Strategic Plan


New Mexico Behavioral Health Collaborative Human Services Department
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Chapter 1: Introduction

Message from the CEO, Behavioral Health Purchasing Collaborative

Dear Friends:

First, thank you to all who are reading, commenting and contributing to the development of this three year strategic plan for the Behavioral Health Purchasing Collaborative. We are in one of the most exciting and challenging periods for behavioral health ever. This plan must be the consumers, families, advocates, providers and state plan. The gains in achieving a behavioral health system that is driven by recovery and resiliency values and practice can not be diminished as we deal with state budget deficits or as we move into health care reform in the state and country.

Implementing health care reform and parity for mental health and substance abuse treatment must be our first priority. Strategies that create strong practice integration between health care providers and behavioral health providers must be developed. The practice integration must address both general health needs and the need of children and adults with severe mental illness and serious emotional disturbances. With a strong practice model in place we can increase access to treatment especially prevention and early intervention, improve outcomes both in physical health as well as behavioral health domains, and maintain the opportunity for individuals to live their lives in recovery. In the 1990s we saw efforts to integrate behavioral health with managed care and we experienced a reduction of funding for behavioral health. This does not need to happen again but we must be strategic in our work over the next three years.

Of course we face barriers or limitations that people identify, not least of which is our on going economic crisis. We need to find ways to grow more trained staff for providers, including peer specialists. We can anticipate state leadership changes in the coming months and we need to sustain our momentum to meet consumer, family, provider and advocate hopes. We are in rapidly changing times and we must focus on the future.

The original comprehensive plan for a comprehensive behavioral health plan for New Mexico is still in place. The vision, values and goals are still there. This plan outlines the strategic actions that we must undertake now in order to be a strong, viable behavioral health system. The next steps are developing work plans and getting to work -- there is so much to do, so much opportunity and so much work for each and everyone of us.

Sincerely,

Linda Roebuck Homer
Chief Executive Officer
New Mexico Behavioral Health Purchasing Collaborative
Chapter 2: Taking Stock

What have we accomplished that will move us forward towards the future?

The Behavioral Health Collaborative created a three year Comprehensive Behavioral Health Plan for Fiscal Year 2008 through Fiscal Year 2010. The Strategic Aim for that Plan was:

People using the publicly funded behavioral health system lead personally meaningful lives reaching personal recovery goals with resiliency and hope.

The Collaborative’s 2008-2010 Strategic Plan consisted of five goals.

**Goal I** – Assist Consumers to Participate Fully in the Life of Their Communities

**Goal II** – Reduce the Adverse Effects of Substance Abuse and Mental Health

**Goal III** – Promote Behavioral Health

**Goal IV** – Develop the Behavioral Health Workforce

**Goal V** – Manage Available Funds Effectively and Efficiently

1. Major accomplishments in each of these goal areas are a strong foundation for the Framework for Action needed over the next three years. Each of these accomplishments supports the Behavioral Health Collaborative in continuing to work toward its Aim and position New Mexico to address the opportunities and challenges of Health Care Reform.

The 2011-2014 Strategic Plan that follows describes a *Framework for Action* that has six components:

1. Holistic service array
2. Infrastructure
3. Quality improvement and performance expectations
4. Consumer and family engagement
5. Workforce development
6. Financing strategies

Some of the major accomplishments within that Framework, as well as the promising beginnings of a range of new projects and pilot activities, include the following:
1. Holistic Service Array

- Almost 89,000 New Mexicans -- children, adolescents, and adults -- received behavioral health services through the Collaborative each year, whether from the traditional treatment and recovery system, the Access to Recovery program, prevention and other services. [Goal I]

- The Collaborative, with a lead role played by the Mortgage Finance Authority, has successfully worked to help create 170 new supportive housing units, coordinated the provision of housing vouchers to many dozens of disabled and other adults in treatment, 20 adolescents annually, and 215 homeless veterans. This is tantamount to a shift to a wraparound approach to recovery. [Goal I]

- Use of the wraparound approach for children with or at risk of emotional disturbance and their families has begun and will lead the state's development of a comprehensive model to be used in the future. [Goal II]

- Multi Systemic Treatment (MST) evidenced-based programs for adolescents are achieving substantial positive outcomes -- including reduced criminal offending, out of home placements, behavioral health problems, school achievement and family functioning. [Goal II]

- Intensive Outpatient (IOP) evidenced-based model programs are established to provide a more effective and more efficient community based treatment option for thousands of high need individuals.[Goal II]

- Successful pilot programs for Veterans and their families have been expanded to include Sandoval, McKinley and San Juan Counties. [Goal II]

- Robust jail diversion programs have been established in six communities to serve individuals who experience mental health or substance abuse critical incidents but have committed no criminal act, so that they do not end up in jail unnecessarily. [Goal II]

- Medication assisted treatment services, an evidence based model, is working in New Mexico to address severe addiction problems and ripe for growth in partnership with primary care physicians. [Goal II]

- More than 35,000 adolescents are screened for behavioral health issues each year through school based health centers. [Goal III]

- Substance abuse prevention services provided by the Collaborative have produced measurable decreases in high risk drinking behaviors by adolescents and adults -- past 30 day drinking, binge drinking, and driving after drinking. [Goal III]
• Prevention services have sustained tobacco sales compliance rates by retailers, through education and compliance checks, of about 93% over the past three years. [Goal III]

• Infant mental health and maternal depression issues have been in the forefront of policy discussions over the past several years. Practitioner training and credentialing in this area has grown and offered the groundwork for service and funding development where possible. [Goal III]

• Behavioral health screening, intervention, and treatment have been designed for people who may be elderly or disabled, and will be integrated into the larger system as funding becomes available. [Goal III]

2. Infrastructure

• Forty-one Core Service Agencies (CSA) have been established in communities throughout the state – these agencies work to provide a comprehensive, wraparound approach to the highest need consumers, both children and their families and adult consumers; Comprehensive Community Support Services (CCSS) were established and funded to create a framework for a self directed, life long recovery for each enrolled consumer. [Goal III]

• Best practice jail based treatment and reentry programs have been established and have shown positive outcomes in recidivism rates. [Goal II]

• Mental health and substance abuse services are being streamlined into a single system that addresses the full range of behavioral health issues. [Goal III]

• Two school and community partnerships, in Espanola and Santa Domingo Pueblo, are engaged in the creation of a comprehensive plan to address students at high risk for drop out, substance abuse and mental health problems, under the direction of the Public Education Department. [Goal III]

3. Quality improvement and performance expectations

• Over 80% of clients with severe alcohol problems reported that they made significant improvements last year, and 61% of clients with severe drug problems reported that they made significant improvements last year. [Goal II]

• Quality Service Review (QSR, a practice improvement tool) has been piloted and now implemented in 12 CSAs.

