

# New Mexico Behavioral Health Collaborative Meeting

Thursday, October 8, 2015

Human Services Department  
37 Plaza la Prensa  
Santa Fe, NM



## Video Conference Sites

*Farmington CSED*

*Las Cruces CSED*

*Roswell CSED*

*Clovis CSED*

# New Mexico Behavioral Health Collaborative

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



Brent Earnest  
Human Services Department  
Secretary – Collaborative Co-Chair

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**Thursday, October 8, 2015**  
**37 Plaza La Prensa**  
**Santa Fe, New Mexico**  
**1:00 p.m. – 4:00 p.m.**

## **AGENDA**

1. 1:00 – 1:15 p.m. **Call to Order**
    - Introduction of Collaborative Member/Recognize Remote Sites
    - Review/Approval of Minutes from April 23, 2015
  2. 1:15 – 1:30 p.m. **Dr. Wayne Lindstrom, CEO Report**
  3. 1:30 – 1:45 p.m. **Centennial Care Update**

Nancy Smith-Leslie - Medical Assistance Division  
Dauna Howerton, PhD - Behavioral Health Services Division
  4. 1:45 – 3:15 p.m. **John Morris, MSW**

Executive Director, The Annapolis Coalition  
Presentation on BH Workforce Challenges and Solutions
  5. 3:15 - 3:45 p.m. **Behavioral Health Planning Council (BHPC) Report**

Lisa Trujillo, Behavioral Health Planning Council

**Local Collaborative Alliance Update**  
Rick Vigil, LCA Chair
  6. 3:45-4:00 p.m. **Public Input**
- Adjourn**

File Tab 1 Call to Order/Minutes



## July 9, 2015, DRAFT Meeting Minutes

### New Mexico Behavioral Health Collaborative

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

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

Topic	Discussion
Video Conferencing Sites	Albuquerque South CSED, Farmington CSED, Las Cruces CSED, Roswell CSED
Present were:	Brent Earnest/HSD, Daphne Rood- Hopkins/CYFD, Retta Ward/DOH, Dr. Wayne Lindstrom/BHSD, Karen Courtney-Peterson/GCD, Richard Blair/DFA, Miles Copeland/ALTSD, Carlos Moya/ALTSD, Loren Hatch/DOT, Annjenette Torres/PED, Nicole Adams/NMHED,
1. <u>Call to Order</u> <u>Review/Approval of Minutes</u>	<p>The meeting was called to order at 1:00 pm.</p> <p>Handout-DRAFT Meeting Minutes, New Mexico Behavioral Health Collaborative Meeting – January 8, 2015 and April 23, 2015</p> <p>A <b><u>MOTION</u></b> was made Secretary Retta Ward and seconded by Secretary Miles Copeland to approve the minutes from January 8, 2015 and April 23, 2015, Behavioral Health Collaborative Meeting. The <b><u>MOTION</u></b> was <b><u>PASSED</u></b> unanimously.</p>
<u>Brent Earnest, HSD</u> <u>Secretary Designate</u>	<p>Brent Earnest called the meeting to order at 1:00 p.m.</p> <ul style="list-style-type: none"> <li>• Agenda modifications were made to accommodate reaching a quorum before voting on action items.</li> <li>• Introduction of Behavioral Health Collaborative Members</li> <li>• Introduction of Community Member in Roswell</li> </ul>
2. <u>Behavioral Health Director</u> <u>and CEO Report</u>	<p>Dr. Wayne Lindstrom, CEO</p> <ul style="list-style-type: none"> <li>➤ Strategic Plan <ul style="list-style-type: none"> <li>• Two year initial planning initiative is planned for July 30, 2015</li> <li>• Focus on three critical domains: Regulations, Finance, and Workforce</li> <li>• Today's meeting and the next two BH Collaborative Quarterly Meetings will be devoted to the three domains.</li> </ul> </li> <li>➤ Major Service Transitions <ul style="list-style-type: none"> <li>• Turquoise Health and Wellness ceased provided BH services in NM effective March 31, 2015</li> <li>• La Frontera announced terminating NM operations effective May 31, 2015. Transitions have been staggered with Otero and Lincoln Counties scheduled for June 30<sup>th</sup>, and Dona Ana County for July 31<sup>st</sup>.</li> </ul> </li> <li>➤ Quality Service Review (QSR) Case Formulation and Clinical Documentation Training is being provided to the new "transitioning providers."</li> </ul>

- UNM Consortium for Behavioral Health Training and Research (CBHTR): Workshops on Behavioral Health Clinical Practice-Free educational workshops for providers planning on expanding behavioral services into their current practices.
- Crisis Triage and Stabilizations Centers: Established by HB 212 in the 2015 legislative session, \$1.75 million was appropriated to establish HSD/BHSD Crisis Triage and Stabilization Centers. These Centers will be health facilities that are licensed by DOH with a planned sustainability funding through Medicaid.
- BH Investment Zones: HB 2, the General Appropriation Act, included a \$1 million appropriation to HSD/BHSD for additional behavioral health services to be allocated through Behavioral Health Investment Zones.
- New Mexico Crisis and Access Line (NMCAL): is expanding to broaden access and utilization of the service:
  - Peer-to-Peer Warm Line: The Warm Line was identified as a need by the House Joint Memorial 17 Task Force to provide telephonic support by Consumer Support Workers
  - Core Service Agency (CSA) After-Hours Crisis Access Program: is a statewide CSA option in collaboration with ProtoCall under the NMCAL contract.
  - Public Awareness Campaign: has been planned make New Mexicans aware of NMCAL.
- Network of Care (NOC): the BH web portal is being customized to become the website for the BH Collaborative with an anticipated launch in July, 2015
- Supportive Housing: BHSD is implementing the following:
  - Project Rental Assistance (PRA),
  - Social Innovation Fund Pay for Success,
  - H2 Action Planning Session, Cooperative Agreements to Benefit Homeless Individuals for States (CABHI-States,
  - Transitional and Supportive Housing Programs
- Certified Community Behavioral Health Clinics (CCBHC): BHSD is applying for one of SAMHSA's planning grants. SAMHSA intends to select up to twenty-five states as recipients of the planning grant funds of up to 2 million for one year: eight of these planning grant recipients will be selected as demonstration states in year two.
- Partnership for Success Grant: BHSD's Office of Substance Abuse Prevention (OSAP) has been awarded this SAMHSA grant of \$1.6 million annually for 5 years (\$8 million total) to address underage drinking and youth prescription drug abuse.
- National Strategy for Suicide Prevention (NSSP): This SAMHSA grant of \$1.47 Million, three year grant awarded to BHSD continues in its 2<sup>nd</sup> year of implementation.
- *Dose of Reality* Campaign: This research-based statewide campaign has been launched statewide by BHSD's Office of Substance Abuse Prevention to raise awareness and to educate teens and parents about the serious risks for addiction and overdose from prescription painkillers.
- Applied Behavioral Analysis (ABA):
- Cognitive Enhancement Therapy (CET)
- Community Engagement Teams (CET)
- Administrative Improvement Projects:
  - Critical Incident Reporting (CIR) Workgroup, Administrative Burden Reduction Workgroup, Clinical Policy Group, Medicaid Behavioral Health Workgroup.

