I. PURPOSE OF THE PAPER

The purpose of this paper is to establish priorities for the next phase in the evolution of the behavioral health system in New Mexico, to stimulate dialogue, and to drive selection of a single statewide entity as its partner. The Interagency Behavioral Health Purchasing Collaborative (the Collaborative) continues to work to achieve the vision, mission and plan outlined in the original April 19, 2004 concept paper. The current concept paper updates, but does not replace, those original concepts. The vision remains: to establish a single behavioral health service delivery system in which consumers and family members are assisted in participating fully in the life of their communities; support of recovery and development of resiliency are expected; behavioral health is promoted; and the adverse effects of substance abuse and mental illness are prevented or reduced.

The vision also contains behavioral health services that are: focused on prevention and early intervention; evidence based and promising practices; consistent with family preferences; consumer-and family-focused, strength-based, acknowledging the individual and family’s capacity for recovery and resiliency; delivered in a culturally competent, responsive and respectful manner via the most appropriate, least restrictive means; coordinated, accessible, accountable and of high quality; evaluated with system performance and consumer and family outcomes in mind; and physically and programmatically accessible. This vision is of a behavioral health system in which funds are managed effectively and efficiently; written and electronic information is uniformly available; CQI is ensured; non-interruption of service delivery as individuals move between correctional programs to community programs and from children’s programs to adult programs is ensured; and school-based and community services are appropriately coordinated and integrated.

The New Mexico behavioral health system has been in the process of significant transformation since September 2003 and is seen as a 10 year developmental process driven by a focus on recovery and resiliency. The selection of a single statewide entity (SE) is one of the many ways New Mexico is working to achieve its vision. The Collaborative’s work is more than the particular strategy of a single statewide entity and this concept paper is broader in nature than the Request for Proposal (RFP) scheduled for release in July, 2008 (for the statewide entity for the next four years from 2009-2013). Some of the public input received in response to the first draft of this Concept Paper identified learnings over the past three years about what is working and what needs improvement. Some of the public comments identified
specific recommendations for the RFP, the next contract with an SE, and policy and implementation priorities for the whole Collaborative effort.

This concept paper will provide: (1) a brief overview of progress over the past three years, (2) a performance assessment based on the proposed developmental phases outlined in the 2004 Concept Paper; (3) an identification of current successes and opportunities for future improvements; and (4) a preliminary list of top priorities for the next request for proposals (RFP).

The original draft of this concept paper has been distributed widely to stakeholders throughout New Mexico’s behavioral health system, who have been encouraged to provide feedback to assist with the identification of priorities for the next RFP and to comment on any other aspect of the Collaborative’s work towards its vision of recovery and resiliency. Five public meetings were held in Las Vegas, Las Cruces, Farmington, Roswell and Albuquerque. An additional public meeting seeking comment on the draft Concept Paper from Native Americans was held in Albuquerque. In keeping with the Tribal Consultation Protocol, a workgroup planned this input meeting and the formal Tribal Consultation meeting scheduled for June.

II. OVERVIEW OF THE PROGRESS OVER THE PAST THREE YEARS

The New Mexico Interagency Behavioral Health Purchasing Collaborative was created by State Statute in 2004, and is a pioneering effort in behavioral health system transformation. The Collaborative Vision calls for both development of infrastructure to support the Vision and development and enhancement of services – what is available, how they are delivered, and how consumer and family voices are sought and heard.

A. INFRASTRUCTURE DEVELOPMENT ACTIVITIES

Over the past three years, the New Mexico Interagency Behavioral Health Purchasing Collaborative (the Collaborative) has launched several critical infrastructure development initiatives, including the establishment of a 17 member policy-making virtual organization that meets monthly to manage the uniquely integrated funding and staffing structure. The Collaborative has also consolidated over $300 million state and federal behavioral health dollars and its management through a single statewide entity under contract with the State of New Mexico, replacing multiple contracting mechanisms and administrative infrastructures. In addition, the Collaborative has created the Local Collaborative structure, comprised of 15 local stakeholder groups that address behavioral health system change.
within their communities, and provide input and recommendations to the Collaborative. Finally, the Collaborative has established the Behavioral Health Planning Council, a statewide Governor-appointed advisory body that assists with planning and policy development, and reviews the mental health and substance abuse federal block grants.

