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The Transformation of Behavioral Healthcare in New Mexico

Cathleen E. Willging, Ph.D. [Senior Research Scientist],

Pacific Institute for Research and Evaluation Behavioral Health Research Center of the Southwest 612 Encino Place, NE Albuquerque, NM 87102 Tel: 505-765-2328 cwillging@pire.org

Louise Lamphere, Ph.D. [Professor Emeritus], and

1 University of New Mexico Anthropology Department Albuquerque, NM 87131-0001 lamphere@unm.edu

Barbara Rylko-Bauer, Ph.D. [Adjunct Associate Professor]

Department of Anthropology Michigan State University 2825 E. Fulton Grand Rapids, MI 49506 basariylko@juno.com

Abstract

Since 1997, public-sector behavioral healthcare in New Mexico has remained under continual transition. We have conducted qualitative research to examine recent efforts in NM to establish a recovery-oriented behavioral healthcare system, focusing on comprehensive community support services, clinical homes, and core service agencies. We examine how decisions made in the *outer context* (e.g., the system level) shaped the implementation of each initiative within the *inner context* of service provision (e.g., provider agencies). We also clarify how sociopolitical factors, as exemplified in changes instituted by one gubernatorial administration and undone by its successor, can undermine implementation efforts and create crises within fragile behavioral healthcare systems. Finally, we discuss findings in relation to efforts to promote wraparound service planning and to establish medical home models under national healthcare reform.

Keywords

Healthcare reform; Patient-centered medical homes; Implementation; Mental illness; Rural

Introduction

Under the Patient Protection and Affordable Care Act (ACA) (42 U.S.C. § 18001, 2010), demand for new service innovations, such as *patient-centered medical homes*, will surely increase. Medical homes are clinical care organizations that typically use an interdisciplinary team approach to coordinate and oversee services for individuals with persistent, life-threatening illnesses. Medical homes generally emphasize prevention, health information technology (IT), continuity of care, self-management of illness, and enhancing communication and shared decision-making with clients and their families (Semansky et al.

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2012). Available literature largely focuses on primary care as providing the foundation for medical homes (Alakeson et al. 2010; Druss & Mauer 2010). However, psychiatric practices, community mental health centers, and behavioral health providers that deliver a wide range of specified services may be designated as medical homes for individuals with (a) persistent mental illness or (b) a mental health disorder coupled with another chronic medical condition (Semansky et al. 2012).

We examine three initiatives, *comprehensive community support services* (CCSS), *clinical homes* (CHs), and *core service agencies* (CSAs), precursors to the establishment of medical home models for people with serious mental illness in New Mexico (NM), a rural state that has recently undergone several statewide reforms of behavioral healthcare services. The CCSS initiative consisted of bundled services that were to assist clients in developing and implementing skills to improve life functioning. By the design of state officials, CCSS would also supplant traditional rehabilitation and case management services. The CHs and CSAs most resembled common medical home models. All three initiatives were intended to facilitate a wraparound approach to planning services for clients and their families (Winters & Metz 2009).

We draw from narrative data collected through document review and qualitative methods in two concurrent studies to illustrate how decisions made in the *outer context* (e.g., the system level) shaped the implementation of each initiative within the *inner context* of service provision (e.g., provider agencies) (Aarons et al. 2011). This case study of system change in NM illuminates the interplay of factors that may affect the uptake and sustainment of service innovations favored under the ACA, especially those advancing comprehensive, coordinated care for a vulnerable population that suffers from high premature death rates due to preventable causes (Colton & Manderscheid 2006). Over the years and across three gubernatorial administrations, the implementation issues arising from the interplay of outer and inner contextual factors have surfaced repeatedly in efforts to reform behavioral healthcare. Based on the research presented here, we encourage state governments to collaborate with local stakeholders to critically consider system- and organizational-level conditions and capacity, foster long-term, data-driven planning and implementation, and allow for ongoing feedback and evaluation for midcourse corrections and quality improvement purposes. This will help ensure that medical homes and other service innovations can succeed in public-sector systems.