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

### 3. Payment Reform & Performance Measurement

Dale Jarvis, CPA

- Arizona Project: Arizona Behavioral Health Payment Reform Toolkit.
  - Value based purchasing:
  - Moving from paying for volume to paying for value
    - Strategies to reduce inappropriate care and increase high value of care
    - 3 components of High Value Care: High Consumer Value, Clinically Effective, Cost Effective.
- Behavioral Health Payment Reform Road Map:
  - Project Plan Development
  - Service Delivery redesign
  - Identify Funding Pools
- Funding Pools and Service Delivery Redesign:
  - Key Question: What service improvements are needed to rebalance the funding pools?
    - Primary Care, Medical Specialty Care, Acute Care Hospital, Pharmacy, Behavioral Health and Other
- Utilization-Financial Modeling: Washington State Return on investment calculator
- Phased Implementation
  - Phase 1- Payment Reform Preparation
  - Phase 2- Begin Pay for Performance
  - Phase 3- Full Value-Based Purchasing

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

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

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

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

- clinically effective, and cost effective care.
- Payment Mechanisms
  - Capacity Funded-Identify staffing requirements and buy capacity
  - Fee for Service-Payment for all authorized visits or days, paid at an agreed rate
  - Stratified Case Rate/Bundled Payment-Payment of a flat fee per patient
  - Sub-Capitation-Payment of a fixed fee per eligible (per member per month) to provide all medically necessary services.
- CCBHC Prospective Payment System
  - Bundled Payments
    - Daily Bundled Rate and a Monthly Bundled Rate
  - Quality Bonus Payment Layer
    - Optional for Daily PPS
    - Required for Monthly PPS
- Pay for Performance: Common Health home example
  - Fee For Service-payments for series provided by Primary Care Providers
  - Case Rate-prevention, early intervention, care management for chronic health conditions
  - Bonus-performance bonus or share of savings from reduced total healthcare expenditures
- Four Phases of Pay for Performance
  - Pay for participation-agree to participate in developing a quality contract that describes the design and measures
  - Pay for Reporting-additional payments to support the cost of moving to a P4P including implementation and use of health information technology
  - Pay for Performance-pay for hitting process targets
  - Pay for Outcomes-paying for care where P4P is working
- The Pay for Performance Process
  - Develop the benchmark metric for each measure (goal)
  - Identify the baseline metrics for each measure for each provider (where are you now)
  - Measure frequently
  - Earn your bonus-Show improvement or hit the benchmark
- Performance Metrics: Follow-up after hospitalization for mental illness (seven days of being discharged from the hospital for mental illness)
  - Set your baseline to a reasonable benchmark. If you set your benchmark too high then no one will receive the bonuses.
  - Show improvement to receive the bonus or meet your benchmark and automatically receive your bonus.

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

#### 4. Action Items

Community Engagement Teams Guidelines (CET):

A **MOTION** was made by Secretary Miles Copeland to approve the Community Engagement Teams Guidelines; and was seconded by Secretary Retta Ward to approve the Pilot Community Engagement Teams Guidelines. The **MOTION** was **PASSED** unanimously

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

Revisions are proposed to the Severe Emotional Disturbance (SED) Criteria:

- Diagnoses: Changes were made to the current SED criteria to make it compliant with the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM). DSM will be generally referenced in the Criteria so that any updates to the DSM edition number will not require a revision to the criteria.
- Functional Impairment: The requirement to report on the Global Assessment of Functioning (GAF) was removed since this is no longer a requirement within DSM V. The wording "The disturbance is excessive and causes clinically significant distress or impairment in social, occupational, or other important areas of functioning," was retained however.
- Personality Disorders (must require clinical or medical intervention) and Borderline Personality Disorder were added.
- Changes are proposed to Symptom Severity and Other Risk Factors.

Revisions are proposed to the Severe Serious Mental Illness (SMI) Criteria:

- Use the new diagnostic coding within DSM-5 for all disorders in the Criteria.
- Symptoms: Mood and anxiety symptoms have been added.

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

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

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

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

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



- Adult Substance Abuse and Medicaid & Children and Adolescent Subcommittee report
- Annual Report: the Behavioral Health Planning Council Annual Report.

Patricia Gallegos, Department Of Health, representing the Local Collaborative Alliance (LCA)

- LCA meets monthly on the 4<sup>th</sup> Tuesday of every month in the Collaborative Conference Room
- 18 Active Local collaborative-each collaborative has 2 members per local collaborative
- Local Collaborative End of Year Report 2015-End of year report from 13 Local Collaborative attached to report.
  - Business Conducted, Ongoing concerns and Issues, Special Projects and Accomplishments, Collaborative Partners, Goals for next Quarter, Presentation and Trainings.

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

6. Public Input

Chris Wendel, Recovery Santa Fe

- Recovery Santa Fe- movement happening locally and nationally around bringing forth the Face of Recovery. September is recovery month and we have on September 20<sup>th</sup>, Recovery Santa Fe Celebration at the Friendship Club. There will be a cookout, exhibitors, art show, movie-Anonymous People,
- National Organization to bring forth the face of recovery. October 4<sup>th</sup>- March in Washington, Unite to face addiction. Organization: Faces and Voices of Recovery.

Tom Starke, Santa Fe Behavioral Health Alliance

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

Delfy Roach, Families ASAP

- It appalled me visiting a children's psychiatric hospital, that it was more like a detention center than a hospital. If there is

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

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

#### Jean Howden-Families ASAP

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

#### Monica Miura, Families ASAP

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

create the best possible outcomes for families seeking services.