In September 2003, Governor Bill Richardson directed all agencies tasked with the delivery, funding or oversight of behavioral health care services in New Mexico, to work collaboratively to create a single statewide behavioral health service delivery system. A Gaps and Needs Analysis in 2002 encouraged New Mexico to seek a better behavioral health care system which would foster increased responsiveness to the needs of New Mexicans. Legislation in 2004 created an Interagency Behavioral Health Purchasing Collaborative comprised of the cabinet secretaries and/or directors of 17 state departments and agencies (See Appendix C). The Collaborative is charged with: (1) inventorying all expenditures for mental health and substance abuse services; (2) Creating a single behavioral health care system that promotes mental health; emphasizes prevention, early intervention, resiliency, recovery and rehabilitation; manages funds efficiently; and ensures statewide availability of services; (3) Paying special attention to regional, cultural, rural, frontier, urban and border issues, and seeking and considering suggestions from Native American communities; (4) Contracting with a single, Statewide services purchasing entity [SE] to ensure availability of services; (5) Monitoring service capacities and utilization in order to achieve desired performance measures and outcomes; (6) Making decisions regarding funds, interdepartmental staff, grant writing and grants management, comprehensive planning, and meeting State and federal requirements; (7) Overseeing systems of care data management, performance and outcome indicator selection, rate setting, service definition establishment; and (8) Monitoring training, assuring that evidence-based practices receive priority, and providing oversight for fraud, abuse, licensing and certification.

The Collaborative’s operational work is guided by the Chief Executive and Deputy Chief Executive and a Steering Team of Collaborative agency staff. Cross Agency Teams (CATs) were established to move the behavioral health system from development to implementation. These CATs operate as a virtual department across the Collaborative. The original CATs are listed in Appendix B and have evolved to become cross-agency work teams with specific tasks and areas of priority focus. The new Consumer and Family Engagement (CAFÉ) team brings both policy and practical assistance to the Collaborative’s efforts to build a values-based delivery system and enhances the system’s recovery and community support orientation.

The Collaborative relies on its advisory body, the Behavioral Health Planning Council (BHPC), to advise on substance use and mental health policies and the development of the behavioral health system in New Mexico. Originally established in the 1990s as a mental health advisory body to the Governor, the BHPC increased substantially in 2007 from 30 to 80 members; diverse in geographic (rural, frontier, urban), cultural, economic, and professional backgrounds. The strategic priorities of the BHPC mirror the goals of the Collaborative, with the additional flavor of members who understand local community priorities which may or not be reflective of statewide needs. The ten Collaborative strategic priorities have also been integrated into the work of the BHPC’s five statutory subcommittees. In addition, the BHPC creates ad hoc committees to address timely matters such as
finance (to study BHPC operating costs); legislative (to review, evaluate and make recommendations on legislative priorities and to find legislative sponsors); non-Medicaid funding (to study and recommend how to increase); and by-laws (to make them more relevant to current needs).

B. SERVICE DEVELOPMENT AND ENHANCEMENT

Infrastructure development activities provided a base for service development. Some of those service developments described here relate to consumer and family services, housing, substance abuse services, community-based services (for children, youth, and adults), integration of primary care and behavioral health.

Consumer and Family Services

The Collaborative Vision has at its heart the principles of recovery and resiliency and the voices of consumers, families and youth in all aspects of policy formation and decisionmaking. In late 2007 the Office of Consumer and Family Engagement (CAFE) was created to focus on all consumers, including adults, children, youth, and families statewide. In 2007 fifty seven Certified Peer Specialists were trained throughout New Mexico, and more have been trained in 2008. In addition, a curriculum to train Certified Family Peer Specialists is currently underway. Importantly, both Certified Peer and Family Specialists meet staffing qualifications for the Community Support Worker position covered in the Comprehensive Community Support Services [CCSS] model for qualified provider organizations. In 2007, the BHPC substantially increased its consumer, family member, and advocate representation (62%) through local collaborative appointments. Increased consumer and family voice will continue to be a top priority for the Collaborative in the coming years, as it works with people who directly experience behavioral health services to learn how to turn Collaborative values into practice.

Housing

Another example of a service enhancement activity is the development of a ten-year permanent supportive housing plan that includes an aggressive goal of creating 5,000 new supportive housing opportunities, locally based supportive housing partnerships, a supportive housing pipeline with public and private funders and developers, rental assistance opportunities, and best practice housing supports and services. Two related initiatives are already underway, including the Housing First: Permanent Supportive Housing for Youth pilot project designed for youth transitioning out of foster care or juvenile justice, and the NM Linkages Permanent Supportive Housing Pilot to provide up to 110 Rental subsidies and support services for adults who are homeless or a risk of homelessness and living with behavioral health issues.
Substance Abuse Services

