CONVENING TAKEAWAYS

# Primary Care and Behavioral Health Partnership on the Banks of the Rio Grande: Using Intention as a Guide

the DELTA CENTER for a thriving safety net

**FALL 2022**

## Introduction

In September 2022, the Delta Center for a Thriving Safety Net convened primary care association (PCA) and behavioral health state association (BHSA) grantees and Delta Center partners (JSI, The ACT Center, NACHC, National Council for Mental Wellbeing, Families USA, and RWJF) in New Mexico at the Hyatt Regency Tamaya for peer sharing and relationship building. The program office selected the venue intentionally, rooted in a commitment to leverage Delta Center resources to advance equity, in this instance by spending convening dollars to benefit historically marginalized and systematically oppressed populations. Tamaya has a unique ownership structure among hotels in that it is co-owned by the Pueblo of Santa Ana. Grantees were inspired by the physical beauty of the historical and present-day homelands of the Tamayame (the name of the people in the Keres language) and had opportunity to learn about the area's history through hotel exhibits and land acknowledgements that commenced the convening each day, one led by JSI and one led by Emmett "Shkeme" Garcia of the Santa Ana Pueblo.

PCA and BHSA leaders from Alaska, Kansas, Louisiana, Mississippi, Oklahoma, New Hampshire, and Pennsylvania commenced the event hearing from Delta Center alumni from New Mexico, and then focused the first day on collaborative problem solving and engagement, and the second day on exploring collective interests and strategies. Over the course of two days, grantees shared insights about strategies for engaging with legislators, learned about recent research and resources on social drivers of health, and were inspired to learn more about and apply for new state planning grant funding for Certified Community Behavioral Health Clinics (CCBHCs).

Below are some key takeaways from the convening.

**The Delta Center for a Thriving Safety Net** is a national initiative launched in May of 2018 that brings together primary care associations (PCAs) and behavioral health state associations (BHSAs) to advance policy and practice change. The ultimate goal of the Delta Center is to cultivate health policy and a care system that is more equitable and better meets the needs of individuals and families.

The Delta Center is led by JSI Research & Training Institute, Inc., bringing together strategic partners including The Center for Accelerating Care Transformation at Kaiser Permanente Washington Health Research Institute, Families USA, the National Association for Community Health Centers, and the National Council for Mental Wellbeing.

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*"The Delta Center was a gift that was given to us."*

*– Delta Center grantee alumni, New Mexico*

## 1. Partnership is an active dance and a platform for advancing policy change

Dr. Joe Parks, Medical Director for the National Council for Mental Wellbeing, presented on the importance of partnerships to make policy change at the state level and practice change at the local level. Multiple partnerships are necessary—not just between community health centers (CHCs) and behavioral health organizations (BHOs), but also with varying state and private entities across the state. He framed the notion of partnership by saying, "You are in the relationship no matter what. It's up to you whether it will be good or bad."

Dr. Parks explained the necessity of having a relationship of basic trust between the array of players in the state, including the Department of Mental Health (DMH), Medicaid, State Budget Office, consumer coalitions, and PCAs and BHSAs. He emphasized that when it comes to risk-taking ventures especially, "You have to know each other for risk-taking to work well." He gave an example of a one-day retreat where the explicit purpose was for the CEOs, CFOs and Lead Clinic Managers from primary care and behavioral health organizations to "really learn the other one's business and constraints." This concerted relationship building helped to build empathy and spurred leaders to figure out how they could help each other with one another's pain points.

Dr. Parks also shared that the foundation for trusting and collaborative partnerships between agencies and associations is often rooted in the leaders and staff who make up those entities. He shared advice he learned while serving as the Director of Missouri's DMH: "Hire each other's middle managers whenever the opportunity arises." And Joe Parks had done just that. He sent one of his most valuable colleagues to the Medicaid office, and when that colleague became the Medicaid Director, Parks expressed it was one of the best decisions he had ever made. As the Director of the Department of Mental Health, Dr. Parks now not only had a strong relationship with the Medicaid agency but he knew that the top leadership had a deep understanding of DMH that would help in advancing a shared mission of improving care.

Similarly, Dr. Neal Bowen, Director of the New Mexico Behavioral Health Services Division, re-emphasized the importance of cross-hiring between PCAs and BHSAs and

the state. Dr. Bowen had actually served on New Mexico's Delta Center team, and when he moved to work for the State, the PCA and BHSA had an instant, knowledgeable partner at the state level who deeply understood the policy and practice challenges that health centers and behavioral health organizations were confronting together.