• Outcome measurement and accountability processes have been broadly established across the Collaborative and its member agencies. [Goal II]
4. Consumer and family engagement

- Annual satisfaction surveys show that 88% of adult consumers and 96% of family members report that they were empowered to be pro-active and engaged in their treatment planning - they report equally high rates of treatment effectiveness. [Goal I]

- Eighteen Local Collaboratives (LCs) have formed that include consumers, family members, advocates and providers in every region of the state, with five Native American LCs, which work across their region in the formation of their local system of care. [Goal I]

- At the state level, the Behavioral Health Planning Council and its five statutory subcommittees (Adult, Substance Abuse, Child and Adolescent, Native American, and Medicaid) provide state level policy and programmatic consultation and advice to the Collaborative. This Council represents all LCs and numerous other stakeholders, and maintains a membership that includes more than 51% consumers. [Goal I]

- Adoption of the New Mexico Consumer, Youth and Family Involvement Standards.

5. Workforce development

- Almost a hundred consumers have completed training and have been certified to be hired as a member of a recovery team in their community; those services are reimbursed by Medicaid. [Goal I]

- Best practice treatment protocols for Co-occurring Disorders have been widely disseminated and adopted by most providers. [Goal II]

- Assertive Community Treatment (ACT -- community based crisis and first responder training and protocols) training programs have been offered around the state, and a system to provide timely response has been established in Albuquerque. [Goal II]

- Child providers trained and coached in wraparound approach by the Wraparound Institute. [Goal IV]

- Curriculum for basic Comprehensive Community Support Services (CCSS) developed by CBHTR and training for provider agencies begun. [Goal IV]

- Functional assessment (CAFAS) training delivered to child and youth providers. [Goal IV]

- Mental Health First Aid training delivered to over 1,800 people statewide. [Goal IV]

- A New Mexico specific cultural competency training curriculum and modules were developed for provider agencies and practitioners. [Goal IV]
• Mental health interpreter training delivered to over 100 people in two locations. [Goal IV]

• Quality Service Reviews offered practice improvement learning to 18 agencies in 8 communities. [Goal IV]

6. Financing strategies

• Fifteen state agencies work together in the Collaborative to identify behavioral health needs; plan, design, direct and monitor a single statewide behavioral health system; contract with and monitor a behavioral health statewide entity, utilizing more than $300 million in funds from 5 state agencies that are braided across 16 funding streams.[Goal V]

• From FY07-FY09, maximized Medicaid funding by approximately $9.9 million by converting claims from other funding streams to Medicaid coverage.

• Opened the Medicaid Plan for Intensive Outpatient (for Youth & Adults), Comprehensive Community Support Services and Multi-Systemic Therapy.

• Competitively won grant awards exceeding $49.7 million:
  • Mental Health Transformation Grant (2006-2010) $10 million
  • Mental Health Transformation Grant (2010-2015) $3.7 million to target communities for supportive housing to homeless persons with SM I or co-occurring
  • System of Care Grant for children (2009-2012) $9 million
  • Jail Diversion Grant (2009-2014) $2 million
  • Access to Recovery II for substance abuse services (2008-2010) $12.9 million
  • Access to Recovery III (2010 -2014) $13 million

These initiatives provide care for thousands of consumers who could not otherwise be served. [Goal V]

The Collaborative’s work over the past five years has emphasized services that promote recovery and resiliency using community-based approaches that wrap around individuals in need and value consumer, family and community relationships and networks. New Mexico is well placed to take advantage of the new opportunities of health care reform because of the Collaborative and the Behavioral Health Planning Council’s promotion of locally based Systems of Care and the development of infrastructure such as Core Service Agencies, a cadre of licensed prevention specialists, and school-based health centers. Although the infrastructure in New Mexico needs much development in rural, frontier and tribal areas, significant progress has been possible through telehealth initiatives and with providers who use wraparound approaches, integrated efforts, or practices such as Intensive Outpatient and Multi-systemic Therapy that produce quality care and real outcomes in the lives of New Mexicans.
Chapter 3: What we have heard from you

What have our local communities and advocates said we need to address?

Local communities provided input on Purchasing Collaborative initiatives during six months of public forum meetings. Peers, parents, advocates and providers voiced strong opinions and recommended changes to the behavioral health system that would be more community centered. The Behavioral Health Council, comprised of local collaborative and state-wide representation, provided similar recommendations. The concerns of these New Mexicans aligned with national and state organization initiatives such as the Department of Health & Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA), the National Alliance on Mental Illness (NAMI), and the New Mexico Health Care Reform Leadership Team. The recurring theme across the forums was that future Purchasing Collaborative plans and initiatives should be culturally and linguistically competent and centered around communities, consumers, families, children and youth.

- Communities desire a system that has a “bottom-up” versus “top to bottom” approach in determining behavioral health needs and resources, i.e., allow communities to identify and help direct the State initiatives versus the other way around. Communities asked for community based services addressing substance abuse and mental illness (Comprehensive Community Support Services, psychosocial rehabilitation, integration of physical and mental health clinical services); recovery support services (access to services such as peer/wellness programs); creative, innovative new solutions to address long-time issues (providing services, types of services provided, billing, and administrative responsibilities). The Collaborative has addressed these recommendations in the Holistic Service Array component of this strategic planning.

- Communities recognize a fragmented system that jeopardizes recovery and wellness and creates frustration, anger and a sense of helplessness. Urban, rural, frontier and tribal areas need assistance with access to a continuum of services through the provision of transportation; geographically convenient and culturally appropriate providers, programs and initiatives; available services for children, youth and adults, including adults over 65; integration of prevention, physical health and mental health services; providers adequately trained by the SE to understand the billing claims system to ensure disruption of services does not occur; communication and collaboration between multi state agencies, counties, local agencies, schools, juvenile justice, corrections, courts, advocacy groups to enhance treatment and services at local levels of care. The Collaborative has taken steps to accomplish this Infrastructure through the designation of Core Service Agencies (CSAs) and the development of local and trauma-informed systems of care.
• Communities do not often see the results of State plans or mandates that were initiated. Lack of follow up information and inconsistent communication leads to rumor and distrust. Communities recommend that State and/or Federal funded agencies collect and share data with their local communities on the types, number and quality of services they provide; Providers ask for Core Service Agency standards; Stakeholders want Statewide Entity (SE) data shared regularly and a transfer of knowledge between SE, State and stakeholders – including Native American communities whenever transitions take place. The implementation of Quality Improvement and Accountability in local communities through Quality Service Review provides one tool for Core Service Agencies to track performance that will benefit their clients and families.

• Communities strive to serve the needs of their residents but often the voices heard are not those from the people we are trying to serve. Incentives must be created to encourage consumers and family members to participate more fully in their local collaboratives to provide their perspectives and recommendations to improving their local behavioral health system; encourage and keenly support consumers and family members to advocate for the services and access they may need; support initiatives that will enhance transportation, workforce development and supportive housing – key elements that will strengthen recovery and resiliency. The Collaborative has supported Consumer and Family Engagement through numerous Certified Peer Specialist trainings, encouraging providers to hire those Peer Specialists. The Collaborative has also begun certified Family Specialists trainings and have involved youth, peers and families in the planning of system of care planning.