Outer and Inner Context

It is helpful to utilize a framework to illustrate the complexities of implementing service innovations. Several frameworks exist (Aarons et al. 2011; Damschroder et al. 2009; Fixsen et al. 2005; Meyers et al. 2012), with most approaching implementation as a complicated process involving several stages and including factors at multiple levels, i.e., system, organization, provider, and client. One framework developed specifically for public mental health and social service settings is the EPIS model (see Fig.1), which divides this process into the following four phases: Exploration, Preparation, Implementation, and Sustainment (Aarons et al. 2011).

We adapted the EPIS model to analyze efforts to integrate CCSS, CHs, and CSAs in NM. Similar to other frameworks, the EPIS model emphasizes the outer context factors that influence the capacity of systems and organizations to successfully implement and sustain service innovations (Greenhalgh et al. 2004; Mendel et al. 2008; Proctor et al. 2011). The outer implementation level is characterized by factors in the state-level environment affecting operations within a service sector and consists of policies, regulations, and procedures, contractual arrangements, and public-sector fiscal resources, in addition to governmental actions that can decisively influence implementation and sustainment (Bruns et al. 2008). The EPIS model considers the downstream effects of these factors on the inner context that comprises organizations and individuals tasked with direct service provision (Aarons et al. 2011). Here, we consider the perspectives of persons situated in the outer context (e.g., state officials and managed care administrators) and individuals within the inner context (e.g., service delivery personnel) to identify and analyze cross-cutting issues affecting implementation of the CCSS, CH, and CSA initiatives within a public-sector service system undergoing major reform.

Background

Over the past 15 years, NM instituted multiple, large-scale reforms of publicly funded behavioral health services. In 1997, the state government established a mandatory Medicaid managed care (MMC) program for physical and behavioral healthcare. Here, the state contracted with three managed care organizations (MCOs), which then subcontracted with three behavioral health organizations (BHOs) to administer services for low-income individuals with behavioral healthcare needs who were eligible for Medicaid. The transition to this multi-tier program led to increased bureaucracy and problems for inner context providers specializing in behavioral healthcare. The severity of these problems also prompted federal government intervention in 2000, resulting in the elimination of BHO subcontracts with MCOs (Waitzkin et al. 2002).

In late 2003, a newly elected NM governor announced another overhaul of public behavioral health services. Officially inaugurated in 2005, this major system change, referred to as “transformation,” involved “blending” and “braiding” all public monies for behavioral healthcare that had been administered by 15 state agencies. State officials positioned in the outer context were optimistic about leveraging these monies in innovative ways to reduce costs and improve efficiency and consistency of care (Hyde 2004). For this reform, the state carved out Medicaid funds for behavioral healthcare from the existing MMC program. The state subsequently contracted with ValueOptions New Mexico (VONM), the largest national for-profit BHO, to manage all state-funded behavioral healthcare dollars and processes for local service delivery. In 2009, OptumHealth New Mexico (OHNM), a division of United Healthcare, replaced VONM. Each company was responsible for collaborating with state officials to develop a comprehensive and seamless care system in which services were “consumer-driven” and supportive of “recovery” among persons with mental illness or serious emotional disturbance (Hyde 2004).

This emphasis on recovery had already taken root in other states (Jacobson 2004), and clients and advocates embraced it in NM (Watson et al. 2011). The “recovery” concept, as

set out by the President's New Freedom Commission on Mental Health (2003, p. 5) and as defined in NM state policy, referred to “the process in which people are able to live, work, learn, and participate fully in their communities,” and “the ability to live a fulfilling and productive life despite a disability.” In dominant recovery discourse, frontline service providers were to “assist” rather than “direct” their clinical encounters, by building “partnerships”, helping them come to terms with their illnesses, and to take responsibility for managing their life choices, including those regarding services (Jacobson 2004; Watson et al. 2011).

The CCSS, CH, and CSA initiatives were to promote recovery through a wraparound approach to planning services that were holistic, based on client and family strengths, culturally appropriate, highly individualized, and flexible enough to address a person's needs across multiple domains—home, school, employment, and community (Milwaukee County 2011). In the broader literature, “wraparound” is described as “a treatment *process* rather than a single intervention for a specific area” (Walker & Koroloff 2007) that “results in a unique set of community services and natural supports” and enables persons with mental illness to remain in their natural environments rather than institutions (Winters & Metz 2009). Such an approach was still novel to service providers in NM at the start of the 2005 reform, although multiple states had implemented wraparound approaches within children and adolescent service systems for more than 20 years. Such approaches are also central to the nationwide “systems of care” program funded by the federal government (Winters & Metz 2009). In addition to wraparound planning, the evolving practice models for CCSS, CHs, and CSAs included use of multidisciplinary teams, much like prevailing medical home paradigms (Bielaszka-DuVernay 2011).

