"We Never Used to Do Things This Way": Behavioral Health Care Reform in New Mexico

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This column describes the first year of efforts in New Mexico to reform the behavioral health system. The process, guided by principles of cultural exchange theory, seeks to establish a "collaborative culture" among all stakeholders involved, including state agencies, consumers, families, advocates, and providers. Challenges have included inadequate system funding; insufficient development of skill sets among state personnel; underestimation of time and labor needed to address complex tasks; varying federal statutory and funder requirements for individual agencies; lack of a solid infrastructure for data collection, management, and dissemination; and clear definitions of the roles and relationships of local stakeholders to the state leadership group. (*Psychiatric Services* 58:1529–1531, 2007)

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In July 2005 New Mexico began a planned five-year process of restructuring its entire public behavioral health care system. The 17 state agencies and offices that finance mental health and substance abuse services were convened into a behavioral health purchasing collaborative ("the Collaborative") that contracted with a single managed care organization (ValueOptions) to administer these services (1,2).

The first year of the restructuring was conceptualized as a period of "do no harm" in which the daily provision of services within community settings was to remain undisrupted while the Collaborative focused on "nuts and bolts" issues, such as instituting new processes for enrollment, billing, and governance within the public sector. In particular, initial reform efforts centered on the development of mechanisms for interdepartmental oversight and collaboration and for involvement of consumers and providers in the restructured system. During this first year, the Collaborative also obtained a section 1915(b) waiver from the federal government to facilitate the carveout of behavioral health services on a statewide basis. In addition, a Mental Health Transformation State Incentive Grant was obtained from the Substance Abuse and Mental Health Services Administration to aid in the overall transformation process.

Set in motion through legislative action, the Collaborative aspires to advance partnerships at the highest levels of state government and with community stakeholders in order to achieve the long-term goals of streamlining service delivery, reducing administrative expenses, boosting the quality of oversight capacity, and decreasing duplicative and costly paperwork demands for providers within the state's fragmented and beleaguered behavioral health system.

We have come together as state officials, providers, and researchers to consider the groundwork put in place thus far to promote and sustain a systemwide ethos of collaboration, an accepted precondition for successful behavioral health reform in New Mexico. In this column we highlight issues that policy makers in other settings might consider as they undertake similar reforms. We offer a reflective account of the cultural exchange process underlying the reform, identifying the challenges that have affected collaboration among multiple stakeholder groups.

Cultural exchange and integration across state agencies

We have found that cultural exchange theory enhances our understanding of critical issues affecting this initiative. The theory emphasizes process-

es of communication, compromise, and negotiation of attitudes, knowledge, and practices among stakeholders from diverse "cultural" environments (in this case, state agencies and local communities) (3–5). Stakeholders' motivations and behaviors are shaped by the experiences, values, and assumptions of colleagues and peers immersed in these environments. Stakeholders must step outside of their traditional settings, explore and adopt new ways of interacting and cooperating with others, and collectively produce a "collaborative culture" to effect comprehensive system change.

The theory proposes the following processes for successful exchanges between stakeholder groups and the formation of a collaborative culture capable of supporting transformation of a large service system:

♦ Establish precedents for effective collaboration at the top

♦ Identify change agents who can communicate to different stakeholder groups by virtue of their experience or role within those groups

♦ Create a common language across stakeholder groups

♦ Provide forums in which these groups can convene, articulate their values and visions, share ideas, and identify areas of compromise and agreement.

State leadership considers interagency collaboration to be vital to the development of an effective and efficient administrative infrastructure for public service delivery. From the cultural exchange perspective, the achievement of reform goals will necessitate the emergence of a collaborative culture among all agencies involved in transition processes. Indeed, anticipating resistance to change, the leadership has fostered conditions for communication, compromise, and consensus building within state government. They organized relevant state agencies into the Collaborative to coordinate policy, service financing, and legislative priorities, while allowing each to maintain its mission and build on its strengths. Collaborative members have included cabinet secretaries and agency directors.

The state's largest purchasers of behavioral health care—the Human Services Department, the Department of Health, and the Children, Youth and Families Department—might easily have dominated collaborative efforts. However, agencies specializing in labor, vocational rehabilitation, education, housing, corrections, and special populations were enlisted as full partners with equal voting privileges in the Collaborative, regardless of how much funding they could commit to behavioral health care. The Collaborative's monthly meetings became a forum for cultural exchange between previously disparate delivery systems and provided the precedent for and modeling of partnerships to other stakeholders. Collaborative members also reached consensus on overarching values and how reform efforts could target specific outcomes, such as lower suicide rates, increased services for special populations, and workforce development.

Another cultural exchange principle—identification of change agents—was addressed through the establishment of cross-agency teams. These teams, which typically comprised agency deputies, met more frequently than the Collaborative to hammer out reform implementation details. Their membership, roles, and responsibilities were defined in such a way as to steer clear of instituting new bureaucratic lines of authority and to instead accommodate candid communication about implementation issues, maximize potential for collaboration, and improve overall system responsiveness and performance. Prominent linkages were in data management and information systems, planning, performance measurement, evaluation, workforce development, licensing and certification, financing, contracting, and purchasing. Care was taken to identify relationships and functions of state personnel working on reform-related projects, opportunities for blending extant knowledge and skills across agencies, and areas in which staff training and greater cultural exchange were warranted. These efforts supported the emergence of a collaborative culture within state government.

