New Mexico Behavioral Health Collaborative Meeting

Thursday, April 13, 2017

Human Services Department
37 Plaza la Prensa
Santa Fe, NM

Video Conference Sites

Roswell CSED
Las Cruces CSED
Clovis CSED
Farmington CSED

New Mexico Behavioral Health Collaborative

Lynn Gallagher
Department of Health
Secretary – Collaborative Co-Chair

Brent Earnest
NM Human Services Department
Secretary – Collaborative Co-Chair

Thursday, April 13, 2017
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 Members/Recognize Remote Sites • Review/Approval of Minutes from January 12, 2017.
2.	1:15 – 1:30 p.m.	**Dr. Wayne Lindstrom, CEO Report**
3.	1:30 –1:45 p.m.	**BH Collaborative Administrative Services Organization (ASO) Contract** Michael Nelson, HSD Deputy Secretary Kathy Slater-Huff, ASO Transition Manager, BHSD
4.	1:45 - 2:30 p.m.	**Action Item: Review & Execution Process for the ASO Contract**
5.	2:30 - 3:10 p.m.	**DOH Turquoise Lodge Hospital – Services, Supports, & Future Initiatives** Shauna Hartley, Administrator & Dr. Mirin, Medical Director
	3:10 – 3:20 p.m.	**Break**
6.	3:20 – 4:00 p.m.	**CYFD Children's Wraparound** Bryce Pittenger, LPCC, BH Services Director
7.	4:00 – 4:30 p.m.	**PED NM GRADS Program** Jessica Aufrichtig, MSW, Project Director
8.	4:30 – 4:40 p.m.	**Behavioral Health Planning Council (BHPC) Report** Suzie Kimble, Chair, Behavioral Health Planning Council Carol Luna Anderson, BHPC Vice Chair
9.	4:40 – 4:50 p.m.	**Local Collaborative Alliance Update** Rebecca Ballentine, LCA Chair Pam Valencia, LCA Vice Chair
10.	4:50-5:00 p.m.	**Public Comment** **Adjourn**

Meeting Minutes

New Mexico Behavioral Health Collaborative

January 12, 2017 · 1:00–5:00 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, Roswell CSED, and Clovis CSED
Present were:	Brent Earnest/HSD, Lynn Gallagher/DOH, Bryce Pittenger/CYFD, Dr. Wayne Lindstrom-BHC CEO/BHSD, Miles Copeland/ALTSD, Karen Peterson/GCD, Edward Mendez/DVS, Elizabeth Cassel/PED, Wendy Price/NMCD, Michael Sandoval/DOT, John Block III/DDPC
1. Call to Order Review/Approval of Agenda	Brent Earnest, Chair, called the meeting to order at 1:00 p.m. with a quorum present. ▪ Introduction of Behavioral Health Collaborative Members. ▪ Introduction of participants. ▪ Changes to agenda- EDIE Presentation from 1:45 to 3:30. We have had a delay of the arrival of Mr. VanHorne, his air flight was delayed and is on his way. We will move the other presentations up. ➢ Review/Approval of Agenda and Minutes A quorum was present-Handout-DRAFT Meeting Minutes, New Mexico Behavioral Health Collaborative Meeting – July 14, 2016 and October 13, 2016. A MOTION was made Secretary Lynn Gallagher/DOH and seconded by Wendy Price/NMCD to approve the minutes from July 14, 2016 and October 13, 2016, Behavioral Health Collaborative Meetings. The MOTION was PASSED unanimously.
2. Behavioral Health Director and CEO Report	Dr. Wayne Lindstrom, Director of BHSD and CEO, Collaborative - Our remote viewing sites were up about fifteen minutes before the collaborative meeting and right before everyone got here they crashed. We have folks troubleshooting but that is why you don't see the remote sites. Welcome to another Quarterly Meeting of the Collaborative. ➢ Administrative Services Only (ASO) Contract Transition ▪ After the formation of Centennial Care January 1, 2014, OptumHealth New Mexico ceased being the single state entity for all of Behavioral Health. Behavioral Health in the Medicaid side was carved into the Centennial Care benefit. With that change came the change from OptumHealth New Mexico being at risk for all of Behavioral Health becoming Administrative Services only organization for our non-Medicaid dollars. This year represents the last year of the one year

optional renewal for that contract. That contract will terminate effective June 30, 2017. We had to begin gearing up for an alternative for that contract.

- Kathy Slater-Huff's main responsibility on our staff is to serve as the ASO Transition Manager and project manage an orderly transition so come July 1, 2017 those providers who get reimbursed for non-Medicaid funded services basically continue to get paid. The other functions that OptumHealth has provided, we need to have a plan in place for how those are going to continue beyond June 30th.
- BHSD Star- All efforts to date have resulted in us making the decision to use BHSD Star. This may be a new term to some of you BHSD Star is an operating system that Falling Colors Technology has been the implementer of and the administrator for on behalf of the Behavioral Health Services Division. Currently Falling Colors Technology processes about 60% of our payments today. Given those realities we made the decision upon review with legal counsel within HSD, I'm happy to say that with CYFD is following a parallel process with us that effective July 1, 2017, the Behavioral Health Collaborative would have a contract executed with Falling Colors Technology to take over the bulk of these ASO functions.
- In my report I have outline the very high level of functions that would fall to Falling Colors Technology, those that we would be doing in-house at BHSD, and those we are engaging conversation with the Center for Behavioral Health Research and Training at UNM to assist with as well. This would be an amendment to an existing contract we already have with UNM.
- In our next Collaborative Quarterly Meeting in April, the plan is that you will have a draft of that contract to consider. We will have to work out a way of voting on that contract in advance of our next quarterly meeting because we would need the contract executed by June 1, 2017

Brent: I think one option may be the Executive Committee which is HSD, CYFD and DOH, the collaborative would just consider giving the Executive Committee the authority to execute the contract. We will discuss that in the April meeting,

- Passage of the Cures Act -Action that happened at the national level, the Passage of the Cures act. One of the things that was included was the ask that the president had made some months previous to have 1.1 billion dollars of new money to deal with the Opioid crisis nationally.
  - The Cures Act appropriated one billion of the 1.1 billion request for the purpose stated. When the continuing budget resolution was passed subsequently there was actually the one billion dollars was allocated. SAMHSA had done a lot of upfront work with the anticipation of the release of these funds because the intent, I think, of both the White House and the Congress was to get these dollars on the street as quickly as possible. We have a very tight turnaround. Before I get to where we are going with that, I would like to get to the stipulations on the dollars and what we are talking about the terms of the dollars.
  - The law indicated that the top priority be given to the states with the highest level of Opioid associated problems in the state. Given that we are one or two nationally with regards to these issues that we would fare better than we did. We ended up with .95% of the one billion dollars, which translates to 4.8 million dollars in FY 17 and another 4.8 million in FY 18.
  - We have to submit an application into SAMHSA by February 17, 2017.