Kendra Morrison - Families ASAP

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

Valerie Quintana, Clinical and Community Linkages Coordinator


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

7. Adjourn

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

## File Tab 2 Wayne Lindstrom-CEO Report

## File Tab 3 Centennial Care Update



**HUMAN SERVICES**  
DEPARTMENT

**Applied Behavior Analysis**  
Dauna Howerton, Ph.D.  
Behavioral Health Services Division  
October 8, 2015

New Mexico Human Services Department

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**What is Applied Behavior Analysis?**

- A new evidence based service delivered to members identified with Autism Spectrum Disorder (ASD) or identified as At-Risk for developing ASD.
- Research and evidence based approach to understanding behaviors in an environment.
- In practice, ABA uses techniques to bring about positive and meaningful changes in behaviors.
- Results in improved communication, learning, and social relationships.
- Increases participation in family and community activities.

Source: Autism Speaks. <https://www.autismspeaks.org/what-autism/treatment/applied-behavior-analysis-aba>




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**What is different?**

- ▶ More members receiving services
- ▶ Wider age range – up to 21 years of age
- ▶ Adds to the array of services CMS requires
- ▶ Service provided by staff trained in Applied Behavior Analysis with national board certification
- ▶ MCOs took the initiative to work together to implement
- ▶ MCOs working together on a common understanding of this new, layered service




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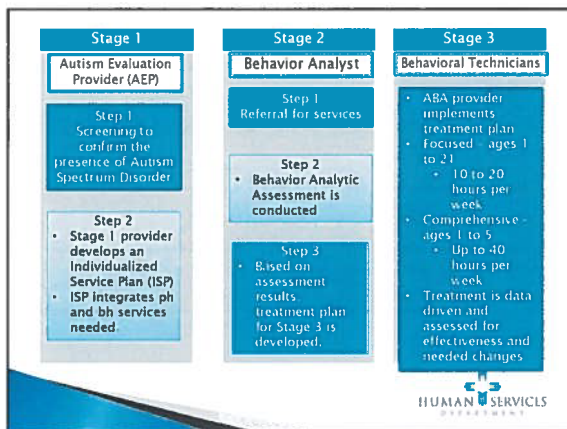
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### Providers

Providers	Location(s)	Phone #
Bridges	ABQ	505-856-6880
	Santa Fe	
Behavior Change Institute	ABQ	866-273-2451 ext 106
	Roswell	
Jumpstart	ABQ	505-828-3837
Pacific Child and Family	ABQ	505-265-5311
ENMRSH	Clovis	575-762-1223
Apprendamos/Mariposa Autism Center	Las Cruces	575-652-3357
Behavior Health Works, Stage 1 Provider in Las Cruces & UNM CDD	Pending Approval	

HUMAN SERVICES

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## Resources

**Regulation – 8.321.2 Section 10**  
[http://www.hsd.state.nm.us/uploads/files/Providers\\_New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing\\_HMAC%20Program%20Rules%20and%20Billing%20Overview\\_8.321.2%20NMAC%20integrated%20approved%20AL%2005-14-15.pdf](http://www.hsd.state.nm.us/uploads/files/Providers_New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing_HMAC%20Program%20Rules%20and%20Billing%20Overview_8.321.2%20NMAC%20integrated%20approved%20AL%2005-14-15.pdf)

**University of New Mexico Center for Development and Disability**  
<http://cdd.unm.edu/>

**Autism Speaks – Applied Behavior Analysis (ABA)**  
<https://www.autismspeaks.org/what-autism-treatment/applied-behavior-analysis-aba>

**Behavior Analyst Certification Board – BACB**  
<http://www.bacb.com/index.php?page=158>

HUMAN SERVICES

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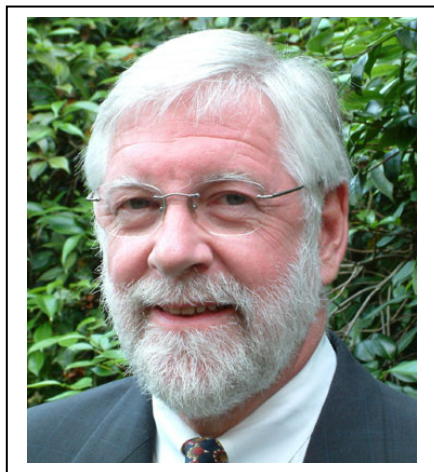
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File Tab 4 John Morris





## Biographical Notes: John A. Morris, MSW

John Morris is Executive Director of the Annapolis Coalition on the Behavioral Health Workforce; the Coalition has provided leadership and technical assistance on workforce issues nationally since 2000. He is also an Independent Consultant with the Technical Assistance Collaborative, Inc., a national not-for-profit consulting group based in Boston, MA. He is past Chair of the Board of Directors of Mental Health America (formerly the National Mental Health Association); in 2009, Mental Health America's South Carolina affiliate recognized John with its Distinguished Service Award. He is also a past president of the American College of Mental Health Administration and of the ACMHA Foundation, and in 2006 he was awarded the Saul Feldman Lifetime Achievement Award, ACMHA's

highest honor. In June, 2010, he was awarded the Victor I. Howerly Award for Lifetime Achievement by the National Association for Rural Mental Health. He is a past-President of the SC Action Council for Cross Cultural Mental Health and Human Services, which recognized him with the Otis Corbitt Leadership and Community Service Award in 1997. In April of 2013 he was the co-recipient (with Barbara Huff, founder of the Federation of Families for Children's Mental Health) of the American Orthopsychiatric Association's Blanche F. Ittleson Award for outstanding achievement in the delivery of children's services and promotion of children's mental health. In May of 2015 the University of South Carolina College of Social Work named him recipient of its Pioneer Award for 2015; he shared this honor with Ohyoung Kweon, Founder and Secretary General of the Korean Alliance on Mental Illness. He is a member of the National Advisory Council to the Georgetown University Technical Assistance Center for Children's Mental Health, and was a member of the Mental Health Policy Research Network of the John D. and Catherine T. MacArthur Foundation from 2004 until its end in 2009 and is currently a consultant to the MacArthur Foundation's multi-site *Models for Change* juvenile justice reform project.