Substance Abuse Service expansion is also underway, including the Total Community Approach (TCA) projects, with the goal of developing effective substance abuse prevention, treatment, harm reduction and law enforcement service systems in local communities. The Behavioral Health Planning Council’s Substance Abuse Subcommittee is taking an active role in advising on substance abuse policies and programs as well as on how to better enlist the involvement of people in recovery and their families. In addition, legislative dollars have been allocated to develop the Los Lunas Substance Abuse Treatment and Training Center, a state-of-the-art substance abuse treatment and training facility that will serve New Mexicans across the State. The Co-Occurring Disorder (COD) State Incentive grant implemented evidence-based practices in co-occurring disorders at four sites (First Nations, Life Link, Rehoboth McKinley, and Youth Development Incorporated); partnered with UNM to train approximately 500 behavioral health providers statewide on Traditional and Western Approaches to Co-Occurring Disorders; developed an adolescent model for COD treatment, implemented a COD track in five rural area drug courts; created a re-entry pilot project for the Corrections system; and trained justice system professional on COD in coordination with the GAINS Center. Substance abuse service dollars have also shifted away from social detox and toward intensive outpatient treatment. The State has received a second Access to Recovery Grant intended to assist with the design and implementation of a voucher program to pay for an expanded array of community-based clinical substance abuse treatment and recovery support. Finally, the Office of Substance Abuse Prevention has become part of the Public Health Division of the Department of Health, working to provide training to preventionists seeking certification, to work with the Statewide Entity on prevention activities and changing community norms, collaborate with other state entities on prevention activities, and to oversee the Prevention Information Management System.

Community-Based Services

Children, Youth, and Family Services

Enhancing and expanding community based services is another top priority of the Collaborative. The Clinical Home/Wraparound pilot was initiated with 10 provider agencies. A clinical home is a single case management provider that coordinates all behavioral health services, including clinical supports (intake, assessment, treatment, service planning), community supports (school, social activities, housing), and existing supports (family, neighbors, friends). Integrated into the clinical home concept is the wraparound training pilot, which promotes the effective identification and use of available supports. Other community-based service expansions for children include CCSS, juvenile justice reentry services (JJRS), and Multi-Systemic Therapy (MST), all of which aim to keep youth in communities. JJRS uses regional transition coordinators to provide behavioral health case management to youth and families upon admission to CYFD facilities. MST provides home and community-based services to youth and family, with the goal of improving relationships and building supports and resources. Both CSS and MST were included as a new benefit in the State’s Medicaid Plan.
Expanding behavioral health services in schools in another priority. This has included the development of the “Success in Schools” workgroup of the Collaborative that is working to identify and ultimately implement standards for school-based behavioral health care and track participation in behavioral health related training by school personnel. In addition, local collaboratives (LC) across the State received allocated dollars to increase school district involvement in their LCs and generate behavioral health awareness across their school district. The Department of Health’s Office of School and Adolescent Health (OSAH) has also launched a statewide crisis line in 2005, and received a federal SAMHSA grant to develop and implement a suicide identification, prevention, and treatment model for youth with depression who are at risk for suicide. OSAH also sponsored several statewide trainings on suicide prevention, awareness, and response; and implemented mandatory screening, crisis planning, intervention, and post-intervention activities for all OSAH-funded school-based health centers. OSAH is currently spearheading a statewide teen dating violence awareness and prevention initiative. In addition to these trainings, the New Mexico Institute for Early Childhood Mental Health Training is currently offering high level advanced behavioral health training for clinicians working with infants and young children.

**Adult Services**

Adult-focused services are being enhanced through Comprehensive Community Support Services (CCSS), with the goal of coordinating and providing recovery-based services, including independent living, learning, working, socializing, and recreation. CCSS supports consumers and family members in crisis situations and provides individual interventions to develop and enhance skills necessary for independence. The Collaborative, in partnership with the cities of Albuquerque and Las Cruces, also established Assertive Community Treatment (ACT) programs designed to provide multidisciplinary psychosocial treatment in community-based settings to adults with severe and persistent mental illnesses. In addition, community-based services are being enhanced for active military, veterans, and their families through a services pilot developed to provide case management and clinical support in coordination with the VA and the current behavioral health system. The Collaborative is also working with SBIRT sites and Aging and Long Term Services in training behavioral health and primary care providers on a national model of suicide prevention. Another critical training initiative is the Compulsive Gambling Training Plan, with the goal of enhancing providers’ abilities to deliver compulsive gambling assessment, diagnosis, and treatment.

**Interface between Primary Care and Behavioral Health**

Improving the interface between behavioral health and primary care is another current effort of the Collaborative. The Screening, Brief Intervention, Referral, and Treatment (SBIRT) grant provided a mechanism for offering substance abuse services through primary care settings, with a particular focus on rural and traditionally underserved communities. In addition, there is currently a common referral process and monthly case consultation meetings between ValueOptions and the managed care
organizations (MCOs) in an attempt to coordinate care for people with both physical and behavioral health needs. Finally, there have been two pilot projects involving psychiatrists training primary care practitioners and providing case consultation, both of which have been very successful. The next step is to determine strategies for improving this important integration.

III. PERFORMANCE ASSESSMENT BASED ON THE PROPOSED DEVELOPMENTAL PHASES

A. ORIGINAL PLAN OF ACTION

The Collaborative anticipated three planning and implementation phases needed to transition to a single behavioral health delivery system. Phase One began in July, 2005 with the awarding of a contract to the single statewide entity (SE) selected through a competitive procurement process. The Collaborative would then work with the SE to ensure that all services continued to be delivered and providers were appropriately paid for these services. The goals of this phase were to work out potential issues that arose during the transition, implement initial data requirements and processes, and develop goals for Phase Two. Phase One goals also included the development of expectations for local systems of care, and the development of such systems with the help of teams of State and SE staff. In addition, the first comprehensive statewide plan for behavioral health would be completed by the Collaborative with the help of the Behavioral Health Planning Council and the SE.