- Given the late time we need to allow for approval processes within state government to get the application out the door, the draft application must be done by the end of next week.
- I think there is a general perception out there consumers and families providers that have picked up on these news, think this is a wonderful opportunity for us to apply for grants and be able to expand treatment capacity etc. These are one time only funds. We are very reluctant to invest in things that in roughly 18 months we would have to dismantle if we couldn't sustain them.
- The breakout for the 4.8 million dollars has been delineated is 80% of the dollars have to go for treatment, 5% can go to administrative and infrastructure and the balance which is 15% has to go to prevention.
- We are working with our colleagues at the Center for Behavioral Health Research and Training to collaborate with us on the application. The award also has stipulations that we do a needs assessment, a strategic plan, and a variety of things, which give the timelines, in some ways are unrealistic. Fortunately with other Opioid grants that we currently have been awarded we have done a lot of that work already. We are building off the work we have already done.
- There is a two page handout. Between now and January 17 any proposals that any stakeholder might want to propose. We are asking for something relatively very brief, one to two pages with a budget. We encourage everybody to use the SAMHSA budget template in creating the budget. We will be meeting on the 20th of January to take our needs assessment, the categories of funding available, and the proposals that we have to see what proposals fit with the priorities from the needs assessment, what the sustainability is beyond the two year period for what has been proposed, and we will make decisions accordingly about what ends up in the application.
- SAMHSA has stipulated that they will have the applications reviewed by the end of April. We have anticipated that the time that we actually receive any money would be by May so half the fiscal year will be over. Fortunately they are allowing us to carry over unexpended funds from FY17 to FY18.

➢ Valle Del Sol of New Mexico (VDSNM) Termination-This is the fourth Arizona provider that came in on 2013 to have issued a termination notice.

- Shortly after the termination notice we had a conference call with their attorney. I expressed at that time my surprise to have received the termination notice because I had a conversation with the CEO roughly six weeks prior to the termination notice inquiring about their financial state. I was assured that they were holding their own and remember him explicitly stating "we are here in New Mexico to stay". As it turns out as most CEO's would normally do when you are managing your overall book of business you will have some service lines or product lines that lose money and others that have nice margins associated with them and balance it all out. If the bottom line is in the black you view yourself in good stead. Kurt Sheppard, CEO for Valle Del Sol was managing his overall business between New Mexico and Arizona in that way. The board had an independent audit done and for whatever reasons apparently they were shocked to learn that after three and half years of operating in New Mexico, that Arizona was still subsidizing their New Mexico operation. They excused the CEO from that board meeting and consulted with their legal counsel and the end result was to issue the termination letter. When we had the call with legal counsel I queried him whether or not there was any receptivity in the part of the governing board to allow for an opportunity for us to understand what their challenges have been and potentially talk about how we might propose some solutions relative to the problems that they present.

They went back to the governing board. They did express such receptivity. We had the organization present to us what they considered a portrayal of their financial challenges and we had a follow up meeting with the MCO's and with Optum this week to talk about what is our respective perspectives were. The result of that meeting we have a face to face meeting with board members and management from Valle Del Sol scheduled for the 17th of January. We have begun the transition planning because the termination notice is still in effect, but this is still all pending the meeting we have already scheduled for next week.

***Brent**: we hold out some hope that there is potential to have a sustainable operation for providers but if not, as Wayne said we are working on the transition and ensuring that it will be the main focus for the consumers and others if needed to find a new provider. We have done this a few times before, we have worked in close collaboration with the MCO's to make it work as well as it can (Wayne and with the local communities as well) so we would anticipate that same process if necessary.*

- Certified Community Behavioral Health Clinics (CCBHC)-
  - We have reported in previous meetings to the collaborative that we had applied and received funding last year for a planning grant to stand up Certified Community Behavioral Health Clinics that would integrate services across behavioral health and health care and between adult and children and a variety of other things. A lot of activity and work went into that planning grant over the last year.
  - Six organizations were certified to be CCBHC's. We are all positive about that work and have been committed regardless of whether or not we would receive a demonstration grant we would still be committed to this as a goal for the system as a whole. We really believe that this was the natural evolution of Community Mental Health Centers to be more comprehensive and have a mechanism for value base purchasing and ultimately better outcomes. We had one year of the planning grant.
  - We submitted an application for the two year demonstration. The two year demonstration did not carry any additional dollars with it and with the planning grant we have had a project team in place, and made the CCBHC's a reality.
  - There were a series of requirements that were expected to be met by SAMHSA by July 1, 2017. Given our workforce challenges in New Mexico we knew it was unrealistic to propose that we could meet the requirements. We decided quite consciously to be very transparent in our application and basically propose what we saw as the realities and we wouldn't be able to meet certain requirements by July 1st. We had some hope that other states couldn't meet them as well and we would score insufficiently and so would some other states and SAMHSA would have to go back to the drawing board to redesign their scoring threshold. This didn't happen, there were eight states that got the demonstration award. New Mexico was not selected as a demonstration state. The only real boon to having that demonstration, we would have an enhanced federal match that would go from 73% to like 78%. This isn't a huge additional contribution
  - We have a no cost extension from the planning grant so we can keep the project team together until June 30th and proceed with what we had proposed as a plan "B" for these CCBHC's as a next step to make them behavioral health homes by July 1, 2017. You will find more specifics in my report on behavioral health homes and CCBHC's that will give you greater detail.
  - These are the four areas I wanted to update you

Dr. Wayne Lindstrom-CEO January 12, 2017 report 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, HSD

- Centennial Care Update
  - In October we had three 1115 Waiver Renewal subcommittee meetings to provide recommendations on our 1115 renewal. There is another meeting taking place tomorrow in Albuquerque. The discussion topics are value-based purchasing initiatives and member responsibility and engagement of the Medicaid program.
  - The final subcommittee meeting will be in February. We plan to draft a waiver renewal concept paper and will provide ample opportunity for public feedback on the concept paper before we officially submit the application to the Centers of Medicaid/Medicare services. Once we have feedback on the concept paper we will be drafting our 1115 renewal application. We will then provide another opportunity for public feedback on the application before we officially submit that to CMS sometime in November of this year.
  - Subcommittee meeting timeline with the different discussion topics. It has been really good robust discussions. Mercer, our contractor, is with us today here at this meeting. They have been leading the discussions with us.
  - I have provided a sample slide from our deck in December where we talked about physical health and behavioral health integration. Karen Meador lead this discussion, we went over the needs we identified from this discussion in terms of Centennial Care moving forward with the renewal.
    - We talked about increasing provider's competency and capacity to manage both physical and behavioral conditions
    - Increasing behavioral health screening across the continuum of care
    - Removing barriers and sharing information between providers, and developing value-based payment strategies that integrate care and are feasible to behavioral health providers.
  - During our discussion we listed on the right had side some of the questions we wanted to feedback to the committee members. Questions included are on slide 4.
    - What is working well right now with Centennial Care
    - How can we support provider's capacity to manage co-morbidity conditions
    - How can we encourage MCO's engage members more effectively and engage providers as well.
    - Can MCO's do a better job working with local and regional leader to create stronger forms of integrated care that improve health outcomes
    - HSD identify screening tools that we can recommend providers use
    - What ways can HSD support better information sharing
    - What types of value based purchasing arrangements will work for behavioral health providers.
  - If you would like to take a better look at our detailed minutes of that discussion we are posting everything on our website at http://www.hsd.state.nm.us/meetings.aspx
  - We are providing a lot of information for each meeting. We are listing all the detailed discussions in minutes. We also have a mechanism to submit public comment on the website as well. We are looking at all the recommendations that

are coming in continually and sharing them with the subcommittees. There is a lot of opportunity for feedback and public comment and we are trying to engage all of our stakeholders. This process is working really well

Questions/ Comments:

Wayne: *Nancy if I can add one thing, the way I often frame this is that this is the creation of Centennial Care 2.0 and if there are things you believe could benefit from improvement or changes in Centennial Care this is your opportunity to make suggestions and recommendations because this will result in a concept paper that Nancy is talking about. Once we have approval from CMS, then this will go into the actual application and negotiations with CMS. If you have things you want to suggest to make recommendations you can access the link that is sited or provide public comment*

- We are also planning a road show this summer so we will be traveling to four or five regions around the state asking the communities to provide feedback. There are a lot of mechanisms we are using to get the feedback that is inclusive to everyone and we will analyze all the recommendations that we receive.