• Communities are experiencing a mix of needs with some communities having a large number of Peer Specialists trained and ready to serve and other communities struggling to build that resource, some of which include rural, frontier and tribal areas. Communities ask for equal partnership with the SE and the State in workforce planning efforts that address the spectrum of urban, rural, frontier and tribal needs; hiring, respecting and supporting peer and family specialists in the work place to help them succeed; the provision of technical assistance and training locally and by the State. The Collaborative recognizes that Workforce development must be a focus point of its strategic planning.

• As the State makes changes to the current or future financial landscape, the lives of consumers, family members and providers should be the at the core when decisions are made regarding expansion, continuation or dismissal of existing programs, services and initiatives. Local input on Financing Strategies may be provided through the local collaboratives that participate on the subcommittees of the Behavioral Health Planning Council.
Chapter 4: What opportunities do we have to move forward, in light of Health Care Reform

Health care reform offers opportunities for building on our successes and strengthening relationships and structures that have people at the center of New Mexico’s health care systems. Health homes, prevention services, and new models for integration and collaborative working to benefit people with chronic and multiple conditions are the most likely aspects for initial focus.

In 2010, the President signed Health Care Reform legislation, the Patient Protection and Affordable Choice Act (PPACA). With the 2008 Paul Wellstone and Pete Domenici Mental Health Parity and Addictions Equity Act (Parity Act) there are new opportunities for adults and children who experience mental illness, substance use disorders, and emotional disturbances to be at the center of the health care system. As Health Care Reform is implemented, pathways are being cleared for people who have so often been stigmatized, marginalized, and under-served by our nation’s fragmented health and social welfare systems. Individuals who share with all New Mexicans a desire to live personally fulfilling lives can have new opportunities for wellness, for building recovery from mental illness and substance use, for creating resiliency to meet the challenges they encounter. Having people at the center of New Mexico’s health care systems means attending to family, friends, housing, education, employment, social, spiritual and other aspects of healthy lives. People at the center also means that services are designed with relationships in mind, the connections and networks that make an array of services into a system of care.

Mental health and substance use conditions (behavioral health) were written into the PPACA from its earliest drafts. The new law fully incorporates the Parity Act, includes behavioral health in the essential benefits package required for the new health insurance exchanges, eliminates coverage exclusions due to pre-existing conditions including those requiring behavioral health treatment, and places a significant emphasis on prevention and wellness. Nationwide the PPACA is estimated to expand health insurance coverage to 32 million Americans, one-third or more of whom are expected to have behavioral health needs. Fundamental changes in what services must be available to people in benefit packages by Fiscal Year (FY) 14 include mental health and substance use disorder treatment as well as prevention and wellness services.

The PPACA also creates incentives to coordinate behavioral health and primary care services. Beginning in FY11 grants and Medicaid reimbursement will be available for the creation of health homes for individuals with chronic health conditions. Chronic conditions can include mental illness and substance use disorders. The concept of health home offers new opportunities for what has been called a medical home or a clinical home. Community-based service options are enhanced, with opportunities for demonstration grants to expand these services to people with long-term care needs. The PPACA also includes provisions to help build the capacity to deliver these expanded benefits through various workforce initiatives and incentives.
With health care reform comes a long to-do list for states with respect to Medicaid expansion, creation of insurance exchanges, and new insurance rules. New Mexico will have opportunities to participate in many new initiatives to promote health, move even more toward community-based options, gear up for wide use of electronic health records, and integrate its primary care and behavioral health services. On April 20, 2010, Governor Richardson established by Executive Order the Health Care Reform Leadership Team, whose members include a number of Collaborative Secretaries and the CEO of the Behavioral Health Collaborative. In July 2010, this Leadership Team adopted a Strategic Plan, Implementing Health Care Reform - A Roadmap for New Mexico. An Office of Health Care Reform will use existing staff resources to plan, coordinate, and administer implementation of federal health care reform. Appendix 4 of the Roadmap outlines the Behavioral Health Collaborative’s Health Care Reform Issue Matrix, including work to be done in areas such as expanded Medicaid coverage, implementation of behavioral health parity, accountable care organizations and their relationship to core service agencies, electronic health records and Federally Qualified Health Centers, and behavioral health practice or service standards.

An emphasis in the PPACA on the integration of primary care and behavioral health services and a strong focus on chronic conditions have the potential to improve services to people with mental health and substance use conditions, but will only do so if more than financial integration is achieved. Clinical integration must receive equal attention if people with behavioral health needs are not to lose out in strategies that attempt to integrate funding. Unequal partnership can mean subordination rather than integration for behavioral health services. That lesson from the 90s became part of the Surgeon General’s Report on Mental Health and a subsequent meeting he called on integration of mental health and primary care practice. Evaluating the degree to which truly integrated care benefits people with multiple and chronic conditions requires focusing first on outcomes.

The following chapters set a strategic direction for the Behavioral Health Collaborative over the next three years that will help take advantage of the new opportunities available and help assure that behavioral health has a strong position in the larger system of health care that includes primary care and necessary hospital care. The chapters are organized around six components of a “framework for action” which address strategies in the near and long term. The Framework for Action also recognizes that any health care system needs to be person-centered and address all aspects of a person’s life that contribute to wellness. These components are:

- Holistic Service Array
- Infrastructure
- Quality Improvement and Performance
- Consumer and Family Engagement
- Workforce Development
- Financing Strategies
Chapter Five: Holistic Service Array

Promote a service array, within available funding, that supports a full spectrum of services that will promote prevention and wellness as well as recovery and resilience outcomes. Emphasis will be placed on evidence-informed service approaches, with special consideration of service delivery to rural, frontier and tribal areas, and with attention to cultural competence.

What we believe

- New Mexico’s behavioral health service array must maximize personal and family choice – and be child or person centered, youth guided, and consumer or family driven

- All programs within the service array must emphasize wellness, and be recovery and resiliency oriented

- The service array must be community-based, integrated, and as comprehensive as possible

- Services throughout the array must be culturally competent and responsive to community needs

What’s important as we move forward

The need to create a more holistic service array is critical from several vantage points:

- To continue the transformation of the behavioral health system to a recovery and resiliency model, it is imperative that the service array includes community-based recovery and resiliency driven services and supports that are evidence based, outcome driven and culturally competent.

- To continue the transformation of behavioral health systems to a recovery and resiliency model, it is imperative that spending be ultimately shifted from expensive and restrictive services to community based services and supports. This is the intent of the Children’s and Adult Purchasing Plans. The Behavioral Health Purchasing Collaborative has developed these purchasing plans to set targets for shifting spending to more community based approaches, consistent with efforts to redirect systems and services to recovery and resiliency outcomes. The task is twofold: to make sure the array includes the community based services and supports that will support this shift, and to make sure the spending targets can reasonably be accomplished, in effect to “size” the purchasing plans.
• If we are going to optimally position behavioral health in the context of health care reform, it is imperative that we build out the array to include services and supports that provide behavioral health prevention and promote wellness. This needs to happen at two levels:
  • prevention and wellness promotion as part of plans of care for individuals and families within primary care delivery systems; and
  • community/population-based behavioral health prevention and wellness.