Phase Two was anticipated to last up to two years (July 2006-June 2008) and focus on the identification of effective ways of combining multiple funding sources and funding mechanisms to support the desired outcomes of local systems of care and the Collaborative. An important goal of this phase was to develop performance indicators and outcome measures for subsequent phases in order to track progress toward the goals of the Collaborative. In addition, local systems of care were to be formed and effectively operating; and additional resources were to be identified to address unmet needs and identify priorities for service expansion. Finally, it was anticipated that Phase Two might also include the securing of additional funding streams and other resources not included in the initial RFP.

Phase Three was anticipated to begin no later than July 1, 2008. The belief was that the system would be mature, performance and outcome measures would be clear, and adjustments to the system could then be undertaken based on the results of the previous years. During this phase additional funding streams included in the SE responsibilities would be included, and the coordination of other related resources would be accomplished. The goal of Phase Three would be to revise the initial comprehensive statewide plan for behavioral health, with input from local collaboratives, the SE, and the Collaborative. New funding streams would also be identified and secured.
B. PROGRESS TO DATE

To date, many goals of Phase One, Two, and Three have been actualized. For instance, the SE contract was awarded to ValueOptions New Mexico on July 1, 2005, and the Collaborative worked with this SE over the course of Phase One to ensure that all services continued to be delivered and providers were appropriately paid for these services. Potential issues during the transition were identified during Phase One, and the Collaborative worked with the SE to rectify these issues (e.g., developing over 35 common service definitions and implementing some initial steps to ensure commonality of reimbursement rates for these services). In addition, initial data requirements and processes were identified during Phase One, including 21 performance measures for the Collaborative. However, considerable work is needed to enhance the data infrastructure of the Collaborative, including the creation of a uniform data system. Expectations for local systems of care were developed during Phases One and Two, with the creation of fifteen Local Collaboratives (LCs) within five common geographic regions (13 judicial districts) and a sixth common “region” for two Native American populations. In addition, several Collaborative staff members were hired to support the newly developed Cross Agency Teams (CAT) charged with implementing the Comprehensive Plan, including one CAT focused solely on supporting LCs in their development. The first comprehensive statewide plan for behavioral health was completed during Phase I by the Collaborative with the help of the Behavioral Health Planning Council and ValueOptions. This work included town hall meetings and stakeholder retreats to identify goals, strategies, and priorities, and resulted in a plan that includes the Governor’s performance measures, recommendations from the Legislative Finance Committee, and goals of the Purchasing Collaborative (see Appendix C). During this phase, the State also applied for and received a SAMHSA Transformation Grant to support the efforts of the Collaborative.

During Phase Two, LCs continued to evolve, and worked toward more stakeholder involvement. For instance, LCs throughout the State were allocated dollars to gain greater participation by their local school districts. In addition, resources were identified during Phase Two to address some of the unmet needs and priorities for service expansion. For instance, service dollars were allocated for several pilot projects, including the clinical home/wraparound services, CCSS, the TCA, the Veterans and Family Support Services (VFSS), and the JJRS. In addition, dollars were allocated to support statewide implementation of evidence based practices such as MST. Dollars were also allocated to support the development of CBHTR, which now leads several evaluation projects (e.g., TCA, VFSS), has submitted several federal grant proposals (e.g., NIMH grant to develop a multimedia approach to evidence based practice training, the SAMHSA Comprehensive Children’s Mental Health Grant-Systems of Care), and is in the process of developing training curriculum for several statewide service initiatives (e.g., CCSS, Wraparound). Thus, there has been an effort in Phase Two to secure additional funding and other resources not included in the initial RFP. In addition, several statewide training initiatives have been completed in order to enhance local provider capacity (e.g., Traditional and Western Approaches to Co-Occurring Disorders, Suicide Prevention Training, Early Childhood Behavioral Health Training, and Integration with Primary Care). Identifying effective ways of combining multiple funding sources and funding mechanisms to support the desired outcomes is an
ongoing effort; as is the development of performance indicators and outcome measures to track progress toward the goals of the Collaborative. The BHPC’s Children’s subcommittee is also implementing a Systems of Care approach to evaluate children’s services and needs in the State. With the input of local collaboratives and other community members across the State, the subcommittee has developed, refined and implemented a survey, and is sponsoring a nationally renowned Systems of Care training in May. The Adult subcommittee is considering a similar approach for adult services.

