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# Behavioral Healthcare System Best Practices to Address OUD/SUD & Related Conditions

Legislative Finance Committee

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# 1. Challenge: Access & Availabilty of Services

1. Mandate that all service providers modify voicemail to include. “In case of a BH emergency, call 988.” 988 operates 24/7/365 & offers voice, text, & chat, Hispanic, vet, LGBTQ, & ASL options.

2. Only 17% of Americans know of 988. Implement an ongoing multi-media public awareness campaign to socialize 988.

3. Develop, fund, & implement an Office of BH Crisis Response, within BHSD that is in alignment with SAMHSA’s National Guidelines.

4. This Office would manage statewide BH crisis response system that serves adults & children.

5. Technologically enable 988 to deploy Mobile Crisis Teams statewide.

6. Enable 988 to be GIS & GPS enabled to overcome the limitations of area codes.

7. Partner with rural/frontier counties to develop, fund, & implement regional BH COGs that are mandated to plan, develop, & fund BH comprehensive continuums of care, including crisis response.

7. Transfer protocols & interoperability standards are needed between NM’s 41 PSAPs & 988.

8. Provide BH clinicians to be co-located within PSAPs.

9. Incentivize providers to make services accessible on evenings, weekends & Holidays, for both center-based & community-based services.

10. Expect that all clinical & support service providers agreements minimize waiting lists & appointment “no show” rates by adopting an *Open Access* Model & *Treat First*.

11. Incentivize the delivery of more tele-psych services & intensive levels of community-based services, such as Assertive Community Treatment (ACT) Teams, Intensive Outpatient Treatment.

12. Incentivize the delivery of more structured group services for major diagnostic categories, thereby freeing up existing treatment capacity.

13. Incentivize the delivery of more family therapy. After participating in family therapy, almost 90% of people report an improvement in their emotional health; 66% report an improvement in their overall physical health; & in child-parent cases, about 73% of parents report that their child's behavior improved

14. Minimize the system barriers associated with the delivery of group & family therapy.

# Challenge 2: Keeping NM Alive

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1. In NM (2019-2021), 11,600 years of life were lost to deaths of people under age 75, per 100,000 people. The average for the U.S. is 8,000. McKinley County is highest with 25,800 & Rio Arriba County with 19,200. **Re-designate these 2 counties as BH Investment Zones & allocate adequate funding to reverse these dynamics.**

2. In NM (2019-2021), there were 39 drug overdose deaths per 100,000 people. In 2024, that number jumped to 53. The U.S. averaged 27. Rio Arriba County is highest with 92, Socorro is 2nd with 65, & Sierra is 3rd at 60. **Prioritize these counties for expanded Harm Reduction strategies.**

3. In addition to the pioneering harm reduction strategies that NM has already implemented, enact legislation to implement Overdose Prevention Centers.

4. As repeatedly reported by DOH, NM has the highest alcohol-attributable mortality rate in the nation. Some alcohol-related causes of death are associated with chronic diseases such as liver cirrhosis, alcohol dependence as well as alcohol related injuries such as motor vehicle crashes, poisonings, falls, homicide, & suicide. Other negative consequences of alcohol use include domestic violence, crime, poverty, unemployment, chronic liver disease, injuries, & mental illness. Again, Rio Arriba and McKinley counties have the highest rates of alcohol-related death, with rates more than double the NM rate & almost four times the U.S. rate.

   i. Significantly increase alcohol taxes. It has proven to be the single most effective way to prevent alcohol related deaths & related problems.
   ii. Enforce server & liquor liability laws.
   iii. Regulate alcohol outlet density.

5. NM is ranked 49th in overall state health rankings for 2024 (U.S. News). NM ranks 50th among states on Public Safety with a violent crime rate of 780 incidents per 100K which is more than 2X the U.S. rate of 381. Violence is caused by poverty, alcohol, guns, interpersonal conflict, BH & social needs, & juvenile trauma – all inter-related.