• We need to recognize the opportunity in health care reform to move beyond our current imperative to provide a safety net for populations with severe behavioral health issues to a service array that provides more to a wider population. Our working assumption is that under health care reform, a number of services and supports will be increasingly provided in, or in partnership with, primary care settings (medical homes as well as school-based health centers). Such services and supports are likely to include prevention and wellness; screening, brief intervention, referral and case management; and some outpatient and medication services. Recovery and resiliency driven services and supports, as well as intensive support services, out-of-home residential services; and acute inpatient services may be provided in specialized behavioral health settings for populations experiencing the most complex needs and serious illnesses. Behavioral health needs to continue its focus on those needing specialty care and to broaden to a wider population and partnership with primary care.

This chapter and its strategies are sorted by children and adults in order to address the needs of persons of all ages, from infant to adult.

**Children’s Service Array**

The focus of the Children’s Purchasing Plan is to reduce unnecessary use of high-end care, to strengthen community-based care, and to incorporate prevention and wellness. As is evidenced in the spending charts below, the Children’s Purchasing Plan currently calls for a reduction from 8% to 5% inpatient, 57% to 45% residential and 18% to 15% outpatient. In turn, intensive outpatient is targeted to grow from 5% to 10% and recovery and resiliency services from 8% to 20%. As is also evident, the Children’s Purchasing Plan needs to be built out to incorporate all the elements of a holistic service array as described above, including prevention and wellness.
a. Actionable in FY11

- Solicit input from the BH Planning Council and its Subcommittees, consumers, family members, and providers, on criteria and strategies to expand and guide the sizing of the Children’s Purchasing Plan – the services needed to build out the array and the targets for shifting to more community-based care

- Work with the NM Health Care Reform Leadership Team and other groups addressing health care reform to ensure that children’s behavioral health is part of their planning related to prevention, wellness, health disparities, consumer protection, education, outreach and communication, and overall payment and delivery system reform

- Continue to promote and deliver training in evidence based practices (e.g., in FY11, train the Matrix Model (IOP) and ASAM placement criteria for implementation of Intensive Outpatient Services for adolescents)

- Pilot an Intensive Outpatient Program for youth ages 18-21 who are leaving the juvenile justice system which includes transitional living and independent skill development

- Develop comprehensive school based plans that address prevention and wellness especially as related to substance abuse and violence

- Promote the integration of special education and IEPs with behavioral health plans and services

- Work with tribal communities to identify needs to build and balance service arrays including increasing prevention, wellness, and community supports
b. Mid-Range

Initiate shifts in the Children’s Purchasing Plan as outlined below. These shifts will prioritize services that are outcome-driven, use evidence-informed practices, are culturally competent, and can be developed in tribal, rural, and frontier communities.

- Expand access to services across the array through the investment of CYFD funds (e.g., care coordination using a wraparound approach, respite services, infant mental health services, and transitional living services)

- Based on the youth Intensive Outpatient Program pilot project, develop a comprehensive clinical model that utilizes a system of care philosophy; and, include an evaluation component to examine the model’s effectiveness.

- Youth with SMI will be transitioned from the youth system to the adult system in a seamless fashion. Incentives for the providers will be developed to better ensure participation.

- Develop a “road map” for employment/vocational opportunities for transitioning youth; partner with public education, vocational rehabilitation, and workforce solutions agencies; educate youth, families & stakeholders in its use.

- Increase screening and assessment in school based health centers

- Create a model for prevention and early intervention systems within school based health centers

- Expand school-based early intervention strategies in school-community collaborations

- Develop a consistent risk and protection approach to a range of prevention issues, including substance use (e.g., underage and binge drinking), suicide, mental health, violence, teen pregnancy, school dropout and delinquency

- Expand community based prevention and wellness as resources become available

c. Long Term (3 Years)

Continue shifts in the Children’s Purchasing Plan as outlined below. These shifts will prioritize services that are outcome-driven, use evidence-based practices, are culturally competent, and can be developed in tribal, rural, and frontier communities.

- Seek funding to expand the evaluated youth IOP model for regional access

- Implement a standardized substance abuse assessment for youth

- Create full time capacity in school based health centers to provide mental health and substance abuse prevention, assessment, crisis intervention, and early intervention services
• Implement comprehensive school based plans that address prevention and wellness especially as related to substance abuse and violence

• Expand the full service community school model statewide

• Develop a coordinated effort linking primary care and behavioral health across communities, including tribal communities, to address prevention and wellness, including positive youth development strategies

• Incorporate expenditures in State facilities currently not under the auspices of the Collaborative into the Children’s Purchasing Plan

**Adult Service Array**

The Adult Purchasing Plan provides a framework for shifting resources toward recovery oriented and community-based emerging and promising practices that effectively support recovery and resiliency as well as embed prevention into the service array. As is evidenced in the spending charts below, the Adult Purchasing Plan calls for a reduction from 13% to 5% inpatient, from 12% to 5% in residential. In turn, intensive outpatient is targeted to grow from 7% to 10%, outpatient from 40% to 50% and recovery and resiliency services from 24% to 30%. As is also evident, the Adult Purchasing Plan needs to be built out to incorporate all the elements of a holistic service array as described above, including prevention and wellness.

![Service Array Charts]

**Legend**

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<tr>
<th>Inpatient</th>
<th>Residential</th>
<th>Intensive Outpatient</th>
<th>Outpatient</th>
<th>Value Added/Other</th>
<th>Recovery</th>
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**a. Actionable in FY11**

• Solicit input from the BH Planning Council and its Subcommittees, consumers, family members, and providers, on criteria and strategies to expand and guide the sizing of the Adult Purchasing Plan – the services needed to build out the array and the targets for shifting to more community-based care
• Work with NM Health Care Reform Leadership Team and other groups addressing health care reform to ensure that adult behavioral health is part of their planning related to prevention, wellness, health disparities, consumer protection, education, outreach and communication, and overall payment and delivery system reform

• Map all prevention, early intervention, and treatment resources across the state -- Access to Recovery (ATR), Total Community Approach (TCA), Substance Abuse Prevention and Treatment (SAPT) and Community Mental Health Services (CMHS) Block Grant funds, compulsive gambling, medication assisted treatment, as well as other General Fund substance abuse expenditures

b. Mid-Range
Initiate shifts in the Adult Purchasing Plan as outlined below. These shifts will prioritize services that are outcome-driven, use evidence-based practices, are culturally competent, and can be developed in tribal, rural, and frontier communities.