Methods

We collected narrative data about the 2005 reform through qualitative methods in two concurrent studies and undertook document review between 2005 and 2011. Study 1 (2005–2011) is based on a long-term assessment of the NM reform that included repeated semi-structured interviews with providers, state officials, and managed care personnel. Study 2 (2007–2008) was a short-term evaluation of the CH project, which included interviews and focus groups with persons involved in implementation, including administrators and providers, juvenile justice officials, and “coaches” (or consultants) with expertise in wraparound services. The Pacific Institute for Research and Evaluation Institutional Review Board approved the research protocols and informed consent procedures utilized in both studies.

Document Review

For document review purposes, we collected, inventoried, and analyzed key texts concerning CCSS, CHs, and CSAs between 2005 and 2011. Documents were gathered via quarterly reviews of state government and managed care contractor websites, at state meetings and public forums focused on behavioral health reform, and directly from provider agencies. Key texts included Medicaid regulations, service requirements, and utilization guidelines related to each initiative. We also collected requests for applications, program

descriptions, fact sheets, pamphlets, newsletters, training materials, and meeting minutes related to the initiatives under investigation.

Study 1

As part of a larger study on adult service delivery under behavioral health reform in NM, we undertook semi-structured interviews with individuals representing several participant types. First, we purposefully recruited 325 personnel employed in 14 service delivery agencies (e.g., community mental health centers, substance abuse treatment centers, homeless programs, and small group practices) over 4 years beginning in April 2006. These recruits included 73 administrators, 197 direct service providers, and 55 support staff. The agencies were located in three rural counties and three counties having metropolitan statistical areas that contained a central city or core of at least 50,000 residents. As we have described (Willing et al. 2013), each agency cared for low-income adults with serious mental illness and received most of their funding from public sources. Interviews with 177 rural personnel and 148 urban personnel occurred at each agency 9 months (Time 1 or T1) after initial implementation of the reform, and 18 (Time 2 or T2) and 36 months (Time 3 or T3) later, enabling us to follow the roll-out of key initiatives. One agency closed after T1, and a second closed after T2, leaving 12 agencies at T3.

We implemented reputational case selection to purposefully recruit personnel specifically involved in adult service provision at each provider agency (Schensul et al. 1999). At T1, we first interviewed a lead administrator who then referred service providers and support staff for participation. These individuals, in turn, recommended other co-workers for study inclusion. This approach made it possible to interview all personnel involved in delivering services to adult clients in all but one site. At T2 and T3, we interviewed members of this same cohort if they were still employed by the provider agency, their successors, and any new staff hired to work with adults. While all interviews focused on how participants experienced system change under the reform and their views of recovery-oriented services, questions during T2 and T3 also centered on knowledge, impressions, and insights specific to CCSS and CHs, in addition to their understandings of and the preparations made by agencies to accommodate the shift to the CSAs.

To obtain a macro-level perspective on the changes during the reform, we also used reputational case selection to recruit 25 state officials (eight political appointees, i.e., cabinet secretaries and deputy secretaries, three legislators, and 14 mid-level government employees) and 15 VONM executive staff for participation in semi-structured interviews in 2007 and 2009. To create this sample, we solicited recommendations from community experts (e.g., leaders of county-based health councils and behavioral health agencies) about the state officials and VONM personnel best exemplifying the individuals involved in developing and enacting policies and procedures for the new reform. The interviews examined the extent of each participant's involvement in key reform-related activities and included specific queries concerning CCSS, CH, and CSAs. Because CSAs had yet to be officially inaugurated during our data collection period, we conducted supplemental interviews between January and May 2011 with a purposive sample of provider agency

administrators (n = 6), state officials (n = 2), and OHNM personnel (n = 2) who were knowledgeable about and/or actively involved in their implementation.

