Behavioral Health Collaborative CEO Report

April 14, 2016

1. Strategic Plan

The BH Collaborative kicked-off its "Strategic Initiative to Strengthen New Mexico's Behavioral Health Service Delivery System" with a day-long strategic planning session on July 30, 2015. Fifty-nine individuals responded to a call for action, and subsequently coalesced into three workgroups to focus on the identified areas of finance, regulation, and workforce. The facilitated deliberations within the workgroups laid the foundation for the detailed set of actions that have been prescribed for the following eighteen-months.

Each workgroup met on three occasions between September and December, 2015 to create specific action plans relative to each goal and objective:

- Finance Workgroup:
  1) To enhance the financial strength of the current provider network;
  2) To move toward a value-based purchasing system that supports integrated care; and
  3) To create ways for state and local governments to collaborate around fiscal issues that lead to better local systems of care.

- Regulations Workgroup:
  1) To identify and recommend how to remedy the complex and sometimes contradictory BH-related regulations and policies;
  2) To increase the ability of providers to engage with consumers more quickly and effectively; and
  3) To integrate the paraprofessional workforce into the system more broadly.

- Workforce Workgroup:
  1) To create easier entry into BH professions;
  2) To support the multi-disciplinary nature of providing integrated holistically oriented care; and
  3) To promote a future of excellence in the workforce.

The Behavioral Health Strategic Plan and its corresponding Implementation Plan have been completed. The draft was submitted to the BH Collaborative at the January meeting for review. It is being presented for formal adoption at the April 14th meeting. The Implementation Team has been meeting weekly to identify appropriate steps and timeframes for all the activities under the Goals and Objectives, and identifying individuals or groups are to assume relevant tasks.

A progress report will be presented at each quarterly meeting of the BH Collaborative through the eighteen-month implementation period. An evaluation of the Plan will be completed at the conclusion of its implementation.

2. Agave Health's Termination of BH Services

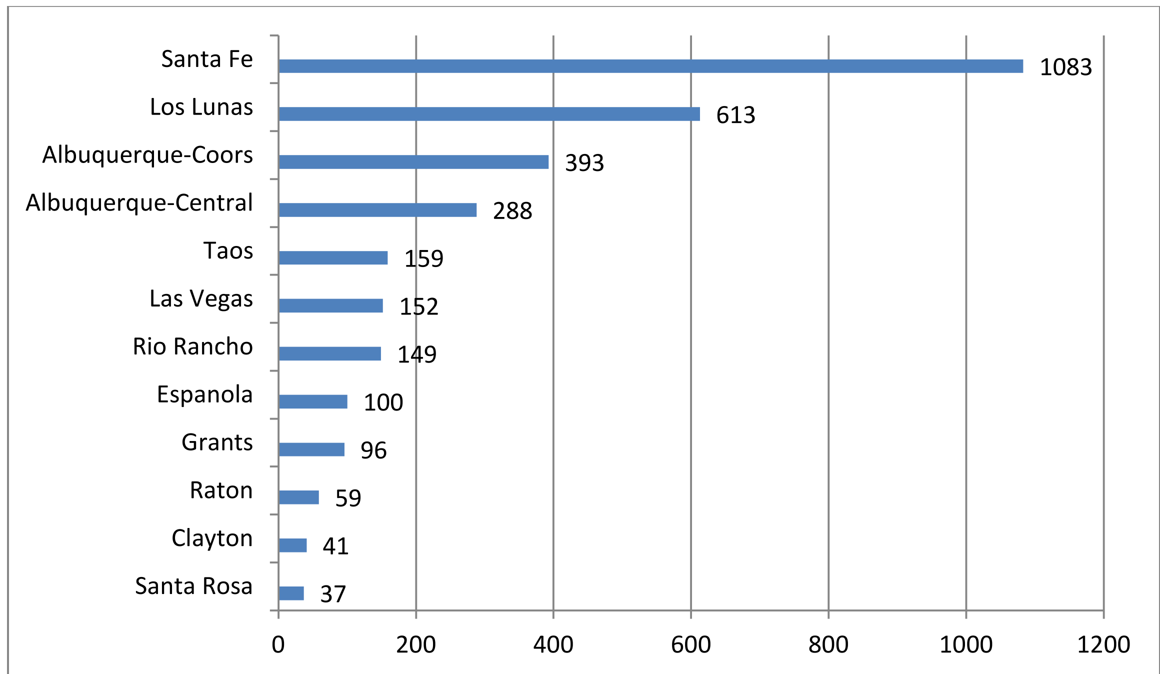
On April 1, 2016, Agave Heath's CEO, Dr. Heath Kilgore, issued a 90 day notice of contract termination to the following:

- MAD and BHSD;
- The four Centennial Care Managed Care Organizations (MCO);
- OptumHealth NM;
- Corrections Department; and
- Supportive Housing Coalition of NM.

Agave Health also issued a 30 day notice of contract termination to the following entities:

- NM Boys and Girls Ranches;
- CYFD;
- Correctional Health Partners (Immediate termination: no services are being provided); and
- DOH - Children's Medical Services

Agave Health has 12 locations in 10 counties and reports to serve 3,170 Centennial Care members. Nine of the locations deliver children's services, two deliver adult services, and one delivers services to both adults and children. Agave reported also on the number of members provided services at each location:



The MCOs and OptumHealth NM are currently reviewing the last 90-days claims data to gather information on members who will require transitioning to a new provider and will need care coordination. The MCOs will submit the information by Friday, April 15, 2016. In addition, the payors will be issuing an RFI to other provider organizations, in each service area, that have indicated an interest in assuming the services of Agave Health.

3. **NatCon2016**
   Representatives of BHSD traveled to Las Vegas, NV the week of March 7th to exhibit at the Annual Conference of the National Council Conference for Behavioral Health which had over 5,000 attendees. Recruitment of BH professionals from out-of-state was the primary purpose of this outreach effort. BHSD interacted with over 2,500 individuals who responded very positively to this promotion. A common refrain heard from attendees was, "I wish our state would do this." BHSD partnered with the NM Department of Tourism and utilized tools of engagement to include job vacancy listings and giveaways with a NM theme. In addition, the CEO of the BH Collaborative participated in a pre-conference institute on BH integration within public health.

4. **CareLink NM Health Homes**
   This system innovation is intended to enhance integration and coordination of primary, acute, BH, and long-term care services and supports for persons with chronic conditions across the lifespan. CareLink NM Health Homes involve a multi-disciplinary team that partner with enrolled members to develop and implement a service plan designed to meet all of the person's behavioral, social, and health needs. This is a patient-centered approach within which care coordination will occur at the community level for both CC enrollees and FFS. The SPA for this program has met with CMS approval and the initial roll-out of CareLink NM is occurring in San Juan County under the auspices of Presbyterian Medical Services (PMS) and in Curry County by Mental Health Resources (MHR). Following this implementation, and based on lessons learned, HSD will consider additional sites in other areas of NM, as well as, expansion of qualifying conditions to include SUD.

5. **Behavioral Health Investment Zones**
   BHSD received a $1 million allocation in FY16 for the establishment of BH Investment Zones. The two counties, Rio Arriba and McKinley Counties, were identified as the two counties in NM with the highest levels of combined incidence of mortality related to alcohol use, drug overdose and suicide. BHSD established an application process for these two counties to be designated as BH Investment Zones which qualifies each of them for $500,000 to implement a plan that will best address the needs in these priority zones. Both counties have completed and submitted their respective applications which have been approved.

   Rio Arriba County has established a coalition know as Opioid Use Reductions (OUR) as the BHIZ collaboration structure. The partners include: the lead agency, Rio Arriba County Health and Human Service Department (RACHHSD), El Centro Family Health Presbyterian Medical Services, Hoy Recovery Program, Espanola Presbyterian Hospital, Rio Arriba County Detention Center, La Clinica del Pueblo de Rio Arriba, Espanola Public Health Office, Espanola Valley School District, Agave Health, Las Cumbres Community Service, Inside Out, Valle del Sol of NM, Santa Fe Mountain Center, North Central Community Based Services, Honor of Our Pueblo Existence, Rio Arriba County Substance Treatment, Outreach and Prevention Program, Rio Arriba Youth Service Providers.

   McKinley County has developed a BHIZ oversight board that includes the City of Gallup as the Local Lead Agency, and the following authorities: McKinley County, Northwest New Mexico COG, Navajo Nation, and Zuni Pueblo. The Implementation Team includes Rehoboth McKinley Christian Health Care Services (RMCHCS), the Northwest New Mexico Council of Governments, Navajo Nation, Pueblo of Zuni, Na'nízhoozhí Center, Inc., Western New Mexico University, Health Alliance, Gallup Police Department, Gallup Fire and Rescue, and Gallup Share & Care Coalition .

6. **PAX Good Behavior Game**

The PAX Good Behavior Game (PAX GBG) has been found to reduce disruptive behaviors, hyperactivity, and emotional symptoms. Its long term outcomes include reduced need for special education services, reductions in drug and alcohol addictions, serious violent crime, suicide contemplations and attempts, and initiation of sexual activity with increases in high school graduation rates and college attendance. The most recent cost benefit analysis on the PAX GBG conducted by the Washington State Institute for Public Policy has shown that the program returns $57.53 for every $1 invested.

Dr. Dennis Embry, President of the PAXIS Institute, has presented to NM's Children's Cabinet on PAX GBG. BHSD's Office of Substance Abuse Prevention (OSAP) is coordinating plans for implementation in approximately 219 elementary grade classrooms across the state by June 30th, impacting about 4585 children. On January 11th & 12th, PAXIS Institute provided the first a two-day PAX GBG training for 35 1st grade teachers and administrators in Farmington as part of a six-school demonstration pilot project, resulting in approximately 825 students receiving PAX through the end of the school year.

One hundred and fourteen teachers and administrators participated in the Santa Fe Public Schools (SFPS) PAX training on March 18th and 19th. Eighty-two classrooms of grades K-6 will implement PAX from April 4th through May 20th, resulting in approximately 1800 students receiving PAX. Additionally, the SFPS Special Education Director has expressed an interest in having all her staff trained in PAX GBG.

Eighty-six teachers and administrators participated in four trainings for the Espanola Public School (EPS) during March. Eighty-four classrooms of grades K-3 implemented PAX GBG from April 7th through May 27th, resulting in approximately 1600 students receiving PAX in Espanola. Additionally, EPS will conduct PAX trainings during their Summer Institute. They intend to train 100 new teachers on June 15th and 16th and will offer two half-day "booster" trainings on June 17th.

A two day PAX GBG training was held for Bloomfield Public Schools on April 1st and 2nd. Eighteen 3rd grade teachers participated and began implementation April 4th through May 25th, resulting in approximately 360 students receiving PAX. In total, BHSD expects 4,585 students to receive at least seven weeks of PAX GBG by June 2016.

7. **Crisis Triage and Stabilization Centers**

Established by HB 212, a Crisis Triage and Stabilization Center is a health facility that is licensed by DOH, is not physically part of an inpatient hospital or included in a hospital's license; and provides stabilization of behavioral health crises, including short-term residential stabilization. The enabling legislation calls for HSD to establish a reimbursement structure for this new Level of Care (LOC) and provided $1.75 million towards their implementation. This is a LOC that has been missing in NM's BH service system and was recommended for establishment by the House Joint Memorial 17 Task Force.