• Increase supportive housing to decrease transitional living services

• Increase consumer-operated services and bolster improvement of psychosocial rehabilitation services

• Increase comprehensive community support services and focus on evidenced-informed outpatient therapies

• Fill gaps in the continuum of available services and ensure substance use residential services are used only when that level of care is appropriate

• Increasing the utilization of substance abuse Intensive Outpatient Programs (IOP)

• Develop a plan for more access to prevention, screening and early intervention, and strategies that promote wellness

• Create a comprehensive, evidence-informed strategy to prevent and reduce substance abuse, including binge and chronic drinking by adults, including adults over 65

• Create an IOP model for mental health; develop a strategy for piloting this model

• Educate providers about appropriate services for elderly and disabled consumers with severe and complex behavioral problems and co-occurring acute medical issues

• Expand community based prevention and wellness as resources become available
c. Long Term (3 Years)
Continue shifts in the Adult Purchasing Plan as outlined below. These shifts will prioritize services that are outcome-driven, use evidence-based practices, are culturally competent, and can be developed in tribal, rural, and frontier communities.

- Invest BHSD (non-Medicaid) funds in services that will fill gaps in the service array
- Expand the capacity of community-based providers that serve people who are elderly and physically disabled with severe and complex behavioral problems and co-occurring acute medical issues
- Expand the capacity of facilities that serve people who are elderly and physically disabled with severe and complex behavioral problems and co-occurring acute medical issues
- Incorporate expenditures in State facilities currently not under the auspices of the Collaborative into the Adult Purchasing Plan
Chapter 6: Infrastructure

Infrastructure refers to the development of local systems of care in which primary care and behavioral health providers and practitioners are aligned and integrated with one another and with other community-based services and supports. Infrastructure development also focuses on ensuring the availability of person-centered care that is culturally competent and community based.

What we believe

- New Mexico’s behavioral health infrastructure must be embedded in the community as a local system of care and its networks and linkages and be responsive to community issues.
- Our services, strategies, and outreach must always be culturally competent in the fullest meaning of culture.
- All services must be integrated within a recovery and resiliency model and demonstrate results, outcomes in the real lives of people and effectiveness paired with efficiency.
- Every service must be designed with a person-centered focus, always remembering that services are meant to support the hopes and potentials of real people.

What’s important as we move forward

The need to continue to develop infrastructure in behavioral health is critical to the continued transformation of behavioral health to a recovery and resilience model, and in creating a foundation for integration of behavioral health and primary care under health care reform. Priorities for infrastructure development are as follows.

- We must continue to develop Core Service Agencies (CSAs) as clinical homes that will serve and support populations with complex behavioral health needs, and eventually provide for their primary care needs. CSAs as clinical homes and primary care settings as medical homes are necessary to create the overall infrastructure to provide the holistic service array discussed above. CSAs are also part of the transformation of behavioral health services and systems to support client-centered, family-focused, and community-delivered care directed toward recovery and resiliency outcomes.
- Primary care and behavioral health have to be deliberately aligned and ultimately integrated. Efforts to ensure such alignment for people with chronic behavioral or other health conditions can begin immediately and will accelerate as grants become available for health homes, screening and early intervention through health care reform implementation.
• Person-centered care and the integration of primary care and behavioral health will require the development of local systems of care. A system of care includes the holistic array of services and supports that are organized into a coordinated network at the community level, integrating care planning and management across multiple domains through wraparound approaches designed to achieve recovery and resiliency outcomes. Systems of care are culturally and linguistically competent, and build meaningful partnerships with families, youth, and adults at service delivery and policy levels. Systems of care have been a high priority for the Collaborative for some time; most recently the State applied for and received a SAMHSA grant to demonstrate core components of systems of care in three communities for children and youth and their families addressing serious emotional disturbance.

• Attention to infrastructure development in rural, frontier and tribal areas is also critical. It will be necessary to expand services provided through telehealth as well as to build new and creative partnerships to reach those areas of New Mexico.

a. Actionable in FY11

• Work with the NM Health Care Reform Leadership Team and other groups addressing health care reform to develop a vision of integrated primary care and behavioral health infrastructure that includes both medical homes and clinical homes (CSAs)

• Establish a workgroup among primary care, FQHC's, 638's and behavioral health providers to agree on a practice model for clinical integration

• Develop mechanisms to share successful implementation strategies across CSAs

• Provide CCSS and Wraparound training to CSAs

• Work with CSAs to develop infrastructure for responding to community suicide crises

• Support local sites in SAMHSA grant to develop logic models, system designs, and strategic plans for local systems of care that can be replicated in other communities

• Develop a statewide strategic plan for the use and expansion of behavioral health telehealth services that minimally starts with psychiatric services in FY11, then other clinical services in FY12, and then non-clinical services in FY13

• Develop funding strategies to support telehealth infrastructure in school based health centers

b. Mid-Range

• Develop a training and technical assistance plan for primary care providers to incorporate behavioral health services in primary care settings, including topics such as: implementation SBIRT, use of Motivational Interviewing skills, administration of depression scale tools, appropriate prescribing practices, treating opioid addiction in families
• Work with NM Health Care Reform Leadership Team and other groups addressing health care
reform to develop at least one pilot project on clinically integrated primary care and behavioral
health that incorporates medical homes and clinical homes

• Pilot and evaluate a medical home approach in school based health centers in three to five sites;
document successful components and outcomes of pilots incorporating medical home
operations within SBHCs; develop process to expand in additional SBHCs

• Integrate physical health initiatives within the behavioral health consumer/recovery population
to focus on health consequences related to major disease processes such as diabetes, heart
disease, and emphysema

• Develop a competency based CSA framework and training plan with competencies framed in
terms of QSR principles

• Develop a strategy for deployment of staff from CSAs to screen, assess, and conduct referrals of
the elderly within primary care clinics and senior centers

• Provide education, training, and technical assistance based on lessons learned from SAMHSA
sites to expand local development of systems of care for children, youth and their families in
communities throughout the State

• Develop a system of care model incorporating wraparound approaches for adults, including
adults over 65; provide education, training, and technical assistance in implementing the
model statewide

• Develop systems to use data to identify emerging trends, e.g., the emergent use of opioids

• Develop strategies and seek grant funds to initiate transportation services for persons with BH
issues in conjunction with DOT, including the implementation of consumer-run services and
the expansion of existing services to the BH population

c. Long Term (3 Years)

• Work with NM Health Care Reform Leadership Team and other groups addressing health care
reform to rigorously evaluate a pilot on integrated primary care and behavioral health and
develop a long term plan for expansion statewide

• Link school based health centers to primary care practitioners and CSAs and other community
based providers in an integrated system that includes a medical home approach

• Develop an integrated model for services and supports to elderly persons that incorporates
behavioral health care with primary care and other services

• Develop processes that ensure that individuals receive screening and early intervention to
minimize severity of illness, symptoms, and functional limitations.
Chapter 7. Performance and Quality Improvement

Performance and quality improvement refers to the identification of a unique set of outcome and performance measures that define a good system of care and, shape programs and practices. In addition, it refers to the importance of promoting quality improvement and assuring accountability.