John retired in 2007 as Professor of Clinical Neuropsychiatry and Behavioral Sciences and Director of Health Policy Studies at the University of South Carolina School of Medicine. Prior to joining the University, he spent more than twenty-five years in the public behavioral health field as a clinician, administrator, and educator. He started his career in public mental health as a ward attendant at the SC state hospital, and prior to his move to the University in 1997 he served a two-year interim appointment as SC State Director of Mental Health, having served as Deputy State Director/Chief Operating Officer since 1990. A 1968 graduate of St. Mary's Seminary and University in Baltimore, he graduated from the George Warren Brown School of Social Work at Washington University in St. Louis in 1978; he later returned annually as Visiting Professor of Mental Health Policy between 1991-2004 and was named a Distinguished Alumnus of the school in 1996. From 2004-2007, during his time at USC, he served as Senior Policy Consultant to Comprehensive NeuroScience, Inc. (CNS) of which he was also formerly a Vice President and the founding editor of *Prescriptions for Progress*. He has served as a member of the editorial boards of *Administration and Policy in Mental Health and Mental Health Services Research* and of the *American Journal of Orthopsychiatry*, a member of the National Board of Editors of the College of Direct Support (University of Minnesota) and is a reviewer for *Psychiatric Services* and *PsyCRITIQUES*. He is the author of numerous publications on the use of evidence-based practices, public psychiatry, and behavioral health workforce development in specialty and integrated settings. He lives in Columbia, SC with his wife Jennie; they have two grown sons, Dan, his wife Megan and their son Benjamin (Charlotte, NC) and Paul, his wife Laura and their daughter Felicity (Columbia, SC).

## Workforce Trends Impacting the New Mexico Behavioral Health Collaborative

John A. Morris, MSW  
Executive Director,  
The Annapolis Coalition on the  
Behavioral Health Workforce



October 8, 2015  
Santa Fe, New Mexico

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### What is The Annapolis Coalition?

- A small not-for-profit
- Large "Coalition"
- Neutral convener of stakeholders
- Source of information & technical assistance
- Vehicle for strategic planning, collective action, & public/private partnerships



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### For more information

[www.annapoliscoalition.org](http://www.annapoliscoalition.org)



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### Today's presentation-national trends

- First, a focus on workforce development in behavioral health specialty settings
- Second, a focus on behavioral health in integrated settings..one of the key developments of healthcare reform in the US and on direct support workers
- Third, overview of resources useful to New Mexico

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### Workforce development

- For decades we have underinvested, and far worse, *wasted* resources
- In the Annapolis Coalition Work, we refer to this collective phenomenon as

**THE PARADOXES OF WORKFORCE DEVELOPMENT IN BEHAVIORAL HEALTH**

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Paradox 1: We train graduate behavioral health professionals for a world that no longer exists

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**Paradox 2:** Those who spend the most time with consumers/families receive the least training

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**Paradox 3:** Training programs persist in utilizing ineffective teaching strategies

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**Paradox 4:** We train only where willing crowds gather

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Paradox 5 (in two parts):  
Consumers and families  
receive little educational  
support...

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Paradox 5: ...and their lived  
experience doesn't inform the  
rest of the workforce

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Paradox 6: The diversity of  
the current  
workforce... doesn't match  
the diversity of those  
served.

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Paradox 7: Students are rewarded for “doing time” in our educational systems

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Paradox 8: We do not systematically retain or recruit staff

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Paradox 9: Once hired, little supervision or mentoring is provided

**“Just Do It”**

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**Paradox 10:** Career ladders and leadership development are haphazard

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**Paradox 11:** Incompetent service systems thwart the competent performance of individuals

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**Some light at the end of the tunnel...**

For behavioral health specialty settings:  
A national action plan... still relevant

For integrated settings:  
The Center for Integrated Health Solutions

For the high volume category of direct support workers:  
Hitachi/Annapolis, the Alaska Core Competencies

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**General Findings (1)**  
**National Action Plan**

- Widespread concerns about the current and future workforce
- High levels of dissatisfaction
  - Persons in Recovery & Families
  - Workforce employers
- "We" are fragmented: disciplines, sectors, & effort
- Historically narrow foci, missing:
  - Life span issues (children & elders)
  - Culturally diverse populations
  - Rural America

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**General Findings (2)**  
**National Action Plan**

- Scarcity of data (NM ahead here)
- Doing what is easy or affordable - not what is effective
- A hunger for "tools"
- Pockets of innovation
- Difficulties with sustainability and dissemination
- Workforce crisis extends throughout health & human services...

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**Goal 1: Expand the Roles of Persons in Recovery (Consumers/Patients) & Families**

**Objectives:**

- Increased educational supports
- Shared-decision making
- Expand peer & family support
- Greater employment as paid staff
- *Formal* engagement as educators of the workforce

*"Transformational" in nature*

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**Goal 2: Enhance Community Capacity to support behavioral health and wellness**

**Objectives:**

- Competency development with communities
- Competency development of the behavioral health workforce in community collaboration
- Strengthening connections between behavioral health organizations and their communities

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**Goal 3: Implement Systematic Retention & Recruitment Strategies**

- Implement & evaluate interventions:
  - Salary, benefits, & financial incentives
  - Non-financial incentives & rewards
  - Job characteristics
  - Work environment
- Develop career ladders
- "Grow your own" workforce
- Cultural & linguistic competence
- Social marketing

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#### Goal 4: Increase the Relevance, Effectiveness, & Accessibility of Training

##### Objectives:

- Competency development
- Curriculum development
- Evidence-based training methods
- Substantive training of direct care workers
- Technology-assisted instruction
- Addition and co-occurring competencies in every staff member
- Systematic support to sustain newly acquired skills

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#### Goal 5: Actively Foster Leadership Development

##### Objectives:

- Identify leadership competencies tailored to behavioral health
- Competency-based curricula
- **Formal, continuous leadership development in all sectors beginning with supervision**
- Succession planning

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#### Goal 6: Enhance Workforce Development Infrastructure

##### Selected Objectives:

- **A workforce plan for every agency**
- Data-driven CQI on workforce issues
- Strengthen HR & training functions
- Improve IT support for training, workforce support, & tracking
- **Decreased paperwork burden: variable, redundant or purposeless reporting**

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**Goal 7: Invest in Research & Evaluation of Workforce Issues**

**Objectives:**

- Federal and state inter-agency research collaboratives
- Technical assistance to field on evaluation of workforce practices

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**LEVERS OF CHANGE**

- Leadership
- Advocacy
- Competency assessment
- Licensure & Certification
- Accreditation
- Financing & other incentives
- Performance monitoring

Workforce development as a lever for transformation

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**Behavioral health/primary care integration**

- Do we really know what this will mean?
- Are providers in either sector really prepared?
- What are the dynamics likely to be?