HSD and DOH are drafting rules both for facility licensing and program reimbursement. The draft rules will allow a community to choose a variety of models of crisis triage and stabilization,

including solely outpatient or ambulatory, residential with and without detox services, not to exceed medically monitored detox (ASAM level 3.7). The facilities will be licensed by the Department of Health, and the Program will be certified by the Human Services Department, Behavioral Health Services Division. While the initial phase of such centers will focus on adults, CYFD is continuing to investigate mechanisms that would allow for similar services for youth. Avenues allowing for prospective payment mechanisms, possibly through the new CFCBHCs, are also being researched to identify other states that have used this form of payment mechanisms.

8. **New Mexico Crisis and Access Line (NMCAL)**

   In March of 2016, the NM Crisis and Access Line (NMCAL) handled 2,624 calls. This includes 1,363 calls on the Statewide Crisis and Access Line and NM calls for the National Suicide Prevention Lifeline (NSPL), 626 calls for the Peer-to-Peer Warmline, and 635 after-hours calls forwarded from NM's Behavioral Health Core Service Agencies (CSA's). While it was not always the presenting issue, concerns related to suicide were reported on 27.1% of clinical calls. During this same period, 274 NMCAL callers reported concerns about suicide – either for themselves, or for the person of concern. NMCAL clinicians work with callers to deescalate the emergency and create safety plans. Hospital or emergency services are referred to only when there is no less intrusive way to keep callers safe.

9. **Network of Care (NOC)**

   The BH NOC is now the official website for the BH Collaborative. The intent is for this website to be the one-stop-shop for everything you ever wanted to know about BH within NM. Key features of the BH NOC include a BH Learning Center which is designed to educate, inform, and provide access to the most relevant BH information available; a user-friendly client interface that enables NOC partners to easily display local content throughout the site; an advanced Social Networking platform which is designed to promote collaboration and coordination across diverse groups; and a HIPAA- and HL7-compliant, Personal Health Record which stores valuable medical and legal information and documents. This portal can be accessed at: http://www.newmexico.networkofcare.org/mh/

   Development of the BH NOC is ongoing. Newest features include Supportive Housing information and a Quality Improvement resource area that shares a broad range of documents on consumer views and study results. Coming soon will be a comprehensive portal for providers, where news, opportunities, training schedules, and resource documents on services and regulations can all be shared. For the period of March 13 through April 12, 2016, the NM BH NOC had 93 visitors per day and viewed 173 pages on average. The mean number of page visits per visitor was 1.86. A total of 5,382 pages were viewed, by a total of 2,901 visitors. The most popular service directory page in the period was Taos/Raton Valle del Sol (74 views), followed by Alternative House Inc/La Posada Halfway House in Albuquerque (55), Agave Los Lunas (53), and Agave Health in Taos (51). For BHSD page, the most frequently visited topic was OPRE (91), followed by the BH Collaborative (68) and Supportive Housing (37).

   The Veterans NOC continues to improve, sharing crucial information about services and opportunities with veterans, family members, active-duty personnel, reservists, members of the New Mexico National Guard, employers, service providers, and the community at large. This site is available at: http://newmexico.networkofcare.org/Veterans/

Other BH Collaborative member organizations are reminded that Trilogy, Inc., has other portal domains available to serve NM and they include: Seniors and People with Disabilities, Children and Families, Developmental Disabilities, Domestic Violence, Public Health, Prisoner Re-entry and Corrections, and lastly, Foster Care. The BH Collaborative strongly supports adoption of additional portals by the respective agencies and is eager to assist with their development.

10. Certified Community Behavioral Health Clinics (CCBHC)

The Substance Abuse and Mental Health Services Division (SAMHSA) selected NM as one of twenty (25) states as a recipient of the planning grant funds to establish CCBHCs. Eight (8) of the 1st year planning grant recipients will be selected as demonstration states in year two. The CCBHCs represent an opportunity for NM to improve BH by providing community-based BH treatment, to advance to the next stage of integration with physical health care, to assimilate and utilize evidence-based practices on a more consistent basis, and to provide improved access to high quality services.

Teresa Gomez has been contracted as the Project Manager and Roxane Spruce Bly as the Medicaid Contractor, Mary Ann Shaening as the Certification Contractor, and Dale Jarvis, CPA, Fiscal Consultant. Ms. Bly, along with Mr. Jarvis and Sally Wait, MAD BH Manager are all responsible for assisting in the development of a Prospective Payment System (PPS), Medicaid Administrative Rules, and State Plan Amendment (if necessary). Dr. Shaening will work with Karen Meador in BHSD to address certification standards in accordance with federal guidance and will develop the Request for Certification for providers who meet the readiness criteria as articulated in the Readiness Assessment.

The CCBHC Implementation Team has completed Readiness Assessments with six of the prospective CCBHC sites. The Team will continue working closely with these sites to develop clinic-specific PPS rates based on their cost reports, provide training on a range of related topics, and provide guidance on improving clinic readiness.

The Request for Certification is in process and incorporates the standards outlined in several federal documents. Standards are being cross-referenced to Readiness Assessment items to assure comprehensiveness and to facilitate the certification decision-making process.

UNM serves as the evaluator of this grant, and have taken the lead on gathering readiness assessment data, designing a statewide needs and gaps analysis, and ensuring timeline data entry into the SAMSHA TRAC database on a quarterly basis. UNM is also working with Steven Flint at BHSD and Dale Jarvis to construct a data request to MAD to gain Medicaid data to inform the needs assessment for each agency and statewide. In addition, UNM is working with Falling Colors Technology to develop the data infrastructure necessary for the CCBHC demonstration project. The statewide Behavioral Health Treatment Gaps Analysis Survey (Needs Assessment) has been reviewed and vetted by various stakeholder groups. UNM's Dr. Deb Altschul, Dr. Caroline Bonham and Dr. Julie Salvador will administer, collect, and analyze the statewide Needs Assessment, which will be used to inform the CCBHC demonstration proposal.

In March, the CCBHC Ad Hoc Committee was convened with approximately 25 participants representing a wide range of stakeholders. The purpose of the Ad Hoc Committee is to guide the process of certification, development of the PPS, and garner stakeholder input and endorsement of NM CCBHC adoption. The Ad Hoc Committee will meet on the 4th Wednesday of each month

during the months of April through September to guide these processes and provide critical stakeholder input.

11. **Sexual Assault Service Expansion**
An increase of funds in the amount of $205,840 was allotted to the five sexual assault programs in December, 2015. Due to budget cuts the NM Coalition of Sexual Assault Programs did not receive an increase to their budget as projected. However the NM Coalition of Sexual Assault Programs is utilizing their current annual allocation of $927,254. Services continue to be provided to consumers with a hold on the expansion of services that included prevention, promoting awareness, and enhancing treatment though increased training to service providers.

12. **Prevention "Partnership for Success" Grant**
BHSD's Office of Substance Abuse Prevention (OSAP) has been awarded this SAMHSA grant of $1.68 annually for 5 years ($8 million total) to address underage drinking and youth prescription drug abuse. The counties receiving funding through the new grant are Chaves, Cibola, Curry, and Roosevelt. These counties were selected using a data-driven analysis of risk factors and need, including youth use of alcohol and prescription drugs. Each county's coalition is undergoing a rigorous needs assessment, capacity building, and planning process to ensure that prevention strategies implemented through the new grant are successful in reducing underage drinking and prescription drug misuse in their respective communities.

The new sub-grantees attended an OSAP Recipient Meeting and New Grantee Orientation Meeting in Albuquerque in February where they received information on substance abuse epidemiological data, community level data collection, NM ATODA Prevention Workforce Trainings, the Strategic Prevention Framework process, training on Synar tobacco prevention activities, and PFS 2015 grant requirements, timelines, and expectations. Technical assistance visits for the new counties were conducted in February and a Coalition Development Training was held in March. A Coalition Development Training will be held on April 27th for the six schools of the NM Higher Education Prevention Consortium. A Needs Assessment Training is scheduled for the counties and schools respectively in April and May.

13. **National Strategy for Suicide Prevention (NSSP)**
This $1.47 million, 3 year SAMHSA grant is implemented in Bernalillo, Otero and Curry counties pilot sites, each of which have completed the first of the standardized screening and safety planning trainings. The trainings were conducted by NSSP/BHSD grant partner UNM. The target audience was BH providers in these counties and their respective surrounding counties. The trainings were well attended and sparked additional training requests. The sites are now in the process of scheduling and finalizing the second round of trainings.

Currently, BHSD and UNM are launching training for primary care and emergency departments. Training modules include a 60-90 minute presentation for physicians, nurse practitioners, physician assistant nurses; and may also be of interest to pharmacists, and administrative and clerical personnel. The primary care provider module covers information about suicidality among patients in healthcare, development of office policies and protocols, patient education, and intervention including screening and safety planning. The emergency department module covers information about suicidality among patients presenting to emergency departments, primary and secondary screening tools, suicide risk assessment, management of the suicidal patient, and discusses SAMHSA's SAFE-T Guide (Suicide Assessment Five-step Evaluation and Triage). A follow

up survey will be conducted to determine if methods were implemented, and if policy and procedures were changed as a result of the trainings.

14. Dose of Reality Campaign

This research-based statewide campaign has been launched statewide by BHSD's Office of Substance Abuse Prevention (OSAP) to raise awareness and to educate teens and their parents about the serious risks for addiction and overdose from prescription painkiller abuse. To date, 64 million Dose of Reality ad impressions have been viewed across TV, internet, digital boards, billboards, news print, and movie theater ads. Two websites provide the media materials free for public use: http://www.nmprevention.org/Dose-of-Reality/Home.html and http://doseofrealitynm.com . Included are education materials, a parent resource kit, fact sheets, and recent state and national epidemiological data. The campaign has provided 399,000 prescription bags with prevention messages to 130 pharmacies statewide.

In addition, a new media campaign was developed to increase awareness of naloxone, a medication used to reverse the effects of an opioid overdose. The campaign began in September 2015 with 353,189 ad impressions viewed across newsprint and 3,090,800 impressions heard over radio through mid-January 2016. An additional 6,826,030 impressions were released through April, to include billboard advertisements. Radio, billboards, news print, and pharmacy bags ads will continue through September, 2016. In March, the naloxone strip print ad (stating "Reverse the deadly effects of a prescription painkiller overdose" in mirror image, followed by "Ask your pharmacist about naloxone") won the American Ad Federation New Mexico Advertising Award for Great Idea.

A BHSD collaboration with Albuquerque City Councilor Diane Gibson was announced in an April 5th news conference to launch a public awareness campaign about naloxone. The public campaign has mounted A Dose of Rxeality posters at bus shelters, inside public buses and in community centers. The campaign includes providing a list of Albuquerque pharmacies dispensing naloxone, and distributing information brochures to community service providers.

Information about prescription opioids, signs of an overdose, and patient education videos can be accessed at: http://doseofrealitynm.com/2015/08/31/more-info-about-naloxone/ . Media materials are available for download on the website.

15. Cognitive Enhancement Therapy (CET)

CET is an evidence-based cognitive rehabilitation training program for adults with chronic or early-course serious mental illness such as schizophrenia or schizoaffective disorder who have prominent impairment in decision making, initiation of activities, and motivation associated with their illness. CET offers a combination of computer skills training, group sessions and individual coaching sessions to improve neuro-cognition, social cognition, and social adjustment and is associated with improvements in quality of life. Each week, clients participate in a weekly group education session, group computer skills training, and a weekly individual coaching session. Lea County Guidance Center (LCGC), Mental Health Resources (MHR) and UNM are the provider sites for this NM CET. LCGC has trained 3 clinicians in this model and is running two CET education groups. During the CET education groups, consumers support each other and pair up as they learn new skills. UNM has trained 6 clinicians and is running two CET education groups. MHR trained 2 clinicians and is running one CET education groups. This model continues to receive

positive feedback from clinicians and participating consumers. One CET clinician stated "I see significant, positive changes in the individuals who have been participating in CET".

