

## New Mexico Medical Advisory Team (MAT) Assessment

MAT Workgroup Name: Behavioral Health Workgroup

Date: September 3, 2020

### Question or request:

1. Define predicted increases in need for behavioral health (BH) services during and after the pandemic
2. Define existing capacity and needed expansion of that capacity – including assumptions of innovations for delivery of services (e.g. Treat First, tele-delivery)
3. Outline needed capacity expansion in actionable format

### Recommendation/s in bullet form:

1. *Define predicted increases in need for BH services during and after the pandemic.*

Based upon the existing literature, **we anticipate a 15-20% increase in need for behavioral health services in New Mexico** in response to COVID-19. We anticipate that a substantial portion of this increase will be seen in primary care settings and other non-specialty behavioral health settings such as emergency departments and other social service settings.

2. *Define existing capacity and needed expansion of that capacity – including assumptions of innovations for delivery of services (e.g. Treat First, tele-delivery)*

**Only 12.9% of psychiatric needs are met in New Mexico** (KFF State Fact Sheet, 2020).

Only 44.3 percent of New Mexico adults 18 years or older with a mental illness receive mental health treatment each year (SAMHSA, 2019). This rate of treatment is similar to the national rates of treatment of any mental illness (43.6 percent). Similarly, only 34.1 percent of New Mexican youth 12 to 17 years received treatment for their major depressive episode each year. (SAMHSA, 2019).

3. *Outline needed capacity expansion in actionable format.*

#### 1. **Improve access to care statewide**

- a. Work to utilize remote service delivery capability to match demand for professional BH services (e.g. prescribing, assessment, therapy) to availability through some form of **centralized scheduling** of assessment, therapy, prescribing
  - i. potentially through Open Beds
- b. Place, virtually and in person, **peers and CHWs in novel locations** to help folks seeking different types of assistance connect to the BH system
  - i. Modify Treat First modality to allow billing for first contact when done exclusively by peers, CHWs, and/or care coordinators
  - ii. Permit peers, CHWs, care coordinators to connect to patients in EDs, Food Banks, Social service agencies, CSED, ISD, senior facilities
  - iii. Create referral processes from NMCAL and other crisis lines, and medical providers to centralized scheduling, to avoid delays in local BH service delivery systems.
  - iv. Train volunteers and staff working with the NM Department of Aging and Long-Term Services as peers to incorporate mental health screening and referral into their outreach services in reimbursable formats.
- c. **Increase and maintain public information and outreach campaigns** about availability of BH services, with clear information about procedures to access such services, throughout New Mexico in linguistically and culturally appropriate ways

## New Mexico Medical Advisory Team (MAT) Assessment

2. **Improve quality of coordinated care** to ensure access to BH service through medical and other systems
  - a. Incentivize Collaborative Care Model through VBP payments to both BH and PH when collaboration demonstrable
    - i. Activate Medicare Collaborative Care CPT Codes 99492, 99493, and 99494 through NM Medicaid and associated commercial insurance codes
    - ii. Implement robust Care Coordination
    - iii. SBIRT style interventions in Primary care for anxiety, depression, trauma reactions – remotely and through in person
      1. Different levels of VBP payment for targets of integration:
        - a. Shared documentation
        - b. Shared, common treatment plan
        - c. Teaming
        - d. Demonstrated connection to needed levels of care
      2. VBP payments triggered by timely and coordinated collaborative care
3. **On-going data monitoring and data collection**
  - a. Syndromic surveillance
  - b. Access to care data
  - c. Satisfaction with care data
  - d. Quality of care data
  - e. identification of additional data sources needed (Limitations of claims data)
4. **Extend the reimbursement billing codes**
  - a. Extend/continue the telephonic service codes
  - b. Activate The collaborative care codes