- Cost Containment
  - Implemented provider rate reductions on July 1, 2016 and August 1, 2016. The second phase was effective January 1, 2017. We reduced most of our provider professional codes that remained above 100% of Medicare down to 94% of Medicare. We received a lot of feedback from behavioral health providers on some of the codes that were planned in the reduction. The department decided to retract those reductions on those codes.
  - Codes that we are not reducing are Psychiatric diagnostic evaluations, psychological and neuropsychological tests, and psychotherapy services. These codes are exempt from the reductions.
  - BH professional codes that were also reduced in august included psychotherapy, group therapy, multiple family group therapy, and comprehensive medication services. These were reduced to the proportionality to the Medicare rate.
- Additional Cost Containment
  - HSD plans to submit in the next two weeks a State Plan to CMS to implement copayments to the Medicaid program. They are nominal copays for certain populations with higher incomes for outpatient visits and inpatient stays. There will be copays across all populations for non-preferred prescription drugs unless there is a federal exemption for a particular medication. There will also be copays for non-emergent use of the emergency room for all populations unless they are specifically exempt per CFR.
- Supplement specific to Federally Qualified Health Centers (FQHC) billing specialized to behavioral health services.
  - Supplement 16-13, was issued in January. The key goal was to ensure greater flexibility for FQHCs for specialized behavioral health services. These include Applied Behavioral Analysis (ABA) Services, Assertive Community Treatment (ACT), Behavior Management Skills Development (BMS), Comprehensive Community Support Services (CCSS), Day Treatment, Intensive Outpatient Program (IOP), Multi-Systemic Therapy (MST), and Psychosocial Rehabilitation Services (PSR). The supplement is eight or nine pages and is pretty detailed. There is a lot of information for FQHCs. We are getting questions from them so we are clarifying those questions. If you have any further questions Kari Armijo from our division is the contact.

Questions/ Comments

Dr. Lindstrom*: I would like add, when we had the previous transitions from the other Arizona provider organizations that*

terminated services in New Mexico, more often than not the federally qualified health centers who ended up serving in the role of the transition provider and taking over the services in the respective service areas. FQHCs for the most part had a history of doing traditional behavioral health center based services, like doing individual psychotherapy for example on assessments etc. We would call more community based than recovery services, most had no such experience, and this has meant a variety of these Federally Qualified Health Centers also serving as community mental health centers. They are very different payment structures, different services. Community mental health center consumers and families tend to profile more consistently with severe mental illness categorization or severe emotional disturbances in terms of a child profile. This supplement was meant to clarify confusion both on the part of the FQHCs as well as the MCO's about how these services as CMHC within a FQHC can be reimbursed and works for the FQHC.

***Brent**: Just to add a little more to the conversation around the discussion on the length teen waiver, I think it worth pointing out that we are doing this and operating this under the rule as we know them today. As we all know the rules and laws we are operating today are likely to change at the federal level so. This has been a good opportunity for us to hear from folks on what works with Centennial Care and what doesn't, what we want to improve. Ultimately as we go forward we will have to leave a little more flexibility, be it our own concept paper or our own waiver agreement proposals to accommodate federal changes. We will keep you all up to date as that goes forward.*

***Brent**: I would like to add the state legislation is going to start on Tuesday. Different proposals from the executive and legislative finance committee on budget items, we are analyzing those today, but ultimately I think depending what happens in the session we will be talking more on cost containment in the Medicaid program. We don't know what that looks like and there is still 60 days to sort that out. Look for ways to ensure we are providing the services that are necessary and doing so in a responsible way. We will keep you all up to date as that progresses*

Q/A:
***Richard**: I would say that the meetings around the 1115 waiver have been responded to very well by the public. They have gotten compliments each time based on the inclusiveness based on the openness, the funding services and the new ideas or at least considering the passing along the needs.*
Centennial Care Update January 12, 2017 report will be posted on the NM Network of Care and Behavioral Health Collaborative Website

4. <u>SYT-P Workforce Mapping Data</u>

Brian Serna, Serna Solutions LLC
Michael Hock, CYFD

- Statewide Youth Treatment Planning Grant (SYT-P)- It is a two year planning grant focused on mapping out resources for adolescent and young adult services across the state. Also mapping out physical resources and investment, what the state does behavioral health wise from every source and also looking at workforce development.
    - Adolescent Substance Use Reduction Effort (ASURE): I would like to acknowledge the UNM CCBTR team who is also here, Dr. Carli Bonham and Molly Faulkner. They and their staff have helped us tremendously and we look forward to working with them as things move forward.

- Though cooperation of regulations and licensing we were able to get email address of everyone in the state who has a license to be a psychologist, social worker, and counselor. If you total the licenses up you end up with a total of 8,000. So we had 8,000 email addresses and were able to send out a survey. A lot of the email addresses were no longer valid.
- Secretary Jacobson called together a taskforce we called ASURT (Adolescent Substance Use and Reduction Taskforce). In the taskforce we have three subcommittees. This is the work of the workforce mapping subcommittee.
- My presentation will be about the second survey that was sent out (Survey 2.0) which closed October 31st, over 8,000 were sent out and we got 2,000 back. We would have liked more but with an online survey with absolutely no incentive we are happy we have the 2,000.
- Questions on the survey: results are on the presentation that is posted on the website
    - Age: The data is in the presentation. Data in the right had corner, I just collapsed some of the age groups together for better understanding of where we are at in the aging workforce.
    - Aging workforce-online survey-typically the younger the person is, the more likely a person is to respond to an online survey. Of the respondents 60% is reported being age 50 and over. 35% are age 60 and over.
    - Currently retired (have you stopped practicing)-No 92.3%, Yes 7.7%
    - If retired, do you plan on returning to the BH Workforce-Yes as a volunteer 14.4%, Yes as a paid professional 53.8%, and No 31.8%. These results are good news because professionals that plan on retirement do plan on coming back to work in Behavioral Health.
    - Do you plan to retire (stop practicing) within the next three years-Yes 16.9% and No 83.1%. 20% of those planning to retire also plan to leave the state.
        - Now is a good time to acknowledge APEX who crunches all the numbers and gets all the data we request.
    - Leaving the state-Yes 21.5% and NO 75.8%. This does not include those planning to retire with in the next three years. Overall attrition from planning to leave the state and/or retiring is at 34%. The total numbers are not duplicated.
- Since 35% of respondents are age 60 or over and 60% are age 50 and over, how can we meet the increasing need for behavioral health services in our state? How do we make careers in behavioral healthcare attractive to future generations? The discussions in our roundtable in our taskforce have a lot to do with stability, reimbursement rates, and clinical supervision. Recommendations are the same as with the BHSD workforce recommendations and UNM recommendations. The recommendations really need to move beyond just recommendations and move into policy if we are going to make a career in behavioral health attractive.
    - Gender-on 1.0 we only asked male or female. With 2.0 this is how we ask gender on the survey. Female 76.8%, Male 21.5%, Transgender (Specify of desired) .4%, Prefer not to answer 1.2%, and Self-Identify (Specify if desired) .02%. Survey is pretty consistent, about 77% of the workforce is female.
    - Cultural has also changed significantly. Survey 1.0 question were: Are you Hispanic/Latino and Yes or No.