Other accomplishments of Phase Two include: (1) Obtaining an Executive Order to address licensing and credentialing of the professional workforce, including psychologists, social workers and counseling professions; (2) Enhancing Medicaid Service coverage for Assertive Community Treatment, Multi-Systemic Therapy, and Comprehensive Community Support Services; (3) Conducting a residential treatment services study for children and adolescents; (4) Commissioning a provider capacity survey and implementing recommendations from this survey to enhance provider development; (5) Working collaboratively between CBHTR and the new Department of Higher Education to address workforce development on evidence-based practices; and (6) Creating a coordinated legislative process among Collaborative agencies. In addition, the expansion of the BHPC by including three representatives from each of the 15 local collaboratives gave a bigger voice to consumers, family members and advocates of behavioral health. Additionally, local collaborative leadership and BHPC members have met with the Behavioral Health Czar in a series of meetings to provide feedback on how the system is working, identify gaps, provide solutions, and get information on the direction of the Collaborative. Recommendations from this group on improving the behavioral health system will be given to the Collaborative in June 2008.

Phase Three is anticipated to begin July 1, 2008. The Collaborative is currently working on revising the initial comprehensive statewide plan for behavioral health, with input from LCs, ValueOptions, and other stakeholders. Several documents are being developed to inform the comprehensive statewide plan, including both the Children's and Adult’s Purchasing Plans (both of which identify services to be developed, where services should be developed, cost, etc.). In addition, data from the Network Development Plan, the Implementation of Priority Work Plans, and the final reports from the Success in Schools and Co-Occurring State Incentive Grant (COSIG) will be incorporated. The Collaborative will expend concerted effort during Phase Three on ensuring service development for children and adults in custody, supervision, and/or Protective Services, including Adolescent Transition; Core Service Agencies; Quality Improvement; and MIS Data, Reporting, and Accountability. In addition, the development of a Uniform Rate Plan and a Fee-for-Service Conversion Plan for BHSD providers will be critical. New funding streams will also be identified and secured in Phase Three. Finally, each of the BHPC subcommittees is expected to adopt at least one strategic priority as part of its work plan and provide recommendations to the Collaborative.
C. GAPS

Although tremendous accomplishments have occurred over the past three years, some identified goals have not been met. For instance, while initial data requirements and processes were identified during Phase One, considerable work is needed to create a uniform data system that routinely reports core data to the Collaboratives’ partners. In addition, LCs continue to need support in their development, as many have struggled over the past few years to recruit members and achieve goals. This is particularly true in rural communities, who are widely dispersed, and therefore have limited access to LC meetings and difficulty completing requests on short time frames. Additionally, the BHPC has not received increased legislative allocation even though its membership and subsequent operating costs have substantially increased. There is also a lack of clarification of the roles of LCs and the BHPC in relation to each other and to the Collaborative; and difficulty with communication that results in information not always being consistently and widely distributed. Although CBHTR has been established and begun to work on critical training and research initiatives, it still lacks a permanent structure, including staffing to support the mission of the consortium. Therefore, it will be important to finalize decisions about where CBHTR is housed, how it will function across the partnering agencies, and who hires the director. Many of the pilot projects developed during Phase II have been very successful, and it will be important to consider obtaining and/or allocating resources for further statewide implementation. Similarly, the training initiatives to date have helped to enhance local provider capacity, and dollars will be needed to continue these training efforts. Therefore, it will be critically important to obtain additional dollars to support service enhancement and expansion; and to identify and implement effective ways of combining multiple funding sources and mechanisms. Additionally, although several performance indicators and outcome measures have been selected to track progress toward goals, the creation of a fully functioning uniform data system and accompanying reporting process is necessary to obtain the core data needed to accurately track these measures. In addition, the number of measures is currently unwieldy, and it will be necessary to define a core set of dashboard indicators for tracking the success of the Collaborative.

IV. SUCCESSES AND OPPORTUNITIES FOR IMPROVEMENT

Information regarding successes of the past three years and opportunities for improvement are provided in the following section. This information was gathered from stakeholder interviews, dialogue at public meetings, and feedback provided through email and posted mail. The input described here and in Appendix A represent the perceptions expressed in response to the original draft of this Concept Paper. Those perceptions are summarized to inform the RFP and Collaborative’s future work.

Some consistent themes were noted across stakeholder groups, including the fact that the change has been long and hard, that progress has been made over the past three years, and that there is a fear of losing these gains. In addition, stakeholders consistently stated that the Collaborative is a means to an end, with the end being a system transformation where consumers and family members as well as
providers and advocates experience being empowered and having a voice in determining what services are provided, how they are provided, and what will support recovery and resiliency among all New Mexicans.

