Full Report

Policy Goals to Improve Behavioral Health Needs of Individuals, Employers and Communities in Rural New Mexico

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CHI
Center for Health Innovation

Center for Health Innovation, New Mexico's Public Health Institute

Table of Contents

Acknowledgments

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EXECUTIVE SUMMARY

With funding from the New Mexico Department of Health, the Center for Health Innovation engaged five rural Southern New Mexico counties in research, analysis and discussion about their healthcare workforce development needs now and in the future. The five counties included Grant, Sierra, Socorro, Catron and Valencia. Project participants included representatives from NM Department of Health-Health Promotion, health councils, hospitals, Community Health Centers, schools, universities, community organizations, Council of Governments, county government, elected officials, and others.

The six month project spanned the period from January to June 2020. The project design included: (1) secondary data analysis; (2) surveys for primary data and analysis; and (3) group discussions for identifying provider and community needs; analyzing current and projected workforce challenges; and discussing and framing system alignment and policy issues that impact needs, services, and capacity to recruit and retain the healthcare workforce.

After being presented with evidence gathered through data collection and analysis, several deep group discussions led to the identification of two primary issues that have a significant impact on the current and future healthcare workforce: (1) the growing percentage of older adults requiring a wide range of services, and (2) the need for a stronger behavioral health system. Participants also revealed two system issues that cut across both issue areas having a significant impacts on workforce development. First, there is lack of alignment between the needs of organizational providers; training, licensing and certification requirements; what services are most needed verses services that are reimbursable by insurance; state departmental policies and procedures; and NM legislation. Second, there are challenges with developing a frontline team of paraprofessionals that provide comparable work across titles, but with different training and certification requirements. Additionally, services provided only by certain paraprofessionals are reimbursable by insurances even though other paraprofessionals may receive similar training and have a comparable scope of practice. In rural communities, these people often do very much the same type of work, with the primary distinction being that some are peers and other are not peers; and some have college degrees and others have high school or associate level educational credentials.

Project participants engaged in dialogue about the two primary issues (older adults and behavioral health) with the aim of agreeing on policy directions that would address the current and future healthcare workforce needs of their communities. Participants identified seven policy goals for each issue (14 total). Each policy goal was discussed further by examining what improvements would be achieved from the policy goal, examples of similar policy strategies in New Mexico or other states, and steps needed to implement the policy goal. Next, the group prioritized the top 2-3 policy goals for each issue. The top policy goals to improve behavioral health needs of individuals, employers and communities in rural New Mexico are to:

- Develop, promote and implement a "common core curricula" covering topics required across multiple professions, and have the curricula available remotely.
- Pass legislation to allow additional behavioral health professionals (licensed, certified and/or credentialed) to receive tele-clinical supervision.

Implementation of the policy goals and strategies will be carried out by the Mid Rio Grande Economic Development Association and the Healthcare Task Force of Grant County's Community Workforce Alliance.

Policy Goals to Improve Behavioral Health Needs of Individuals, Employers and Communities in Rural New Mexico

THE ISSUE: MAXIMIZING RECRUITMENT, INTEGRATION AND RETENTION OF PARAPROFESSIONALS

Certified/credentialed professionals lacking a clinical license, also referred to as "paraprofessionals", can fill behavioral health service gaps. System changes will be necessary to ensure that a diverse workforce can efficiently and effectively meet the behavioral health needs of individuals, health service providers and communities and services can be sustained over time.

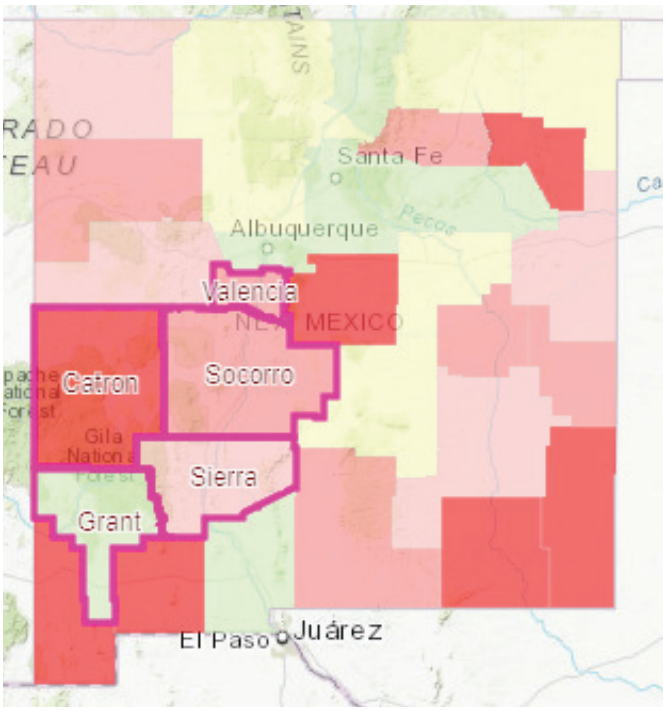
BACKGROUND

Behavioral Health in Rural New Mexico

Like physical health disparities between rural and urban areas, the U.S. also sees disparities across geographies for behavioral health. Additional burdens faced by rural communities include increased travel distance to reach health services, a lack of public transportation, and in many cases, greater rates of uninsured populations. Rural U.S. residents ages 18 to 64 years old are uninsured at a rate of 13.7% compared to their urban peers at 12.3%.