16. Administrative Improvement Projects

a. Critical Incident Reporting (CIR) Workgroup
   A BH sub-workgroup has convened to work on improving definitions and process for BH CIR. The workgroup will make recommendations to BHSD to define, track and trend CIR that are identified as sentinel events. This revised process will align with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards. If accepted the new protocol will provide the mechanism to ensure the safety and well-being of those receiving BH services. This project is intended to streamline and reduce the administrative burden for BH providers by targeting concerns that require further attention by the relevant authorities.

b. Administrative Burden Reduction Workgroup (ABRWG)
   ABRWG continues to address items that can reduce the administrative burden of providers. The major focus of ABRWG is on creating efficiencies by adopting more common MCO provider network training, monitoring, reporting, and auditing processes. To this end, ABRWG has agreed to task smaller workgroups based on recently solicited information on the top five administrative burden concerns from the NM Hospital Association, NMBHPA, Nursing Facility Association, and Long Term Care Association. The concerns were assigned to the following workgroups for study and recommendations:
   - Site Reviews;
   - Prior Authorizations and Concurrent Reviews;
   - Joint MCO trainings; and
   - Manual Claims Reviews.

c. Medicaid BH Workgroup
   Applications for certification of Behavioral Health Agencies (Medicaid Enrollment Provider Type BHA-432) for Clinical Supervision continue to be accepted. The process includes a Certification Attestation form that guides providers through the requirements and which is submitted along with an application request, a review of the organization's policies and procedures, a review of the clinical supervision program, and a subsequent site visit when the initial requirements have been determined to be met. There are initial educational materials provided to each applicant and technical assistance offered.

   Over the course of two months, approximately half of all applications submitted have been processed; all applications have received an initial review with most still requiring further technical assistance. Approximately 40 of 75 non-independent licensee applicants are now rendering services which serves to expand service capacity. The application process is being streamlined to reduce the time required for review from 60 days to 30 days or less. This includes a consideration for "deemed status" if national and/or international clinical supervision certification have been acquired; provider networking to learn from other's successful clinical supervision programs; and developing a self-survey readiness tool to help providers determine what gaps they may need to address before completing their application.

   The updated definition of a BHA-432 and rule change is still pending.

d. BH Provider Guidance

An important part of building capacity in our BH workforce is helping providers understand the BH system and how to navigate it. The BH Provider Guide is a significant part of the plan to do so. It is in its draft stage and set to be released for review and comment to relevant stakeholders, including the BH Provider Association, by the close of April. In addition, our first educational summit for new Master level students at local universities is being planned for the Fall Semester of 2016 in Albuquerque. This will give an opportunity for those students entering into Master's level programs for Social Work, Counseling, or Psychology to learn about becoming a provider in NM. The content will include specialty certifications, licensure, rendering services in both public and private practice settings, state regulations and practice information, types of providers and services in the state, and how to navigate the current system structure. The plan is to review the feedback from this summit in order to develop a similar program for the Spring Semester.

17. Naloxone Pharmacy Technical Assistance

BHSD's Office of Substance Abuse Prevention has contracted with the Southwest CARE Center to provide technical assistance to NM pharmacies currently reimbursed by Medicaid to dispense naloxone, a medication used to reverse the effects of an opioid overdose. On-site technical assistance focuses on increasing patient/customer access to naloxone, increasing the number of pharmacists credentialed to dispense naloxone, and reducing pharmacy barriers to dispensing and billing for the medication. OSAP's A Dose of Rxeality media campaign works to coordinate with and supply this project with corresponding media materials. The release of the March 18th pharmacy standing orders for naloxone has spurred collaboration with DOH's Prescription Drug Overdose Prevention Program. SW CARE and DOH are working with the NM Pharmacy Association to develop CEUs for the technical assistance provided by Southwest CARE and are developing a "pharmacist on call" program to launch in early April to further assist pharmacists to increase access to naloxone.

18. FY16 Withdrawn Initiatives due to State Budget Crisis

- Prescription drug collection boxes which would have provided a monitored source of disposal for many unused and improperly stored prescription opiates often sitting in home medicine cabinets;
- Prescription drug incinerators would have provided local communities and law enforcement agencies with a means to collect prescription painkillers and dispose of them without problems associated with bio contamination, theft, transportation and transfer;
- Mobile Crisis Response Teams, that were planned for McKinley and Rio Arriba Counties, would have diverted those in BH crisis from psychiatric hospitalization, would have linked suicidal individuals discharged from the emergency department and hospitals to community-based services; and would have also provided diversion from arrest and subsequent jailing;
- NM Supported Employment BH Center of Excellence would have built a supported employment service capacity in NM using an evidence-based best practice;
- NM Peer Empowerment Center would have been peer managed and operated to serve the recovery needs of youth, family, and peers whether veterans, first responders, law enforcement, corrections, or emergency room staff who require recovery supports for PTSD and other related conditions;

- Behavioral Health Planning Council (BPHC) was slated to receive additional funding to develop and implement an orientation and mentorship program that would have included an orientation manual for new members; and a small portion of this additional funding was to be used to support the designated BHPC members who review and analyze the Block Grant Application and other reports;
- Local Collaborative Alliance (LCA) was also slated for additional funding to match its resource development achievements to support capacity-building and infrastructure development; and
- Mesilla Valley Hospital Addiction Recovery Center would have supported the expansion of services to include partial hospitalization, residential, and IOP treatment.

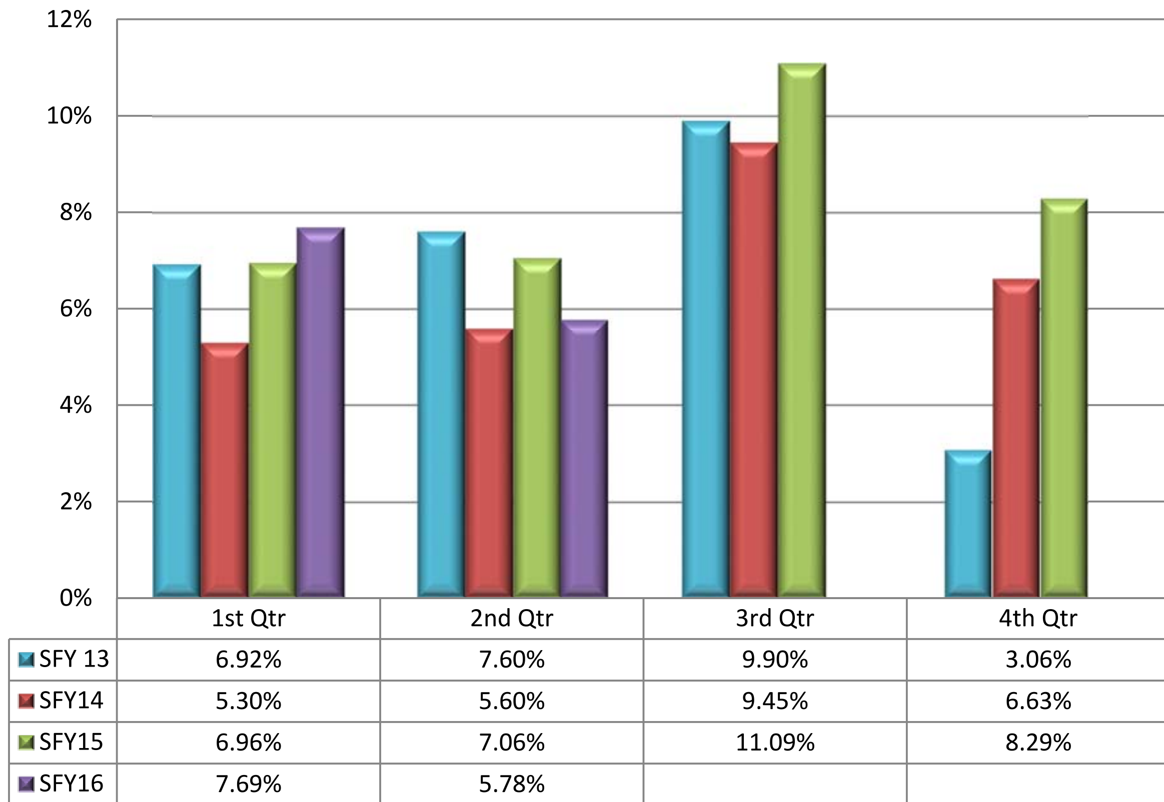
Behavioral Health Collaborative Second Quarter FY 2016 Performance Measures

COLLABORATIVE: Children with Improved Level of Functioning at Discharge

Strategic Goal: Improve Behavioral Health Services
Measure: Percent of readmissions to the same level of care or higher for children or youth discharged from behavioral health residential treatment centers and inpatient care.

SFY 16 Target: **5.0%**
SFY 16 2nd Quarter: **5.8%**

Comments: The data reflects performance across the four MCOs. It does not include Medicaid Fee-For-Service clients or non-Medicaid clients. In the 2nd quarter, there were 519 youth discharges from Residential and Inpatient facilities; this is a 0.2% decrease from the 520 discharges in the SFY 2016 1st quarter. Thirty youths (5.78%) were readmitted to a same or higher level of care within thirty days. This is a 24.84% decrease in readmission percentage from the SFY 2016 1st quarter. The newest quarter's results may underestimate admissions and/or subsequent readmissions due to delays in claims submission or processing by providers and MCO's. The Performance Review Team will be reviewing the trends to assure continued improvements, with strong emphasis on increasing post-discharge follow-up treatments to prevent readmissions.



	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
SFY 13	6.92%	7.60%	9.90%	3.06%
SFY14	5.30%	5.60%	9.45%	6.63%
SFY15	6.96%	7.06%	11.09%	8.29%
SFY16	7.69%	5.78%		

Data Sources and Methodology:

1. *Data Source:* Centennial Care Report #5 on Readmission.
2. *Methodology used to collect data*: Recipients of this service are identified by CPT, diagnosis, and revenue codes. The report includes all children under the age of 21 who are receiving services through Medicaid and discharged from a Residential Treatment Center (RTC) and then readmitted to the same or higher level

of care within 30 days of discharge. Transfers within the same RTC are not considered a discharge and re-admittance. Multiple discharges and re-admittances for the same recipient are counted, but only if the re-admittance is within 30 days of the discharge. Partial hospitalization (non-resident) is not considered a higher level of care.

3. *Responsible persons*: Quality Improvement Committee
4. *Timeframe for data collection and reporting*:

Data Validity:

1. *Methodology used to determine data validity and reason used*: The External Quality Review Organization (EQRO) validates managed care encounter data periodically.
2. *Appropriateness of the measuring instrument*: OHNM is required to provide quarterly reporting on RTC re-admissions as part of their contractual performance measures with the Medical Assistance Division.

Data Reliability:

1. *Methodology to determine reliability*: Validation of claim and payment accuracy is through the Payment Error Rate Measurement Program (PERM); (b) Periodic OIG review of reasonability of the methodology.
2. *Reliability of the Measure*: Reliable.
3. *Limitations of data*:

Comprehensive Measure Definition: Same level of care: A patient admitted into an RTC or facility within 30 days of discharge from an RTC. Higher level of care: A patient admitted into an inpatient psychiatric hospital within 30 days of discharge from an RTC.

