhance Workforce Development Infrastructure: A workforce plan for every agency, data-driven CQI on workforce issues, strengthen HR & training functions, improve IT support for training, workforce support, & tracking, and decreased paperwork burden: variable, redundant or purposeless reporting
- Invest in Research & Evaluation of Workforce Issues; Federal and state inter-agency research collaborative, and technical assistance to field on evaluation of workforce practices.

➢ Plan summary
- Strategic goals & objectives are a guide for assessment & planning, State / organization plans must be unique and tailored
- Levers of change: Leadership, Competency assessment, Financing, Accreditation, licensure & certification, Advocacy

➢ Behavioral health/primary care integration: Do we know what this will mean, are providers really prepared, and what are the

dynamics likely to be?

- Stakes are high: The history of behavioral health integration in the US has some scary precedents
  - Reduced access and benefits, Inappropriate limits on visits and medications, and dramatically under-priced reimbursement rates.
  - Narrow definitions of medical necessity that negatively impacted using natural supports and peers; resistance to inclusion of substance use treatment in basic coverage and Loss of recovery focus in care to medical management
- Reasons for optimism: Behavioral health actually has something to bring to the table. Co-occurring disorders are increasingly recognized as the norm not an anomaly
- Resources are on the SAMHSA-HRSA website.
  - Core competencies for providing integrated primary and behavioral health services.
- Focusing on the Direct Support Workforce: Demand for services has always out-stripped supply of graduate trained behavioral health professionals. Rise of recovery-peer and other peer specialists is helping to fill the gap and increased focus on direct support workers can also help fill that gap.
- The Pacesetter Awards:
  - Criteria for finalists: Novelty, Effectiveness, Significance, Transferability, Durability/sustainability (added by Annapolis Coalition). 51 programs nominated and 5 National Award Winners, and 2 Programs of Merit
- Employer improvements by site: patient satisfaction, patient outcomes, revenue/reimbursements, and implementation.
- Worker outcomes by sites: Wage gains, benefits, lower turnover, and employee satisfaction.
- New Mexico already has a great start:
  - Approach the challenges in as systematic a way as you can…one step at a time.
  - Borrow and adapt where you can, tailoring your plans to New Mexico reality.
  - Remember that change is a complex and dynamic process…in closing, one man's view of policy change
- Coalition Motto: I get up each day determined to change the world – and to have one hell of a good time. Sometimes this makes planning the day difficult.

Questions-Comments:

Nichole-I think you really nailed it really well when you're talking about other models and interpreting it and adapting it into your own state. I feel that health care in behavioral health it's across the board. To take other states models and willing to adapt them is just perfect.

John-Other things that I do is evidence based practice. I believe very firmly that there are somethings that EBP isn't just an EBP because you call it one, and is not something that you can just adapt to it, but if you're doing very mindful thoughtful documents adaptations the likelihood that it will be successful goes up.

Mr. Dr. Marcello Maviglia: You listed eleven paradoxes how effective in your view I Is the application of evidence based methods without taking care of those paradoxes?

John: I think that is a very good question, I think use of evidence based practices of any kind without sensitivity of the cultural content is probably doomed. That said, just taking the themes and adapt them without being systematic and thoughtful about it to someone interpretation of the cultural context is very troubling. The best EBP's in my judgement in the behavioral health side start

with the clients and families perception of the problem and work in an ecological way, so the best systems of EBP's begin with nesting it in a cultural context of the family or social environment. I think the extent of it being successfully implemented in the way it was intended which is in that context, and then it should work.

The systems in general the paradox deals with a person that deals most with the families has the least amount of training What are we doing in New Mexico to deal with that particular paradox. Are we or do we have plans or are we making progress in that area?

Brent: there has been much more significance in the community health worker imitative through peer support and the behavioral health world there is still work to do here. There is trainings to do and I think in that capacity it has to be recognizing that we are closer to the front line worker

Patricia Gallegos, DOH-has introduced certification for our community health workers with eleven competencies that are required, so in the moment as we speak those who have been doing the work are getting grandfathered in. In New Mexico with our cultural diversities primarily we are talking about the Native American communities. They will all be certified as soon as all the applications come in and then will roll out with classes in the different community colleges.