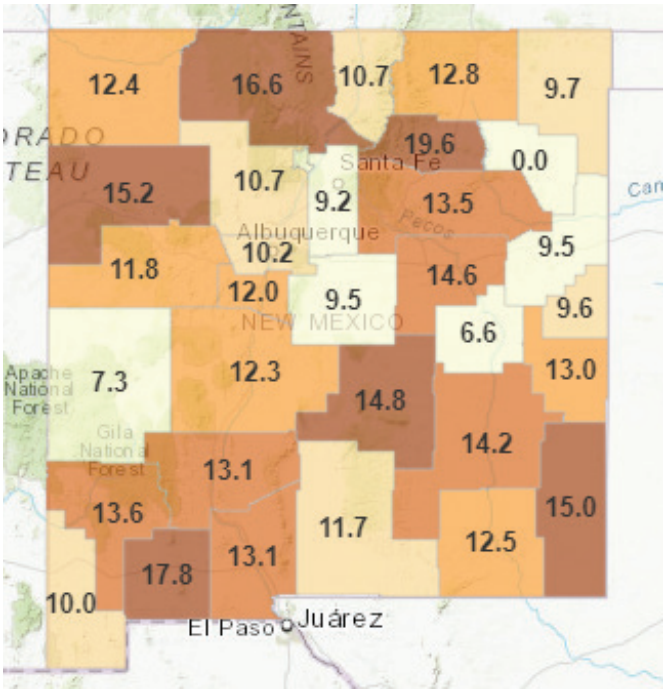
Rural areas across New Mexico experience healthcare professional shortages, including shortages of behavioral healthcare professionals and paraprofessionals, at increased rates compared to their urban counterparts. In addition, rural New Mexico Counties also experience higher rates of mortality due to drug overdose, at 26.7 per 100,000 compared to urban areas at 24.4 per 100,000.

Such trends correspond with higher percentages of residents living with substance use disorder, who need treatment services, all of which are detailed in the maps below.



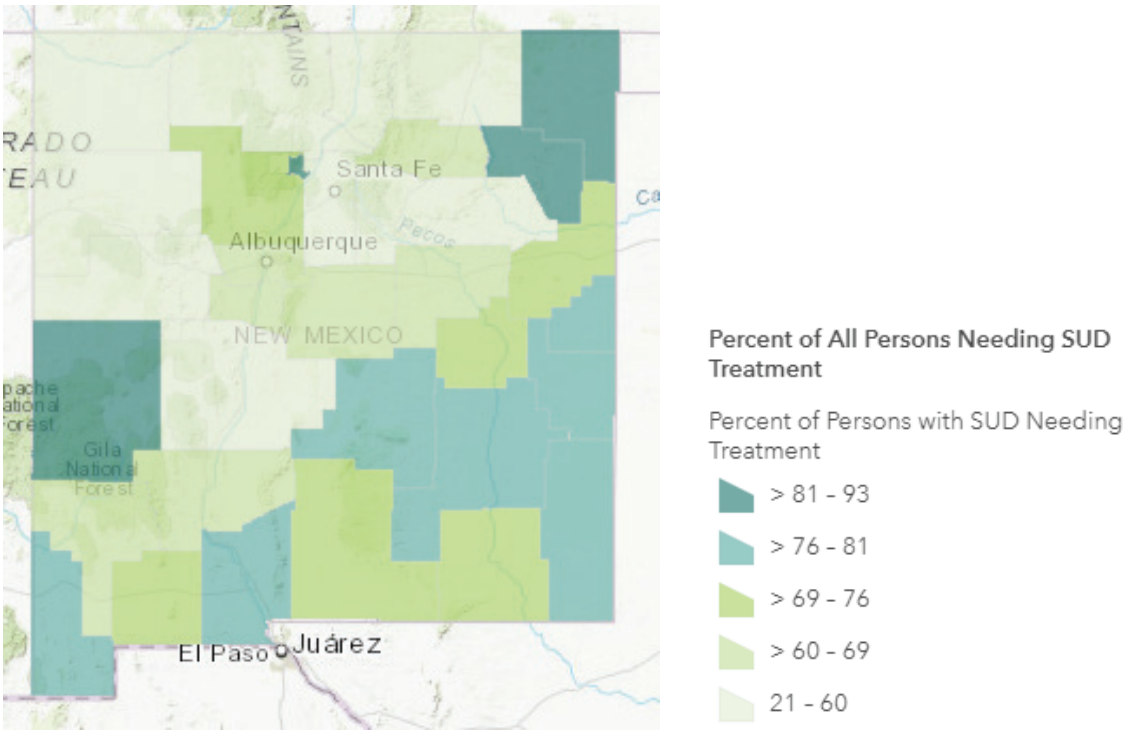
New Mexico Behavioral Healthcare Workforce Provider Shortage, by county, 2018

Map Source: New Mexico Community Data Collaborative; New Mexico Health Care Workforce Committee, 2019 Annual Report, October 1, 2019



Self-reported Mental Health Status, NM residents age 50 and older, 2011-2015

Map Source: New Mexico Community Data Collaborative; New Mexico Behavioral Risk Factor Surveillance System



Percent of Persons Needing Substance Use Disorder (SUD) Treatment, 2019

Social Determinants of Behavioral Health

Various factors contribute to behavioral health status of individuals and communities, including socioeconomic status, access to food, educational attainment, employment stability, housing status, poor physical health, and access to health and behavioral health services.[1] The table below displays how such factors differ between rural and urban areas of New Mexico.

Select determinants of metro and non-metro New Mexico counties

Characteristic	Metro Counties	Non-Metro Counties
Poverty	17.3%	22.6%
Low access to healthy foods	50.1%	70.7%
Population without High School diploma	13.1%	18.1%
Unemployment	5.7%	6.3%
Median household income	$53,000	$43,000
2-3 chronic health conditions	18.9%	22.6%
Primary care physicians per 10,000	8	5

Sources: U.S. Census Small Area Income and Poverty Estimates; National Center for Health Statistics Data Finder; U.S. Census ACS; HRSA Area Health Resource Files

Healthcare Workforce Needs

All of New Mexico is designated as a Behavioral Health Professional Shortage Area. Recruiting and retaining a qualified and diverse workforce is especially challenging in rural areas of New Mexico. There is a growing amount of research which demonstrates that integrating paraprofessionals into the healthcare workforce has multiple benefits. The use of certified/credentialed professionals, such as Community Support Workers (CSWs), Peer Support Workers (PSWs), Community Health Workers (CHWs) and others helps to provide better care, improved health outcomes and lowers costs. Use of certified/credentialed professionals also creates opportunities to grow a diverse workforce where workers come from to better reflect the culture and language of that community. A locally developed workforce will hopefully remain in their communities.

