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Building

Rural Behavioral Health Challenges, Issues and Community Responses
October 8th Meeting of the LHHS Behavioral Health Subcommittee

Challenges: Service Gaps, Needs, and Cost Shifting

Since the 2012-2013 cutback of funding for services which had a destabilizing effect on the behavioral health infrastructure, rural communities have faced challenges. Many services are not available locally in Sierra County and other rural counties. In most rural communities, these usually include crisis response, detox, residential treatment, and inpatient care. Other services are limited in scope and availability, such as intensive outpatient and medication assisted treatment (MAT).[1] Those most impacted by these service gaps are people with the greatest life challenges, who are least able to address these challenges without help. Our state is becoming increasingly attuned to the impact that the social determinants of health (SDOH) and health risk factors play in our individual and community lives, which must be addressed if we are to make lasting positive change.[2]

Community needs have continued to increase in many rural communities, shaped by: (1) poverty and economic inequality; (2) lack of education and poor job readiness; (3) limited job opportunities, and challenges with economic development; (4) behavioral health risks; (5) lack of access; and (6) greater intensity of these risks among minority/majority racial and ethnic groups. Here are a few snapshots. [3]

County	Poverty Rate	Median Household Income	Have Primary Care	Unable to Access Care due to Cost
Sierra	27%	$30,467	70.5%	21.3%
Socorro	25.4%	$33,239	68.4%	16.6%
Catron	23.2%	$34,868	68.5%	12.3%
Valencia	18.6%	$43,819	72.6%	19.9%
New Mexico	19.1%	$46,844	71.5%	13%
US/Nation	14%	$57,617		

The region has a higher than state average incidence of behavioral health problems with alcohol, drugs, and self-injury. New Mexico has a more significant level of behavioral health challenges than we see nationally.

1 *MRGEDA HealthCare Committee Phase II Report*, Anne Hays Egan with Sharon Finarelli, supported by Presbyterian Healthcare Services.

2 Robert Wood Johnson's *County Ratings and Roadmaps*, DHHS Office of Minority Health, Con Alma Health Foundation, NM DOH.

3 Data from MRGEDA HealthCare Committee Phase II Report; data from NM DOH IBIS 2016 (income); and 2016-2017 (healthcare).

The opioid epidemic has had a devastating impact upon our people, jobs, the workforce, the economy, economic development, and overall community health. A comprehensive analysis by Altarum Research indicates full health, social, workplace, law enforcement, economic, and years of life lost costs to communities runs at $800,000 per opioid-related death.[4]

Given these needs combined with service gaps, people in rural communities are either not seeking help, or are overutilizing (1) detention centers or jails and (2) hospitals. This creates a large cost burden for counties, driving up the cost of care. The Middle Rio Grande Economic Development Association (MRGEDA) realizes how behavioral health issues are impacting workforce and economic development and is addressing this complex issue. County leaders, like the Sierra County Manager and others, are reporting that the costs for detention centers and jails runs between 35% and 60% of county budgets and is rising. This is unsustainable, and addressing the issue is a priority for Sierra County, BHSD, and NM Counties. This rising cost provides an example of shifting costs of care from the behavioral health system to detention centers and jails. Sierra County is now providing leadership to intercept-model-based jail diversion network development, through the BHSD Intervention Demonstration Project and funding from the federal Department of Justice. A new behavioral health center, Olive Tree, is developing to provide both traditional behavioral health and asset-based holistic services. Sierra County has been working to develop a community schools model, with case management support services at schools and in the classroom. At the state level, these issues are being addressed by HSD and BHSD through Medicaid funding for more types of care by different levels of staff, including expansion of funding for peer support, crisis response services, and other core community services. They need continued attention by BHSD, HSD, DOH, CYFD, the NM Behavioral Health Collaborative, and the Governor's Executive HHS Policy Advisor. We need Medicaid funded service expansion; rural crisis response; intercept-based jail diversion (through BHSD's new Justice Liaison); community support and peer support service expansion, with more local training and MCO attention to updating reimbursement protocols; and ongoing funding and technical assistance to address key behavioral health issues with evidence-based models.

Policy and MCO Alignment, Licensure, Certification, and Funding Issues

Structural and system redesign work is happening at state and county levels and should continue and expand. A collective examination of how policies, procedures, licensing, certification, and funding are working, and how they can be brought into greater alignment is needed. We should conduct mapping and look at workflows, with attention to barriers and areas where these are not in alignment to support effective community-based services. There are some policy, training, licensing, certification, billing, payment and funding barriers that the MRGEDA HealthCare Committee has identified that are impeding effective service delivery in the four rural counties it serves. This is available in the *MRGEDA HealthCare Committee Phase II Report*, supported by Presbyterian HealthCare Services. One way we might address this alignment issue would be to form a Task Force of local providers, local government officials and policymakers charged to work with state government departments to map these issues, develop workflows to identify the barriers. That would guide quality improvement and system changes at all levels, provide recommendations for state and local policy and funding changes, and build the case for fund acquisition.