Wayne-John, you made several references to our state health care work force. Carly I was wondering if you would you please give everybody an update on the recent report.

Caroline Bonham- in state legislation a couple of years ago, all license data would be collected systematically. When every clinician submits for their license renewal, they also fill out a survey. The survey information how many clinical hours they are doing and where is their practice locations. This survey data helps us see how many hours are they seeing patients, and so it's across the board. Its physicians, nurses, phycologists, social workers, and counselors. It helps us understand which counties don't have access to prescribing amongst people who have training in behavioral health. When we dive and see more into the data it also helps us go further it helps see which patients are being reimbursed by Medicaid and who is providing behavioral health but not in the public sector. This will give us more information on which areas actually more underserved what professions and how we are working as a team to correct these issues. .

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

5. <u>Behavioral Health Planning Council (BHPC) Report and Local Collaborative Alliance</u>

Lisa Trujillo, Chair, Behavioral Health Planning Council (BHPC)

- Block Grant Application-A group of BHPC members read the SAMHSA grant application for FY 2016-2017. The group will get together around November to review this year's current block grant report.
- Subcommittees and Regional Representation-Our bylaws require us to seek representatives from each of the Local Collaboratives to represent our subcommittees. We are having problems getting representation so we are looking at changing our bylaws to switch representation from our local collaboratives to essentially start using the regional representation. We will to try to seek out diversity and make sure that the state is being well represented. We have come to the collaborative because the local collaboratives were created by the purchasing collaborative.
- Membership-we continue to request new appointments to be made to the council however we now have a new person to support us, thank you Secretary Earnest for your support in forwarding our request to the Governor's office.
- Collaborative Initiatives-we continue to provide a range of voices to participate in your Strategic Planning process. We have had very valuable presentations. We continue to provide input regarding the initiatives that involve efforts between the collaborative agencies, including the Network of Care, Supportive Housing initiatives and Community Health Workers.

- Subcommittee and BHPC Budget reports are attached.

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.
    - 400.00 were distributed to local collaboratives who submitted an end of year report.
    - Con Alma Grants Committee met with the LCA leadership and completed a site visit.
    - Elections for Chair and Vice Chair were held at the September 2015 Meeting. Membership nominated and elected Rick Vigil, to continue as LCA Chair and Rebeca Ballantine as Vice Chair.
    - LCA entered into a new contract with Ms. Valerie Ingram, Grant Writer.
    - Lifelink continues to be our fiscal agent.
- Health Councils and Local Collaboratives:
    - Similarities:
        - Both were established as community health coalitions
        - Both serve as the voice of citizens and consumers of health care services
        - Both serves as communications link between local and communities and state government.
        - Memberships of health councils and local collaboratives often overlap-particularly in smaller, rural communities.
        - Both are represented by statewide Alliances.
        - Both groups share values of local control and self determination
    - Differences:
        - Are listed in the attached chart on the LCA Report
- Local Collaborative September budget report attached.
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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

- Events:
    - Recovery Santa Fe- (celebrate advocate, educate, coordinate, and initiate recovery) is 18 month old. We started with celebrations, we had one last fall, and we had an event on September 20, 2015. I would like to thank Behavioral Health Services Division and Impact DWI for supporting us financially. I would also like to thank DOH, CYFD, HSD, and Aging for attending and having booths in our celebration. There was a cookout thanks to Peas and Pods catering. There were about 30-35 artists showing their work, and 32 exhibitors from various parts of the communities.
    - National even October 4, 2015, Unite to face addiction, Organization Faces and Voices of Recovery.

Tom Starke-Santa Fe Behavioral Health Alliance

- Coordination organization-I pull every organization involved with people with mental illness in the criminal justice system in Santa Fe County together. I have been supported by our district court system. We have been trying very hard to figure out how to get the people out of the criminal justice system that have mental illness, because we find they don't do well there. They decompensate, degenerate, and eventually they die. If they are not in a special program that has mental illness, in probation, they almost have a

	100% chance of going back to prison. The success rate is almost zero. I would strongly urge you and our communities, our state officials, there needs to be a conversation between the care community and the courts.
7. Adjourn	A **MOTION** to adjourn meeting was made by Secretary Brent Earnest and seconded by Secretary Myles Copeland. The meeting was adjourned at 4:15 p.m.