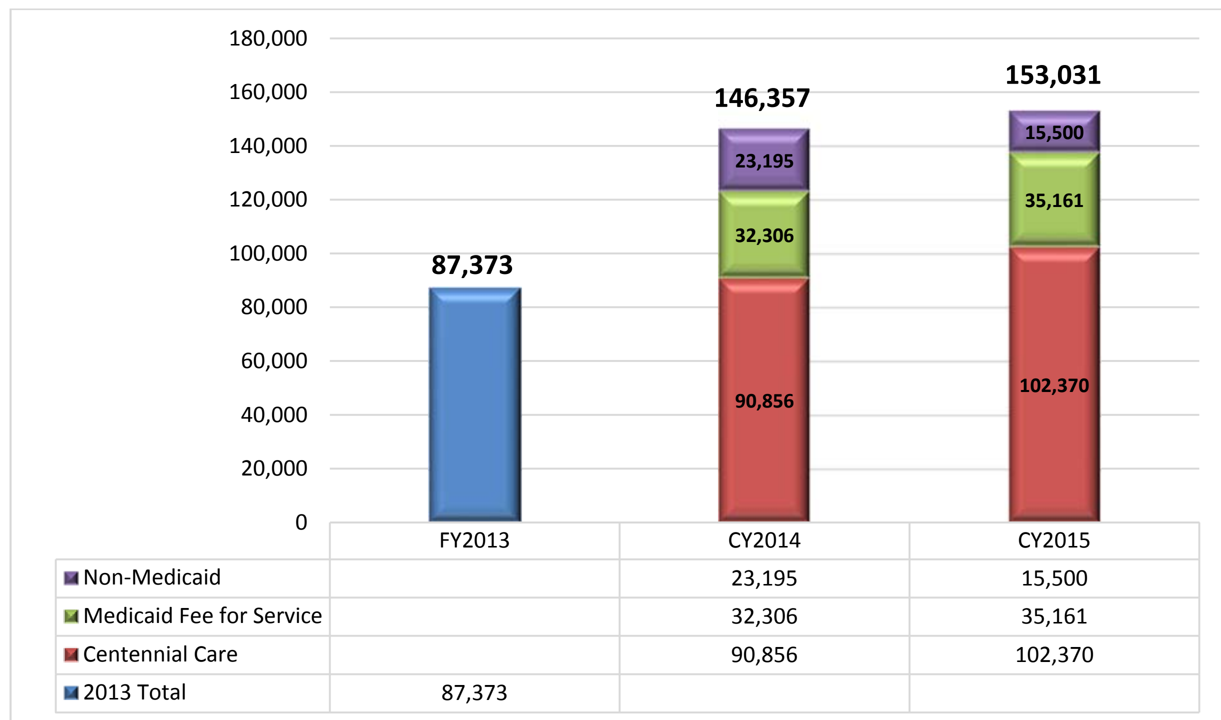
Collaborative: Improve Behavioral Health Services

Strategic Goal: Improve Behavioral Health Services
Measure: Number of individuals served annually in substance abuse and/or mental health programs administered through the Behavioral Health Collaborative, Centennial Care and the Medicaid Fee-For-Service Programs.

FY 16 Target:	**110,000**	**General Appropriation Act Measure**
FY16: 1st Quarter (CY15 Q4):	**153,031**	**(January-December 2015; see comments)**

Comments: This measure tracks unduplicated count of individuals served over a 12-month period. We continue to see increased use of behavioral health services since the implementation of Centennial Care and the expansion of Medicaid to those under 138% of the federal poverty limit (FPL). With this change, we are now tracking utilization by calendar year, and the data presented here reflects that shift.

The chart below provides a comparison of calendar years 2015 and 2014 to fiscal year 2013. Of the 146,357 persons who received behavioral health services during CY 2014, 23,195 individuals (or 15.9%) were served by non-Medicaid* funds. Centennial Care recipients make up 62.1% (90,856 members) of the total served. Medicaid Fee-For-Service recipients represent 22.1% (32,306 persons) of the total served. Of the 153,031 persons who received behavioral health services during CY 2015, 15,500 individuals (or 10.1%) were served by non-Medicaid* funds. Centennial Care recipients make up 66.9% (102,370 members) of the total served. Medicaid Fee-For-Service recipients represent 23.0% (35,161 persons) of the total served. Since the implementation of Centennial Care, there has been a 67% increase (58,984 individuals) in persons receiving behavioral health care in comparison to SFY 2013 (*see* note). The 2015 counts are preliminary, based on claims submitted within thirty days after the year's end.



	FY2013	CY2014	CY2015
Non-Medicaid		23,195	15,500
Medicaid Fee for Service		32,306	35,161
Centennial Care		90,856	102,370
2013 Total	87,373		

Overall, the 2015 data shows a continued increase in behavioral health clients served, with 4.6% more clients receiving services than in 2014, based on preliminary 2015 data. Centennial Care showed a 12.7% rise in clients served, and fee-for-service Medicaid showed an 8.8% rise. For Non-Medicaid services, there was a 33.2% drop in the number of clients served, believed to reflect increased Medicaid coverage for populations that non-Medicaid services formerly served.

The counts shown for 2014 in this report differ from those reported in early 2015, reflecting improved and corrected reporting of behavioral-health-specific service counts by the MCOs since that time, and refinements in OptumHealth claim processing to prevent duplication of client counts when service providers incorrectly routed Medicaid claims to OptumHealth in 2014 rather than to Medicaid. The updated counts are more accurate and precise, and they constitute a more reliable measure of clients served than earlier, preliminary values did, for future reference and for meaningful comparison to 2015 reports.

*Non-Medicaid: Includes behavioral health services funded from state general funds and federal funds administered by BHSD, CYFD and NMCD.

Data Sources and Methodology:
Data Source: BHSD Data Warehouse, Reports from the Medicaid Fee for Service office, and the Medicaid unduplicated counts from Centennial Care Report #41.

1. *Methodology used to collect data*: Claims-based data from payment systems
2. *Responsible persons*: Quality Improvement Committee
3. *Timeframe for data collection and reporting*: Quarterly reporting, 30 days after the quarter.

Data Validity:

1. *Methodology used to determine data validity and reason used*: The OHNM system can produce a total of unique unduplicated consumers served. The Centennial Care Report #41 identifies the unduplicated count of persons served in each of the four MCOs
2. *Appropriateness of the measuring instrument*:

Data Reliability:

1. *Methodology to determine reliability*: Claims data are the most accurate measure of the numbers of persons served.
2. *Reliability of the Measure*: Reliable. *Limitations of data*: Currently, we are not able to unduplicate client counts across the three data bases (i.e., Medicaid Managed Care, Medicaid Fee-For-Service and the Non-Medicaid data.)

Comprehensive Measure Definition: Number of unduplicated individuals served in the report period.

<u>COLLABORATIVE: % of adults with major depression receiving care</u>

Strategic Goal: Improve Behavioral Health Services
Measure: Number of adults diagnosed with major depression who received continuous treatment for 180 days with an antidepressant medication.

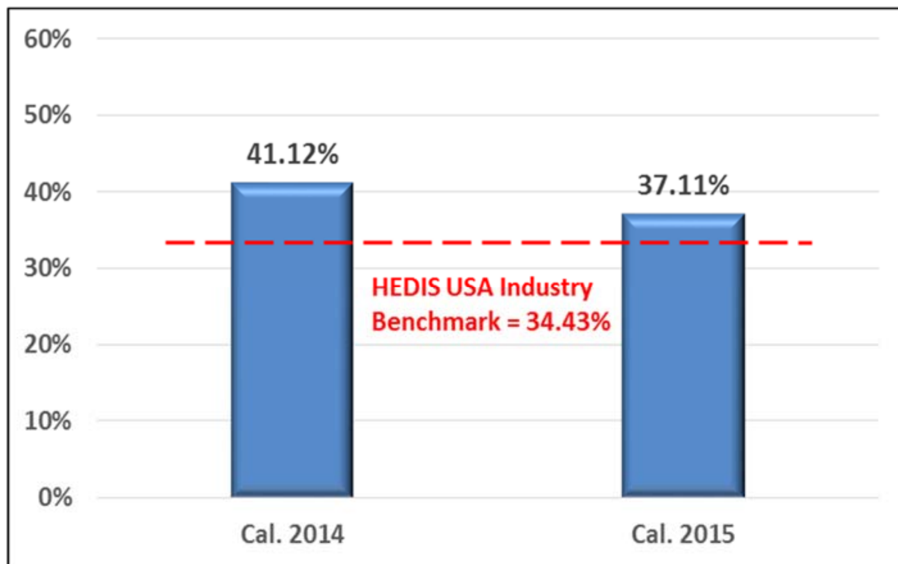
SFY 16 Target:	**375**	
SFY 16 2nd Quarter:	**4,720**	**Cal. 2015 Q1-Q4 Cumulative: 37.11%**
SFY 15 Actual:	**2,048**	

Comments: This is a new measure being collected for Medicaid members only. It is a HEDIS measure collected by the Centennial Care MCOs, and annual reports are submitted six months after the end of each calendar year. Starting in SFY 2016 the MCOs submit quarterly interim measurements based on preliminary data, showing calendar year-to-date cumulative values by quarter. The calendar 2015 Q1-Q4 (corresponding to SFY 2016 Q2) preliminary cumulative percentage was 37.11%, exceeding HEDIS national average of 34.43%, and approaching the 2014 New Mexico value of 41.12%. A final cumulative percentage will become available in April, 2016.

Because the 2015 value is calculated based on six-month compliance with medication after a prescription resulting from a diagnosis between May 2014 and April 2015, the quarterly values prior to the final calendar year 2015 quarter will show smaller percentages, since many of the diagnosed patients from that diagnosis period will not yet have had six months elapsed after the prescription date.

The Quality Improvement Committee will partner with the Quality Assurance Bureau of MAD to identify the barriers to raising the percentage further.

Note: While this target and measure are expressed in language referring to the number of adults diagnosed, percentages represent a more meaningful planning and comparison tool. It is a measure reported annually because of the May-April timing cycle prescribed in the HEDIS definition, but quarterly measurements allow some interim assessment of progress on the annual cycle.



Data Sources and Methodology:

1. *Data Source:* MCO data reports.
2. *Methodology used to collect data*: Analysis of population diagnosis and claims data.
3. *Responsible persons*: Medical Assistance Division, Quality Assurance Bureau.
4. *Timeframe for data collection and reporting*: Annual.

Data Validity:

1. *Methodology used to determine data validity and reason used:* This is a HEDIS (Healthcare Effectiveness Data and Information Set) national quality measure.
2. *Appropriateness of the measuring instrument*: This is a HEDIS measure for Effective Continuous Phase Treatment (180 days.)

Data Reliability:

1. *Methodology to determine reliability*: This is a HEDIS measure.
2. *Reliability of the Measure:* This is a HEDIS measure for Effective Continuous Phase Treatment.
3. *Limitations of data*: The method of calculating outcome is limited to only those individuals with a diagnosis of major depression.