With 2.0 participants can identify with any of the following ethnic categories: Native American or Alaskan Native 6.5%, Black or African American 2.7%, White 63.4%, Asian .8%, Native Hawaiian or other Pacific Islander .3%, Hispanic/Latino 27.1%, do not identify with an ethnic category 2.5%, prefer not to answer 4.1%, and other (specify if desired) 20.1%,

- Language-what language are you able to provide services: 97.6% said they could provide services in English, especially since the survey was in English, makes you wonder about surveys. 20% did say they could speak in Spanish. We added the indigenous language groups that are indigenous to New Mexico just to see what is out there. There were providers that offered services in indigenous languages in New Mexico, which is encouraging. Obviously we need more people who speak in Spanish but also need Indigenous language speakers especially when working with families.

- How do we recruit more males into our workforce? How do we recruit and retain bi-lingual providers? How do we support those individuals once recruited?
  - Education-most of the behavioral health providers are master level providers 76.8%. There were respondents that had doctorate level providers 15.3%, high school/GED providers .9%, associates 1.1%, MD .1%, Juris Doctorate .2% and none .1%.

- **Other Survey responses are on the presentation and will be posted on the NM Network of Care and Behavioral Health Collaborative Website**
  - Selected Comments:
    - What training do you feel like you need to better serve the youth of your community? People could type in anything they wanted. It was not a forced choice.
      - More motivational interviewing, Addictions (trainings around addictions), Interventions Assessed in the Survey (ASAM, Matrix, Seven Challenges, seeking safety and MI), Cultural issues, Dialectical Behavior Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR), Community Reinforcement and Family Training (CRAFT), Adolescent Community Reinforcement Approach (A-CRA).
    - What training do you feel like you need to better serve the youth of your community?
      - I can have all the training in the world, the problem is finding more services for clients outside of the sessions.
      - Free trainings in rural areas-not everyone can afford the money or time to go to Santa Fe, Albuquerque or Las Cruces. Provide free CEU's on the WEB. People get trained and never use these models because the trainings don't teach you how to apply the tools.
  - What training do you feel like you need to better serve the youth of your community?
    - Better funding of services. How can we have time to get more training when we are struggling to pay the rent? A poorly funded state stays poor on so many levels. Magical training initiatives will not solve the problems, especially when there is so much developmental trauma, complex PTSD, and occurring disorders. Many of us are wondering how long we can stay in this state and we are tired of the smoke and mirrors

approach to employing our services. It comes down to funding. More funding, more time for training."

- Our workforce is rapidly aging and it is not representative of the clients/consumers served. Reimbursement for supervision and for services delivered by trainees will increase services and develop a new cadre of professionals. Recruit, retain and incentivize professionals from backgrounds and linguistic groups that are in closer in alignment with those we serve.
  - ❖ Financial incentives such as tax relief, student debt repayment, scholarship opportunities. Pay differentials for services provided in languages other than English.

If you have any questions, comments, or reflections on this report you can reach Mr. Hock at Michael.Hock@state.nm.us or me, Brian Serna at brian@sernalolutionsllc.com

***Dr. Lindstrom**: Brian, It really struck me and I would also direct this to Molly Faulkner. We are getting an increasing good handle on what our triton rate is across behavioral health professions, but I don't know we have as good of a tracking of what the pipeline is producing. I think we need to better delineate policy makers what that potential disparity is. The pipeline question isn't how many we are producing, but once we produce them, how many go on to independently licensing and how many end up staying in the state. So as we go down this road I would like us to have a conversation about how we can start doing a better job of acquiring that data.*

***Lynn Gallagher**: a general question, have we ever considered any incentives that may be available for particularly retired personnel who might be in another state to encourage them to come into New Mexico. Like you said there is a large group of people who are retired that are leaving the state but what about encouraging retirees to come to New Mexico to provide those services be it maybe on a part time basis.*

Brian: there might be a way through telehealth services and technology. They still have the expertise and still know the communities.

***Dr. Lindstrom**: we don't have any strategies developed around that. One of the historic areas has been the problems around reciprocity from other states. We had legislation passed last year for reciprocity and we are now tracking, Molly Faulkner is working on that, across all the licensing boards in terms of their rule making for their respective professions through rural reciprocity barriers. When we have that information I think we will be in a better position to do what you suggested.*

***Chris Tokarski**: one of the things I would like to see is that I think is missing is when we are really looking at the workforce is asking if people are working in the rural areas, that has me concerned. Another thing that might be helpful is to see how many practitioners are military spouses because in our area we have the air force base and they come and go all the time because they are transferred out.*

***Brian**: to your first question, we definitely have that data we just need to pull it out because we have zip codes that everyone responded to the survey and we have an interactive map so maybe we can see the numbers. We will work on those numbers.*

***Byrce**: I would like to get our higher institutions that are producing these, like Highlands, NMSU, and UNM involved in partnering with students, especially students of color and bilingual to promote their success. We know if they make it through their first semester and second semester of the bachelor's level program they are much more likely to graduate and move on. Being able to utilize folks in our communities that could partner and help them through the process.*

SYT-P Workforce Mapping Data Presentation will be posted on the NM Network of Care and Behavioral Health Collaborative Website

5. Mental Health Parity and Addiction Equity Act (MHPAEA)

Jessica Osborn, Mercer
Jonathan Myers, Mercer

Jessica: Mercer is a consultant with the state and one of the projects we are working on is providing technical assistance to Medical Assistance Division on Mental Health Parity. This is a very complex and not a very easy project and we are in the beginning stages. We were asked to come in and talk about as much as overview as we can give you in the short period of time of what this entails and what is required. What I would like to talk about today is how MHPAEA applies to Medicaid and CHIP
Jonathan: The information we are providing today is the current understanding we have and are working with based on the Federal Regulations that came out last year, more importantly right now HSD and BHSD are working together to tackle this problem. I am not necessarily characterize it as a problem but work has already begun to look at the analysis, to put the documentation together of the analysis and to meet the compliance needs that are coming later on this year.

- Mental Health Parity Addiction Equity Act (MHPAEA) background-I would like to give you an overview on how this applies to Medicaid and CHIP specifically and also on what the components of the rules and what the expectations of tasking and what are the documentation requirements.
- MAPAEA-I am going to talk about MAPAEA as Parity. The concept is not new, it has been around and floating federal regulations are for quite some time. The only difference now a days, is last year the application came out specifically as a rule for Medicaid and CHIP. Parity started in 1996 was focused on life time and annual dollar limits for mental health to ensure that no aggregated limits applied to medical. In 2008 they furthered out the regulation to require the financial requirements and treatment limitations. They expanded aggregate limits requirements to substance use disorders. In 2010 they came out with the interim rule for commercial plans. The commercial plans already have to do work with these requirements to do the analysis. March 30, 2016 the final rule s for commercial plans published for Medicaid and CHIP published with a compliance date of October 2, 2017. I am going to get to what the requirements are and the documentation that CMS expect.
    - Overview: Parity prohibits limits on Mental Health (MH) and Substance Use Disorder (SUD) benefits that are more restrictive than those placed on medical benefits. This is a very general statement but that is fundamentally the concept. Below are some examples:
        - Cannot have higher copays for a MH office visit than for a medical office visit. This is what we would consider a Financial Requirement (FR)
        - Cannot have a limit on 30 day inpatient treatment for SUD services. If there is a 60 day limit on all inpatient medical treatment. That would be considered a Quantitative Treatment Limit (QTL). What you have here is obviously is a restrictive limit for the 30 day than the 60 day limit.
        - Cannot limit eating disorder treatment to $50,000 per year, if there are no dollar limits on medical treatment (Aggregate Dollar Limit).