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## Agreed. The stakes are high.

The history of behavioral health integration in the US has some scary precedents...

- Reduced access and benefits
- Inappropriate limits on visits and medications
- Dramatically under-priced reimbursement rates
- Narrow definitions of medical necessity that negatively impacted using natural supports and peers; resistance to inclusion of substance use treatment in basic coverage
- Loss of recovery focus in care to medical management

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## On the other hand.

- Data on mortality and morbidity for people diagnosed with major mental illnesses, including comorbid substance use disorders = a scandal for our field
- Life expectancy reductions of 20+ years cannot be allowed to continue

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## The way forward: Reasons for optimism

- Behavioral health actually has something to bring to the table (more on this later)
- Co-occurring disorders are increasingly recognized as the norm not an anomaly
- The new buzz word in US integration circles is "bidirectional": not a foregone conclusion that the mergers or integration will all be from behavioral health into primary care.

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## Lessons from the rest of healthcare

- The history of how we arrived at the current general healthcare "system" is every bit as haphazard as ours.
- Atul Gawande, MD: Health care development was "path-dependent", following the paths of least resistance

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## Some tools and resources

- New resources
- Exemplary models

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The SAMHSA-NRSA Center for Integrated Health Solutions, part of the National Council for Community and Juvenile Justice Services, is a national center for the U.S. Department of Health and Human Services, in partnership with the Department of Justice, Office of Justice Programs, and the Department of Education, Office of Education Programs. The Center provides the development of integrated programs and services to address the needs of individuals with mental health and substance use disorders, whether in specialty behavioral health or primary care settings.

**Our Support Workforce Benefits 1 video!**  
 From October 18-20, 2014, the Center will host a series of three webinars that will address how these innovative Centers are integrating evidence-based interventions that reduce hospitalizations for people in recovery from substance use disorders.

**ABOUT THE IHSI**  
 Eight states recently joined the Support Workforce through Centers, providing needed leadership, vision, and resources, join us for this free webinar that will address how these innovative Centers are integrating evidence-based interventions that reduce hospitalizations for people in recovery from substance use disorders.

**Our website will help meet 10 common questions about our Support Centers and how they support meeting the behavioral health care needs of their patients/communities. From Support Centers and other collaborative care for patients, our behavioral health programs, an IHSI roadmap, and how to help primary care physicians learn more about these Centers.**

**Learning Communities Logo**  
 Enhance your knowledge and expertise on integrating primary care and behavioral health into your practice.

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### Recently released

- Core competencies for providing integrated primary and behavioral health services
- Expert panel methodology
- Available at the SAMHSA-HRSA Center for Integrated Health Solutions

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### Consensus categories

- I. Interpersonal Communication
- II. Collaboration & Teamwork
- III. Screening & Assessment
- IV. Care Planning & Care Coordination
- V. Intervention
- VI. Cultural Competence & Adaptation
- VII. Systems Oriented Practice
- VIII. Practice Based Learning & Quality Improvement
- IX. Informatics

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### Focusing on the Direct Support Workforce

- Historically, in the US at least, very little attention paid to this group
- Demand for services has always out-stripped supply of graduate trained behavioral health professionals
- Rise of recovery-peer and other peer specialists is helping to fill the gap
- Increased focus on DSW can also help fill that gap

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## The Pacesetter Awards

- A partnership between The Annapolis Coalition and The Hitachi Foundation
- Better Jobs, Better Services, Better Business
- 51 programs nominated
- 5 National Award Winners, 2 Programs of Merit

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## Pacesetter Awards

- Criteria for finalists based on the Kennedy School Innovations in American Government Awards:
- Novelty
- Effectiveness
- Significance
- Transferability
- Durability/sustainability (added by Annapolis Coalition)

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### Employer Improvements by Site

Case Study	Patient Satisfaction	Patient Outcomes	Revenue s/ Reimburse	EBP Implementation
Borinquen	✓	✓	✓	✓
Family Services of Western PA	✓	✓	✓	
Hartford Dispensary	✓	✓	✓	✓
SSTARR	✓	✓	✓	✓
Thresholds	✓	✓	✓	✓

✓ Anecdotal or modest improvement    ✓ Significant measured improvement    Blank – Insufficient data

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### Worker Outcomes by Site

Case Study	Wage Gains	Benefits/ Credentials	Lower Turnover	Employee Satisfaction
Borinquen	✓	✓		✓
Family Services of Western PA	✓	✓	✓	✓
Hartford Dispensary	✓	✓	✓	✓
SSTARR	✓	✓		✓
Thresholds	✓	✓		✓

✓ Anecdotal or modest improvement    ✓ Significant measured improvement    Blank – Insufficient data

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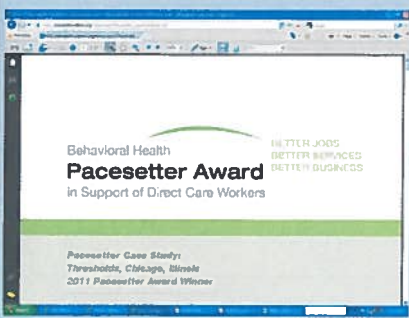
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Case studies:  
[www.annapoliscoalition.org](http://www.annapoliscoalition.org)



Behavioral Health  
**Pacesetter Award**  
 In Support of Direct Care Workers

BETTER JOBS  
 BETTER SERVICES  
 BETTER BUSINESS

Pacesetter Case Study:  
 Thresholds, Chicago, Illinois  
 2011 Pacesetter Award Winner

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### Implications for New Mexico

- You have a great start already.
- Approach the challenges in as systematic a way as you can... one step at a time.
- Borrow and adapt where you can, tailoring your plans to New Mexico reality.
- Remember that change is a complex and dynamic process...in closing, one man's view of policy change...

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### Policy pinball.



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### In closing

- The **True North** of all healthcare has got to be improved over-all health outcomes for real people in the real
- There can be no health without behavioral health.
- As New Mexico faces the future, a renewed focus on the workforce is critical to ensure quality and relevance going forward...as you clearly already know!