Comprehensive Measure Definition:

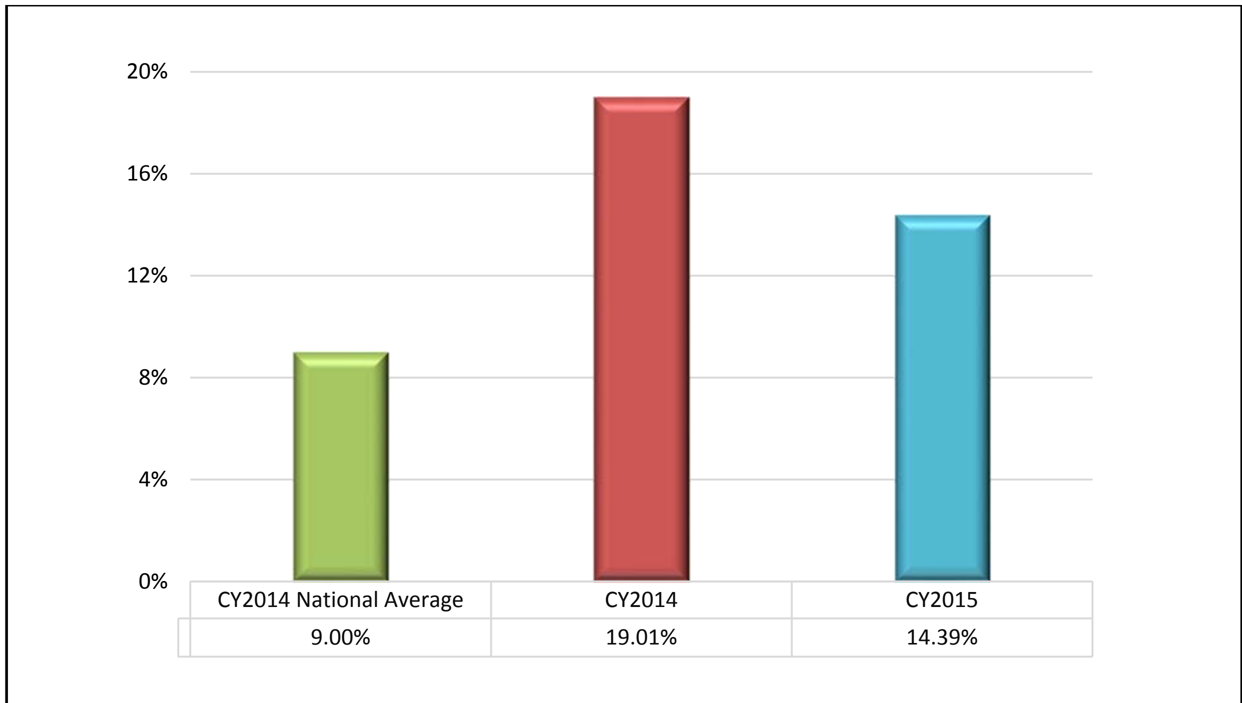
The number of members 18 – 64 years old who were treated with an antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 180 days, (6 months).

COLLABORATIVE: Number of Persons Receiving Substance Abuse Services

Strategic Goal: Improve Behavioral Health Services
Measure: The percentage of people with a diagnosis of alcohol or drug dependency that initiated treatment and received two or more additional services within 30 days of the initial visit.

SFY 16 Target: 35%
SFY 16 2nd Quarter: 14.53% (6 months) Semi-Annual measure
SFY 15 Actual: 19.01%

Comments: This was a new semi-annual measure for SFY 2015. The measure targets a cohort of individuals who initiated substance abuse treatment and were still engaged in care 30 days after initiation. The measure is part of the National Healthcare Effectiveness Data and Information Set (HEDIS), reported annually by the New Mexico Medicaid Managed Care Organizations, and, for the first time, data from the MCO's for Calendar 2014 is now available. HSD has requested quarterly interim measures for annual HEDIS values from the MCOs, starting with quarterly data for 2015. Joining that data for Centennial Care behavioral health clients with OptumHealth records for non-Medicaid behavioral health clients shows a preliminary count of 30,446 clients who had initial substance abuse diagnoses, of whom 4,425 individuals (14.53%) completed at least two additional services within 30 days. That compares to 19.01% for 2014, when 4,427 of 23,289 individuals completed two additional services. The federal Health and Human Services Department reported a 9% national benchmark for this measure for 2014, so New Mexico's levels exceed the national benchmark for both years. Fee-for-Service Medicaid clients are not included in these counts, since HEDIS measures are not available for that population at this time.



Data for this measure, now including Medicaid Centennial Care data, show a lower proportion of follow-up services, among a much higher count of diagnosed clients, compared to prior reports' data on non-Medicaid clients only. A number of factors influence this effect:

- As Centennial Care moved beyond its 2014 Transition Year, dependence on alcohol or other drugs is being diagnosed by Centennial Care providers far more often than before, very often in physical health settings. Improved diagnosis in integrated care settings is an important step forward, in part because the diagnoses can affect the course and effectiveness of physical health treatments. However, physical health providers do not necessarily always have the means to facilitate strong engagement in substance abuse treatment after diagnosis.
- Since Medicaid offers a restricted range of services for adults needing substance abuse treatment, its clients may have sought treatment services outside the Medicaid system, using non-Medicaid, VA, IHS, local, non-profit, DWI offender, other insurance, or private treatments that would not be reflected in MCO claims data and therefore would appear as cases without follow-up in their measurements.
- A shortage of Medicaid-eligible provider capacity might limit clients' and providers' ability to secure those two additional services within 30 days.
- Medicaid clients who received substance abuse diagnoses may have originally sought treatment for a separate health issue, such as for physical health conditions or injury, and they may lack motivation at that time to follow up on their substance abuse diagnosis, as compared to non-Medicaid clients who self-select for willingness to seek behavioral health care by their act of seeking non-Medicaid assistance.

HSD will seek to improve performance on these measures by improving coordination of MCO and provider efforts, including trying to increase use of non-Medicaid services to fill the gaps in Medicaid substance abuse service coverage availability, as much as is feasible given other demands on those funds. As well, HSD will investigate methods to better measure follow-up from services outside the range of Medicaid and non-Medicaid coverage, in order to quantify the extent that follow-up does happen but is not being measured in HSD claims systems.

Data Sources and Methodology:

1. *Data Source:* BHSD Data Warehouse using claims data and MCO HEDIS reports.
2. *Methodology used to collect data*: Analysis of population diagnosis and claims data.
3. *Responsible persons*: Quality Improvement Committee.
4. *Timeframe for data collection and reporting*: Semi-annual.

Data Validity:

1. *Methodology used to determine data validity and reason used:* This is a HEDIS measure.
2. *Appropriateness of the measuring instrument*: The measure is similar to the HEDIS measure for effective engagement in alcohol or drug (AOD) treatment.

Data Reliability:

1. *Methodology to determine reliability*: This is a HEDIS measure.
2. *Reliability of the measure:* The measure is similar to the HEDIS measure for effective engagement in AOD treatment.
3. *Limitations of data*: The method of calculating outcome is limited to only those non-Medicaid individuals with an AOD diagnosis.

Comprehensive Measure Definition:

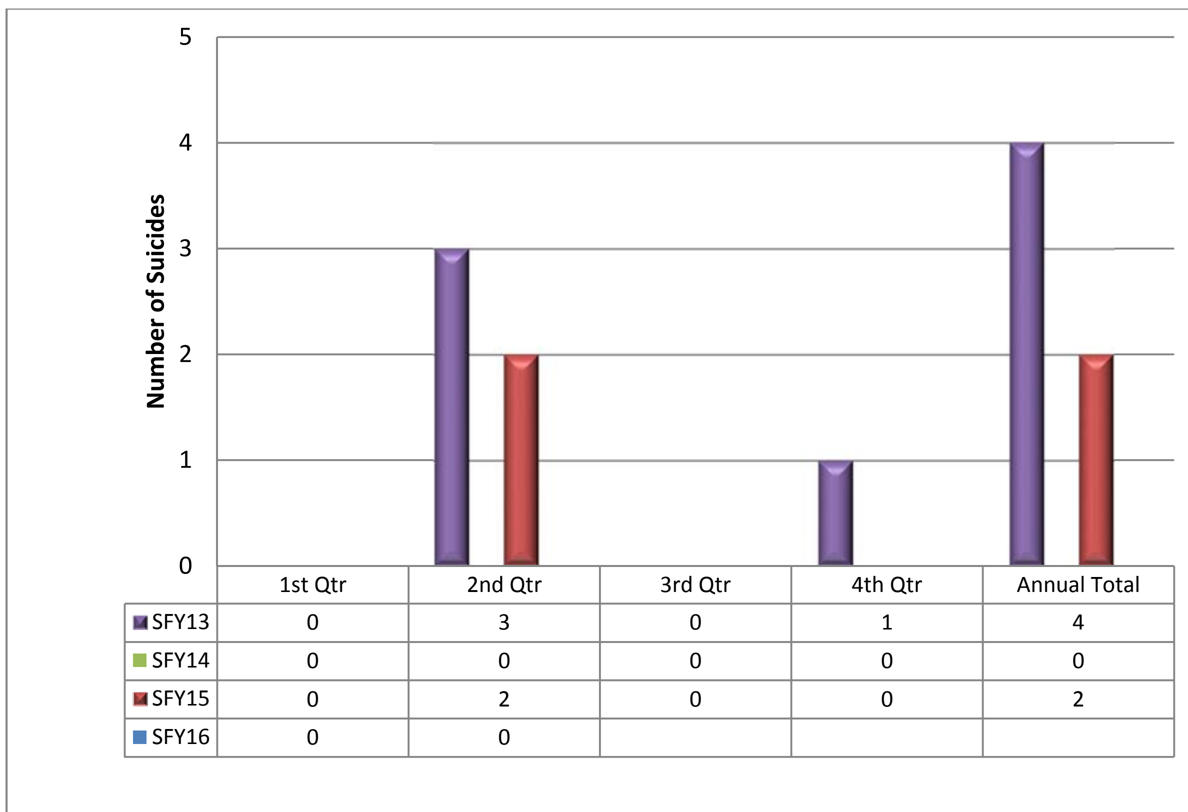
This includes Individuals with selected Alcohol and Drug Dependence diagnoses. *Initial treatment* counts clients who have had no claims with diagnosis of AOD dependence for a period of 60 days prior to start date. *Engagement in treatment* will count those clients who, after initial treatment, received two or more inpatient admissions, outpatient visits, or intensive outpatient services with any AOD diagnosis within 30 days after start date.

COLLABORATIVE: To improve prevention and harm reduction

Strategic Goal: Improve Behavioral Health Services
Measure: Number of suicides among youth served by the Behavioral Health Collaborative and Medicaid programs.

FY 16 Target: 2
FY 16 1st Quarter: 0
FY 15 Actual: 2

Comments: No suicides were reported during FY 16 2nd quarter among this age group served by Behavioral Health Collaborative and/or Medicaid programs.



	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Annual Total
SFY13	0	3	0	1	4
SFY14	0	0	0	0	0
SFY15	0	2	0	0	2
SFY16	0	0			

Data Sources and Methodology:

1. *Data Source:* OHNM Report CI-4 Critical Incidences and Centennial Care Report #36 Critical Incidents (via the Sentinel Events sub report)
2. *Methodology used to collect data*: Collected through the Critical Incident System managed by OHNM and by the Centennial Care MCO's
3. *Responsible persons*: Quality Improvement Committee
4. *Timeframe for data collection and reporting*: Quarterly data available 30 days after the quarter.

Data Validity:

1. *Methodology used to determine data validity and reason used*: Death registration has a high degree of validity for the registration of a death and age of the decedent. Validity hinges on the correct reporting of cause of death. In some cases, the medical investigator is unable to determine the cause of death and lists it as undetermined. It is also possible that some deaths ruled as accidents (unintentional injuries) may

actually be suicides. Death registration files are checked for completeness, including the cause of death and demographic data that is submitted. Corrections may be requested from the funeral home where the demographic portion of a death registration is completed, or from the attending physician or OMI, who complete the cause of death portion of the registration, when incomplete or erroneous information is submitted on a death certificate.