Editor's Note: This column is the ninth in a series of reports addressing the goals that were established by the President's New Freedom Commission. The commission called for the transformation of the mental health system so that all Americans have access to services that promote recovery and opportunities to pursue a meaningful life in the community. The series is supported by a contract with the Substance Abuse and Mental Health Services Administration (SAMHSA). Jeffrey A. Buck, Ph.D., and Anita Everett, M.D., developed the project, and Dr. Buck and Kenneth S. Thompson, M.D., are overseeing it for SAMHSA.

Challenges to integration

The process of arriving at productive cultural exchanges between state agencies and consensus about common values and goals is far from a straightforward undertaking. We contend that it requires open appraisals of the "real world" considerations shaping the work of state personnel involved in system change.

Several challenges to interagency integration within New Mexico—and, we suspect, within other large state systems of care—have been encountered. Inadequate funding for the behavioral health system has hindered hiring of additional state personnel to aid reform initiatives. Insufficient development of skill sets among state personnel to work in new areas, such as cross-system planning, financing, evaluation and performance measurement, has also been problematic. Although changing work demands create opportunities for employee growth and advancement, they are also stressful in the absence of systematic skill development. Another challenge has been underestimation of time and labor needed to allow cross-agency teams to struggle with complex tasks, such as defining and implementing common service definitions and standards and monitoring the ValueOptions contract. Attempts to explicate key contributions of member agencies have led to occasional turf battles within teams.

In addition, federal statutory and funder requirements and the political-

ly defined accountability under which individual state agencies must continue to operate complicate attempts to create a consolidated system for oversight and responsibility within state government. Reflections of this tension are reports that cross-agency teams feel limited in decision making in areas where cabinet secretaries retain final authority.

Lack of a solid infrastructure for data collection, management, and dissemination has impeded interagency collaboration efforts. A stronger infrastructure is needed to share evaluation reports, information, and updates with stakeholder groups in "real time." Also, some state agencies with priorities outside the scope of behavioral health care will most likely require incentives to allocate funds and personnel to advance reform initiatives over time. Finally, despite the Collaborative's relative success in speaking as one, how its messages are circulated and interpreted among agency leadership and personnel has varied, sometimes causing confusion in agencies and in their communications with the public.

The Collaborative is attempting to address such challenges while tempering expectations and accepting that the reform process is not a "quick fix" to endemic problems of fragmentation.

Cultural exchange with community stakeholders

The engagement of community stakeholders as partners in system transformation efforts is a significant, albeit particularly demanding, component of effective cultural exchange in the public sector. From the outset, state officials sought to establish mechanisms for cultural exchange between themselves and community stakeholders. First, they embedded the Behavioral Health Planning Council—a governor-appointed statewide advisory committee of consumers, families, advocates, and providers—into the enabling legislation for the Collaborative. Second, they created a statewide network of local collaboratives (LCs) to function as "the voice of the people" within specific geographic areas. Because the council's linkages to this burgeoning LC network were not clear, each LC now nominates individuals to serve on the council.

Although a great deal of energy and enthusiasm was devoted to the development of the LC network, the facilitation of meaningful cultural exchange between LCs and the Collaborative was not easy. New Mexico could not build on established stakeholder systems and lacked other viable mechanisms to systematically solicit and act upon input from various communities within the state (6). This deficient infrastructure made the identification of appropriate local representation in the LCs problematic. Protracted and tense negotiations ensued over the definition of "consumer" and the appropriate balance of consumer-family and provider-agency members in each LC. Many community members also remained unaware or skeptical of the LC initiative.

The Collaborative also wrestled with what types of decisions should be made at the state level versus the community level, how to distinguish which specific stakeholder groups possess power to influence and act upon such decisions, and how to adjust to their new role of supporting community voices across formerly distinct behavioral health and human service systems.

It was difficult to establish the forums that cultural exchange theory suggests are essential for community stakeholder groups to articulate values and priorities, identify areas for compromise, and forge collaborative cultures. Major problems such as distances that rural stakeholders must travel, time and financial resources required to attend meetings, and differential social capital of community and state agency representatives stymied the communication of local perspectives in meetings. Some community stakeholders—especially those removed from urban areas where most reform-related events were held—remained pessimistic that their voices mattered and confused about the roles of the Collaborative and the cross-agency teams. In their eyes, ValueOptions was the most recognizable face of the reform, and some harbored suspicions that a for-profit partner such as ValueOptions would actually prioritize the improvement of behavioral health service delivery.

Conclusions

Research on innovation diffusion has shown that "adoption of new ideas or technology is often hampered when the stakeholders . . . share similar values but organize them differently" (3). Conflicting notions about stakeholders' roles and relationships pose barriers to system-level change. Such barriers were present in New Mexico before the recent reform. However, state officials have recognized the need to introduce a collaborative culture to effect systemwide transformation.

Ongoing efforts to agree on definitions of stakeholder roles and to treat stakeholders as equal partners are intrinsic to this effort. Although power differentials remain—that is, between higher- and lower-ranking state personnel, between agencies with large and small behavioral health budgets, and between these agencies and the Collaborative, the Council, and the LCs—this endeavor to change state bureaucracy from within through the institutionalization of a partnership approach portends favorably for the transformation process. Lessons learned in the first year of New Mexico's attempt to nurture collaborative culture offer important insights for other states that wish to pursue cross-agency work and community engagement to enhance systems of care.

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