A recent survey of providers from five rural counties (see "About the Project/Study" section below) asked about current and future healthcare workforce needs. There are many common needs among these counties, as evidenced by comparisons in the chart below. What is important to note is that providers indicate high levels of current and anticipated behavioral health needs, including both licensed and paraprofessional behavioral health workers. When asked to anticipate future staffing issues and turnover levels, most providers indicated that the challenges will be greater in future years, with higher turnover levels. They anticipate higher-than-current turnover levels among behavioral health workers. Chart 1: Comparing Current and Future Healthcare Workforce Needs

Other factors influencing the behavioral healthcare workforce and delivery of behavioral health services include the following.

- Training, onsite internships and certification requirements vary among comparable paraprofessional positions, creating gaps and challenges for local providers.
- Licensing for masters' level therapists, supervision, and practicum requirements also vary, create excessive costs and burdens to providers, lengthening time from obtaining a degree to the ability to practice and bill Medicaid and other third party insurers.
- Policies are continually reshaped by successive state administrations, which creates challenges for provider organizations, and can be helpful, or limiting, depending upon the administration.
- Multiple policies and procedures developed over a decade or more are added to the HSD, BHSD and DOH systems. This creates a lack of internal and cross-agency alignment within system policies, as well as an excessive number of policies, procedures, eligibility designations and regulations. This impedes the development of access to care, Treat First approach and Crisis Home models.
- Ever changing rules, eligibility requirements, and procedures for behavioral health service reimbursement create challenges. There is inconsistency ~~in~~ among payers as to which services are reimbursable and who is an allowable service provider.

About the Study/Project:

The Center for Health Innovation (CHI) was able to engage five counties at a deep level of engagement in terms of research, analysis and discussion about healthcare workforce needs, challenges, pipeline issues, recruitment and retention. Groups were involved with rating and ranking ~~of~~ priorities, and group discussions to develop priorities and recommendations for healthcare workforce development. These priorities and recommendations address two topical areas (behavioral health and older adults) as well as the two system issues that can either facilitate or impede healthcare workforce development.

Selection

The counties selected included Grant, Sierra, Socorro, Catron and Valencia. They were selected for the following reasons:

1. They are part of a CHI Rural Communities Opioid Response Planning (RCORP) project and healthcare planning work in collaboration with Presbyterian Health Services, New Ventures Community Building, Behavioral Health Services Division (BHSD) at the New Mexico Human Services Department (HSD), Aging and Long Term Services Division (ALTSD), the New Mexico Department of Health (DOH), the regional Council of Governments (COG), and economic and workforce development groups.
2. These counties have already engaged in behavioral health systems planning work, and, due to a short project turnaround time, are the counties determined to be the most able to leverage their ongoing work to address the healthcare workforce development issues in a timely fashion.
3. Providers in the region have a history of working together in different configurations, and can leverage a broad base of cross-sector relationships.
4. There have been some excellent healthcare-economic development-education cross-sector planning projects among these counties and relationships have been established which provide a needed model for effective healthcare workforce development.

Project Leadership

The project leader is Ms. Susan Wilger, Executive Director of CHI. Rev. Dr. Anne Hays Egan, Principal of New Ventures Community Building serves as the co-lead and project consultant. Other key project personnel include: Ms. Sharon Finarelli, Consultant; Thomas Scharman, NM Department of Health Community Epidemiologist; Dr. Joan Goldsworthy, NMCDC Consultant; Ms. Emily McRae, NMCDC Consultant; Ms. Bala Salgado, CHI FORWARD NM AHEC Director; Ms. Paris Conerly, CHI Program Specialist; and Ms. Alexis Brandt, CHI Data Specialist.

Methodology

The project lead and co-lead developed the methodology, informed by the other project staff. The design includes: (1) secondary data analysis; (2) surveys for primary data and analysis; (3) group discussions for (a) identifying provider and community needs; (b) analyzing current and projected workforce challenges; (c) discussing and framing system alignment and policy issues that impact needs, services, and capacity to recruit and retain the healthcare workforce.

There have been multiple meetings on a monthly basis, from February through April, where providers from the counties discussed the needs and key issues; completed surveys; analyzed and prioritized the topic and systems issues; and developed policy recommendations. During this time, the groups also participated in a CHI Data-to-Action Training with the New Mexico Community Data Collaborative (a program of CHI) and a Policy Workshop Training and Discussion.

Because of the configuration of county working groups, these five counties divided into two primary groups which did some work separately: Grant County, and Sierra, Socorro, Catron and Valencia Counties (which form the Middle Rio Grande Economic Development Association (MRGEDA) and its Healthcare and Social Services Committee). All five counties met together for the policy work, and for the final plan development, utilizing a working group to go over the plan summary matrices and plan narrative in two working group meetings. The full group held its final meeting on June 12, 2020 to review and adopt the final plan draft.

There were several direct service providers that participated during the course of the planning process. The counties that were the most deeply engaged included Grant, Sierra and Socorro Counties. Some of the participation was impacted by the COVID-19 crisis, which took many of the core community healthcare leaders away from non-emergency work. However, even with these healthcare and economic challenges from COVID-19, a significant proportion of healthcare leaders from these counties did participate, including DOH frontline and management staff.