2. *Appropriateness of the measuring instrument*:

Data Reliability:

1. *Methodology to determine reliability*: Death registration is considered to have a high degree of reliability. After investigation, OMI determines the cause of death, which is reviewed by the New Mexico Vital Records and Health Statistics nosologist and further reviewed by nosologists at CDC's National Center for Health Statistics (NCHS). Additionally, statisticians, epidemiologists, and researchers at DOH, OMI and NCHS analyze suicide data to determine what type of changes may occur from one year to the next. Before publication, death rates are calculated at least twice to check for accuracy and reliability in the calculation.
2. *Reliability of the Measure*: Reliable
3. *Limitations of data*:

Comprehensive Measure Definition: As stated.

COLLABORATIVE: Improvement in the Continuity of Care

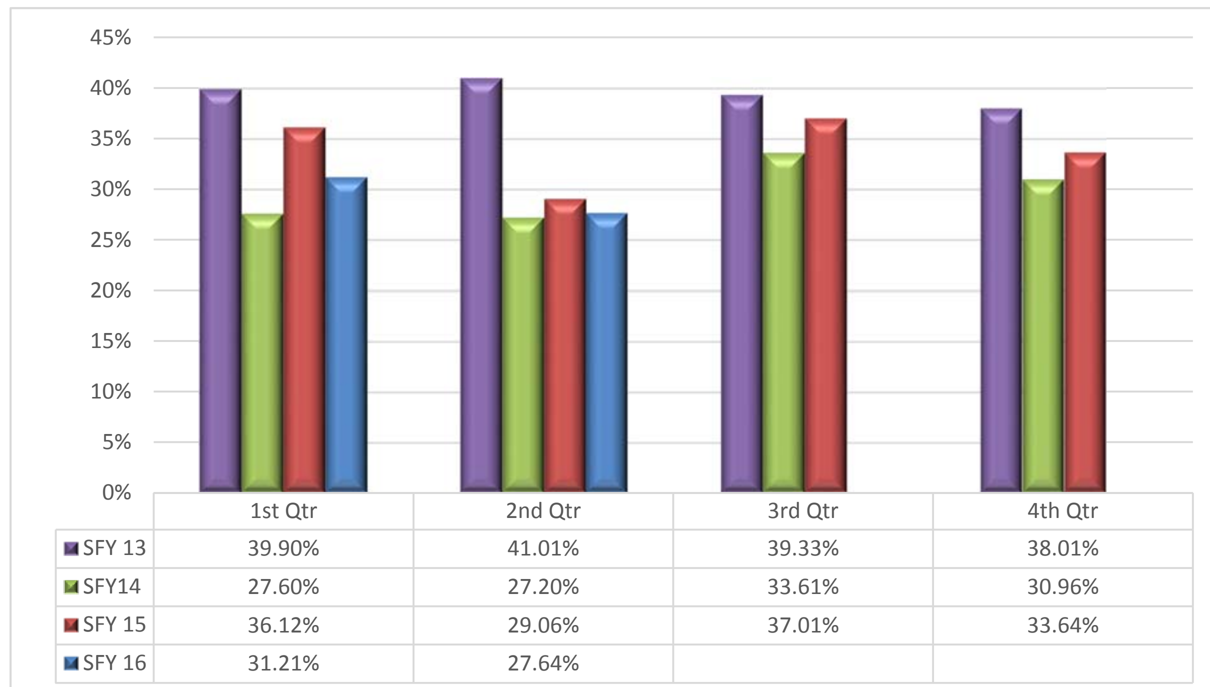
Strategic Goal: Improve Behavioral Health Services

Measure: Percent of individuals discharged from inpatient facilities who receive follow-up services within seven days.

SFY 16 Target:	**45%**
SFY 16 2nd Quarter:	**27.64%**
SFY 15 Actual:	**33.04%**

Comments: This measure includes only Medicaid Centennial Care members. In SFY 16 2nd quarter, there were 1,230 inpatient discharges, a 23.2% drop from the discharges in the prior quarter (1,602). In 340 of those discharges (27.6%), the individuals were seen for follow-up within 7 days of discharge from the inpatient psychiatric facility. The apparent drop in discharges for the most recent quarters is likely due in part to routine delays in submitting inpatient care claims. Similarly, the apparent drop in 7-day follow-up percentage is likely due in part to delays in claims for follow-up appointments.

The Quality Improvement Committee is leading a Performance Review Team (PRT) with the intent of meeting or exceeding the established target, and MCOs are working aggressively on improving discharge planning and follow-up coordination, to improve outcomes and prevent costly re-admissions. The MCOs are placing discharge coordinators on-site at major facilities to improve discharge-planning, and they are having their care coordinators work more closely with hospital discharge planners and follow-up care providers to improve transportation and appointment attendance. The PRT is assembling national standards documents on discharge planning best practices for the MCOs, hospitals, and providers to consider, and it has launched review committees on discharge medication practices and data analysis protocols to improve use of best practices. HSD has prioritized improvement on this measure in contracts with the MCOs, and HSD's Carelink and Certified Behavioral Health Clinic initiatives include follow-up services as special priorities for their work. The PRT anticipates further work on provider coordination, in collaboration with CYFD, DOH, the MCO's, and the Provider Association.



	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
SFY 13	39.90%	41.01%	39.33%	38.01%
SFY14	27.60%	27.20%	33.61%	30.96%
SFY 15	36.12%	29.06%	37.01%	33.64%
SFY 16	31.21%	27.64%		

Data Sources and Methodology:

1. *Data Source:* Centennial Care Report #5 for follow-up.
2. *Methodology used to collect data*: The report provides information on continuity of care for those hospitalized with an acute episode of mental illness. It estimates the percentage of patients age six (6) years of age and older who were hospitalized for selected mental disorders and who were seen on an outpatient basis by a mental health provider within seven days after their discharge from hospital.
3. *Responsible persons*: Quality Improvement Committee.
4. *Timeframe for data collection and reporting*: Quarterly in the second month following each quarter.

Data Validity:

1. *Methodology used to determine data validity and reason used*: The Centennial Care Report #5 describes the methodology of data used.
2. *Appropriateness of the measuring instrument*:

Data Reliability:

1. *Methodology to determine reliability*: Data are reviewed and trended by the Quality Improvement Committee of the collaborative.
2. *Reliability of the Measure*: Reliable.
3. *Limitations of data*:

Comprehensive Measure Definition: The percentage of recipients age six (6) years of age and older who were hospitalized for selected mental disorders and who were seen on an outpatient basis by a mental health provider within seven days after their discharge from the hospital.

COLLABORATIVE: Improvement in Continuity of care

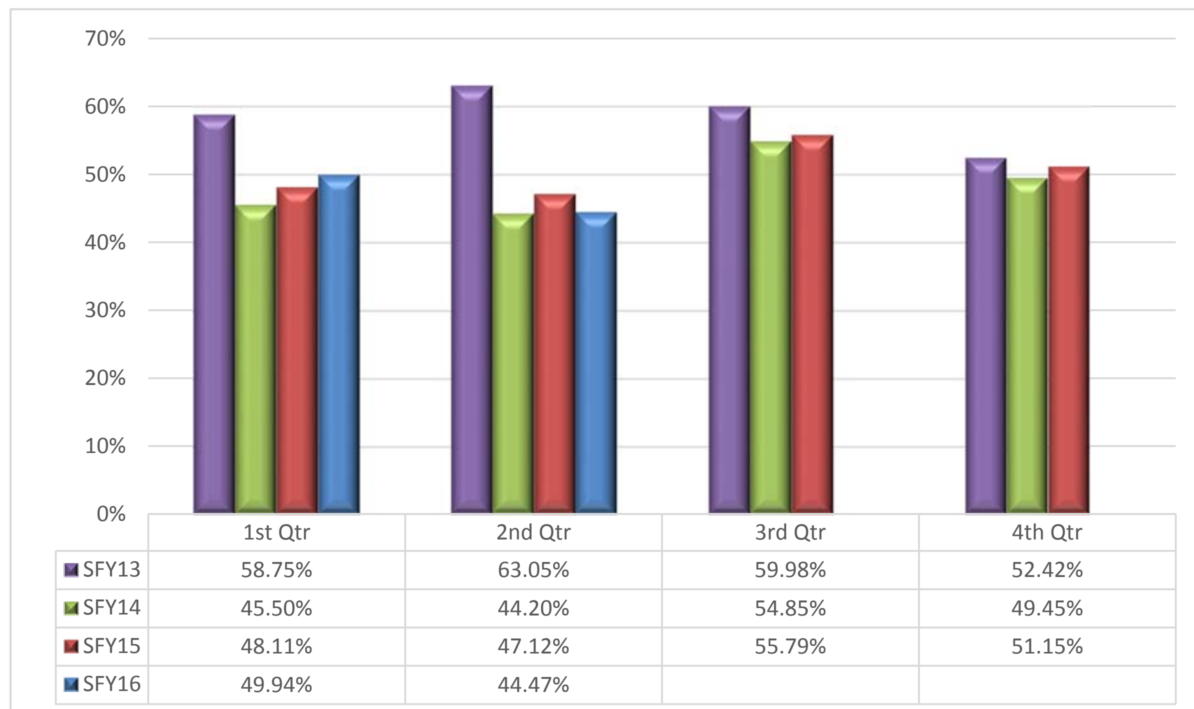
Strategic Goal: Improve Behavioral Health Services

Measure: Percent of individuals discharged from inpatient facilities who receive follow-up services within thirty days**.**

SFY 16 Target: 65.0 %
SFY 16 2nd Quarter: 44.47%
SFY 15 Actual: 49.28%

Comments: This measure only includes Medicaid members. In SFY16 2nd quarter, there were 1,272 inpatient discharges, a 23.2% decrease from the discharges in the prior quarter (1,602). In 547 of those discharges (44.47%), the individuals were seen for follow-up within 30 days of discharge from the inpatient psychiatric facility. The drop in discharges for the most recent quarters is likely due in part to routine delays in submitting inpatient care claims. Similarly, the apparent drop in the 30-day follow-up percentage is likely due in part to those delays.

The Quality Improvement Committee is leading a Performance Review Team (PRT) with the intent of meeting or exceeding the established target, and MCOs are working aggressively on improving discharge planning and follow-up coordination to improve outcomes and prevent costly re-admissions. The MCOs are placing discharge coordinators on-site at major facilities to improve discharge-planning, and they are having their care coordinators work more closely with hospital discharge planners and follow-up care providers to improve transportation and appointment attendance. The PRT is assembling national standards documents on discharge planning best practices for the MCOs, hospitals, and providers to consider, and it has launched review committees on discharge medication practices and data analysis protocols to improve use of best practices. HSD has prioritized improvement on this measure in contracts with the MCOs, and HSD's Carelink and Certified Behavioral Health Clinic initiatives include follow-up services as special priorities for their work. The PRT anticipates further work on provider coordination, in collaboration with CYFD, DOH, the MCO's, and the Provider Association.