Study 2

To assess the CH program, we completed six focus groups, three with CH providers (n = 22 participants) from the 10 clinical sites, and three with juvenile justice professionals (n = 25 participants) responsible for referring youth at risk for detention to the program and taking part in wraparound planning activities. Each group included 5 to 10 participants. We completed 17 semi-structured interviews with CH providers (n = 9), coaches (n = 3), and juvenile justice judges (n = 5) who also made referrals, tailoring data collection guides to each specific stakeholder group. The protocols covered several domains: ideas about and experiences related to CHs, preparation needed to implement CHs, coaching and training needs, perspectives on core CH processes, and suggested improvements to the CH model in NM.

Data Preparation and Analysis

Documents were indexed according to type, purpose, source, and date within an electronic database. We developed a brief summary for each document. Based on key components of the EPIS model and our review of these documents, we developed a basic list of codes relevant to implementation of the CCSS, CH, and CSA initiatives (e.g., program goals and objectives, target population, service restrictions, expectations for collaboration, wraparound approach, etc.)

For Studies 1 and 2, the semi-structured interviews and focus groups were digitally recorded and professionally transcribed. Interviews lasted approximately 45 to 60 minutes, focus groups an estimated 90 minutes. We used an iterative process to analyze data derived from the resulting transcripts. For the purpose of the analyses presented here, we utilized NVivo 8 (QSR International 2008) software to undertake targeted searches of all references to the CCSS, CH, and the CSA initiatives in our NVivo database by participant type (e.g., state official, managed care administrator, service delivery agency personnel). Second, we engaged in *open coding* to locate themes and issues in data specific to each initiative. Here, we assigned codes to text segments ranging from a phrase to several paragraphs according to inner and outer context variables and the *a priori* constructs comprising the EPIS model (e.g. sociopolitical factors, funding issues, service innovation fit), and added and defined new codes not previously considered. Third, we used *focused coding* to determine which of the themes and issues emerged frequently and which represented less common concerns (Emerson et al. 1995; Corbin & Strauss 2008). Coding proceeded iteratively: three anthropologists coded all text pertaining to the CCSS, CH, and CSA; created detailed memos linking codes to each theme and issue; and then passed on their work to one for review, discussion, and interpretation during research team meetings. To facilitate accuracy checks across coders, we also produced and compared independently written summary reports that detailed themes, issues, and the status of each initiative over time. As part of our analytic process, we triangulated the interview and focus group findings across participant types by creating matrices that included supporting data while detailing themes pertinent to

the CCSS, CHs, and CSAs for each specific implementation phase described in the EPIS model.

Results

Table 1 reviews cross-cutting themes and issues from the interplay of outer and inner context factors by EPIS phase. The supporting narrative illustrates how processes associated with the exploration, preparation, implementation, and sustainment phases played out in the CCSS, CHs, and CSAs initiatives. Selected text from document review and quotations exemplifying the participants views and concerns by type and common experiences illuminate key events and issues affecting their implementation and the transformation of behavioral healthcare in NM. Some quotations were edited to enhance readability.

Comprehensive Community Support Services

According to state officials, CCSS would further the aim of providing coordinated care to clients with complex conditions in communities and reduce reliance on care delivered in more expensive treatment settings. As its implementation with the inner context progressed, the “cost” of CCSS ascended as a chief concern within the outer context.

Top managers of the NM reform had strategically advanced CCSS in response to Congressional efforts during the President George W. Bush administration to pass new regulations that would limit the definition of rehabilitation and case management services, and to subsequently reduce related expenditures under Medicaid. In interviews and official documents, they reportedly put forth CCSS as a viable alternative to rehabilitation and case management services, claiming that it would also reduce dependency on frontline service providers and empower clients to pursue “independent living,” “learning,” “working,” “socializing,” and “recreation” by cultivating skills in problem-solving and coping (NMIBHC 2011). Implementation rested upon the activities of the “primary community support worker,” tasked with coordinating and facilitating team meetings with treatment providers and families. Through CCSS, an individual with mental illness and his/her family were also to be “surrounded” with services and resources “necessary to promote recovery, rehabilitation, and resiliency” (NMIBHC 2011). Many providers were excited by the prospect of implementing CCSS, a service that state officials had hoped to initiate soon after the reform started. However, it took the Centers for Medicare & Medicaid Services (CMS) 2 years to approve the state's request to incorporate CCSS into the NM Medicaid benefits package.