- ❖ Cannot require prior authorization for intensive outpatient treatment (IOP) if no outpatient medical services require prior authorization (Non-Quantitative Treatment Limit or NQTL)
- ❖ At the end of the day the goal is that we are looking at is that mental health services needs to be in Parity with comparable to medical services. This doesn't mean it has to be all equal there is ways through the analysis through documentation that the state has, at its disposal, to justify certain limitations that are already in place in the substance abuse side that can stay. The point is that the analysis has to be done and the justification has to be made.
    - The intent of the rule is not force the state to add services or to make things completely equal. It is to make sure that you are looking at all the services and benefits that are available

➢ The application of Parity, in terms of Medicaid and CHIP (Children Health Insurance Program). There are four components where Parity applies:

- Medicaid MCO's-Parity requirements apply to all MH/SUD benefits provided to Medicaid MCO enrollees regardless of whether all MH/SUD and M/S benefits are provided by the MCO. The application to this rule primarily in line with MCO enrollees. As we get through the four quadrants, when it comes down to fee for service, when these beneficiaries they are outside of managed care the state has the optional decision whether or not to do the Parity analysis.
- ABPs- the Medicaid MCO requirements aren't any different to the non MCO ABPs with the exception of dollar limit rules.
- CHIP- programs must comply with Parity regardless of delivery. CHIP can be provided by manager care or fee for service. The idea is they are still responsible for the same requirements as the managed care side. The only difference here with clarification with CMS is separate CHIP programs providing full EPSDT screening. Those programs are deemed to be compliant. The EPSDT have different restrictions because of the way the benefits are structured.
- Medicaid FFS (Fee for Service)-Parity requirements do not apply to Medicaid beneficiaries who are not enrolled in an MCO/not receiving ABP benefits (e.g. PIHP, PAHP, PCCM, FFS only) in the rule of federal regulations CMS suggests in recommends each state look at these populations /programs anyway. For example this could be a fee for service your Native America population in New Mexico. The workgroup we are working through the Native American will be included in the analysis but is not a requirement. It is focused on enrollees and managed care and also enrollees who are receiving services outside of managed care to the fee for service environment.

Brent*: we are taking a very comprehensive approach and all for boxes apply to New Mexico. The CHIP program is really just an expansion of eligibility to higher income kids. We have largely managed care here and a smaller fee for service program.*
Jessica*: You all have an expansion CHIP program so you will see that term in the documentation. You do not have a separate CHIP Program which a lot of folks analysis of the rule and CMS has been slow with guidance. Our interpretation is that it is a separate CHIP Program, that the deeming doesn't apply but we are asking clarification on because it would certainly relieve a lot of the work on the part of the folks that HSD/BHSD who are working on this*.

➢ How does MHPAEA apply to Medicaid/CHIP benefits

- MHPAEA applies to MH/SUD benefits for Medicaid MCO enrollees, one thing I didn't include I that it also applies to long term care benefits. There were a lot of kickbacks on the comments that in the interim rule why they weren't including long term care, so in the interim rule they did not have it and in the final rule they finally did.
- If a Medicaid MCO enrollee receives some benefits on a fee for service before Parity applies to future.
- MHPAEA applies separately to each benefit package. An example benefits provided to a specific population, regardless of delivery system.
- States are encouraged to apply MHPAEA to benefits even when it isn't required by law.
- When we talk about Parity there is a couple of important things I would like to talk about now is to look at benefit package, it's not a look at services, not looked at what is carved in or out. With the 1115 adult/children population, you have the waivers, you have the MHPAEA population, and it's really looking at Parity across within each benefit package.

➢ Types of Parity Limits-when it comes to the analysis, it really is about testing. In the guidance that came with the federal regulations there were essentially five types of limits and three types of tests. Parity itself is a concept that is a very simple concept, when you are looking for comparable mental health substance use disorder services. When you start looking deeper and see what limits you have and the types of limits you have it gets very complex.
- Financial Requirement (FR)-payments by beneficiaries for services received that are in addition to payments made by the state, this includes copayments and coinsurance.
- Quantitative Treatment Limitations (QTL)-limits on the scope or duration of a benefit that are expressed numerically. This includes day or visit limits.
- Aggregate Lifetime or Annual Dollar Limits (A/LDL)-Dollar limits on the total amount of a specified benefit over a lifetime or on an annual basis.
- Non-Quantitative Treatment Limits (NQTLs)-these are soft limits. Prior authorization requirements, service exclusions, network admission requirements including provider reimbursements rates, formulary design or other factors that limit the scope or duration of MH/SUD benefits.
- These requirement or limits must pass three specific tests to be permissible under the state

➢ Types of Parity Tests-
- FR's include copays, coinsurance, and deductibles, out of pocket maximums. The beneficiary will have to pay while receiving the service. FR's does not include aggregate lifetime or annual dollar limits
- QTL's- are numerical limits on the scope or duration of benefits including limits on number of days and visit limits
- The Parity test for FRs and QTLs- the way regulation reads is any FR or QTL applied to MH/SUD is no more restrictive than the predominant financial requirement or QTL applied to substantially all medical/surgical benefits.

➢ Testing FRs and QTLs- Essentially what this means is- what it is, is a two part claims test. Over a period of time look at the medical/surgical side first, and then do a claims analysist to see whether or not certain services meet the predominant test. One of distinctions is when you look at the FR QTLs, typically what you would do is when you are looking at the analysis you would start looking at the medical surgical benefits first and the look at the expenditures over a time period. When you look at the Non-Quantitative Treatment you would typically look at the behavioral health side first the Mental Health Substance use Disorder side. Here we have an example of the substantially all and the predominant test would look like, looking at it

from the medical/surgical side.

- Substantially All-the substantially all test requires a type of FR or QTL, a copayment or visit limit, to apply to at least two thirds of the expected payments in a year for all M/S benefits in the same classification. If the medical/surgical benefits within the classification meet the test, then you would move on to the predominant test.
- Predominant- to pass the predominant test is looking at the magnitude of the type of FR, copayment, or QTL, visit limit, must apply to more than one-half of the medical/surgical benefits in the same classification that are subject to that type of Fr or QTL. This is not a one for one analysis, this is not if we charge 5 dollar copay on the medical side that we must or cannot charge 5 dollar copay on the behavioral health, mental health side. It is important for you all to understand the complexity of, in the way which we start looking at your benefits and programs though you may have not looked at them in that way before.

- Testing NQTLs-The simple way to explain is you've tested your FR and QTL is one side of the equation. The next and more complex is you imagine NQTLs are limitations that are not expressed numerically, but otherwise limit the scope or duration of benefits. These are Soft limits, soft limits allow for an individual to exceed numerical limits based on medical necessity.
  - Medical management standards-medical necessity or appropriateness criteria and processes or experimental/investigational determinations.
  - Prescription drugs formulary
  - Admission standards for provider networks
  - Provider reimbursement rates
  - Restrictions based on location, facility type, or provider specialty
  - Fail first policies or step therapy protocols
  - Exclusions based on failure to complete a course of treatment
- Testing NQTLs-under the policies and procedures of the state/MCOs. You wouldn't necessarily expect to have identical the same policy and procedures. There would be variations across plans. You are also looking at policies and procedures on how they are written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and applied no more stringently than the processes, strategies, evidentiary standards or other factors used in applying the NQTL to M/S benefits in the classification.
  - NQTL analysis is not a serve to service comparison or classification to classification comparison for each benefit package. So in the final rule CMS came out with four classifications. Inpatient, outpatient, fee for service and pharmacy. There is also a fifth component where you can break out outpatient to office visits which we are not going to do. One thing we are now is we are identifying our services and then we are classifying them to one of the four classifications.
  - Again this does not require a one to one comparison of an MN/SUD service to an M/S service. It is not required that the result of applying an NQTL is the same for MH/SUD and M/S benefits to pass the Parity test.
- Achieving Compliance-if a benefit package does not meet MHPAEA requirements, the state can amend the state plan so the package complies with Parity requirements, add benefits or adjust limits in the benefit package provided by the capitated entity without amending the state plan, and/or facilitate resolution. Compliance is not done October 2nd of this year, compliance is an ongoing requirement.