	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
SFY13	58.75%	63.05%	59.98%	52.42%
SFY14	45.50%	44.20%	54.85%	49.45%
SFY15	48.11%	47.12%	55.79%	51.15%
SFY16	49.94%	44.47%		

Data Sources and Methodology:

1. *Data Source:* Centennial Care Report #5 on follow-up.
2. *Methodology used to collect data*: The report provides information on continuity of care for those hospitalized with an acute episode of mental illness. It estimates the percentage of recipients age six (6) years of age and older who were hospitalized for selected mental disorders and who were seen on an outpatient basis by a mental health provider within 30 days after their discharge from the hospital.
3. *Responsible persons*: Quality Improvement Committee.
4. *Timeframe for data collection and reporting*: Quarterly, 2 months after the quarter's end

Data Validity:

1. *Methodology used to determine data validity and reason used*: The Centennial Care Report #5 describes the methodology of data used.
2. *Appropriateness of the measuring instrument*:

Data Reliability:

1. *Methodology to determine reliability*: Data are reviewed and trended by the Quality Improvement Committee of the collaborative.
2. *Reliability of the Measure*: Reliable.
3. *Limitations of data*:

Comprehensive Measure Definition: The percentage of recipients age six (6) years of age and older who were hospitalized for selected mental disorders and who were seen on an outpatient basis by a mental health provider within 30 days after their discharge from the hospital.

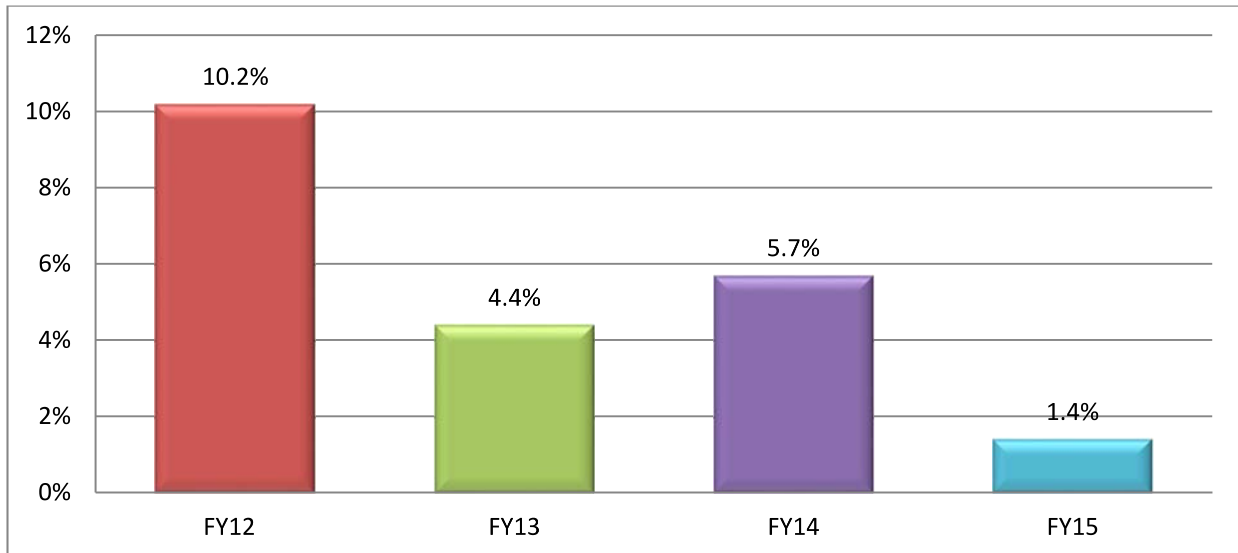
COLLABORATIVE: 8th Grade Math Proficiency Gap

Strategic Goal: Improve Behavioral Health Services
Measure: Reduction in the gap between children in school who are receiving behavioral health services and their counterparts in achieving age appropriate proficiency scores in math (eighth grade).

SFY 16 Target: 10.9%
SFY 15 Actual: 1.4%
SFY 14 Actual: 5.7%

This is an annual measure.

Comments: The SFY 2015 actual measure is significantly below the SFY 16 target of 10.9%. There was only a 1.4% gap in math among the 8th graders who were receiving behavioral health care as compared to their counterparts who do not receive behavioral health care. Public Education Department's goal is to reduce the gap to 5% by 2020. The progress is encouraging. HSD is investigating the ways that changes in Medicaid and other behavioral health service eligibility and availability enlarge or alter the population demographics of children involved, and ways that those changes might interact with their education achievement in general and the measured gap for eighth grade mathematics in particular.



Data Sources and Methodology:

1. *Data Source:* Public Education Department.
2. *Methodology used to collect data*:
3. *Responsible persons*: Cindy Gregory, Evaluation Unit, PED and the Quality Improvement Committee.
4. *Timeframe for data collection and reporting*: Annual. Scores are calculated in November.

Data Validity:

1. *Methodology used to determine data validity and reason used:*
2. *Appropriateness of the measuring instrument*:

Data Reliability:

1. *Methodology to determine reliability*:
2. *Reliability of the Measure*: Reliable
3. *Limitations of data*:

Comprehensive Measure Definition: This measure is calculated on the percent of 8th graders who achieved proficiency. Students who received behavioral health services in the prior year are compared to a virtual control group from the same school district, including grade level, gender, ethnicity, ELL, special education, and free or reduced cost lunch eligibility who did not receive services. The percentages reflect the gap in proficiency between the two groups. Goals are projected to the year 2020, at which time the gap is targeted to be narrowed to 5% or less.

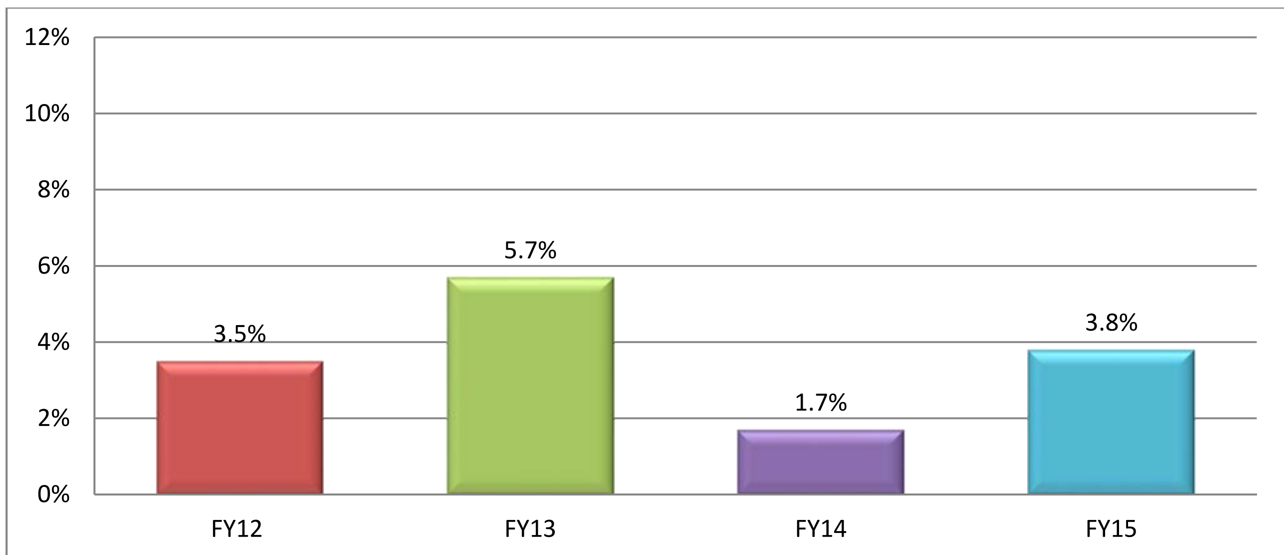
COLLABORATIVE: 5th Grade Reading Proficiency Gap

Strategic Goal: Improve Behavioral Health Services

Measure: Reduction in the gap between children in school who are receiving behavioral health services and their counterparts in achieving age appropriate proficiency scores in reading (fifth grade).

SFY 16 Target: **7.2%**
SFY 15 Actual: **3.8%** **This is an annual measure.**
SFY 14 Actual: **1.7%**

Comments: For SFY 15 there was a 3.8% gap in reading among the 5th graders who were receiving behavioral health care as compared to their counterparts who do not receive behavioral health care. This is significantly below the SFY 2016 target, a trend we hope to show has been maintained when annual data for SFY 16 are available. The SFY 15 measure is already better than PED's 2020 goal of 5%. The increased gap for SFY 2015 relative to SFY 2014 is under investigation.



Data Sources and Methodology:

1. *Data Source:* Public Education Department
2. *Methodology used to collect data*:
3. *Responsible persons*: Cindy Gregory, Evaluation Unit, PED and the Quality Improvement Committee.
4. *Timeframe for data collection and reporting*: Annual. Scores are calculated in November.

Data Validity:

1. *Methodology used to determine data validity and reason used:*
2. *Appropriateness of the measuring instrument*:

Data Reliability:

1. *Methodology to determine reliability*:
2. *Reliability of the Measure*: Reliable
3. *Limitations of data*:

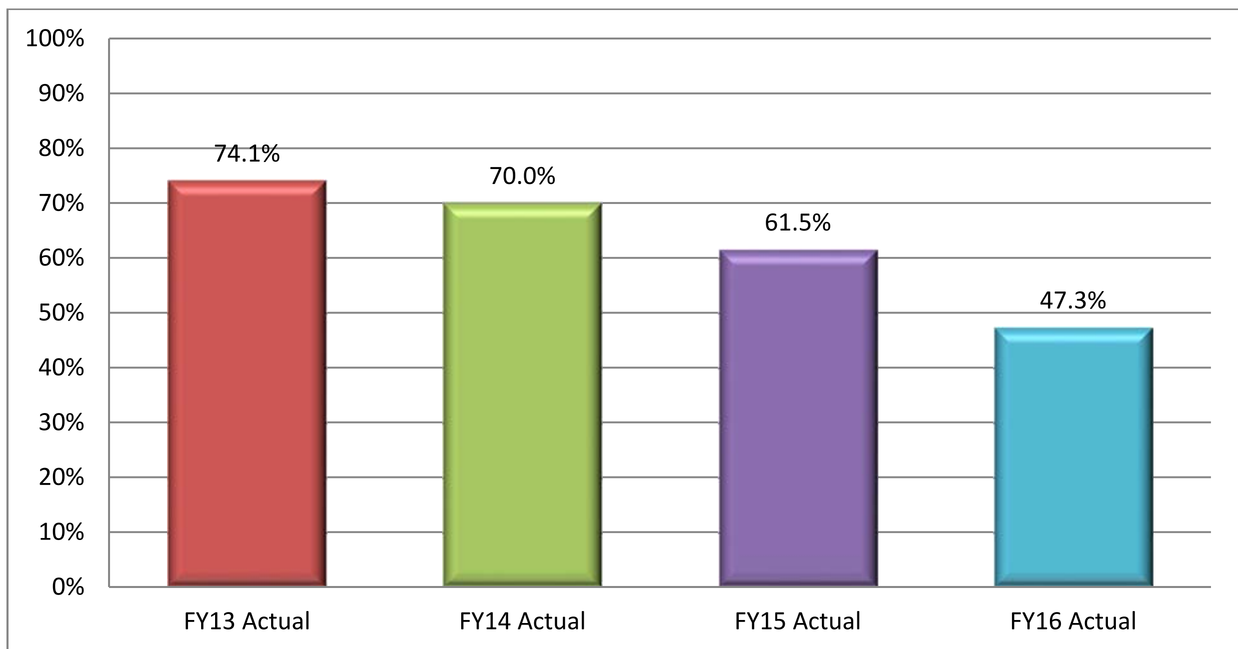
Comprehensive Measure Definition: This measure is calculated on the percent of 5th graders who achieved proficiency. Students who received behavioral health services in the prior year are compared to a virtual control group from the same school district, grade level, gender, ethnicity, ELL, special education, and free or reduced cost lunch eligibility who did not receive services. The percentages reflect the gap in proficiency between the two groups. Goals are projected to the year 2020, at which time the gap is predicted to be 5% or lower.