### **Assessment:**

#### **Background**

The COVID-19 pandemic has resulted an increase in anxiety, depression, insomnia, PTSD, and generalized psychological distress in response to COVID-19 (Guo et al, 2020, Wang et al, 2020, Abba-Aji et al., 2020, McGinty et al, 2020, Huang et al, 2020, and Gonzalez-Sanguino et al, 2020) which is similar to previous public health disasters of Ebola, SARS, Hurricane Katrina, and the World Trade Center Disaster in addition to natural disasters such as earthquakes, tsunamis, and fires (Beaglehole et al., 2018; Boscarino et al., 2004; Wang et al., 2007; Galea et al., 2007). Given the relationship between substance use disorder and behavioral health conditions, the pandemic is likely to exacerbate the prevalence and severity of substance use (McKay and Asmundson, 2020; Ornell et al., 2020). Economic hardship, unemployment, and social isolation are anticipated to amplify the impacts of COVID-19 creating an “epidemic within the pandemic” of “deaths of despair” (Petterson, et al., 2020).

There is no current data to predict need for additional behavioral health services in the context of COVID-19 but trends can be extrapolated from the literature documenting the increased mental health service utilization after Hurricane Katrina and the World Trade Center Disaster. In the year following the World Trade Center Disaster, a community sample of adults in New York City reported a 13% increase in seeking mental health treatment directly related to symptoms attributable to this public health disaster (Boscarino et al., 2004). Similarly, in a survey of a representative community sample of adults residing in Alabama, Mississippi and Louisiana, 16% reported newly seeking mental health services directly related to their experiences after Hurricane Katrina (Wang et al., 2007). In this

## New Mexico Medical Advisory Team (MAT) Assessment

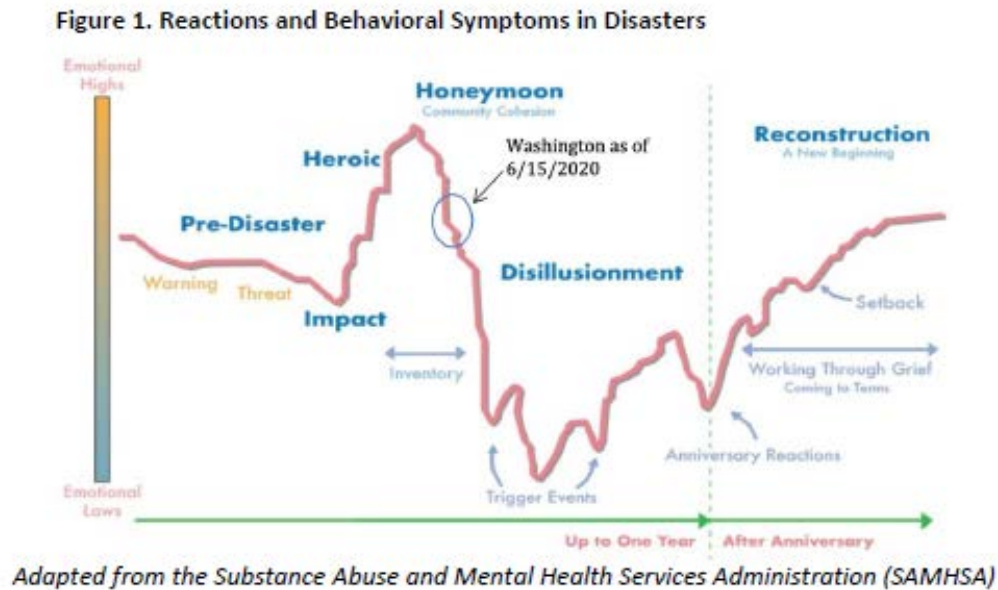
study, most of these new behavioral health services were received through primary care settings which is consistent with research that individuals seeking behavioral health care tend to approach primary care providers before specialty behavioral health care (MacDonald et al., 2018).