- Documentation and Disclosures
  - States must submit documentation regarding Parity compliance with an MCO contract/contract amendment for a carve-out program, an ABP SPA or a CHIP SPA.
  - States must also provide documentation of compliance with Parity to the general public and post this information on the state's Medicaid website by October 2, 2017.
  - Documentation, including the parity analysis, must be updated when there is a change that impacts compliance.
  - Certain information must be made available upon request. An example is criteria for medical necessity determinations and reasons for payment denials.
  - Anyone who has worked with CMS knows there is a lot of questions especially with something as complex as this. Looking for a lot of guidance, for example, what kind of documentation is required? Do the MCO contracts need to be part of the documentation, reimbursement rates, do this also need to be part of the documentation. What we are trying to do is work forward as best as we can. We don't want to be stuck in a situation this summer where all this guidance all of a sudden comes out and nothing has happened. Through discussion with CMS, with decisions we are making now and the analysis we are getting now externally is not likely to change.

Lynn Gallagher*: Are we making forward movement, final rules seem to come out end of March 2016, we are almost a year and a plan had to be developed so do we have some forward movement?*
Jessica*: we do have movement, there are some tight time frames, and they always feel tight when there are lots of moving parts and things that hold the capacity of staff that are working on it. I don't believe there is any reason to be alarmed or concerned that we are not going to be compliant. The lag time from the rule being published, there was a lot of scrambling on everyone's part to read the rule, interpret the rule, and start issuing guidance.*
Brent*: a couple of things, one can you comment on or do you know, is this process similar to a commercial plans had to go through several years ago or is it different?*
Jonathan*: It's a similar process. There are for example PDLs which is Medicaid component, the formulary design review is not the same but one of the things we have notice when the plans did have to do just a couple of years ago so there were a lot of lessons learned there.*
Jessica*: There is a lot of alignment between the commercial rule and managed care rule that have extended commercial rule to Medicare/Medicaid.*
Brent: *the second question I had is generally how it is going to be applied is parity with the medical side meaning there is an assumption that there are more restrictions on the behavioral health/mental health side. In New Mexico we have also done a lot of prohibiting prior authorization on certain services behavioral health, exempting copayments for behavioral health services. If you behavioral health or mental health services are more generous than on the medical side, what is the thinking of that?*
Wayne: *my understanding is there is a great deal of variability on the part of commercial health plans and their conformant to the parity rule and there is also a lot of variability in terms of department of insurance in states and terms of enforcement of parity so you kind of find this all over the map depending on where you are.*
Jessica*: We have been asked the question as recently as today, we had a group meeting today, what happens if we don't make the time line? What is the penalty? Who is coming after us, who is looking at this. CMS has their hands full so what you want to*

walk away with is you always want to be as compliant and on task, the risk is that CMS can always audit and are found not to be in compliant and if anyone did come in and look, then what is at risk is your federal match.

Mental Health Parity and Addiction Equity Act Presentation will be posted on the NM Network of Care and Behavioral Health Collaborative Website

6. Behavioral Health Planning Council (BHPC) Report

Carol Luna Anderson, Co-Chair
Susie Kimble, Chair was unable to travel here today
One of the main responsibilities of the BHPC is to oversee and advise on the Block Grant development, implementation, and evaluation. One of the major issues that has been brought to our attention is that our Planning Council is out of compliance for membership according to federal guidelines and we also have a state statute that we have to comply with. We are still waiting on approval of several individuals by the Governor's staff to be considered for appointment to the BHPC. We are waiting patiently for word on the appointments. We are a small number but we do most of our work under our subcommittees. There is a great concern over the BHPC budget.

- BHPC December Meeting- was very well attended. We joined with the Adult Substance Abuse Medicaid Subcommittee to hear interesting information. One of the topics was on Treat First and what are the effects and some of the findings of the results given of the first pilots that were there. Parts of the summaries are and findings are also in Dr. Lindstrom's report. Lots of positive comments that came from the presentation that Betty Downes gave. The other topic was the legalization of cannabis as a recreational drug. We would like to know more information. It is hard to have an opinion, if you don't have real accurate data and information. We asked a couple of individuals to come in a present to us with their expertise. One presenter was Dr. Foster from UNM department of psychiatry who gave is a very interesting presentation on cannabis itself. The other was Emily Kaltenbach, Director of the New Mexico Drug Policy, who shared with us the information on what is it that we need to be concerned about. BHPC has agreed to review our bylaws and Policies and Procedures to ensure everything that can be done under statute will be done to ensure the Native American voice is heard.
- Behavioral Health Day at the state legislature- we will once again celebrate BH Day at the state legislature in 2017. BH Day will be held on February 15th 9:00-12:00 with a celebration of innovation in New Mexico to be held on February 14th from 9-3 at the Lodge of Santa Fe. We hope you can all join us for these important gatherings. There are many exhibitors that have signed up and will be sharing information on what is happening in our state in terms of behavioral health.

Comment: *on the legalization of marijuana, the thing to know is that knowledge is power. We have to gather the information and gather facts and to hear all sides. There are a couple of reports that have recently been approved by the federal government on the effects of legalization of marijuana in Colorado and Washington. They are relatively new and they have statistics and looked at evidence based data. It bears a good read from New Mexico as we make an informed decision. I have the two reports and can send it to Wayne to send it out.*

Behavioral Health Planning Council report will be posted on the NM Network of Care and Behavioral Health Collaborative Website

7.	Emergency Information Department Exchange	Tristan Van Horne, VP of Network Development We have been working with New Mexico for a several months on a project that is called ER is for Emergencies. We are getting help from HSD, from the four MCO's, and the New Mexico Chapter of American College of Emergency Physicians. We are very appreciative of all the support of this program. ➢ New Mexico ER is for Emergencies project update ▪ Where are we with New Mexico ➢ Background of the company ▪ Collective Medical Technologies was started by an ED Social Worker. Patti Green was based in Boise Idaho at St. Luke's Hospital. She had the same suspicion that we all had. How we could better help our patients. She took her community and collaborated with them. She worked with other ED social workers. Patti published a paper with Massachusetts General Hospital. At this time her IT department was very busy so she took her to her son who was a college student in Brigham Young University and his college roommate and asked them to develop the program. That program became Emergency Information Department Exchange. ▪ We have 16 states have requested interest in our company. New Mexico, Massachusetts, Virginia, West Virginia, Oregon, Washington, California, Montana, New Hampshire ect. The American College of Emergency Physicians took notice of our work and nationally they voted in endorsing us. We are in 900 hospitals, UC's, and clinics. ➢ The problem-Situation ▪ Small numbers of patients generate a disproportionate volume of visits, less than 5% of patients with about 21% ED visits. Are we utilizing ED appropriately? This is a challenge because physicians don't have information when they have a rapid work flow. They don't know if a patient is going from hospital to hospital. They don't know if that patient has substance use disorder. If they are unfamiliar with the patient, they don't know how to treat them, so what we are trying to do is help them identify the most at risk, most complex patients and the most vulnerable populations so they can better treat them. ▪ The approach is to look over the entire state, so we can identify immediately when patients show up at the ED that are complex. We then notify their care team, everyone on their disciplinary care team is notified via the ER System. ➢ Pre Manage Platform starts with minimal data. It facilitates communication outside of the ED and can manage sophisticated event notification. ▪ Identification-notification to ED providers for ED/in-patient visits, shared platform for ED care coordination information and high utilization/Complex ED patients. This will give us basic demographics, the diagnosis, and identify the patient, and we can see the patients ED history. For example mis-utilization pediatrics patients, we can allow clinicians to have notifications sent to them when pediatric patients present more than once in the ED. We can support a program that says on the questionnaire there is a 24hr nursing hotline, did you know there is pediatric clinic down the street, or did you know your primary care physician is available. We can make sure you can use this program for educational help. We can use this for the crisis hot line. We can pass information if someone has suicidal ideation, did you know there is a suicide hotline available. We can use this information to educate the patient. ▪ Targeted notification-communication is very important. We can send notifications to multiple parties across ED at the

same time, In-Outpatient Visits either by fax, text, we can integrate into any system possible. This is targeted-half the people that are identified as the multidisciplinary team carried that patient so as a caseworker/case manager, if a visit triggers a pre-set criteria the case management team will be notified by email, text or other ways as requested.