Developing adequate levels of funding for our rural behavioral health infrastructure is difficult because many of our rural counties have been losing population, jobs and capital for more than a decade, according to the NM Rural Economic Analysis Project and the EIG Distressed Communities Index. Building healthy rural communities means addressing this large, complex picture where systemic economic development is key.

DCI from 2012-2016	Catron	Sierra	Socorro	Valencia
Population	3,550	11,440	17,320	75,990
% Distressed Zip Codes	67.20%	66.30%	68.10%	29.30%
% Prosperous Zip Codes	0%	0%	0%	0%
DCI Score (Out of 100)	81.8	88.4	82.4	70.6
Change in DCI Score (from 2007-2011)	11	5	-13	-5.6

5 DCI score of 75 indicates significant levels of distress. The region shows high distress levels. Adding costs to counties exacerbates economic distress and impedes economic development and building healthy communities.

4 "Economic Toll of Opioid Crisis in U.S. Exceeded $1 Trillion Since 2001," Altarum Group.

5 Economic Innovation Group's *Distressed Communities Index*, a leading national research organization.

Rural counties play a large role in rural economic development and behavioral health system development. Funding should be structured to address these rural realities, with more Medicaid funding for a broader mix of services, with fewer licensing, certification and MCO-related barriers. The system needs to provide more supports for rural clients, including tele-health/tele-psych; and tele-training for providers with more partnerships with local lead organizations. We need to have crisis response and crisis stabilization available in rural communities, along with case management and other therapeutic resources that help people stabilize. The Living Room, Treat First, and Any Door models all provide excellent evidence-based practices (EBPs) that fit well with the limits and strengths of rural communities. Because of costs, the more intensive detox, rehab and inpatient treatment options will usually need to be offered in hub communities. However, transportation, housing, and much more support for "warm handoffs" and strong partnerships with local providers to offer ongoing behavioral health services will be key, as people don't do well if they are treated in one community and dropped off back home, with few supports.

Addressing Cross-Agency and Cross-Sector Collaboration

Rural communities don't have the population density or provider capacity to develop models that work well in urban areas. Although the clinical and practice protocols need to be met across all platforms, there are ways to shape the rural service provider network that address unique rural needs and assets. Because there is a more limited population, staff in rural agencies wear multiple hats, and agencies often address a wide range of needs. The systems are much more horizontal than vertical. This allows rural communities to have greater cross-agency, cross-sector collaboration as people who are leaders find themselves together in multiple meetings each week, from the School Board, to Rotary, to the Community Health Council and different behavioral health working groups. The potential for collaboration is better because people know one another, and the opportunity for gaining traction on any initiative where funds are invested (such as the Intervention Demonstration Project) are greater. It's possible to pilot new ideas, test them, and gain traction quickly, as long as the different partners in the community all experience support for their work, and share in the funding. The County Manager, Jail Administrator, and AppleTree's CEO and Chair of the MRGEDA HealthCare Committee are excellent examples of community leaders that are addressing behavioral health challenges and building capacity utilizing these rural assets.

Recommendations

This consultant recommends that (1) the Behavioral Health Subcommittee and the Legislative Health & Human Service and Finance Committees continue to work with the state departments to address gaps, recommend evidence-based services, and secure funding to enable local communities to continue to rebuild our behavioral health system. Our Congressional Delegation is deeply concerned about this issue and is interested in working with the state and our communities to leverage federal funding and other resources to partner with New Mexico.

This consultant recommends that a Task Force be created that includes a mix of providers that can engage in mapping and workflows to identify barriers that exist that impede client and provider ability to maximize services at the local level. The barriers most often identified include: (1) service gaps due to funding constraints, lack of provider capacity, and staffing; (2) services not funded by Medicaid and/or billing and payment challenges; (3) licensing and certification barriers, and limited access to certification trainings; (4) agency capacity and need for training, clinical quality improvement, and system development; (5) need for more effective local interagency collaboration; (6) state policy changes needed; (7) local and state policy alignment improvements required; and (8) state interagency collaboration at bureau and frontline levels (Secretaries and Deputies are working collaboratively to address these complex issues).

Thank you for inviting me to speak to the Behavioral Health Subcommittee. I trust that my comments have been helpful to the subcommittee. If you need further information, or copies of any of my reports, please let me know: aegan@cybermesa.com or 505-699-7706.