Community Engagement

The healthcare providers have been actively engaged in the following work to build the plan:

1. Identification of needs: through secondary data analysis work with CHI's NMCDC, surveys, and group discussions;
2. Discussion of goals and priorities: through using data for planning (Data-to-Action Workshop); surveys; group discussions; and prioritization process;
3. Analysis of key strategies and policies needed to address both provider healthcare workforce needs, as well as systemic issues that need to be addressed which impact workforce development, and healthcare workforce recruitment and retention;
4. Review and development of final plan drafts.

Implementation and Ongoing Work

The Work Group, an integrated subgroup of the larger groups, provided the priority goals for policy work to the larger group, which met on June 12, 2020. The implementation of priorities established by the partners will occur at multiple levels, by a diverse constituency of providers:

1. Local providers will work to implement specific areas of the plan, particularly those identified in the plan as provider and/or county-related.
2. Local providers will continue to meet in regional groups to move the larger policy issues forward. Goals that relate to state training, certification and licensing; policies and law; and Medicaid rules and processes will be led by the following teams:

    a. MRGEDA's Healthcare and Social Services Committee;
    b. Grant County Community Workforce Alliance (County-Council of Governments-CHI partnership);
    c. Local Health Councils.
3. In addition, CHI will be working with its state partners, including DOH, HSD, the Behavioral Health Collaborative, the Department of Workforce Solutions, the Department of Economic Development, the New Mexico Public Health Association, the New Mexico Association of Counties, and others, to address the healthcare workforce development issues. Because CHI has multiple projects and programs that address healthcare and healthcare workforce development, collaborative efforts and partnerships can continue to move key policy and system development issues forward.

POLICY GOALS

The five counties in the project shared concerns about the lack of alignment that runs throughout the local, regional and state work in both the areas of behavioral health and aging. The five counties shared these concerns in multiple group meetings, through the survey, and in workgroups that discussed the issues and policy goals. This lack of alignment includes both horizontal and vertical lack of alignment. This happens as a natural result from (1) silos created between departments at local, regional and state levels; (2) ongoing additions and changes to policies and procedures at multiple levels; and (3) a lack of alignment within and across levels and types of care. Vertical alignment includes the different levels: local, regional, state and national/federal levels. Horizontal alignment refers to the intersection across different fields or areas of work.

The alignment challenges include the following:

- Community needs and adequate levels of quality services to meet needs;
- Local government procurement and contracting practices, and lack of alignment between these and services, as well as state contracting;
- Lack of alignment between healthcare staffing needs, training available, licensing and certification requirements, and supervision requirements;
- State policy issues, contracting procedures and requirements, and funding, with challenges caused by interagency and intra-agency lack of alignment between contracting departments, excessive contracting and reporting requirements;
- Medicaid requirements, provider challenges with managing Medicaid services and billing, and need to expand options for rural providers to expand with Medicaid services in multiple settings.

These alignment issues are woven throughout the policy descriptions, resources and next steps in the following section. The following policy goals focus on improving healthcare workforce education, training, licensure and certification; healthcare workforce recruitment and retention; placement and integration; diversity; and overall system effectiveness in the areas of behavioral health.

THE PURPOSE AND LONG RANGE IMPACT OF OUR POLICY EFFORTS

A more diverse and culturally and linguistically appropriate healthcare workforce in New Mexico to address behavioral health, medical needs and social determinants.

1. Improved recruitment and retention rates of the behavioral health workforce in rural New Mexico.

2. More effective workforce integration and service delivery.
3. Increased access to a broader range of services will help to lower health care costs due to decreased emergency room visits, recidivism in detention centers, etc.
4. Economic development and growth driven by a strong healthcare workforce and broader range of reimbursable services.
5. Decreased morbidity and mortality rates resulting from mental health and substance use disorders and related risk factors through increased access to appropriate levels and continuity of care.

POLICY GOAL 1: Promote and implement a "common core curricula" covering topics required across multiple professions and to have the curricula available remotely, which Boards and agencies that certify/credential behavioral health professionals help to develop and promote.

► *Improvements Achieved by This Policy Goal*

Streamline and standardize common training requirements across credentialed/certified professions so that more individuals can receive training and work effectively.

► *Examples of How New Mexico and Other States Have Successfully Implemented This Policy*

- Various health profession education programs have addressed the creation of core curricula or standards of practice across levels of licensing, such as core curriculum for Occupational Therapists and Certified Occupational Therapy Aides licensed by the American Occupational Therapy Association (AOTA) . Other agencies, like the Interprofessional Education Collaborative (IPEC), work to develop and promote core competencies for health care and allied health professionals across a multitude of national certifying boards . Developing a "common core curriculum" for behavioral health professionals and paraprofessionals certified or credentialed in New Mexico is an innovative approach. We are not aware of any existing programs that have developed such plans to meet certification requirements of multiple behavioral health professions at the state level. Having a "common core" will allow (1) more people to achieve competency levels more quickly; (2) facilitate the movement of people across different practice areas, without having to "start over,"; and (3) strengthen the workforce pipeline across similar types of professional and paraprofessional positions.

► *Steps Necessary To Accomplish This Goal*

- CHI will identify competencies/requirements that are common across 10 certified behavioral health professions by 7/31/2020.

- Western New Mexico University will review core curricula and provide feedback. ENMU-Roswell to review.
- Share information to credentialing boards and agencies. Get their support to promote to authorized educators.
- Work with training providers to develop a "common core" curriculum.
- Identify existing authorized training providers and formats (e.g. in-person, via technology, etc.) and what it takes to bring more remote training opportunities to local communities.
- Work with employers to incentivize training towards certification/credentialing.
- Work with training providers and certification boards/ credentialing agencies to increase promotion and awareness of expanded training opportunities.