What we believe:

- Strong practice models are at the heart of effective care.

- Quality improvement and other evaluation processes can and should be used routinely in all programs; it can improve practice and result in positive client and community outcomes. Accountability and results should be expected at all levels of the system: among state agencies, with the statewide entity and across individual providers.

- Clinical and financial decisions made on the basis of sound data are better decisions that can lead to improved outcomes. Data and performance results should be shared and discussed broadly.

- Not all programs are equal, some programs and interventions work better than others; and, all work better when adapted to fit the individual’s needs and the community context.

What’s important as we move forward

- Our focus must support processes that promote practice improvement, strengthen systems for assessing clients needs and functional levels, and determine which services or programs have the most impact on successful client outcomes.

- A targeted set of client and system performance measures should provide feedback on the effectiveness of the service delivery system and point to areas for improvement.

- We must routinely report performance indicators to stakeholders and the public and improve communication with providers about performance expectations.

- To improve outcomes, all major initiatives should be evaluated, results shared broadly, and improvements identified and implemented, with fidelity to proven models.

- Building communities of learning through Quality Service Reviews, collective learning groups, and school mental health communities of practice, will help us grow knowledge and skills. Successes in practice improvement can then be celebrated across providers and with local community stakeholders.
a. Actionable in FY11

- Establish a “Client and System Performance Dashboard” that monitors gains in a limited set of key measures addressing: improved functioning, reduction in problems, achievement of recovery or resiliency goals in children and adult consumers’ lives
- Promote practice improvement through expanding Quality Services Reviews with Adult and Children’s CSA’s statewide
- Implement quality improvement processes within CSA’s to assure implementation of core functions and service to eligible populations
- Use results from statewide CCSS adult provider audits to create ‘next steps’ in development of a recovery- and resiliency-based system of care; incorporate with CSA implementation
- Provide training and implement functional assessment (e.g., CAFAS) in Children’s CSAs
- Guide changes in the services array by trending services received 7 and 30 days after discharge from Adult Residential Substance Abuse and Adult Psychiatric Inpatient
- Improve quality through Fidelity Assessment and Compliance monitoring:
  - Implement Intensive Outpatient (IOP) Fidelity Tool for all adult IOP providers
  - Strengthen current Assertive Community Team (ACT) Fidelity Tool utilization by the six Medicaid ACT programs
- Monitor appropriate access to services for older consumers with behavioral health disorders by tracking services and diagnoses by age

b. Mid-Range

- Develop standardized functional assessment tool options for adults and older adults
- Standardize functional assessment tool for children (i.e., Child Adolescent Family Assessment Scale (CAFAS))
- Implement Intensive Outpatient (IOP) Audit Tool for Medicaid providers of IOP
- Implement concurrent review for residential substance abuse services
- Modify patient placement criteria for substance abuse services to incorporate harm reduction approaches and self-directed recovery skills
- Develop and implement treatment standards that address appropriate transitions between levels of care; include incentive structures to support changes
c. Long Term (3 Years)

- Expand implementation of functional assessment (e.g., CAFAS) in Child serving agencies who are not CSAs
- Implement functional outcomes as the standard measure of child and youth outcomes
- Develop strategies to increase access to community support services for older adults by designing several pilot initiatives within CSAs to explore access issues for the elderly and disabled
- Evaluate core service agency (CSA) effectiveness in achieving recovery outcomes, learning opportunities for improvement, and incorporating learning into practice
- Conduct a study of comprehensive community support services (CCSS) to determine its effectiveness in supporting recovery-oriented outcomes
Chapter 8: Consumer, Youth & Family Engagement

Consumer, youth and family engagement refers to the importance of engaging consumers and family members in person-directed service planning towards recovery and resiliency; ensuring shared decision-making; and strengthening consumer and family voice in the development of local systems of care.

What we believe

- People diagnosed with mental illnesses, trauma-effects, and behavioral health challenges contribute immensely to the well-being of society.

- Consumers, youth and family members who are informed and actively directing their own recovery will achieve better long term outcomes. Peer and consumer-operated services provide opportunities for independence, leadership, and expanded recovery options.

- Peer and family support is an important part of recovery and resiliency. Recovery is a life-long process that has many phases – consumers, youth, and family members must have access to information and resources as needed from their immediate circle of peers/friends and family; from their community supports; and from provider agencies.

- Diverse groups of community members who mobilize to participate in broad coalition-based prevention and treatment efforts can change important norms, policies and practices that lead to resilient and healthy communities.

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- Consumers, youth, and family members should be partners in strategic planning, policy development, priority setting, service implementation, resource allocation, and evaluation in order to create an integrated and effective system of care.
What's important as we move forward

- **True engagement will come when consumer, youth, and family voice is recognized and acted upon.** Consumers, youth, and family members should be partners in strategic planning, policy development, priority setting, service implementation, resource allocation, and evaluation.

- **Consumers, Youth and Families are most empowered when they can determine how the system serves their needs.** There must be shared decision-making at the systems level, consumer driven service planning, and consumer-driven and peer operated services.

- **Peers serving peers is a powerful component of recovery.** Continuing improvement to the peer and family specialist trainings will build the behavioral health workforce, and assist with recovery. Engaging peers and families in dialogues with provider agencies to learn what can remove the roadblocks to hiring peer and family specialists will lead to practice improvements and healthy communities.

- **Consumers who understand their rights and responsibilities can better benefit from treatment and recovery supports.** All consumers must be aware of their right to psychiatric advance directives, grievance and appeal processes, and treatment options.

- **Consumer, youth, and family voices are needed at all levels.** As leaders, trainers, educators, and advocates in their communities they can promote and assist in recovery and resiliency by directing their own care; designing tools for adult consumers to create their own recovery; continuing to build the infrastructure for developing leadership capacity, peer support, and recovery oriented initiatives; and assisting those who are unfamiliar or inexperienced with the system to understand what is meant by consumer involvement. Consumers can create strategies that build resiliency in youth and adults for developing life-long mental well-being. They can also identify ways to address the risk of youth substance abuse, teen suicide, teen pregnancy and serious emotional disturbances.

**For Adults, Youth, and Families**

**a. Actionable in 2011**

- Identify strategies that support development of consumer and youth resiliency in services and trauma-informed systems of care. For instance, train youth and families how to engage in advocacy and educate providers on the value of consumer, youth, and family member involvement
• Increase the number of Peer, Family and Youth Specialists throughout the state and promote their employment in community mental health organizations as Community Support Workers (CSW) or Assertive Community Treatment (ACT) team members

• Ensure that consumers, youth, and family members are partners in strategic planning, policy development, priority setting, service implementation, resource allocation, and evaluation

• Revitalize Local Collaboratives to welcome consumers, youth, and family members; and to ensure members are adequately trained in legislative advocacy, mental health first aid, etc.