Nationally, nearly half (45%) of adults in the United States reported that their mental health has been negatively impacted due to worry and stress over the virus (Panchal, 2020). Average weekly data from June 2020, indicates that adults reporting anxiety and depressive symptoms increased 11% over 2019. In New Mexico, 19% of the adult population suffer with some mental illness (KFF State Fact Sheet, 2020). As of 2018, New Mexico had the highest suicide rate in the nation at 25.0 per 100,000 or approximately 525 deaths due to suicide. Further, over 60% of adults with moderate mental illness and over 30% of adults with serious mental illness in the past year did not receive mental health treatment (KFF State Fact Sheet, 2020).”

### Data

Data analysis and projection modeling for New Mexico BH needs is currently in process with both Presbyterian and Los Alamos Labs analysts. An updated recommendation incorporating these data sources with the additional question asked by the Secretary will be forthcoming. The figures below are from the June Update Report of the Washington State Department of Health. Combined with the literature review, these inform our recommendations.

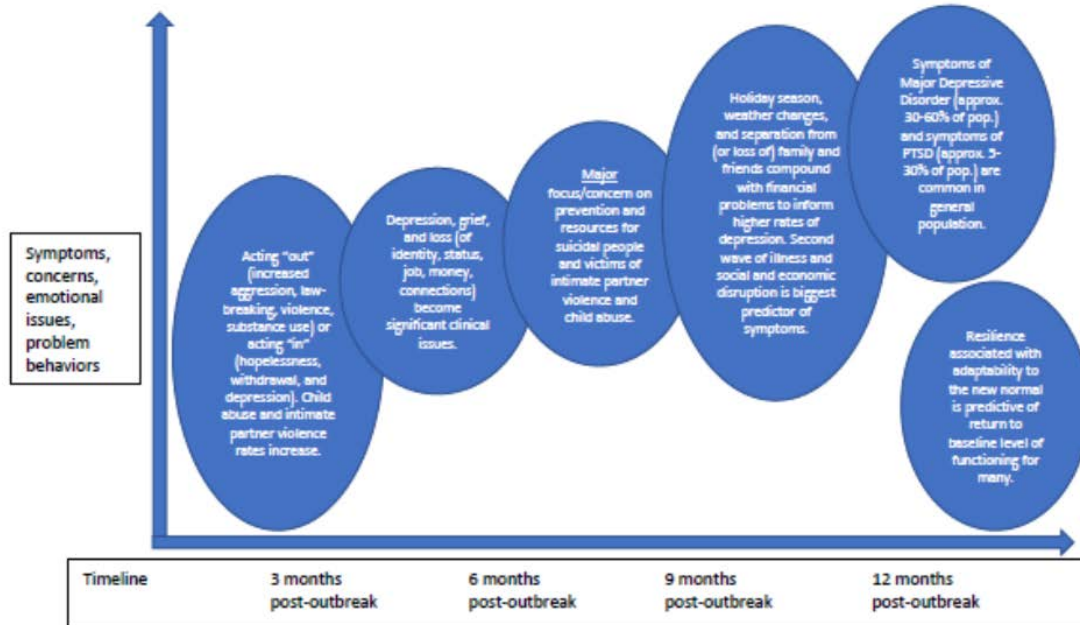
(Washington State Department of Health, June Update)



(Washington State Department of Health, June Update)

## New Mexico Medical Advisory Team (MAT) Assessment

Figure 2. Forecasted Behavioral Health Symptoms (without additional pandemic waves)



Note: Where people start on this chart is strongly predicted by their baseline level of functioning before the pandemic.