POLICY GOAL 2: Pass legislation to allow additional behavioral health professionals (licensed, certified and/or credentialed) to receive tele-clinical supervision.

Improvements Achieved by This Policy Goal

More behavioral health workers can meet supervision requirements in a shorter period of time and at less cost and receive licensure/credential/certification sooner.

Examples of How NM and Other States Have Successfully Implemented this Policy

- Precedents for telesupervision were established in New Mexico beginning in 2014. In 2019, HB 539 was passed and signed into law. This bill amended the Social Work Practice Act to allow for telesupervision of social workers, and it gave the Board of Social Work Examiners the authority to determine when telesupervision would be appropriate. Like New Mexico, several states allow for telesupervision of Licensed Clinical Social Workers; these states include Alaska, Arizona, California, Colorado, Georgia, Minnesota, Mississippi, and Montana.
- Across the country, states are expanding telesupervision for licensed behavioral health professionals. In New Mexico, the Board of Psychologist Examiners allows Psychologists to complete some of their required supervision hours virtually. Arizona allows more licensed behavioral health professionals to use telesupervision, including professional counselors, Marriage and Family Therapists, Substance Abuse Counselors, Psychologists, and Behavioral Analysts. Some states have gone even further by allowing all supervision hours to be completed via telesupervision. Utah allows Psychologists, Clinical Mental Health Counselors, Behavioral Analysts, and Substance Use Disorder Counselors to receive all their supervision hours either in-person or virtually.
- Telesupervision makes it possible to train health professionals in rural areas, where there may not be enough licensed professionals to provide consistent face-to-face supervision.

In Australia and Northern Ontario, rural health workforce training models have successfully incorporated telesupervision and distance education. By receiving supervision virtually, students are able to complete their applied training in a rural community. Research shows that health professionals who are trained in rural areas are much more likely to practice in a rural community. Models from Australia and Ontario models have successfully increased the health workforce in rural communities and have also dramatically strengthened local economies.12 By allowing behavioral health professionals to receive telesupervision, we can help New Mexico train and retain a rural behavioral health workforce. This will enable our state's healthcare leadership to address what is a growing priority: strengthening the healthcare workforce in rural areas.

- The COVID-19 pandemic has forced healthcare communities to explore new ways of delivering care and supervising health professionals. Like many states, New Mexico's Counseling and Therapy Practice Board is allowing licensed behavioral health professionals to receive supervision online for the duration of the COVID-19 emergency, provided that all telehealth activities comply with state and HIPAA regulations. Although this measure is temporary, it represents an opportunity to make tele-supervision a more permanent practice among behavioral health professionals in New Mexico.

Steps Necessary To Accomplish This Goal

- Identify which professions are in most need of telesupervision and why. Meet with licensing boards and professional associations.
- Research specific telesupervision requirements / regs/ legislation for clinical psychologists and prescribing psychologists.
- Research which specific BH licensure boards allowed tele-supervision due to COVID
- Identify which certified/ credentialed professions have supervision requirements and if tele-supervision is allowed.
- Reach out to the New Mexico Counseling and Therapy Practice Board. Determine whether the Board will continue to allow tele-supervision after the COVID-19 pandemic.
- Determine whether this can be accomplished through administrative policy change or whether it requires legislation.

NON-POLICY GOALS THAT CAN BE AIDED BY THIS EFFORT

► *Increase local training opportunities for credentialed/certified behavioral health professionals and students.*

- Promote behavioral health paraprofessional remote learning opportunities, especially in rural communities.

- Identify authorized paraprofessional training providers and ask them to increase remote learning opportunities and/or to provide more in-person raining opportunities in rural communities.
- Ask local providers to become authorized/certified trainers and provide local training opportunities.
- Work with local Area Health Education Centers and educational institutions to provide information about behavioral health career opportunities, where individuals can go in their careers, how to access career path opportunities.
- Partner with BHSD, HSD, the NM Behavioral Health Professionals Association and other providers to provide ongoing updates and solutions to HSD Medicaid Division and MCOs regarding credentialing and service reimbursement issues and delays.

► *Complete and disseminate information on all requirements for behavioral health credentialed/certified professionals.*

- Compile information on all requirements, fees and training opportunities.
- Develop and disseminate information on behavioral health career opportunities.

► *Ensure there is adequate broadband for remote learning and telehealth*

- Review current broadband system and gaps.
- Identify financial and technical resources to plan, finance and implement local broadband infrastructure
- Identify key individuals to champion local broadband infrastructure development.

► *Develop local systems and resources to provide work experience and support to the behavioral health workforce (coaches, mentors, supervision, etc.).*

- Connect local behavioral health providers willing to provide students with relevant work experience (e.g. internships, apprenticeships, volunteer experiences, etc.) with educational providers.
- Plan and implement AmeriCorps opportunities that promote behavioral health career pathways.
- Identify and promote training opportunities for potential coaches, mentors and supervisors.
- Identify and promote evidence-based or best practices for coaching, mentoring and supervision.

OTHER POLICY STRATEGIES FOR CONSIDERATION

During the course of the project there were a total of seven policy strategies identified with the top priorities listed above. An addition four policy strategies, listed below, were discussed at length and although not ranked as a top priority, they deserve mentioning.

What Organizational Providers Can Do

POLICY GOAL: Organizational service providers adopt internal policies and/or practices to improve internal systems and build capacity to deliver and administer behavioral health services. Effective practices may include but are not limited to: interdisciplinary treatment teams, local residency and internship programs, apprenticeship programs, supervision, coaching and other on-the-job training opportunities to improve the capacity of behavioral health service providers.

► *Improvements Achieved by This Policy Goal*

Better trained staff, stronger and better-integrated services and service outcomes, increased client satisfaction, better health and economic outcomes for individuals and communities.