- Make increasing investments in housing, in health care, jobs programs, education, after school programs, gun violence prevention. They have all been proven to quantifiably reduce violence.
- Sign on to Reentry 2030, a national initiative that aims to improve reentry success for people exiting prison & those under supervision. Combined with diversion from CJ involvement & appropriate screening, assessment, treatment, & recovery services while incarcerated, it has demonstrated reduced recidivism & cost.

6. Problem-solving courts are evidence-based specialized dockets within the CJ system that address underlying BH conditions that contribute to the commission of certain criminal offenses, often providing treatment rather than punishment. The most common types of problem-solving courts are drug treatment, mental health, family, youth, veterans' treatment courts, & others. Specialty dockets have been associated with reduced incarceration & improved outcomes. Including case management & connection to services, such as housing & employment, increases the likelihood of success.

- Many NM problem solving courts have been funded by federal grants. These grants are limited in scale, offer temporary operational support, & do not offer sustainability. NM should be providing sustainable funding to each Judicial District to build & expand their respective specialty docket capacity & infrastructure.

# Challenge 3: BH Service Demand Continues to Increase, while Service Capacity Lags & Costs Climb

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1. There is a growing body of research demonstrating that there are effective strategies to promote healthy development, enhance social & emotional well-being, & prevent & reduce a host of BH problems. Because there are overlapping risk factors for several problem behaviors & disorders, interventions targeting common risks can result in beneficial outcomes in multiple areas. Additionally, economic analysis has demonstrated the cost benefits & cost effectiveness of a wide range of evidence-based prevention.

2. There are many evidence-based program (EBP) models. Additionally, there are several common risk factors for emotional, behavioral, & substance use problems (e.g., child maltreatment, severe household discord, & other early life traumas), as well as common protective elements (e.g., presence of a caring adult, positive connection to school, community, and pro-social peers, etc.),

3. Several prevention-based efforts have shown benefits in multiple areas:

- Nurse Family Partnership (NFP) is a well-studied model for low-income women who are pregnant with their first child. Intervention services occur from early pregnancy until the child is 24 months, with a focus on prenatal health, enhancing maternal skills, & personal development of the mother (education, self-sufficiency, etc.). Results include reduced child maltreatment; reduced maternal substance use; reduced emergency room visits; improved emotional health of the child at age 6; improved school readiness; & a decrease in arrests & alcohol use in the children at age 15.

- The Good Behavior Game (GBG) is a classroom-based behavior management strategy for elementary school designed to prevent disruptive activity. Classroom teams are given small rewards for positive behavior such as being on-task or displaying cooperation.

- GBG has been successfully implemented across NM, & it has been shown to increase academic engagement, reduce disruptive behavior, & to reduce the later development of conduct disorder, substance abuse, & suicidal ideation.
- Big Brothers/Big Sisters is a community-based mentoring program in which a youth ages 6-18 from a single-parent household is paired with an adult mentor volunteer. Professional staff offer mentor training, support, and supervision. Positive effects include improved school engagement and performance; decreased likelihood of initiating drug/alcohol use; improved relationships with parent/caregiver; and a decrease in youth aggression.
- The Incredible Years Program has demonstrated effectiveness as a combined sector prevention program. It includes components for parents, teachers, & children and is designed to promote emotional
- and social competence & to prevent/reduce aggressive & problem behavior in children. The parent training portion encourages positive parent-child interactions & communications; the teacher training highlights effective classroom management; & the curriculum for children emphasizes skills such problem-solving, taking perspective, showing empathy, & anger management. The program has been shown to improve positive parenting practices, enhance school readiness, & reduce problem behaviors.

4. Funding for evidence-based practices to prevent BH problems & promote emotional well-being has been inconsistent & fragmented. There needs to be on-going support of prevention initiatives to bring them to scale.

5. NM would benefit from ensuring that the resources necessary to collect reliable data are built into prevention planning. Similarly, mechanisms to utilize implementation & outcome data to inform ongoing quality improvement is an essential component of generating positive results.

7. Community Schools require support as they are crucial in supporting both educational & health outcomes, making them a key strategy for improving the well-being of students across NM.