## Recommendations

### 1. Improve access to care statewide

- a. **Establish a Statewide infrastructure** to utilize **remote service delivery capability** to match demand to availability through a **centralized scheduling model** of assessment, therapy, prescribing to reduce fragmentation.
  - i. potentially through Open Beds
- b. Place, virtually and in person, **peers and CHWs in novel locations** to help folks seeking different types of assistance connect to the BH system to expand capacity.
  - i. Modify Treat First modality to allow billing for first contact when done exclusively by peers, CHWs, and/or care coordinators
  - ii. Permit peers, CHWs, care coordinators to connect to patients in EDs, Food Banks, Social service agencies, CSED, ISD, senior facilities

Our first two recommendations are designed to improve access and expand capacity by addressing the fragmented and complex behavioral health system and adding to the workforce. First, **development of a statewide infrastructure** will assist New Mexican's identify and schedule services to reduce barriers to access. Second, to improve patient navigation and encourage treatment in those who might be ambivalent, the **placement of peers and CHWs in novel locations** will expand capacity and focus on engagement. The Treat First approach has been piloted in behavioral health agencies and allows peers and CHWs to engage individuals and immediately address their needs rather than starting with an extensive intake process. We recommend **extending this approach** to new locations such as social service sites and Emergency Departments where individuals in distress first start to seek help.

## New Mexico Medical Advisory Team (MAT) Assessment

Multiple factors contribute to barriers when attempting to access behavioral health services including workforce shortages, stigma, and a fragmented public behavioral health system (Mechanic, 2002). In a recent national survey, 46% of individuals who had not previously received mental health treatment reported that they would not know where to go for behavioral health services. Additionally, 22% percent of respondents indicated that it was too hard to figure out how to get mental health treatment (Cohen Veterans Network, 2018).

- c. **Increase and maintain public information and outreach campaigns** about availability of BH services, with clear information about procedures to access such services, throughout New Mexico in linguistically and culturally appropriate ways.

### 2. Improve quality of coordinated care

Improve quality of coordinated care to ensure **access to BH service through primary care**

- a. Incentivize Collaborative Care Model through VBP payments to both BH and PH when collaboration demonstrable
  - i. **Activate Medicare Collaborative Care CPT Codes** 99492, 99493, and 99494 through NM Medicaid and associated commercial insurance codes
  - ii. Implement robust Care Coordination, extending from what has been learned with Health Homes
  - iii. **SBIRT style interventions in Primary care** for anxiety, depression, trauma reactions – remotely and through in person
    1. Different levels of VBP payment for targets of integration:
      - a. Shared documentation
      - b. Shared, common treatment plan
      - c. Teaming
      - d. Demonstrated connection to needed levels of care
    2. VBP payments triggered by timely and coordinated collaborative care

Collaborative care models, integrating BH services with primary care and other urgent care settings are which reduces fragmentation and increases BH capacity. It is critical to engage primary care as most individuals who seek behavioral health services for the first time begin by approaching their primary care providers. In a recent analysis of NM Medicaid utilization of outpatient treatment, 82% of individuals with substance use disorder saw a primary care provider and only 18% sought specialty behavioral health care. Therefore, *primary care practices are ideally suited* to hosting collaborative care interventions (e.g. SBIRT) which promote integration of behavioral health and physical health.

Over time, collaborative care models demonstrate overall cost effectiveness through a reduction in physical health utilization and expenditures and an increase in behavioral health utilization (Archer et al., 2012). To develop a viable financial model to incentivize the development of these collaborative services, it will be critical to implement Value Based Purchasing (VBP) payments that can be shared across primary care and behavioral health treatment providers. One example to consider is the activation of the Medicare CPT codes for Collaborative Care within NM Medicaid.

### 3. On-going data monitoring and data collection

## New Mexico Medical Advisory Team (MAT) Assessment

- a. **Inclusion of behavioral health symptom measures in Statewide COVID surveillance activities**
- b. **Adopting Statewide quality measures**
  - i. Consistency of use across agencies
  - ii. Facilitate innovative VBP reimbursement models to promote collaborative care

A major barrier to the implementation of structural changes in the behavioral health system is the lack of consistent, uniform data on behavioral health. The Epidemiology Response Division in the Department of Health has community level data on important behavioral health outcomes such as mortality related to suicide, drug overdose and alcohol related injuries. However, the time lag, typically 3 months, in these data make it difficult to track anticipated changes related to new public health phenomena such as the current pandemic. **Inclusion of behavioral health symptom measures in statewide COVID surveillance activities** would provide real time data on changes in behavioral health needs that would allow New Mexico to adapt to changing needs.