► *Examples of How Organizations Have Successfully Implemented this Policy*

- The Access to Clinical Telesupervision New Mexico (ACTS NM) is a free program offering supervision by televideo to Licensed Master Social Workers (LMSWs) doing clinical work in agencies where supervision towards an Licensed Clinical Social Worker (LCSW) license is not offered. ACTS NM is particularly focused on rural areas of New Mexico, where there are fewer clinicians available to provide supervision. Since 2014, 24 LMSWs have finished supervision requirements through this program.
- The Behavioral Health Services Department, Children Youth and Families Department and the New Mexico Behavioral Health Collaborative partnered to develop a guide for best practices and tools for clinical supervision. The guide is available at: ClinicalSupervisionGuide_BHSD_2018 Training videos are under development and should be available in the Summer of 2020.
- The New Mexico Primary Care Training Consortium (PCTC) is working with a few communities to develop rural integrated family medicine and psychiatry residency

programs. Through HSD and other sources of support, PCTC is working with Gallup, Santa Fe, Las Cruces, Alamogordo and other communities to expand community-based physician training or residency program. Priorities include assistance in developing primary care and behavioral health services integration.

- BHSD OPRE's policies for becoming a Provider Peer Support Intern Site, for placement of PSWs following their initial training, to maximize workforce recruitment and placement.
- BHSD's training and TA resources and the Behavioral Health Collaborative resources for Medicaid providers identifying service and practice policies, standards, processes, and outcomes, to maximize effective placement and integration, and retention.
- State and national FQHC and BH models for service integration that include Medicaid and non-Medicaid funded services; BHSD's BHIZ and RISE Yes initiatives; the BHSD county-based Medicaid BH network pilot project with Rio Arriba County. This helps to maximize integration, performance quality, and retention.
- IT models developed by BH and Accountable Health Community Networks utilizing real-time interactive provider dashboards (Unite Us, Now Pow, EMR Bear, Advance MD, etc.). This improves performance and outcomes, minimizes redundancy and administrative ineffectiveness, improving retention.
- BH Network models for effective practices which provide maximum Medicaid reimbursement levels, such as assessment, group therapy, and CCSS. This maximizes reimbursement and provides ROI, with the potential to offer more competitive salaries, thus improving retention.

Steps Necessary To Accomplish This Goal

- Identify and disseminate evidence-based on-the-job training practices or models.
- Explore resources available through Area Health Education Centers, HSD Behavioral Health Services Division, NM Workforce Solutions Department or others to assist employers in designing and implementing programs.
- Promote TeleECHO peer mentoring opportunities to organizations.
- Identify, adopt and integrate elements of effective PSW services, including becoming a PSW Site, hiring, training and integrating PSWs into the system.
- Review and integrate BHSD and BHC frameworks, tools, and resources through a staff QI team and staff training.
- Update service frameworks to create better integrated services which can utilize the staff most needed and able to be recruited and trained through the workforce pipeline through staff leadership.
- Improve IT systems to improve processes and service quality, through an IT team and provider leadership for IT system development and funding.
- Utilize the internal QI team for system framework and process development.
- Provider leadership would network with other local providers in an informal collaborative or more formal network.

What Can Be Done at the Local, County and/or Regional Level

[Local and regional level efforts refer to city and county government, regional Council of Governments, etc.]

POLICY GOAL:

Provide training and technical assistance to local county governments to build greater contracting, financing and administrative capacity to provide services directly and/or through partnerships with local BH providers; strengthen the local service delivery system; and receive reimbursement for behavioral health services.

► *Improvements Achieved by This Policy Goal*

- Counties will be able to provide more and better integrated services, directly and/or through partnerships. They expand the number and types of services offered in the county (directly and through partnership), and the mix of types of funding for services (Medicaid, grants and contracts).
- Counties can receive greater support for developing and expanding behavioral health services through partnerships, and further develop Medicaid and contract revenues; state staff expand their capacity to work in this complex arena which involves cross-sector partnerships; the state is able to maximize Medicaid billing.

► *Examples of How Organizations Have Successfully Implemented this Policy*

- Sierra County's Behavioral Health Network, which is a highly delegated model where the county serves as the lead for multiple state and federal behavioral health grants and contracts, partnering with OliveTree, the local BH Hub. This includes BHSD RISE, and BHSD BHIZ state contracts; and a federal DOJ COAP grant. The RISE and DOJ COAP funding support a variety of behavioral health, jail diversion, court diversion, jail-based, and re-entry services. BHIZ supports non-Medicaid funded behavioral health prevention, early intervention, and system development work. Olive Tree is also in the process of becoming a Medicaid provider. The Sierra County Manager does not wish to create a Sierra County HHS Department, as that would duplicate already-existing behavioral health resources in a small, rural county. The model is a highly delegated partnership model, which would work well in many rural, under-resourced counties. It represents a partnership between the county, BH network hub, courts, jail, school system, health council and SUD-related local coalition.