• Increase Local Collaborative participation via telehealth and webinars to ensure that Local Collaboratives have a voice in decision-making

• To gather information on specialized behavioral health needs and concerns, engage special populations in natural settings, such as older adults through senior centers and people with disabilities through vocational programming

• Develop stakeholder-friendly surveys and reports on consumer, youth & family satisfaction; share findings broadly and identify relevant quality improvement measures

b. Mid-Range

• Engage consumers, youth and family members in designing systems of care that capitalize on their local community resources and needs

• Ensure that Local Collaboratives include public schools, community programs, law enforcement, housing, employment, child welfare, juvenile justice and other stakeholders in their systems of care

• Evaluate the mechanisms and effectiveness of consumer engagement for special populations including Native Americans, veterans, older adults, and people with disabilities

• Implement Community Wellness and Recovery Resource Centers as peer-run and peer-driven pilots tailored to the needs of communities

• Support peer-to-peer school based programs such as Natural Helpers

• Increase public awareness by expanding the number of mental health focused public service announcements focused on recovery and stigma

• Implement statewide the New Mexico Consumer, Youth and Family Involvement Standards which focus on the role of state agencies, employment, media and marketing, community providers, individual roles and responsibilities, recruitment of consumers, outreach, service delivery, consumer choice, early intervention, consumer satisfaction, ethics and rights protections
c. Long-term (3 years)

- Expand drop-in centers as resources for consumers to continue growth and development in their lives

- Engage youth and their families in designing systems of care in their own communities to craft the changes needed

- Recruit and train consumers from special populations (i.e., Native Americans, veterans, older adults, and people with disabilities) to work as peer support specialists

- Increase awareness of early childhood development and the effectiveness of early intervention in terms of long-term health and mental wellbeing for children and families, including early intervention for psychosis

- Track data on behavioral health system outcomes (e.g., where referrals for behavioral health services are made) to determine greatest needs
Chapter 9. Workforce Development

Workforce development refers to the importance of ensuring that institutions of higher education produce an adequate number of appropriately credentialed and competent primary care and behavioral health care professionals; augmentation of the existing workforce to include trained family and peer specialists and community health workers; and creation of new learning models to ensure that the existing workforce has the information, technical assistance and training to effectively implement evidence-informed practices.

What we believe

- Persons in recovery, family members, and natural supports are pivotal members of the workforce.
- New Mexico’s behavioral health workforce must utilize the best evidence-informed practices available.
- New Mexico’s workforce must reflect the diverse cultures of New Mexico.
- New Mexico must have a professional, culturally competent prevention and intervention workforce that emphasizes wellness and recovery and is trained to work in public behavioral health settings.

What’s important as we move forward

- The state’s higher education system and licensing boards must train and support the growth of a professional workforce that possesses the appropriate skills and experiences to be recovery oriented, culturally competent, and prepared to work in the public sector.
  - Health Care Reform and Parity for Mental Health will require a significant growth in the available behavioral health workforce.
  - A more concerted pre-professional training effort can prepare new frontline and professional providers for the modern service delivery system that is consumer and family-driven, recovery-oriented, culturally competent and evidence-based.
  - Consumers, youth, family members, and providers have valuable contributions of knowledge and experience for current curriculum to ensure that individuals are appropriately trained at the pre-service level.
  - Consumers and family members must be part of the paid workforce, including as trained family and peer specialists.
We can review and prioritize for implementation recommendations of the Task Force on the Behavioral Health Workforce Report, recruitment and retention strategies to expand the workforce, especially in rural, frontier and tribal communities.

- The Collaborative must develop more opportunities for provider training and cross-agency collaboration, especially across member agencies of the Collaborative.

- Health care reform can offer way to create new teams and partners among independent practitioners as well as among provider agencies.

- We must strengthen, standardize, and improved licensure and certification standards.

a. Actionable in FY11

- Augment the existing workforce to include trained peer and family specialists as part of the paid workforce by:
  - Continuing training for Peer and Family Specialists and assisting with job placement
  - Improving the Peer and Family Specialist curriculum after quarterly reviews and feedback from participants to ensure that they are appropriately trained to enter the workforce (e.g., include more training on documentation)
  - Developing an internship process for Peer and Family Specialists to experience the workplace
  - Conducting media campaigns to promote the benefits of Peer and Family Specialists as essential parts of the workforce

- Increase readiness of provider agencies to employ Peer and Family Specialists and identify funding strategies to support the work of these individuals

- Expand outreach and identify successful efforts to provide behavioral health services in areas of limited workforce capacity (e.g., rural and tribal communities)

- Deliver training in the Matrix Model to assist in the implementation of substance abuse and mental health Intensive Outpatient Services for adolescents and adults

- Provide Comprehensive Community Support Services and Wraparound training to ensure that the workforce is adequately trained to work in public behavioral health settings

- Seek support to sustain and expand the prevention certification program

- Work with Health Care Reform Leadership group to evaluate funding opportunities for workforce development. Include Workforce Solutions in this proces
- Work with licensing boards to encourage adoption of the New Mexico developed cultural competency curriculum as the standard for all behavioral health continuing and higher education programs

- Expand mental health interpreter training by offering additional training opportunities

b. Mid-Range

- Develop new learning models, such as web-based trainings and web-based learning collaboratives to ensure that the workforce has the information, technical assistance and training to effectively implement evidence based and promising practices. Training examples include:
  - Specialized training on unique issues of older adults and persons with disabilities.
  - Education on the warning signs and appropriate responses to youth and adult suicide concerns.
  - Training to school personnel on behavioral health needs in school settings.

- Develop and implement a Core Service Agency Integrated Training curriculum

- Develop training methods for Core Service Agencies workforce to support shared decision making and shared planning

- Provide training to Certified Family Specialists to serve as care coordinators/wraparound facilitators and to provide family support services

- Seek funding and mechanisms for expanding mental health treatment guardians

- Create a specialized curriculum for Veteran Peer Specialists focusing on trauma spectrum disorders

- Train school staff about behavioral health issues; signs and symptoms of substance abuse, depression, suicide, and appropriate methods of response, referral, etc.

- Develop Training Initiatives to Engage Workforce Outside of Behavioral Health. Training examples include:
  - Behavioral health training for nursing home staff to address the needs of the nursing home residents.
  - Mental Health First Aid for first responders (e.g., fire departments, law enforcement, EMTs), reception staff in public offices, teachers or other school personnel
  - Training to Primary Care staff on integrating Primary Care and Behavioral Health (CME’s).
c. Long Term (3 Years)

- Develop and train the workforce in clinically integrated models to serve the general population as well as populations with SED and SMI

- Seek funding and develop mechanisms to support consumer, family member, and provider participation in trainings

- Develop a Training Academy, in conjunction with the Collaboratives' Consortium for Behavioral Health Training and Research, for long-term statewide training delivery

- Develop strategies and incentives to encourage cross-agency and cross-system collaboration

- Strengthen licensure, re-licensure, and certification requirements; develop a Continuing Medical Education (CME) or Continuing Education (CE) curriculum for professionals with Geriatric specialty or developmental disability specialty.