Additionally, there is a separate need for **behavioral health outcome measures to be used consistently across agencies** to better understand the needs of those who seek treatment. Over the last five years, the NM Behavioral Health Providers Association and the NM Primary Care Association have made considerable strides in identifying meaningful behavioral health outcomes that can be tracked across entities. Adopting statewide quality measures would help **facilitate innovate VBP reimbursement models that would promote collaborative care** and other innovative service delivery models.

#### 4. Extend the reimbursement billing codes

- a. **Extend/continue the telephonic service codes**
- b. As stated above, **Activate Medicare Collaborative Care CPT Codes** 99492, 99493, and 99494 through NM Medicaid

Behavioral health care is ideally suited towards telehealth since there are limited technological needs for behavioral health interventions. The current NM Medicaid modifications have allowed behavioral health providers to extend services through telephone and telehealth. Although the NM Telehealth Act has encouraged the use of telehealth between agencies, the current pandemic has expedited the adoption of telehealth directly to an individual's home.

Additionally, the current modifications have allowed for telephonic visits. Qualitative data from the NM Behavioral Health Providers Association indicates that providers are noticing an *increase in appointment attendance and a reduction in no-show rates* when using the telephone in addition to videoconferencing and in-person visits. This trend appears to be *particularly pronounced in tribal communities* who may experience increased barriers to service including limited transportation, limited bandwidth, and especially high shortages of behavioral health providers.

#### **Timeline and Action Steps/Approvals**

Attached as addendum

#### **In Progress:**

5. Projections Modeling with LANL and Presbyterian data analysts

## New Mexico Medical Advisory Team (MAT) Assessment

### **Future Work needed:**

6. Collaboration among Behavioral Health, PED, and School Districts to assess unmet needs of students in remote schooling and identify ways to meet the needs and identify at-risk students
7. Assess and identify unmet domestic violence needs
8. Assess and identify unmet mental health needs of homebound and seniors in facilities. Develop and expand mental health services to this population.

### **Red flags and concerns**

- Limited Behavioral Health Epidemiological data
- Paucity of qualified behavioral health providers of all levels
- Lack of data from private insurances
- Primary care school-based clinic data missing and not included in analysis

### **Contributors:**

- Neal Bowen, NM Human Services Department
- Bryce Pittenger, NM Human Services Department
- Justin White, University of NM
- Caroline Bonham, University of NM
- Victoria Dirmyer, Presbyterian
- Kalyani Gopalan, Presbyterian
- Laura Burton, University of NM
- Nicole Baca-Montano, University of NM

### **Resources/Reference:**

Abba-Aji, Adam; Li, Daniel; Hrabok, Marianne; Shalaby, Reham; (2020). COVID-19 Pandemic and Mental Health: Prevalence and Correlates of New-Onset Obsessive-Compulsive Symptoms in a Canadian Province (Preprint). *JMIR Public Health and Surveillance*.

Archer J, Bower P, Gilbody S, et al. (2012). Collaborative care for depression and anxiety problems. *Cochrane Database Syst Rev*. 2012;10:CD006525.

Beaglehole B, Mulder RT, Frampton CM, Boden JM, Newton-Howes G, Bell CJ. Psychological distress and psychiatric disorder after natural disasters: systematic review and meta-analysis. *Br J Psychiatry*. 2018;213(6):716-722. doi:10.1192/bjp.2018.210

Boscarino, J. A., Adams, R. E., & Figley, C. R. (2004). Mental health service use 1-year after the World Trade Center disaster: Implications for mental health care. *General Hospital Psychiatry*, 26(5), 346–358. <https://doi.org/10.1016/j.genhosppsy.2004.05.001>

Cohen's Veterans Network (2018). Accessed at <https://www.cohenveteransnetwork.org/americasmentalhealth/>