- Grant County's partnership with behavioral health providers through multiple projects, including the BHSD RISE initiative for jail diversion, court diversion, jail-based and re-entry services utilizing the Assertive Community Treatment (ACT) model; partnerships between Grant County and Hidalgo Medical Services for a range of navigation and case management services; partnership between Grant County and the SWNM COG for an economic development plan and system building work, which includes healthcare workforce development as a priority area. This represents a partnership between the county and multiple provider "hub" organizations, including the FQHC, COG, justice system, and local university.
- Santa Fe County's CONNECT Program is an Accountable Health Community (AHC) network of over 60 partners, including professional and paraprofessional health navigators at clinics, community organizations, and city and county programs. Navigators are community health workers, volunteers, or social workers who link people to services and resources in our community. Agencies in the network are connected through a shared technology platform (Unite Us) enabling navigators to send and receive secure electronic referrals, address residents' social needs, and improve individual and community health. This is a county-funded AHC, with significant amounts of network funding coming through the county budget, grants and contracts. Medicaid billings are managed by the network providers. This represents a highly delegated and participatory network model, based upon the Social Determinants of Health (SDOHs), with navigators serving a core function.
- Rio Arriba County's Behavioral Health Network (OUR Enterprise) Rio Arriba County was the first county in the state to develop a county HHS department. OUR Enterprise is a BH Hub Network of over 20 different agencies working together to address multiple areas of MH, SUD and OUD and incorporates providers across the continuum of care, from outreach and prevention to harm reduction, early intervention, intervention (outpatient and intensive outpatient). The BH Hub is funded through a wide range of state and federal grants and contracts, which primarily support specific types of initiatives and capacity building. RACHHS is also the first county to become a Medicaid provider. RACHHS and New Ventures Community Building have developed a short white paper on policy, structural, systemic and service delivery challenges that counties face in managing grants and contracts, and becoming a Medicaid provider, which includes an analysis of county infrastructure and capacity issues; lack of alignment between DFA requirements of counties and BHSD and Medicaid requirements; and difficulties in navigating the intricacies of the Medicaid system of care. BHSD is working with RACHHS in a pilot initiative to address these structural issues, pilot system development and improvement strategies, build county capacity, and improve county-state and state interdepartmental processes.

► *Steps Necessary To Accomplish This Goal*

- Identify county governments that are interested in providing and/or expanding behavioral health services, and the model most appropriate for that county.
- Build upon the BHSD pilot with RACHHS, integrating and informing those learnings.

- Identify key barriers counties currently face when providing behavioral health services and solutions to overcome those barriers, and obtain training and technical assistance to address barriers for both counties and state bureaus.
- Support local efforts to ensure healthcare workforce is part of state and local workforce and economic development planning.
- Ensure that the leadership of county governments and NMAHC helps to shape and deliver training and TA, along with overall leadership from BHSD, BHC and DOH.

What Can Be Done at the State Level

[State level policy efforts refer to the legislature, Office of the Governor, state agencies, state licensing boards, etc.]

POLICY GOAL: Create a Task Force for behavioral health system redesign led by BHSD in partnership with the Behavioral Health Collaborative (BHC) and the New Mexico Association of Counties, with the charge of building capacity to involve counties as partners in the provision of behavioral health services and to improve economic development.

▶ *Improvements That Would be Won By Achieving The Policy Goal*

- More well integrated system of care that involves counties in ways that address the multiple potential models for county participation in behavioral health, and incorporating their needs, challenges, assets, overall capacity, and preferences for partnering with behavioral health providers.
- Better vertical and horizontal integration across county and behavioral health systems of care, which would support counties in taking a larger role in addressing behavioral health needs through integrated systems of care.

▶ *Examples of How Organizations Have Successfully Implemented this Policy*

- BHSD's partnership with Rio Arriba County Health and Human Services Dept. to conduct a pilot with a county which has developed a behavioral health hub, has billed Medicaid and is expanding its Medicaid capacity. The pilot has identified and analyzed systemic challenges that exist within counties and the state, which require system re-design, crosswalks and collaborative structures, training and TA.

- Sierra County's highly delegated partnership with the local Behavioral Health Hub, with shared planning, fund development, oversight and policymaking, with the delegation of behavioral health services to the BH Hub.

► *Steps Necessary to Accomplish this Goal*

- Continue to support the BHSD Pilot Project with RACHHS, and disseminate learnings.
- Develop partnerships between BHSD and BHC, with New Mexico Counties and the NM Alliance of Health Councils, to create a framework that exists at both state and county levels. This cross-sector network can share tools and resources; serve as a platform for supporting county-based partnerships for BH network planning and development; and support ongoing system development and funding.

POLICY GOAL: Develop cross-agency teams for contracting reform and system redesign that involve local behavioral health providers. Redesign state contracting system to focus on streamlining and aligning requirements (including data/reporting), programs and systems within and among state agencies,, vertically and horizontally, resulting in greater efficiencies and reduction in unfunded mandates

► *Improvements Achieved by This Policy Goal*

- Lower costs due to greater coordination and efficiency at the state and organizational levels. Reduce duplication of effort and unfunded mandates.

► *Examples of How NM and Other States Successfully Implemented this Policy*

- New Mexico is not alone in calling for contract reform. A 2010 national study of government contracting with nonprofit organizations found that over half of the nonprofits surveyed had experienced problems with their contracts and grants. These including late payments, changes to contracts, complex applications and reporting requirements, and insufficient payments to cover mandates and expenses.[2] This study found that in New Mexico, well over half the nonprofits reported that government contract payments did not cover the full cost of contracted services, and that these

2. ET Boris, E de Leon, K Roeger, M Nikolova. National Study of Nonprofit Government Contracting: State Profiles. The Urban Institute. https://www.urban.org/research/publication/national-study-nonprofit-government-contracting-state-profiles/view/full_report. Published October 7, 2010. Accessed June 2020.

unfunded mandates were a problem for the organization.[3] New Mexican nonprofits have also reported delays in reimbursements, inefficiency in receiving signed state contracts, challenges due to cumbersome reporting requirements, and unfunded mandates.[4] Since the state government makes up 84% of all government contracts in New Mexico, there is a significant need for state policy reform.