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### Action is key

- Pay attention to workforce issues as a core business strategy
- Make workforce central in all quality improvement approaches
- Plan to influence every element of preparation and support of an effective workforce:
  - strategic recruitment
  - pre-service education,
  - in-service training & supervision,
  - science-driven retention strategies

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### The Coalition Motto:

I get up each day determined to change the world – *and* to have one hell of a good time.

Sometimes this makes planning the day difficult.

Adapted from  
E.B. White

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### Keep in touch...

[www.annapoliscoalition.org](http://www.annapoliscoalition.org)

[Jmorris@tacinc.org](mailto:Jmorris@tacinc.org)

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File Tab 5 Behavioral Health Planning Council Report Lisa Trujillo  
Local Collaborative Alliance Update Rick Vigil

**BEHAVIORAL HEALTH PLANNING COUNCIL REPORT  
TO THE PURCHASING COLLABORATIVE  
10/08/15**

**BLOCK GRANT APPLICATION** – A hard-working and thoughtful group of BHPC members read, then met to critique and contribute to the SAMHSA Substance Abuse/Mental Health block grant application for FY2016-2017. The group will convene again soon to review this year's report on the current block grant.

**SUBCOMMITTEES AND REGIONAL REPRESENTATION**- Our bylaws require us to seek representatives from each of the Local Collaboratives (LC'). In recent years we have not been able to get many LC representatives to our subcommittees. This means that our efforts at the Planning Council are not as well informed as we would like. We know that the Behavioral Health Collaborative put a lot of effort into the creation of the LC', but feel that we must also look at other methods of obtaining broad representation and input from around the state.

Some Local Collaboratives are active and serve a vital role in their communities; others have lost representation from important, necessary segments and struggle to function. Some have been inactive for a long time, and others are making attempts at reviving their activities. We are long since aware that there are communities never actually represented by any LC, mostly because of geographic considerations, and the reality is that attending distant meetings was never a feasible option. At the same time, we are appreciative of collaborative efforts in many communities to bring innovative change to behavioral health delivery, primarily in crisis response but also in other realms. These are the kinds of efforts that LCs were designed for but are now occurring both within and beyond the LC framework.

We would like to be connected with and informed by any honestly collaborative community efforts. Some LCs have long worked together with their local county Health Councils. It is our hope that reaching out to Health Councils across New Mexico will be a step to gathering information in order to encourage and support local efforts at coordinated services. In light of Centennial Care and the assimilation of behavioral and physical health, this outreach would allow us to model the integrated approach so vital to New Mexicans' well being.

In light of all this, we are revisiting our by-laws to redirect our focus to regional representation. Changing the language regarding LC involvement and our subcommittee membership will better allow people to vote with their passion, by being present. This way someone interested- from a Health Council, consumer group, active local collaborative (where there is one), whatever it might be- can be involved, the commonality being informed people who are interested and passionate. A group of Council members, forming an ad hoc by-laws subcommittee, will be meeting soon to

discuss appropriate changes. And we would like a vote of confidence from the Collaborative as we look to strengthen our advisory function and capacity.

**MEMBERSHIP** – We continue to request that new appointments be made to the Council, however this has long proven a difficult and often frustrating process. Many thanks to Secretary Earnest for his support in forwarding our requests to the Governor’s office!

**COLLABORATIVE INITIATIVES** –We are very grateful and happy to continue to provide a broad range of voices to participate in your Strategic Planning process. We continue to inform ourselves and provide input regarding initiatives that involve cooperative efforts between Collaborative agencies, including the Network of Care, new Supportive Housing initiatives, and Community Health Workers. We were also informed about and supportive of the Dose of Reality campaign. We have heard about promising alternatives to detention for both youth and adult populations. Our Children and Adolescent’s Subcommittee continues to work on boosting membership, organizing feedback for CYFD, and forming recommendations to the Collaborative about Infant Mental Health, and specifically the position paper to recognize youth programs that include behavioral health through alternative and restorative justice programs.

**SUBCOMMITTEES** - You will find reports from our statutory subcommittees in the following pages. All of our statutory subcommittees have been meeting regularly.

**ATTACHMENTS:**

Subcommittee Reports

Budget Variance



## **BEHAVIORAL HEALTH PLANNING COUNCIL**

Adult/Substance Abuse/Medicaid  
Subcommittee Quarterly Summary  
July- Sept., 2015

### **July 21st**

#### **Independent Peer Review Committee**

##### **Shana Aldahl, (SAPT Program Manager)**

SAPT (Substance Abuse Prevention and Treatment) is one of the biggest grants we receive. As per federal requirements, they re-established the independent peer review committee and were seeking a good regional representation in order to expand participation to professionals in all areas of the state, especially rural and frontier.

**Cathi Valdes, State Block Grant Planner**, updated and spoke to the ASAM, seeking input into the Block Grant (BG) application. Dr. Lindstrom very much wanted to involve the BHPC, and several members of the Council were to be included in the July 30 priority and strategic planning process. That was one of the pieces that went into the application. (The application itself was due in just over a month, on Sept. 1st). In the meeting, some discussion ensued about addressing Hepatitis C, not duplicating efforts, and other feedback/ concerns.

#### **Updates:**

**Karen Meador, Deputy Director, Policy and Quality**, announced she would be transitioning out as ASAM chair and Cathi Valdes in; also, BHPC member Cindy Collyer announced her up and running statewide consumer network.

**Steven Flint, BHSD Quality and Data Manager**, updated the ASAM on the Social Network of Care (NOC), which is up and running.

**MCO Updates:** Presbyterian, Molina, United Health Care, and Blue Cross Blue Shield all had representatives who presented updates: trying to locate hard-to-find consumers, updates on peer support programs, and provider trainings.

**September, Recovery Month**, was announced along with several planned events throughout the state.

### **August 18th**

**Strategic Planning Retreat:** Karen Meador and Betty Downs updated the ASAM on the July 30 strategic planning retreat, which focused on the three priorities: finance, regulations, and workforce. Also, Dr. Lindstrom spoke to consumers in particular, he is here to support peer efforts but this also requires peer organization and ownership.

**New Mexico Care Link, Health Homes (HH):** Karen Meador updated the ASAM on the HH state plan, which focuses on people with severe mental illness (SMI), what health homes are and are not, plus how and why they are dealing with HH's in NM in a very different way than in other states. When the State Plan Amendment (SPA) is available, and as the process unfolds, we will receive ongoing updates.