Further Develop the Local Collaborative Structure

There were mixed opinions of the local collaborative structure, with some stakeholders feeling that LCs have been successful in bringing groups together that previously existed in isolation, and in providing a forum for consumers and family members to speak. Other stakeholders noted that LCs are dominated and/or controlled by providers and that there is a lack of appropriate oversight and technical assistance from the State. LC representatives highlighted the need for regionally available office space where consumers and family members can access Purchasing Collaborative information via the web and respond to requests. Many comments also noted the need for support with issues related to transportation and communication, and for increased technical assistance regarding community development. Many LCs expressed their difficulties in getting an adequate cross representation of their communities, and that disagreements between advocates and providers sometimes results in little work being accomplished. In addition, LC members noted that they are often asked to respond to the State within time frames that are too short with little technical assistance provided (particularly in rural and frontier communities). LC representatives and BHPC members requested more face to face time with State personnel and more action taken based on their recommendations. Some LC and BHPC members felt heard, while others felt that little attention was paid to their thoughts and suggestions. In general, many reported that the LC concept appeared to be a good idea, but implementation has been difficult, with several people feeling that their time and efforts have not led to anything. Additionally, some LCs cover multiple counties and communities, and this was noted as a structural problem.

Ensure that Consumers, Family Members, and Providers have a Voice in the Purchasing Collaborative

Stakeholders felt that the bringing together of 17 departments has resulted in greater coordination of care. Several stakeholders noted frustration with a lack of evidence that their input was heard at Collaborative meetings, and that although consensus is often reached after long meetings, implementation decisions based on consensus do not always follow. There was a suggestion that public comments be moved higher in the agenda of the Purchasing Collaborative meetings because input provided through public comments may impact decisions. Several stakeholders noted that the Purchasing Collaborative process is difficult to navigate, and should be simplified. They also mentioned confusion over the names of the Purchasing Collaborative, Local Collaboratives, and the Behavioral Health Planning Council. Community engagement was also highlighted as an area of growth, with consumers, family members and providers desiring more voice. Stakeholders suggested that bidders should have to articulate how they will engage communities and keep them involved, and how they will help develop an independent statewide consumer network and consumer operated services. In addition, they noted the need to recognize and support safety net providers who serve significant numbers of indigent clients and are at a high risk of
losing money, dropping services, and in some cases going out of business. They also highlighted the need to include providers in planning, policy development, and implementation.

**Clarify the Role of the State and the SE**

Many stakeholders noted confusion between the role of the State and that of the SE, and the desire to have a public description of the roles and responsibilities. Several noted the need to better clarify the role of the SE in relation with the Collaborative on issues such as care coordination, grant oversight, policy development, prevention, ensuring consumer and family involvement, and compliance with block grant requirements. Several suggested that the State should take a more active role in monitoring and influencing the SE. Additionally, stakeholders suggested that the SE contract should be for administrative services only, with the State maintaining direct oversight and responsibility. Some stakeholders also suggested that the SE profit should be based on outcomes.

**Implement a System of Care Approach**

Stakeholders noted the desire for the State to implement a “systems of care” [SOC] approach for children, youth, and adults. They felt that the RFP should adopt this system of care approach, and that bidders who have experience implementing a system of care approach should receive additional points on their RFP scoring. A SOC approach would increase partnerships with communities, and engage consumers, youth, family members, and providers in problem solving. In addition, it would ensure that assessments would be more functional and follow people across systems.

**Improve Funding Mechanisms**

Several stakeholders highlighted fiscal initiatives that have been going well, such as improvement in the billing system with the institution of direct deposit. Providers also spoke about the fiscal burden of moving toward a system of care, especially in rural and frontier communities. They noted that a rate analysis should be conducted and providers should be paid appropriate rates that take into account the cost of doing business (e.g., gas expenses). The move to fee-for-service had mixed reviews. Some noted concern of moving to a fee-for-service structure, as safety net providers are in poor financial health. They suggested that the SE needs to be allowed to develop creative funding structures, such as capitation, at-risk contracting, and case rates. Other stakeholders had hope that the fee-for-service model might be more flexible than the current system, and recommended that the RFP require a documented plan to dialogue with consumers and other stakeholders on how best to improve flexibility of funding. Stakeholders also highlighted the need to determine strategies for improving services in rural and frontier communities, and ensuring cost effectiveness. Stakeholders noted that on-time payment of claims is happening to some degree, but there are still large areas of improvement (such as review of denied claims). In addition, several providers suggested the need for assistance with developing their financial infrastructure. They also noted that billing and quality assurance paperwork should be minimized and
better coordinated, and that the RFP should explicitly state plans for moving to electronic billing. Many noted that changes are costly to providers and urged the State to ensure that mandates are well thought out and funded. Also highlighted was the need to move from coordinating funding to blending/braiding funding. It was suggested that bidders must submit a detailed project plan for accomplishing braiding, including the elimination of administrative overhead currently necessary to support multiple funding activities.