- The New Mexico Legislature has acknowledged the need to support nonprofits through contracting reform. In 2015, the state passed House Memorial 129, calling for an Interim Legislative Nonprofit and Public Sector Collaboration Work Group to help New Mexico improve the effectiveness and efficiency of its collaborations with nonprofits.[5] the work group was charged with studying opportunities to improve contracts, contracting processes, capacity to meet state programmatic needs, and methods to build relationships between government and nonprofits. Unfortunately, there were no appropriations or other funding resources for the study so it was never carried out.
- States have been working to take advantage of the Office of Management and Budget's 2015 OMB Uniform Guidance rules, which streamline cost allocation rules and allow nonprofits to be reimbursed for more of their direct costs.[6] Under the new rules nonprofits can use up to 10% of federal funds (it may be lower with certain types of grants) to cover indirect costs if they do not have a federal negotiated indirect cost rate. This rule applies to federal block grant or other federal funding that is granted or contracted out to not-for-profit organizations.
- The California Association of Nonprofits' Overhead Project is working to increase available funding for overhead costs, by educating both the public sector and the nonprofit community about how to better adhere to the new OMB Uniform Guidance rules.[7]
- Nonprofit associations in multiple states, including Washington, Arizona, and North Carolina, support state legislation that ensures the full cost of nonprofit services is covered by public funds dedicated to the service. These associations provide policy guidance and educational
- Approximately a dozen different State Nonprofit Associations partnered with the National Council of Nonprofits in a multi-year pilot to test out contracting reform. The strategies differed by state, from small changes to intensive system re-redesign. Illinois, which engaged in intensive system re-design, saved at least 1% of the state budget in the first year they collected outcome data, more savings projected for the future. See https://www.councilofnonprofits.org/trends-policy-issues/government-nonprofit-contracting-reform

3. Ibid.
4. S Wilger. HM 129: Nonprofit and Public Sector Collaboration. Center for Health Innovation. Published 2015. Accessed June 2020.
5. Nonprofit and Public Sector Collaboration Group, House Memorial 129 (2015). https://www.legiscan.com/NM/bill/HM129/2015. Accessed June 2020.
6. National Council of Nonprofits. Government Grants and Contracting. CouncilofNonprofits.org. https://www.councilofnonprofits.org/trends-policy-issues/government-grants-contracting. Accessed June 2020.
7. California Association of Nonprofits. Nonprofit Overhead Project. Calnonprofits.org. https://calnonprofits.org/programs/overhead/about-the-nonprofit-overhead-project. Accessed June 2020.

► *Steps Necessary To Accomplish This Goal*

- Explore the development of a State Contracting Reform Task Force. This can be done in partnership with the NM State Nonprofit Association, NM Thrives, CHI and New Ventures Community Building, which have all been working on this issue.
- Identify specific unfunded mandates required of behavioral health providers and the related costs.
- Assess the intended and unintended consequences if these mandates are not provided. Assess what the consequences of unfunded mandates have been and address with state and/or providers in community.

POLICY GOAL: Strengthen the HSD/BHSD and MCO process for managing and contracting for care coordination services. This includes increasing local provider capacity for shared care coordination and delegated care coordination functions.

► *Improvements Achieved by The Policy Goal*

- Improved client health outcomes due to services provided by a local behavioral health paraprofessionals who are familiar with local, regional and state resources.
- Local behavioral health providers have greater flexibility to provide a full continuum of services to meet client needs at the appropriate level of care.

► *Examples of How NM and Other States Have Successfully Implemented this Policy*

- New Mexico is among many states that have used the 1115 Waiver to allow for greater flexibility in Medicaid reimbursable services. The most recent revisions
- HB35, introduced in 2011,
- Peer Member Per Month/capitated rate financing (e.g. I-PACS program)

► *Steps Necessary To Accomplish This Goal*

- Conduct more research on which organizations have case management contracts with MCOs, where they are located, and the criteria for successful administration of these services.

Behavioral Health Policy At-a-Glance Summary Matrix

This Policy Matrix offers a summary of the top policy goals discussed during the project. Across the top of the matrix, there are the different levels at which each of the priority areas can be addressed, from the local provider to local government; training, licensing and certification; and state policies and procedures. There are also federal regulations promulgated by the Centers for Medicare and Medicaid (CMS) and other federal entities as well as national certification bodies for specific fields, which are not included in this matrix, but which do shape policies and procedures, and require a significant amount of time to address and modify.

GREEN = Top Priority	**Provider or Agency**	**County Government**	**Training, Certification, Licensure**	**NM State Policy**	**Medicaid**
High level of continuing need, as well as unmet need, lack of access to care. Difficulties with stigma in many communities. MH, SUD and OUD impact individuals, families, workplaces, county budgets, and local economies. More and better integrated services are needed for MH, SUD and OUD across the spectrum of care, with better local access to services.	Organizational service providers adopt internal policies and/or practices to improve internal systems and build capacity to deliver and administer behavioral health services. Effective practices may include but are not limited to: interdisciplinary treatment teams, local residency and internship programs, apprenticeship programs, supervision, coaching and other on-the-job training opportunities to improve the capacity of behavioral health service providers.	Provide funding and resources for training and technical assistance to local county governments to build greater contracting, financing and administrative capacity to provide services directly and/or through partnerships with local BH providers; strengthen the local service delivery system; and receive reimbursement for behavioral health services.	**Promote and implement a "common core curricula" covering topics required across multiple professions and to have the curricula available remotely, which Boards and agencies that certify/credential behavioral health professionals help to develop and promote.** **Pass legislation to allow additional behavioral health professionals (licensed, certified and/or credentialed) to receive tele-clinical supervision.**	Create a Task Force for behavioral health system redesign led by BHSD in partnership with the Behavioral Health Collaborative (BHC) and the New Mexico Association of Counties, with the charge of building capacity to involve counties as partners in the provision of behavioral health services and to improve economic development. Develop cross-agency teams for contracting reform and system redesign that involve local behavioral health providers. Redesign state contracting system to focus on streamlining and aligning requirements (including data/reporting), programs and systems within and among state agencies,, vertically and horizontally, resulting in greater efficiencies and reduction in unfunded mandates	Strengthen the HSD/BHSD and MCO process for managing and contracting for care coordination services. This includes increasing local provider capacity for shared care coordination and delegated care coordination functions.