**Announcements** included MCO job openings for peers and several Sept. Recovery Month events.

**The MCO's, along with normal updates, announced they now have Ombudsmen:**

- **BCBS:** Carlos Galaviz, [\(505\) 816-4213](tel:(505)816-4213) - Albq. Area, [\(888\)243-1134](tel:(888)243-1134) - Toll Free, [nmcentennialcareombudsman@bcbsnm.com](mailto:nmcentennialcareombudsman@bcbsnm.com)
- **Presbyterian:** Marina Estrada, (505) 923-5780.
- **Molina:** Christopher Salazar: 1-800-377-9594, ext. 180553. direct mobile: (505) 348-0553.
- **United Health Care:** Elizabeth Portilo, (505) 449-4251.

**Sept. 15, 2015**

**Cathi Valdes opened** the meeting. She began with a **Block Grant update**, this document turned out to be more than 600 pages long. Members interested in receiving a copy were offered one, and all those who helped profusely thanked.

**By-Laws Revision**, to redirect our focus and broaden representation from regions, allowing people to vote with their passion, by being present. This way someone interested from a Health Council, consumer group, or active local collaborative (where there is one)- whatever group it might be- can become involved, the commonality being people who are interested, informed, and passionate. There was pretty unanimous support for this in the Executive Committee and this is what they will propose to the full Council.

**Strategic Planning Update:** Karen Meador updated our members that in Aug., they held the SP retreat and formed three workgroups that will meet three times between now and Christmas. Their objective is to concentrate in a very implementation/ work-plan focused way, taking each priority- workforce, finance, regulations- and its respective subtopics forward in order that the Collaborative can look at its full plan in its Jan. 2016 meeting. Meeting notices and details about what's coming out of these three groups will be shared as an ongoing agenda item.

**Email Protocol:** Based on SC meeting discussions last (fiscal) year, and the June BHPC meeting member feedback and discussions, Karen and Cathi put together a document that the Executive Committee had already reviewed. Some examples: use caution before hitting "send," a reminder that BHPC emails could potentially be seen were there an issue/ investigation, and, very important, when and when not to use one's Council member designation.

**Substance Abuse Treatment Services/ Gaps and Needs:** Dr. Lindstrom was about to leave to participate in a summit in Washington DC, involving three delegates from each state. He mentioned variables that affect substance-use and barriers to medication-assisted treatments, such as people being denied admission to detox in cases where there is no co-occurring disorder. There was a long discussion about these and other points, including alcoholism and the stigma around it particularly for Natives seeking treatment. Also, limits to LADACs practicing, how they might be more efficiently employed to bridge these gaps.

**MCO's invited to share:** Karen talked about the MCO's coming and talking to us next meeting about substance use treatment and barriers they see.

## **Native American Sub Committee Quarterly Report for the BHPC**

**July-September 2015**

*NASC's key continued accomplishments for the Quarterly Report include:*

- *Conducting monthly NASC Planning Committee Meetings at the Indian Affairs Department offices – comprised of leadership from Local Collaborative 16, Local Collaborative Alliance, Behavioral Health Services Division of the Human Services Department, and among others, to guide meaningful agendas for the monthly NASC meetings; and*
- *Conducting Monthly NASC Meetings on the 4<sup>th</sup> Thursday of each month; and*
- *Requesting MCO's to provide written reports to be distributed at each monthly meeting; and*
- *Ongoing support from Sandoval County DWI & Prevention Program, for the services of Becky Ballantine, Tribal Liaison, in drafting NASC Minutes; and*
- *Planning the 5<sup>th</sup> Annual Behavioral Health Summit to be held on November 6, 2015 at the Route 66 Casino Hotel, located on the Pueblo of Laguna; and*
- *LC 15 coordinated a health fair on July 13<sup>th</sup> where networking and health insurance enrollment was conducted; and*
- *LC 16 hosted successful DWI & Prevention Powwow and Meet and Greet events. The LC supports veterans at the behavioral health wellness center where veterans learn traditional art therapy with a sewing and quilting program in the works; and*
- *LC 17 conducts monthly meetings where attendance has ranged from 6 to 35 individuals. They have collaborated with multi-cultural healing, acupuncture, and Medicaid sign ups. They are working with the Albuquerque Police Department and the Native American Homeless Council; and*
- *The NASC Meetings continue to meet monthly to discuss behavioral health issues and concerns affecting tribal members, consumers, families and providers. The following providers made presentations; ASAM Network of Care Social Networking and Albuquerque Area Southwest Tribal Epidemiology Center.*
- *NASC membership is currently being reviewed to ensure the specific behavioral health needs of the Native Americans within the state are being met, and to better serve the LC communities; and*

*Natalie Rivera*

*HSD/BHSD*

*BHPC Coordinator*

*(505) 476-9265 - Phone*

*(505) 476-9272 - Fax*



**Behavioral Health Planning Council**

Budget 2015-2016

**Operations**

<b>Category</b>	<b>Frequency</b>	<b>Line Item</b>	<b>Budget</b>	<b>Sub-total</b>	<b>TOTAL</b>
Council Meetings	5 per year				
		Stipends	\$5,000.00	\$5,000.00	
		Mileage	\$4,000.00	\$4,000.00	
		Food	\$1,800.00	\$1,800.00	
		Per Diem	\$2,700.00	\$2,700.00	
					<b>\$13,500.00</b>
Statutory Sub-Com	Stipends \$15/hr	Adult/SA/Medicaid	\$7,500.00	\$7,500.00	
5 Committees		Children	\$2,500.00	\$2,500.00	
		Native American	\$2,500.00	\$2,500.00	
					<b>\$12,500.00</b>
	Mileage	All Subcommittees	\$200.00	\$200.00	<b>\$200.00</b>
	Food	Subcommittees	\$500.00	\$500.00	<b>\$500.00</b>
Ad Hoc Committees		stipend/mileage	\$900.00	\$900.00	<b>\$900.00</b>
Block Grants					
Others					
Behavioral Health Day	Annually	All costs	\$4,000.00	\$4,000.00	<b>\$4,000.00</b>
Administrative Support	Monthly	All costs	\$5,000.00	\$5,000.00	<b>\$5,000.00</b>
Misc. Operational		All costs	\$46.68	\$46.68	<b>\$46.68</b>
<b>Total</b>			<b>\$36,646.68</b>		<b>\$36,646.68</b>
<b>Budget Allocation</b>	Contracts Funds	BHSD July 15-June 16	\$31,000.00	\$31,000.00	<b>\$31,000.00</b>
		Optum Health	\$5,646.68	\$5,646.68	<b>\$5,646.68</b>
					<b>\$0.00</b>
					<b>\$36,646.68</b>



# Local Collaborative Alliance



Local Collaborative Alliance (LCA) mission is to support the active participation of the communities of New Mexico regarding behavioral health services; and to forge a relationship between the Behavioral Health Collaborative and the Local Communities to enhance and protect their voice through providing, and creating continuity.