- Community schools provide access to school-based health centers, offering physical, mental, & services directly on-site, ensuring students receive timely care without missing instructional time.
- Embedding health & BH services in community schools allows for early identification of issues such as trauma, anxiety, or SUD, leading to timely interventions that improve long-term outcomes.
- When students' physical & BH needs are met, they are better able to focus on academics, reducing absenteeism, improving classroom behavior, & increasing academic performance.
- Community schools act as hubs where families can access comprehensive health services, supporting overall family stability & student well-being.
- These facilities reduce the strain on EDs & other healthcare services, providing more sustainable, cost-effective care to underserved populations.

# Challenge 4: Lack of Applied Implementation Science

1. Given the strength of the science base in prevention, intervention, treatment, & recovery, as well as the clear NM need to invest in our human capital, the provision of technical assistance resources seems essential. Technical assistance on evidence-based practices, the creation of Centers of Excellence (COE), the expansion of state epidemiological data, accessing & using national data sources, partnership development, & outcome and/or implementation benchmarks would all be beneficial. The capacity & infrastructure needed to assure broad scale implementation is not predictably available at any level of NM government, & it needs to be present at all levels.

# Challenge 5: Minimal Care Coordination

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1. Care coordination can prevent delays in care, unnecessary hospitalizations, duplicate tests, medication errors, & gaps in care, while reducing risks & costs, Improving outcomes & helping clients stay healthier longer, manage chronic conditions, & experience care that's consistent with their goals. It promotes accurate diagnosis and treatment, ensures that all providers have relevant information about a client's overall care, & improves the client's experience. Care coordination can help avoid unnecessary treatments & tests, which can save money while still providing quality care. It can often result in receiving more personalized attention.
2. There are several factors that can prevent providers from conducting care coordination, including:
    - Interoperability: Electronic health records (EHRs) need to be able to communicate with other EHR systems to allow for the secure exchange of patient information.
    - Working with specialists: Referrals can be challenging, & there can be disagreements about who is responsible for sharing client information.
    - Payments: Providers may not be reimbursed or reimbursed enough for care coordination efforts.
    - Medication coordination: Polypharmacy, or taking multiple medications that interact negatively, can make care coordination difficult.
    - Access to resources: Providers may lack the resources they need to coordinate care.
    - Time constraints: Providers may not have enough time to coordinate care, especially for complex patients.
    - Healthcare workforce: Shortages of healthcare providers may severely limit care coordination.
    - Access to specialty services: Limited access to specialty services & providers can make care coordination challenging.

3. There are ways that BH providers can perform care coordination:

- BH providers can use the same platform for electronic health records so that all caregivers can see & update a client's medical history or instead they can use NM's HIE, SYNCRONYS which can integrate with existing EHRs , however most BH providers do not participate.
- Providers can participate in other care coordination tools, such as Unite Us, which is an automated closed loop referral system that is fully implemented in Santa Fe County, & is being implemented in Dona Ana, & Bernalillo Counties. Unite Us is not limited to BH & includes human service providers for referrals relative to the social Determinants of health (SDOH).
- The reactivation of Open Beds (Bamboo Health), a bed & OP service registry, is necessary for service providers, family members, & others to know where there are available treatment & support resources.
- For these care coordination tools to be utilized by BH providers, the following is necessary:
  - Provider Agreements with payers must be amended to require that these respective tools be utilized.
  - Financial incentives are required to support capacity building & infrastructure development relative to the use of these tools.
  - Care coordination needs to be paid for and there are billing codes available for this purpose & payment rates need to be adequate to sustain care coordination.

# Challenge 6: Nonrecurring Funds

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Start-up funding would be a meaningful use of nonrecurring funds.  For example, to implement an Assertive Community Treatment (ACT) team, which is an EBP for SMI, it takes on average 1.5 years to have sufficient enrollment to reach a breakeven point under Medicaid.  Most provider organizations do not have the operating reserves to financially support a protracted implementation period.

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# Thank you!

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