## New Mexico Medical Advisory Team (MAT) Assessment

- Galea S, Brewin CR, Gruber M, et al. Exposure to hurricane-related stressors and mental illness after Hurricane Katrina. *Arch Gen Psychiatry*. 2007;64(12):1427-1434. doi:10.1001/archpsyc.64.12.1427
- Guo, J., Feng, X. L., Wang, X. H., & van IJzendoorn, M. H. (2020). Coping with COVID-19: Exposure to COVID-19 and Negative Impact on Livelihood Predict Elevated Mental Health Problems in Chinese Adults. *International Journal of Environmental Research and Public Health*, 17(11), 3857. <https://doi.org/10.3390/ijerph17113857>
- Huang Y and Zhao N (2020). Chinese mental health burden during the COVID-19 pandemic Asian *J Psychiatry*. 2020 Jun; 51: 102052. Published online 2020 Apr 14. doi: [10.1016/j.ajp.2020.102052](https://doi.org/10.1016/j.ajp.2020.102052)
- KFF Mental Health and Substance Use State Fact Sheet (2020). Mental Health in New Mexico. KFF (July, 2020).
- MacDonald, K., Fainman-Adelman, N., Anderson, K. K., & Iyer, S. N. (2018). Pathways to mental health services for young people: A systematic review. *Social Psychiatry and Psychiatric Epidemiology*, 53(10), 1005–1038. <https://doi.org/10.1007/s00127-018-1578-y>
- Mechanic D. (2002). Removing Barriers to Care Among Persons with Psychiatric Symptoms. *Health Affairs* 21(3). doi: <https://doi.org/10.1377/hlthaff.21.3.137>
- McGinty E, Presskreischer R, Han H, & Barry C. (n.d.). *Psychological Distress and Loneliness Reported by US Adults in 2018 and April 2020 | Anxiety Disorders | JAMA | JAMA Network*. Retrieved June 15, 2020, from <https://jamanetwork.com/journals/jama/fullarticle/2766941>
- Panchal, N., Kamal, R., Orgera, K., Cox, C., Garfield, R., Hamel, L., Munana, C., & Chidambaram (2020). The Implications of COVID-19 for Mental Health and Substance Use. KFF's Issue Brief, Coronavirus (Covid-19) (April 21, 2020). <https://www.kff.org/health-reform/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>
- Petterson, S., Westfall, J. M., & Miller, B. F. (2020). Projected Deaths of Despair During the Coronavirus Recession, Well Being Trust. May 8, 2020. WellBeingTrust.org. <https://wellbeingtrust.org/areas-of-focus/policy-and-advocacy/reports/projected-deaths-of-despair-during-covid-19/>



## New Mexico Medical Advisory Team (MAT) Assessment

SAMHSA Behavioral Health Barometer (2019). Substance Abuse and Mental Health Services Administration.

Behavioral Health Barometer: New Mexico, Volume 5: Indicators as measured through the 2017 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services. HHS Publication No. SMA-19-Baro-17-NM. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2019.

Wang, C., Pan, R., Wan, X., Tan, Y., Xu, L., McIntyre, R. S., Choo, F. N., Tran, B., Ho, R., Sharma, V. K., & Ho, C. (2020). A longitudinal study on the mental health of general population during the COVID-19 epidemic in China. *Brain, Behavior, and Immunity*. <https://doi.org/10.1016/j.bbi.2020.04.028>.

Wang, P. S., Gruber, M. J., Powers, R. E., Schoenbaum, M., Speier, A. H., Wells, K. B., & Kessler, R. C. (2007). Mental Health Service Use Among Hurricane Katrina Survivors in the Eight Months After the Disaster. *Psychiatric Services (Washington, D.C.)*, 58(11), 1403–1411. <https://doi.org/10.1176/appi.ps.58.11.1403>.

Washington State Department of Health (June 18, 2020). June Update: Statewide High-Level Analysis of Forecasted Behavioral Health Impacts from COVID-19. *Publication 821-103*.