- Improve recruitment and retention efforts in rural, frontier and tribal communities by increasing access to telehealth or enhancing availability of peer and family specialists

- Pursue education and training grants for behavioral health service providers as they become available under health care reform

- Work with institutions of higher education to ensure that issues relevant to public behavioral health are integrated into existing non-medical and medical curriculum

- Develop tax or educational incentives to increase the number of prescribing professionals practicing in New Mexico

- Review the recommendations from the Annapolis Coalition Workforce Development report and prioritize steps for New Mexico
Chapter 10: Financing Strategies

*Financing strategies refer to the development of payment strategies that are linked to performance and that are sufficiently flexible to promote a more effective and value-based system of services and supports.*

What we believe

- Funding for behavioral health services will be increasingly limited over the next few years. The on-going economic challenges require creative strategies to increase efficiency and more effectively utilize limited available dollars. Funding strategies can promote the integration of primary and behavioral health care.

- A focus on performance and outcomes suggests new options for financing that can improve our system over time. Fee-for-service funding strategies are limited and other funding options such as capitation and pay for performance should be initiated.

- Flexible funding strategies that encourage improvements produce better outcomes.

- We can and will purchase evidence-informed strategies that have proven outcomes – and that provide the least restrictive care within an individual’s home community.

What’s important as we move forward

- It will be essential to develop financial strategies that provide the appropriate amount of financial flexibility while keeping focused on performance and outcomes and finding new ways to share decision-making with consumers, youth and family members.

- We must pilot and use innovative and effective funding strategies that produce improved practice and outcomes.

- Financial incentives can encourage the development of a comprehensive services array that includes health promotion and illness prevention, evidenced based and promising treatments, and strong aftercare and recovery services.

- Funding formulas and processes for integrated service delivery must be tested and applied to advance the clinical integration of behavioral health and primary care as appropriate.

- A menu of evidence-informed practices must be developed for prioritized funding that reflects both the best available research findings and the unique characteristics of New Mexico.
• The Collaborative should explore options to braid more funding streams that together create more comprehensive service arrays. Departments should work together to increase efficiency in braiding all behavioral health funding.

• The Collaborative has been working over the past years to include funding for evidence informed-practices with proven outcomes. These efforts move New Mexico’s system from merely purchasing a set volume of services to purchasing the most effective services and supports.

• Additional financial strategies are needed to provide incentives and flexible strategies to pay for system performance, reward consumer outcomes and move toward clinical integration of primary and behavioral health services when appropriate.

  a. Actionable in FY11
  
  • Increase consumer and family involvement in funding allocation discussions
  
  • Review the states Behavioral Health Purchasing Plan and develop a strategic plan for behavioral health funding that takes into account the limited dollars available
  
  • Move toward equitable access to services across the major funding streams (i.e., Medicaid, state general funds dollars and federal block grant funds) through braided funding strategies
  
  • Demonstrate flexible payment strategies within the Provider Network by implementing risk-sharing pilots in three areas of the state with children and adult CSAs, thereby establishing case rates and strategies to allow more flexible use of funds
  
  • Support implementation of wrap-around supports in the three anchor sites of the Systems of Care initiative by testing case rates for the targeted populations in those sites
  
  • Apply for the federal “Money Follows the Person” planning grant that allows for planning a demonstration project to use flexible funding to move clients from institutional care to community-based services
  
  • Evaluate providers on performance and target incentives for improvements in:
    
    • Consumers Outcomes (e.g., increasing housing and housing supports; increasing employment; improving satisfaction with services; reducing drug or alcohol use; increasing integration into communities, alleviating symptoms as appropriate).
• Service System performance (e.g., demonstrated efficiencies in service provision: as evidenced by: reducing waiting times, reducing no shows, reducing hospitalization rates, increasing outpatient admissions, and increasing continuation rates).

• Conduct a system analysis of the use of Medicaid reimbursement for school based behavioral health services, including services provided in school-based health centers, special education, and via other school personnel

• Develop a workgroup with state; provider; tribal; and consumer, youth and family representation to address expected Medicaid shortfalls

b. Mid-Range

• Develop a cost study resulting in recommendations for expanding behavioral health services in schools by school-based health centers, special education, and other school personnel

• Develop a cost study resulting in recommendations for expanding substance abuse services for adolescents.

• Develop financial strategies to support vulnerable services such as: care coordination/wraparound facilitation, respite services, transitional living services, and early childhood/infant treatment services

• Develop financial strategies to establish uniform crisis mobile outreach services statewide.

• Implement pay-for-performance and shared-risk payment methodologies as research indicates

• Develop financial incentives for CSAs to develop outreach strategies and implement integrated models that reach Native American populations, the elderly and adults with disabilities

• Rigorously evaluate risk sharing pilots and develop a plan for modification and/or expansion

• Pilot efforts in the use of flexible funds in wraparound plans within the three anchor sites of the System of Care initiative

• In accordance with Health Care Reform, work with Medicaid and managed care organizations to dedicate funds to promote the clinical integration of behavioral health and primary care when appropriate

• Reimburse Intensive Outpatient services based on demonstration of Co-Occurring Disorder treatment competencies established through the COSIG grant
c. Long Term (3 Years)

- Develop policy and financing strategies for financing adult and child wraparound approaches and other peer and family support services
- Establish Medicaid code to support treatment integration across service sectors (e.g., behavioral health, developmental disability, primary care) so that needed services can be provided efficiently rather than in silos
- Develop incentives to service populations who are high-need, high-risk and have complex needs
- Develop models to reimburse services based upon provider performance
- Expand proven risk-sharing methodologies statewide
- Increase availability of flexible funds for wraparound plans
Chapter 11: Next Steps

How we plan to move the strategies forward.

This strategic plan is the first step in positioning New Mexico to have a robust behavioral health system in the context of healthcare reform. There will be many opportunities for stakeholders and policymakers to improve the plan.

These are some of the next steps to gather input, educate others and begin action:

- September 28, 2010: Meet with the Collaborative appointed Review Team to gather recommendations for improvement of the plan. Modify accordingly.

- October 19, 2010: Utilizing the mechanism of the Behavioral Health Planning Council and all of its subcommittees (i.e., Children, Adult, Medicaid, and Native American), as well as other interested stakeholder groups, invite interested parties to join in a discussion about the directions taken in the strategic plan. Participation will be available at a distance through "Meeting Bridge."

- October-November: Post document on the Behavioral Health Purchasing Collaborative website for ongoing input.

- December, 2010: Present final document to the Collaborative for its approval.

- December, 2010: Conduct briefings with the Transition Team for the new Governor.

- Early January, 2011: Present the plan to the Legislative Finance Committee and the Legislative Health & Human Services Committee for their review.

- January/February, 2011: Develop Work Groups to draft the Implementation Plan