Expand Pilot Projects and Other Needed Services

Stakeholders noted that several pilot projects (e.g., wraparound) have been successful, but there is little information on how these pilots will be maintained, what the plan is for fiscal sustainability, how they will be rolled out to other communities, and how other evidence based practices will be funded. Safety Net Providers consistently noted that they have taken on new services such as ACT, but are not receiving enough dollars to support their fundamental operations. These agencies reported needed support, and suggested that in the absence of legislative appropriations, they should receive comparable funding and services to those under Medicaid.

In addition, several federally funded grants have enhanced service capacity (e.g., COSIG, SBIRT), and there is interest in ensuring sustainability. Stakeholders noted that recommendations made from these pilots and grant projects should be implemented, and several identified the clinical homes pilot as a positive example of the State spending significant time getting community input. Information on what is working and not working should inform future decision-making.

Several stakeholders identified services that they hope to have identified in the next RFP, including: substance abuse and co-occurring disorder residential treatment services (including services for those on probation/parole), psychiatric facilities for youth and children outside of Albuquerque, gender-responsive and trauma informed services, supported housing, homeless outreach, geriatric services, gambling addiction services, free or low cost medication, RTC, weekend and expanded case management, crisis services and crisis mobile outreach, consumer operated services, wraparound services, acu-detox, help with disability benefits, supported employment, family treatment, and culturally appropriate services such as sweats and drumming. In addition, transportation continues to be a major issue, as wide distances traveled drains county budgets and makes services inaccessible. Some stakeholders felt transportation should be coordinated by the SE.

Improve the Data System

The need for data was a consistent theme noted during public meetings. Many stakeholders reported it was difficult to provide input without having access to data. In particular, it would be useful for LCs to receive data on gaps in services for children, youth, families, and adult consumers on an ongoing basis.
The need for the accurate reporting of core data to determine effectiveness of services and identification of consumers served was also highlighted, as was the need to present information in easily understood language and to gain broader consumer, family member, and provider input. Several stakeholders highlighted the need for a uniform data system. It was suggested that each bidder should submit a detailed project plan for developing a uniform data system, specifically addressing timelines for implementation, and financial and technical support to providers for instituting changes. Stakeholders were also concerned that progress to date may be lost in the next RFP process, and suggested that bidders submit detailed implementation time tables from bid award date to contract start date. In addition, it was noted that each bidder should demonstrate the capability of their IT system to authorize services, process claims, pay claims, and generate data reports; and document their history of customer satisfaction with their claims processing system.

Improve Training and Workforce Development

The need for workforce development and training was also highlighted. Some stakeholders felt that the move toward evidenced based practice was positive, but required significant training and cost. Others felt that promising practices should be valued and that evidence bases practices are a one size fits all approach that might not be uniformly appropriate in New Mexico. There was also concern that training has been completed on a variety of topics without support and/or resources for implementation.

Improve Communication with and Services in Tribal Communities

Some stakeholders felt that the system transformation has been positive for Native communities by creating opportunities for increased funding and services. Other stakeholders noted that many ideas have not been carried through to tribal communities, and noted the delay in hiring a director for Region 6 greatly impacted forward movement. Several stakeholders noted that LC14 is spread across the State, and represents too many interests, including Pueblo and Urban Indians. There was a strong suggestion to add additional LCs to support this diverse group of stakeholders, with a specific recommendation of creating an LC for Urban Indians. Other stakeholders highlighted the need for formal government to government relationships to be established with the State and tribal communities. In addition, the need for culturally appropriate service planning and implementation was highlighted.

General Comments

In general, stakeholders highlighted the need to enhance the development of the provider networks (i.e., determining service needs, developing provider competencies), and to be clear about defining the target population (i.e., who is a collaborative consumer). In addition, many stakeholders spoke about the need to better serve individuals not covered by Medicaid. Other issues identified include the need to improve communication across the system, organize the Collaborative so that it is positioned to monitor the SE, align the Collaboratives’ vision with the realities of providing services in New Mexico, align the benefit
package with consumer eligibility and need (not who is paying the bill), and ensure that the SE is culturally competent and prepared to follow the Collaboratives’ prioritized needs.

V. **TOP PRIORITIES FOR THE NEXT RFP**

Based on input from various stakeholders, the following have been identified as top priorities. Further details and recommendations from stakeholders that support these priorities are contained in Appendix A.

- Further Develop the Local Collaborative Structure
- Ensure that Consumers, Family Members and Providers Have a Voice in the Purchasing Collaborative
- Clarify the Role of the State and the SE
- Implement a System of Care Approach
- Improve Funding Mechanisms
- Expand Pilot Projects and Other Needed Services
- Improve the Data System
- Improve Training and Workforce Development
- Improve Communication with and Services to Tribal Communities

VI. **NEXT STEPS**

The goal of this concept paper is to provide a brief overview of the progress in implementing the Collaborative’s vision over the past three years, and consider future priorities for the SE and the system as a whole. A major lesson learned over the past three years is that the plan and accompanying RFP must be flexible and adaptable to an ever changing behavioral health system. The best source for identifying needed changes is at the local level, thus, stakeholder input is critical. Stakeholders are encouraged to continue to provide written feedback regarding priority areas to focus on in the next phase of this developmental process.