<u>COLLABORATIVE: % of Adults Satisfied with Housing Supports</u>

Strategic Goal: Improve Behavioral Health Services
Measure: Percent of adults with mental illness and/or substance abuse disorders receiving services who report satisfaction with staff's assistance with their housing need.

FY 16 Target: 75%
FY 16 1st Quarter: 47.3%
FY 15 Annual: 61.5%

Comments: This is an annual measure and data will be available in September, 2016.
The Annual Consumer and Family/Caregiver Satisfaction Survey is administered by the Behavioral Health Collaborative during the current state fiscal year for services provided in the previous state fiscal year. Within it, there is a subscale addressing housing. In 2015, our methodology changed. The subscale was modified to focus <u>only</u> on those respondents who indicated that their housing situation was <u>getting in the way</u> of their mental health/recovery. This is a smaller subset of all surveyed, one that includes only those who self-select as clearly <u>having more problems</u> with their housing. Even so, about one-half of them (47.3%) indicated that they were satisfied with their support in treatment for housing issues. The question was phrased to ask "*When I had a housing problem, the staff helped me solve it.*" If the staff tried to help but failed due to housing shortages, the consumer might well disagree with the statement despite the staff's high efforts, so the response could be below the target due to shortages in available housing options, to insufficient assistance from providers' staff, or both



Data Sources and Methodology:
1. *Data Source:* Annual Consumer and Family Satisfaction Survey.
2. *Methodology used to collect data*: Telephone survey of a randomly selected sample of consumers receiving care in the fiscal year studied.
3. *Responsible persons*: The Behavioral Health Collaborative through the Steering Committee for the Consumer Youth and Family Satisfaction Project.

4. *Timeframe for data collection and reporting*: Annual. Data collection conducted in summer and final report available in late September.

Data Validity:

1. *Methodology used to determine data validity and reason used*. A Housing Subscale was created of four items. The scale has a reliability score of .821 on the Chronbach Alpha test.
2. *Appropriateness of the measuring instrument*:

Data Reliability:

1. *Methodology to determine reliability*:
2. *Reliability of the Measure*: Reliable
3. *Limitations of data*:

Comprehensive Measure Definition: For individuals who responded "Yes" to the survey item "*Is your housing situation getting in the way of your mental health/recovery?*", analysis is conducted on three subsequent survey questions that are treated as a Housing Subscale.

1. *Housing needs were part of my/my child's treatment plan.*
2. *If I had a housing problem, the staff helped me solve it.*
3. *My housing situation has improved.*

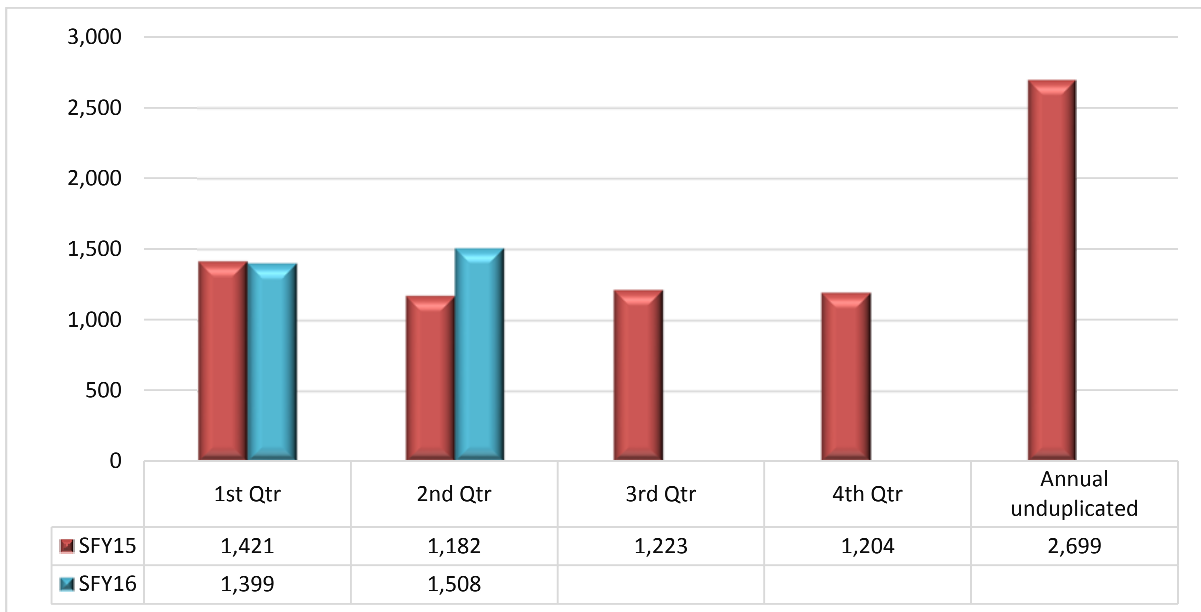
The percentage reflects the proportion of responses that were either "*Strongly Agree*" or "Agree".

COLLABORATIVE: Number of Persons Receiving Services through Telemedicine

Strategic Goal: Improve Behavioral Health Services
Measure: Increase in the number of persons served through telehealth in the rural and frontier counties.

SFY 16 Target: 1,500
SFY 16 2nd Quarter: 1,508
SFY 15 Actual: 2,699

Comments: This is a Medicaid service. While this is a quarterly measure under Centennial Care, there have been some modifications required in the current calculations of this report. The data represents an unduplicated count per quarter and an annual unduplicated count. In any one quarter of SFY 2015, over 1,200 persons were served through telemedicine in rural and frontier counties. In SFY 2015, 2,699 unduplicated persons were served in these counties. This serves as a solid baseline against which to monitor expansion of telemedicine services going forward. For the 2nd quarter of SFY 2016, the MCO's reported 1,508 clients served, an increase of 7.8% from the 1st quarter of SFY 2016, for which the MCO's reported 1,399 clients served. The 2nd quarter value is likely to undercount persons served slightly, as the claims submission for the quarter is not yet complete at the time of its calculation.



	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Annual unduplicated
SFY15	1,421	1,182	1,223	1,204	2,699
SFY16	1,399	1,508			

Data Sources and Methodology:

1. *Data Source:* Centennial Care Report #54. For FY2015 and FY2016, this data came from an Ad Hoc report of all MCO's.
2. *Methodology used to collect data*: Analysis of claims data.
3. *Responsible persons*: Quality Improvement Committee
4. *Timeframe for data collection and reporting*: Quarterly

Data Validity:

1. *Methodology used to determine data validity and reason used:* Service claims count of telehealth services is a valid measure
2. *Appropriateness of the measuring instrument*: It is appropriate.

Data Reliability:

1. *Methodology to determine reliability*: Service claims count of telehealth services is a reliable measure. Data are refreshed on a quarterly basis
2. *Reliability of the Measure:* It is a reliable measure.
3. *Limitations of data*: Specific to Medicaid members only.

Comprehensive Measure Definition:

Report captures member utilization of behavioral health telemedicine services cumulatively across reporting periods. It differentiates members residing in rural and in frontier counties.

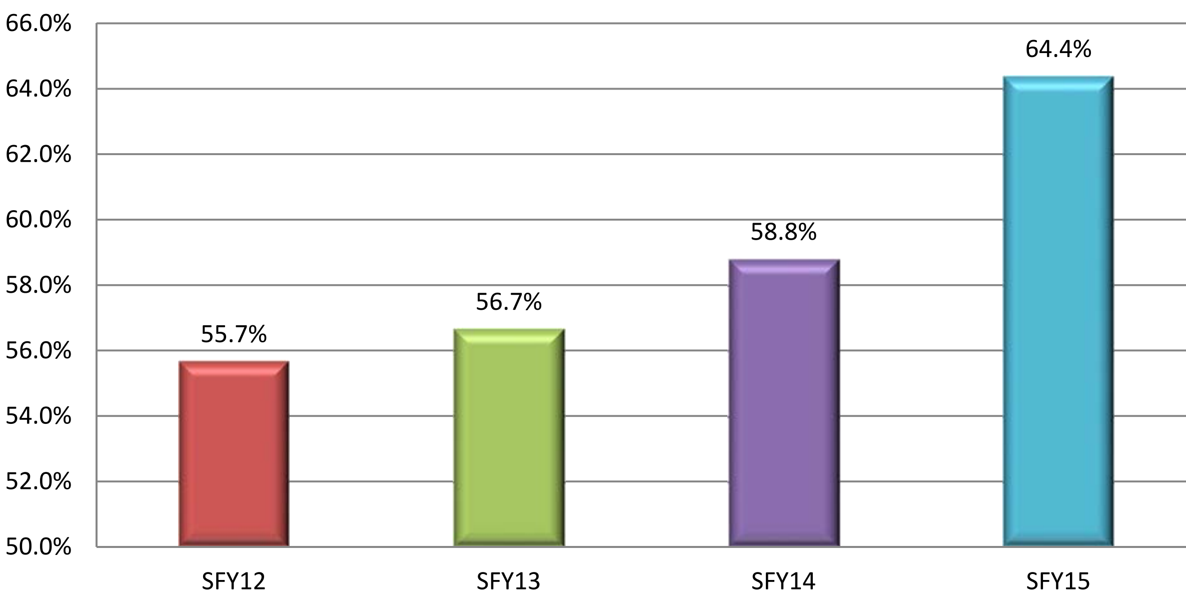
COLLABORATIVE: Children with Improved Level of Functioning at Discharge

Strategic Goal: Improve Behavioral Health Services

Measure: Percent of youth on probation who were served by a statewide entity.

SFY 16 Target:	**54%**	**Appropriation Bill Measure**
SFY 16 1st Quarter:	**This is an annual measure, with data typically available 30 days after the close of the state fiscal year.**	
SFY 15 Actual:	**64.4%**	

Comments: There was a slight decrease in both the number of juvenile justice clients receiving services while on probation (2%), as well as the total number of juvenile justice clients on probation (11%) during FY15. However, the percent of youth on probation who received services has increased by almost six percent points, to 64.4%.



Data Sources and Methodology:

1. *Data Source:* OptumHealth NM, Medicaid and CYFD (Juvenile Justice).
2. *Methodology used to collect data*: The OHNM data extract plus the Medicaid (Managed Care & Fee For Service) data set is matched against JJS data. The denominator is the unique number of clients, age 18 years or younger, with one date of service encounter in the reporting period. The numerator is the unique number JJS youth with the date of first probation in the reporting period that match the clients in the denominator.
3. *Responsible persons*: Quality Improvement Committee
4. *Timeframe for data collection and reporting*: Annual

Data Validity:

1. *Methodology used to determine data validity and reason used*: OptumHealth NM is required to provide a fiscal year data extract and Medicaid submits data on persons served; and has been found to be reliable and valid. This extract is forwarded to Juvenile Justice, who performs the data extraction process.
2. *Appropriateness of the measuring instrument*: See comment.

Data Reliability:

1. *Methodology to determine reliability*: OptumHealth NM and Medicaid data are checked before sending to Juvenile Justice for correctness and reliability. Juvenile Justice data extraction and reporting reliability is assumed.
2. *Reliability of the Measure*: Reliable
3. *Limitations of data*:

Comprehensive Measure Definition: The percent of youth who were on any level of probation who received behavioral health services during the reporting period.