The Oklahoma grantee team echoed the sentiment that partnership starts with people when they shared their story of how the relationship between the PCA and the BHSA was transformed when the PCA hired a CEO who came from a behavioral health clinic. Both the New Mexico and Oklahoma examples highlight how the Delta Center can provide a venue for concerted relationship building between PCAs and BHSAs, and that these partnerships can springboard policy change at the state level as primary care and behavioral health leaders speak with coordinated voice or even become government officials with a deep understanding of the health centers and behavioral health organizations.


Grantees asked Dr. Parks about what partners—regardless of whether partners are a PCA and a BHSA or PCA/BHSA teams working with Medicaid—should do when there is a history of distrust. He advised:

- "Inscrutably and randomly do nice things to the other;"
- "Don't start by asking for something;" and
- "Address a pain point for the partner, as gratitude is often disproportionate to the resources spent in addressing the pain point."

In pursuit of the ultimate goal of care systems that best meet individual and families' needs, Parks emphasized the power of building relationships between stakeholders,

*"We have to say we don't know what we don't know."*

*– Corina Pinto, JSI*

*"Before asking what community engagement looks like, ask yourself: This community has been harmed for generations, Black and Brown people. If I had been harmed, what would need to happen to trust the healthcare system to even talk? How do our efforts change how people feel when it's so deep? This is hard work."*

*– Program Officer, Robert Wood Johnson Foundation*

and then leveraging those relationships to pursue policy change through collective action. He encouraged grantees to start by finding common ground on big ideas first, noting, "Strategy is about a broad general direction and not a detailed roadmap." Parks suggested that PCAs and BHSAs have an opportunity to "focus on continuous incremental change—as big sweeping change scares people." Pulling on his experience as a ballroom dancer, he concluded that it is critical to remember that partnerships are a long-term dance, and the investment is worth it.

## 2. Intentional consumer engagement is essential.

State associations are increasingly realizing the importance of intentional consumer engagement in their practice and policy work. On Day 1, each grantee presented updates and challenges in their work to support well coordinated primary care and behavioral health services. Grantees then met in small groups to share experiences and strategize solutions to shared challenges. A common challenge was how to effectively and equitably engage a representative consumer population. As a cohort, grantees are asking themselves: Who are we engaging with? How? Who is missing? How do we bring them in?

Ultimately, grantees agreed that the most important step is to get started, while keeping in mind these considerations and questions:

- Invest in ongoing training—for association members and leadership teams— regarding cultural competency and diversity equity and inclusion practices. This internal work is important to becoming competent and comfortable engaging diverse communities in vulnerable discussions.
- Lead with relationships and build community knowledge before engagement. Honest conversations require trust to be created and maintained. What does it look like to give back, and how can data be collected in a way that is not extractive?
- Leverage community strength to partner with local leaders and community-based organizations. For example, working with professional peers and community health workers is one potential strategy for engaging with and hearing the voices of valuable

subpopulations, including non-English speakers.

- Language is important. Can the field begin to transition away from social determinants to social drivers of health as a way of recognizing the historical and political factors that contribute to health disparities (and might be addressed through policy change) rather than focusing on solutions primarily at the individual level?
- There is great potential power in associations taking bold public stances on racial equity. This work is a process not a destination. It is non-linear and requires persistence practice, engagement, vulnerability, and reflection.

## 3. Workforce is a crisis for everyone, and crisis can catalyze change.

The second day of the convening included hot topic sessions in which grantee teams engaged in rich discussion with one another. Workforce was most definitely a hot topic. The discussions underscored that state associations have unique opportunities to work together and reimagine innovative workforce strategies—strategies that shift from competition for the same resources to building overall capacity, together. One participant urged that there needs to be an intentional shift away from the scarcity mentality that pervades the healthcare workforce by working together to increase the size of the pie (healthcare workforce supply for primary care and behavioral health) instead of fighting over the same slice. This includes simultaneously focusing on developing new workforce and redeploying the existing workforce more effectively across the state.

The Kansas team shared a story of how their workforce crisis was one impetus for their decision to pursue CCBHCs at the state level. Kansas was losing workforce across state lines to other states that expanded Medicaid and had additional resources to pay behavioral health providers more. Concurrently, legislators were looking for a solution to address this crisis combined with a greater awareness of behavioral health needs in the state. Thanks to planning by Delta Center team members and other advocates, CCBHCs "allowed legislators to do something" to address these crises of declining supply of providers and growing demand for services. Indeed, a 2021 National Council for Mental Wellbeing impact report on CCBHCs confirms that CCBHCs have been able to hire additional staff (addressing supply) and address behavioral health

**Resources of Interest for PCAs and BHSAs**

- Legislative Engagement Tactics
- Social Health Resources
- CCBHC Insights
- Health Centers and Value-Based Payment: A Framework for Health Center Payment Reform and Early Experiences in Medicaid Value-Based Payment in Seven States
- Increasing Access to Behavioral Health Services in Rural Alaska: The Power of Telehealth

needs before they result in crisis (addressing demand).