- The next step is where the social worker comes into place. The program can amplify your voice, perhaps you have written up a program for the patient, you can share a pain contract. John Doe goes into an ED and you can have hat pain contract attached into the system.

***Wayne**: posting of advance directives would also be appropriate for that.*

- we can upload PDF's, EKG's are good examples of uploads,

- Typical workflow-Real-time situational awareness if you are a patient with ex: Lovelace. Patient presents at hospital check-in. The registrar would hit send. The ED message would be send immediately from the hospital to CMT. Pre-Manage correctly identifies the patient. Our system correctly identifies a patient 99.99999% and cross references patient with visit history across our systems. This is how good our system works. If a visit triggers pre-set criteria, we send out the notification that contains the visit history (if the patient has been in the ED within 90 days), diagnoses, prescriptions, guidelines, and any other clinical data with a patient specific care plan. The ED has the information at hand even before he/she sees the patient. (Pink handout) here is an example of a Pre-Manage ED alert. Make sure you have the ED Alert in bright yellow, fuchsia, bright orange, a lot of the small hospitals have a very small system, and they don't have the kind of resources so they put us in their printer or in their fax. It is printed in color paper so they can identify so when the clinician walking into the room they have this notification. They have the 90 seconds of critical time to look at the notification. The handout is factious, and the ED alert has been submitted because Charles has recommended care guidelines. You can see his psychiatrist and cardiologist information is available. You can see there is an EKG uploaded so if you need to do another EKG you have something to compare it to. If you have to admit the patient you can call his cardiologist. You can also see that the patient's pain is cardiac related, and to please use nitroglycerin for pain and not to use controlled substances in the ER unless there are new findings as patient is very sensitive to opiates. You can see the patient history and where the patient has been with the visit summary. You can see the total visit summary on this handout and what the primary diagnosis is in the system

Sally: so you have your own database for a client weather he is in the hospital, in the ER or is just an outpatient in some clinic
***Tristan**: Our implementation is typically taking place in a hospital. As I said we are 100 % in a hospital at least in contracting mode. We have 6 hospitals contract and have several implementing going live this quarter. We also have the support of the MCO's. The hospitals have the insights, those insights are shared across the community. As members of the community can contribute to the care plan. For example some smaller hospitals don't have the capability to feed us electronically so they access our portal so they can add care recommendations directly into our portal.*

- Edie Notifications push targeted insight directly into the provider's workflow, only when relevant, without having to be asked, and to limited to a single hospital or health system.
  - If you look in the slide of the example of the Edie EHR integration, halfway down you see the EDIE Alert has been pushed directly into the ED tracking log.
- On the next slide is the state-level Data I brought from Washington. Washington experienced a 101% drop in total Medicaid

ED visits every year that shows a Medicaid savings of about 34 million with the significant credit give to Pre-Managed ED (EDIE). It also showed a 27% reduction in opioid overdose, 24% reduction is ED visits with opiate prescriptions and a 27% decrease in number of high utilizers with prescribers.

Olivia Ridgeway: *how is HIPAA addressed and how are kids confidentiality addressed?*

Tristan*: on the next slide we have the legal opinion with the detailed analysis of federal and New Mexico laws.*

- Patient Consent-the HIPPA Privacy Rule allows hospitals to disclose PHI for treatment, payment, health care operations, and public health activities without patient consent/authorization. New Mexico state law is consistent with this HIPAA Privacy Rule TPO disclosure framework
- Pre-Manage ED can operate on opt out basis, share information unless the patient opts out. With Pre-Manage ED the opt in requirement for New Mexico Electronic Medical Records do not apply.
- Sensitive information- Some categories of PHI are subject to extra privacy restrictions, this usually requires additional patient consent requirements. Some examples are psychotherapy notes, substance abuse treatment information, HIV test results, and genetic testing information. These examples are information we don't need to know or need to share so we work with teams that the correct very clear consent forms are signed.
- Christensen Legal Opinion and the Master subscription agreements and Pre-Manage ED service order is available for review by all New Mexico Hospitals.

Sally: *so when a patient goes into an ED, that is when you have them sign the release?*

Tristan*: we fall under the general consent so hospitals-ED's have the general consent forms. We fall under that consent form. So if a patient was flipping around he wouldn't have to sign the consent form.*

Tristan*: correct, he could opt out, but we could identify that patient as someone we could treat. Pediatric would also fall under general consent TPO.*

Olivia Ridgeway*: I am looking at New Mexico Children's code has age distinctions that kids 14 and over can decide and sign releases around medications so the parents don't have to sign so there is some kind of special consideration.*

Tristan*: New Mexico need sub deversation consent, additional consent for mental and behavioral health. We train all users not to enter psychiatric notes etc.*

Brent*: I think I should have given a little introduction, it is mostly mute now but this in large been driven in part of what we have been pushing in the managed care organizations and through Centennial Care to really drive appropriate services in the appropriate. It's great to see this presentation on how it actually works. My question is how would this technology then work with community providers or connect them to other services? How a patient presenting in the ED, the provider be notified that your patient is now in the ED.*

Tristan: *The notifications are set up for the entire management team. The entire disciplinary time that has been identified, anyone who was identified as part of the group would be set up in the notification system. The group/team would have access to the system because they have established a TPO relationship as a clinician for that group. They would be able to be alerted whenever that patient is presented in the ED, they would be able to enter into that system and enter the care recommendations for that particular patient treatment protocol. They would have the ability to work with and communicate either be by phone or identify who is on the team as well, anytime the patient presents across the community.*