Comments should be provided via e-mail to bhcollaborative@state.nm.usm, by mail to: PO Box 2348 Santa Fe, NM 87504 attn: Angel Roybal; or by fax to (505) 476-7183 attn: Angel Roybal. Native American communities are encouraged to submit input directly to Kim Horan, Tribal Liaison for Behavioral Health Services Division at (505) 827-2637.
APPENDIX A

- Further Develop the Local Collaborative Structure
  
  a. State should provide more technical assistance on community development and methods for meeting state requests
  
  b. LCs should have regionally available computer-equipped office space
  
  c. SE should provide resources for transportation and communication
  
  d. Schedule more face to face time with State personnel
  
  e. Create mechanism that demonstrate how input is used and acted upon
  
  f. Create additional LCs to cover both smaller regions (e.g., single counties) and unique needs (e.g., Off-Reservation LC)

- Ensure that Consumers, Family Members and Providers Have a Voice in the Purchasing Collaborative
  
  a. Develop consumer and family operated services
  
  b. Move public comments to the beginning of the Purchasing Collaborative meetings so that input can be acted upon
  
  c. Provide a monthly easily-understood orientation to the Purchasing Collaborative process and State system
  
  d. Decrease confusion by renaming entities such as the Purchasing Collaborative, local collaboratives, and the BHPC
  
  e. Require bidders to articulate how they will engage and actively work with consumers, family members, and providers to increase their voice in system development, evaluation and oversight
  
  f. Include consumers, family members, and providers in planning, policy development, and implementation
  
  g. Develop an independent statewide consumer network organization
  
  h. Develop consumer operated services
  
  i. Provide support to safety net providers, including increasing funding for consumers who are non-Medicaid enrolled and indigent

- Clarify the Role of the State and the SE
a. Provide a public written description of the roles and responsibilities of the State and the SE
b. SE contract should only be for the administration of services
c. State should maintain oversight of SE and responsibility for the system of care
d. SE profit should be based on outcomes

• Implement a System of Care Approach
  a. RFP should adopt a system of care approach
  b. Bidders with demonstrated experience implementing the system of care approach should receive points toward their RFP score

• Improve Funding Mechanisms
  a. Conduct a rate analysis and change rates to reflect the cost of doing businesses
  b. SE needs to be allowed to develop creative and flexible funding structures (e.g., capitation, at-risk contracting, and case rates)
  c. Bidders should show documented plan to dialogue with stakeholders on how to best improve flexible funding
  d. Cost effectiveness needs to be considered in rural and frontier communities
  e. Bidders should provide demonstrated experience with positive claims process
  f. Provide technical assistance to providers on creating viable financial infrastructures
  g. Bidders should articulate plans for minimizing billing and paperwork
  h. Bidders should submit plans for moving to electronic billing
  i. Bidders should provide a detailed plan for moving from coordinated to braided funding

• Expand Pilot Projects and Other Needed Services
  a. Plan should be developed and distributed that explains how pilots will be maintained, plans for fiscal sustainability, plans for statewide roll-out, and plans for evidence based practice implementation
  b. Safety Net Providers should receive support and additional resources
  c. Grant initiatives (e.g., SBIRT and COSIG) should be maintained
  d. Recommendations from pilot projects and grants should be reviewed and acted upon
e. Additional services noted on page 11 of this report should be included in the RFP
f. Bidders should demonstrate plans for coordinating and alleviating transportation issues

- Improve the Data System
  a. Create a uniform data system for collecting and reporting core data
  b. Create capacity to track identified performance indicators and outcome measures
  c. Identify 10 concise performance indicators and outcome measures
  d. Bidder should demonstrate the ability to prepare quarterly data reports for each LC and determine a useful strategy for reporting quarterly data to LC14 and LC 15 (since neither are by county)
  e. Bidder should demonstrate ability to report data in an easily understood format
  f. Bidder should submit a detailed project plan for developing the uniform data system, including timeline for implementation and financial and technical support that will be provided to providers.
  g. Bidders should submit implementation time tables from bid award date to contract start date to ensure smooth transition.
  h. Bidder should demonstrate their IT system to authorize services, process claims, pay claims, and generate data reports
  i. Bidders should document their history of customer satisfaction with their claims processing system

- Improve Training and Workforce Development
  a. Support and resources for implementation should be planned and administered following trainings
  b. Create an environment that values promising practices as well as evidence based practices
  c. Determine a structure for CBHTR to lead the State’s training and workforce development initiatives
  d. Identify funding to sustain workforce development training efforts

- Improve Communication with and Services to Tribal Communities
  a. Work with tribal communities to develop culturally appropriate strategies for service planning and implementation
b. Establish formal government to government relationships

c. Create additional LCs to better represent Native communities (e.g., an Off-Reservation LC)