State associations also shared with one another regarding short and long-term strategies to address their states' workforce challenges. The table below is a sample of what PCAs and BHSAs shared regarding their activities to address the workforce crisis:

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| **Pennsylvania** | • Major regulatory reform<br>• Grant-funded position that has a sole focus on redeveloping workforce pipeline<br>• Peer networking groups to share workforce strategies across the state |
| **Mississippi** | • Programs that pay towards scholarships versus loan repayment<br>• Expanding community health workers as part of multidisciplinary teams<br>• Expanding roles and capabilities of Nurse Practitioners<br>• Credentialing process for individual mental health professionals |
| **Alaska** | • Student loan repayment funded through donations (no state dollars) for any healthcare worker (the SHARP Program)<br>• Apprenticeship programs in behavioral health<br>• Health Workforce Coalition core team comprised of representatives from the departments of labor and education, universities, and trade associations to leverage resources for the pipeline |
| **New Hampshire** | • Creation of NH Healthcare Consumers and Providers Association made up of over 50 provider organization to push workforce policy agenda<br>• Regular workforce survey of community health centers and data presentations to legislators |

*Workforce Strategies*

## 4. Value-based payment is "a way to align incentives so our neighbors get the services and system they deserve."

Grantees discussed how their members continue to engage in value-based purchasing discussions with their states and value-based payment discussions with their Medicaid managed care plans. For example, the Oklahoma PCA and BHSA formed a provider-led entity that was actively working on a response to compete against traditional health plans in their state's Medicaid managed care procurement.

Rachel Tobey from JSI hosted a discussion where she shared a framework of value-based payment as a multi-layered model, where each layer served a distinct purpose, such as providing flexibility, new investment, or incentives to improve quality, access or total cost of care. Under the model, distinct payment layers could potentially be negotiated with different stakeholders and funding sources in the Medicaid system. Days after the convening, The Milbank Quarterly published a paper written by JSI, the University of Chicago, and HRSA further detailing the multi-layer model and how health centers have engaged in it.

*Thank you to all those who contributed:*

- Dr. Joe Parks, Medical Director, National Council for Mental Wellbeing
- Dr. Neal Bowen, Director, New Mexico Behavioral Health Services Division
- New Mexico Primary Care Association
- New Mexico Behavioral Health Providers Association

*Funding stipulations from the Robert Wood Johnson Foundation prohibited the use of Delta Center funds for engaging in direct or grassroots lobbying. Grantees used their Delta Center funding to support a broad array of policy activities, including background research, education and training, stakeholder engagement and convening, and building shared policy agendas. As state associations, Delta Center grantees used other non-Delta Center funding sources when they engaged in lobbying and legislative advocacy to advance policy.

In another session, Dr. Neal Bowen, the current Director of the Behavioral Health Services Division for the State of New Mexico, who was also a former Delta Center grantee team member when he was a Director of Behavioral Health Services at a health center, shared insights about the relationship between value-based payment and care. Reflecting on his experience working as a clinical psychologist in health centers and the behavioral health system, Dr. Bowen shared the following:

- The behavioral health system has been "grossly underfunded for a long time." Now a lot of money is being "thrown at an arid field that can't absorb the investments." New Mexico is bringing in CCBHCs next year to intentionally pair appropriate reimbursement with a robust care model.
- When thinking about PC/BH integration, it is important to distinguish between primary behavioral health care, "which can and should be integrated into primary care" and specialty behavioral health care which "should not be integrated into primary care" but rather treated as any other specialty health service
- To date, value-based payment is a "brilliant idea with immense promise, but seems to underperform on the ground." He noted two opportunities: 1) to work with Medicaid to view value-based payment not just as a way to pay differently but as "a way to align incentives so our neighbors get the services and system they deserve;" and 2) to reinforce behavioral health business practices so that providers build their capacity to accept risk.

The National Council echoed Dr. Bowen's sentiment about CCBHC being an important model for increasing funding for behavioral health services that has allowed former communtiy mental health centers to hire new staff, expand access and add new services. In demonstration states, National Council also shared that two states (OK and NJ) had selected a per-member-per-month payment model while the other states in the first demonstration chose a daily rate, reflecting that "both are better than the status quo."

Overall, the first post-COVID in-person convening of Delta Center allowed PCA and BHSA teams to reflect, share, and plan for their next year together. Our hope is that the current states will one day share the sentiment that the alumni New Mexico team led their presentation with: "The Delta Center was a gift that was given to us."