Lynn Gallagher: *I think some folks get tied up in the ED language so the system itself is available for any provider of services mental, medical ect. correct? and then that information you've created the database based on ED data that you've received of patients and if you're in the system you are part of that connection to receive that information and those alerts. If someone hasn't ever presented it an ED, and lets use NMBHI as an example, NMBHI doesn't have an emergency room we just have an intake. We bring patients at various stages, there is not an ED. If someone has not presented they would still go into the system if they came first to NMBHI if we used the EDIE System?*
Tristan*: The NMBHI could add a CSB file to identify who their population are if they wanted to. We could establish that membership to that institution, any facility, or any individual. I would also like to add the ED ADT is also the inpatient ADT. When hospitals are implemented, we take two years of data so when we start implementing across all the hospitals with two years of data from each individual hospital across New Mexico, we should have most of New Mexico in the system for anyone who has presented. If you have never presented in a hospital we wouldn't have that information.*
Lynn Gallagher: so if a patient had been transitioned from NMBHI and later presented at UNMH and there were issues of prescribing, that would present?
Tristan*: if they triggered the criteria that would notify the individual clinician in that ED.*
Sally Wait: *Let's say the care team is multiple providers throughout the community or state, how do they get their notification that they want to be notified into your system.*
Tristan: *They would have to establish a TPO relationship either through the hospital facility or as an individual clinician with the relationship to a patient.*
Sally*: We have these Health Homes (facilities), with a group of practitioners, so the Health Home could contact each hospital or contact*
Tristan*: you would contact us and grow the relationship with us which would then grow the network.*
Molly Faulkner*: The Health Homes are attached to a managed care organization so they would be the entity that would get the notification and then let the Health Home know.*
Tristan: *We could do it either way, as long as the TPO relationship has been established, however your team wanted to be notified as long as that patient had that relationship with your facility.*
Sally: *I think one of the challenges is that individual change their MCO's and so that relationship pretty often stays very static with their local providers.*
Tristan*: We would identify them no matter what MCO the individual would have.*
Question*: What is your relationship with free standing psychiatric hospitals? My understanding is that ADT do not come from free standing hospitals.*
That is typically correct so. They would have to identify themselves so we would get a CSV file of all the providers so we would have to we would have to establish a CPO relationship with each individual clinician. They would benefit from the network. They could enter the individual manually. If there is no ADT we would use an excel file
Edward Mendez: *Have you spoken with the VA? Any way we they could share their data?*
Wayne: *IHS would also be another one.*
Tristan*: we haven't worked with them, we would love to but because they are such a solid system they tend to work well across*

the country. The answer is that we would like to someday work with the VA system. The second questions was to integrate with the Indian Health Services, we are actively talking with potential pilot sites in Gallup. Dr. Christensen is going to meet with us, I had to reschedule because my flight was delayed and I was to meet with her this morning so, we are going to reschedule for next week that we are back in town. We want all the citizens of New Mexico to be taken care of with this informational system.
***Wayne**: I would like to add, this is going to be a great asset to our system overall and that is why we wanted everybody to have the opportunity that this is being rolled out across the state and for you all to be thinking about how this can assist you in your various spheres of influence around us doing a better job in care coordination and coordinated delivery system excreta.*
***Edward**: I asked about the VA because the VA is offering the choice program where some of the vets can go out into the community and been seen and be it medical or behavioral health addressed and if they can't share that information with an entity then they have to go through the whole process.*
***Tristan**: Is there anyone we could be introduced to?*
***Edward**: That would have to be at the Federal level because they are all federal hospitals throughout the country. It's not like we can just do it here with the hospital in Albuquerque.*
***Lynn**: Something we could do through Department of Health is as we are working with the transition of the state veteran's home here perhaps we could have a joint meeting with the state VA and VA's as we are doing that transition to see if this doesn't make sense.*
***Wayne:** Maybe we can get some kind of sanction from the VA nationally to allow New Mexico to be a pilot site/program.*

- <u>Local Collaborative Alliance Update</u>

Patricia Gallegos, NM Local Collaborative Alliance
In your packet is the Local Collaborative Alliance report. There are several reports and I will elaborate on that. The Local Collaborative Alliance supports grassroots efforts that enhance the experience of the local communities across New Mexico.

- The alliance meets every other month. At these meetings we include local collaboratives across the state. We initially had 18 local collaboratives representing 3 counties per collaborative, we are now down to 10 active Local collaboratives. We are very happy with the 10 local collaboratives. The Alliance has its Chair, Vice Chair, clerical administrator, grant writer, and myself the alliance coordinator. In 2016 the alliance received monies from Molina Healthcare & United Health Care Community Plan, OPRE, Con Alma Foundation, the Santa Fe Community Foundation, Jack & Mary Gillian Endowment Fund as well as from the Native American Sub-Committee (NASC).
- Local Collaborative Highlights for 2016- along with my report is the individual collaborative end of the year reports so attached is the document detail of their reports. Not all the collaborative committees have submitted their end of year report before we had to give the packet to Luby. I have as of this date received all the reports except one.
  - LC4 partnered with Highlands University to put together a Take Back/ Family Fun Day. They had 30 vendors, 250 in attendance and received 92lbs. of drugs, 5 boxes of sharpies, some heroin, and gave out Medicare lock boxes. LC4 was very successful in their Take Back. they also funded a NMHU Social Work Intern for training and travel cost on Moral Reconation Therapy (MRT) which will be implemented in the newly build reintegration center at the San Miguel County

Detention Center for the next two years.

- LC5 held their annual meet and greet in September at La Casa in Roswell, NM. LC5 provided water bottles, coordinated food, clothing & supplies distribution to its homeless population.
- LC15 priority is to address depression in Navajo Communities. This LC works closely with Behavioral Health Investment Zone and the Domestic Violence Taskforce in Gallup.
- LC16 most successful local collaborative. In March 2016 meet and greet as well sponsored along with Indian Affairs Department a Tribal Local Collaborative of the State of NM a strategic planning session came together. Each of the four collaborative met together to determine what they would do for outreach to improve the lives of the community members who they work with. The event was attended by 100 tribal, state and county administrators. LC 16 works closely with the Kewa Veterans program, the Silversmith Program, NASC and Native American Health Councils. They also sponsor the Annual Save a Live POW WOW funded by DWI and Prevention with approximately 500 people in attendance.
- LC17 is comprised of urban Native Americans living in the greater metro area of Bernalillo and partner with the American Indian Women's Center, ABQ Indian Center, First Nations Community Healthsource, All Nations Wellness and Healing Center, plus many more. LC17 is working with the American Indian Women's Center to develop a domestic violence shelter for Native American Women and work with Molina Health Care.
- LC8 recently had a strategic planning group meeting and identified vision, mission, value principals, and issued priorities. They voted on what priority areas they were going to work on this year. There is an action plan that is attached that you can take a look at.

Local Collaborative Alliance Update report will be posted on the NM Network of Care and Behavioral Health Collaborative Website

➢ Public Comment

Lisa Trujillo-I have a couple of issues I think are important. It keeps coming up that the providers in our county have now become really dependent on Medicaid. Now we are looking at possibilities of further cuts in reimbursements and possibility of losing the expansion population. I just wanted to point out that the dependency is larger than it used to be in the past and there noticing that. There is a serious risk of damage so in our discussions around Valle del Sol closure which affects Espanola because it's our primary children's provider of behavioral health services. The group as a whole is trying to come up with, why does this keep happening, and why is this happening now. The gentleman representing Valle del Sol that met with us really wasn't very explicit. We are functioning we are on the very bare bones budget, they are not doing anything extravagant so it comes down to the question of reimbursement rates and the one that has come up is the BMS reimbursement rate. It is very hard if one organization after another has not been able to survive on these rates so it is a very good chance that someone else will not be able to survive on the same reimbursement rate unless they have some other income to support themselves. If they do have other incomes, why would they take the risk to take on these new populations?

Another thing that came up was discussion on suicide prevention. This comes back with the discussion we had with the collaborative on where suicide efforts sit? DOH has one for kids, one for adults, we have been able to learn with the attorney

General's Office is doing some, and BHSD historically has done some, I don't know where that stands now.
Wayne: *Lisa in my CEO report under the suicide prevention grant and the status on that grant*
Lisa- I just want to make sure there is more coordination between the different efforts going on so that we can be more effective and more helpful because it is such a challenge. I just thought I would bring these couple of things to your attention. I am grateful to be in this position to do that

A MOTION to adjourn meeting was made by Michael Sandoval and seconded by Secretary Gallagher. The meeting was adjourned at 5:05 p.m.