## LC Alliance New Mexico October 2015 Report

**History:** The Local Collaborative Alliance NM (LCA) was formed in response to a statewide gathering of Local Collaboratives Leads. Representatives of LCs at this meeting determined the following priorities:

- Local collaborative including in state initiatives
- Local collaborative sustainability and funding
- Local collaborative will continue to be community voice

In the effort to support these priorities, the Local Collaborative Alliance NM was formed with membership that represents all active Local Collaboratives. Alliance officers were selected at the July 2013 Meeting. Monthly meetings with all Local Collaboratives are held every 4<sup>th</sup> Tuesday of each month from 10:00 to 12:00.

### Announcements:

- Received funds from 4 MCO a total of \$15,500 to support local collaborative efforts. \$400.00 were distributed to the 13 active Local Collaboratives who submitted an end of year report.
- Con Alma Grants Committee met with LCA Leadership and completed a site visit. We will hear from Con Alma Foundation about our grant application in October 2015.
- LCA convened a meeting at the August LCA meeting with NM Health Council Alliance Coordinator Ron Hale and Con Alma Health Foundation Executive Director Dolores Roybal re: opportunities to leverage resources, decrease duplication of services, and increase collaboration between the two groups. In preparation of the meeting Ron Hale and Patricia Gallegos drafted the attached document Similarities and differences. One area of future collaboration will be to combine a state wide policy committee to address both health disparities and support behavioral health priorities.
- Elections for Chair and Vice Chair were held at the September 2015. The membership nominated and elected Rick Vigil, to continue as LCA Chair and Rebecca Ballantine as Vice Chair. Congratulations to both as this will provide continuity for LCA strategic direction.
- LCA entered into a new contract with its Grant Writer, Ms. Valerie Ingram who continues to seek funds and support LCA sustainability efforts.
- LCA Financial Summary to date attached provided by Life Link LCA fiscal agent.

Submitted by: Rick Vigil, LC Alliance Chair [rvigil@pueblooftesuque.org](mailto:rvigil@pueblooftesuque.org) & Patricia Gallegos, LCA Finance Committee member [patricia.gallegos@state.nm.us](mailto:patricia.gallegos@state.nm.us) October 2015

## Health Councils and Local Collaboratives: Similarities and Differences

### Similarities of Health Councils and Local Collaboratives:

- Both health councils and Local Collaboratives were established as community health coalitions.
- Both serve as the voice of citizens and consumers of health care services.
- Both serve as a communications link between local communities and state government.
- Memberships of health councils and local collaboratives often overlap—particularly in smaller, more rural communities, where community volunteers end up serving on multiple groups.
- Both groups were established with State funding and staff support, but both now operate with minimal funding.
- Both health councils and Local Collaboratives are represented by statewide Alliances
- Both groups share values of local control and self-determination

### Differences:

Characteristics	Local Collaboratives:	Community Health Councils:
<b>Total Numbers:</b>	18 Local Collaboratives, including 5 tribal LC's (at present 13 LC's are active members of LCA)	38 Health Councils, including 5 tribal communities
<b>Geographic Distribution:</b>	Local Collaboratives are based in Judicial Districts, covering multiple counties or tribal areas.	Each health council is based in a single county or tribal community.
<b>Focus:</b>	Local Collaboratives have a specific focus on substance abuse, behavioral health; Prevention, Mental Health 1st Aid/stigma, recovery.	Health councils are concerned with comprehensive community health, with priorities that include access to health care, behavioral health, oral health, population health, and social and economic determinants of health.
<b>Membership:</b>	LC Members represent consumers, family members & providers of behavioral health services. Stakeholders include 4 MCO's other state agency's & interested parties.	Health council members represent various community sectors, as outlined in the MCH Plan Act of 1991
<b>Funding:</b>	Local Collaboratives have received funding from managed care organizations (currently \$20,000). Individual LC fundraising encouraged.	Health Councils currently receive approximately \$10,000/year through the Dept. of Health
<b>Statewide Representation:</b>	2 members of each LC are considered voting and financial representatives on the Alliance (one has to attend all meetings).	Each health council is a voting member of the Alliance of Health Councils, each with a designated representative.
<b>Organizational support:</b>	Life Link manages money & is the LCA fiscal agent. Each LC access funds directly from LL to include LC stipends for consumer & family members.	NM Alliance of Health Councils is a non-profit organization with 501-c-3 status with the IRS; health council funding is managed by DOH
<b>State support:</b>	DOH currently provides one staff person to work with LC's. LCA contracts administrator for its minutes and grantwriter.	DOH Regional Health Promotion Teams work with the health councils

**LC Funds**

as of September 30, 2015

LC	Total Support	Other		Total
		Fundraising and	Grant Writer	
		Donation Funds		
1	\$2,225.01			\$2,225.01
2	\$1,600.00	\$0.00		\$1,600.00
3	\$0.00	\$312.67		\$312.67
4	\$2,052.04			\$2,052.04
5	\$110.86			\$110.86
6	\$1,050.76	\$1,196.00		\$2,246.76
8	\$475.32			\$475.32
9	\$0.00	\$1,969.21		\$1,969.21
10	\$2,050.00	\$140.53		\$2,190.53
11	\$2,139.07			\$2,139.07
12	\$346.03			\$346.03
15	\$705.98			\$705.98
16	\$434.54			\$434.54
17	\$193.55			\$193.55
18	\$875.61	\$450.00		\$1,325.61
Alliance	\$233.40	\$12,500.00	\$1,001.84	\$13,735.24
				\$0.00
	<b>\$14,492.17</b>	<b>\$16,568.41</b>	<b>\$1,001.84</b>	<b>\$32,062.42</b>

File Tab 6 Public Input  
Adjourn