State officials understood that the new wraparound emphasis in CCSS meant providers must engage in planning and managing care that was more intensive and individualized than under traditional case management. Because of delays in procuring approval from CMS, preparation as outlined in the EPIS model was a low priority, as competing demands related to the larger reform occupied the attention of state officials. Consequently, when CCSS was finally implemented in 2007, only limited training was given to service agency administrators and providers on the underlying wraparound philosophy and practical aspects of implementation. Rather than gradually replace established case management services by phasing in CCSS over time, the state prohibited providers from billing for it under Medicaid

for unsure reasons at the very outset of the transition. In response, many agencies renamed their case management programs as “Comprehensive Community Support Services,” reclassified case managers as “CCSS workers,” and billed in earnest under the new CCSS service code. Even though efforts to decrease “dependency” were part of each client's CCSS service plan, providers had quickly come to rely on CCSS as a means to compensate for lost revenue.

The target population for CCSS included persons having serious mental illness with substantial functional impairment and children and adolescents with serious emotional disturbance. In contrast to case management, 60% or more of CCSS was to be provided face-to-face and *in vivo*, meaning places where the client was located, rather than in an office. However, as provider agencies were barred from billing for transportation costs of CCSS staff in rural communities, care was compromised. By design, CCSS workers could not “do things for consumers” or “tell them what to do,” as one state official remarked. CCSS workers were to serve in a supportive capacity, as “teachers and trainers, coordinators and communicators, facilitators and linkers.” At first, most case managers were excited by this new role and did not view CCSS as a major threat to their work routines or relationships with clients. However, when we interviewed these same individuals soon after CCSS went online, the distinction between it and case management remained blurry. In terms of their own practice, CCSS meant completing new forms that emphasized goal setting for assessment and service planning purposes. For example, providers were now tasked with helping clients outline measurable steps to accomplish each goal (e.g., learning to write checks to manage money, planning menus to enhance nutrition, or monitoring symptoms to stay well). They also had to document outcomes. Yet, other than adherence to new paperwork, the day-to-day work of CCSS seemed to reflect business as usual.

Case managers may not have been fully aware of the new expectations of the CCSS model. At one of the few training sessions at the outset of this centerpiece initiative, key ideas such as “teaching,” “training,” and “supporting” were ambiguously defined, as was the core concept of recovery. Rather, billing was emphasized, or the monetary aspects of reform. One agency administrator noted, “The training focused on how to switch from this code to this code, and there wasn't an implementation plan. [Telling people] it's not case management isn't enough.” Little effort was devoted to cultivating CCSS skills, such as helping clients set achievable goals. It was not until April 2010, over 3 years into CCSS implementation, that the state government finally released its 20-hour CCSS training program and manual.

An even larger issue was that state officials had not considered the real costs of time and labor required for the teaching, training, and coordinating involved in CCSS provision. Alarmed by the growing expense of delivering CCSS, state officials required VONM to impose traditional managed care techniques within the first 5 months of implementation, including prior authorization and retrospective utilization review requirements to limit the use of CCSS.

The number of 15-minute CCSS units that clients could receive was restricted. Clients could only access up to 72 units each quarter, or 6 hours of CCSS each month. Providers argued that these restrictions constituted a reimbursement “cap” for CCSS. State officials and the

managed care contractors, however, disagreed with this terminology, countering that they had instead advanced “an expectation for usage” rather than a “cap.” Regardless, providers viewed the cost-control measures as counterproductive to CCSS.

Providers were also blindsided by the decision to limit CCSS and case management for individuals with serious mental illness. They found themselves spending extra time procuring authorizations to deliver CCSS, asking for additional hours, and devising ways to compensate travel costs incurred through provision of *in vivo* services in rural areas. Providers were still unclear about the expectations of state officials one year after the CCSS restrictions were set: “They don't have the criteria down yet.... The state says they know what they want, but, for some reason, it hasn't been interpreted well enough to providers for us to be doing it correctly.”

In qualitative interviews, state officials admitted that more planning and greater emphasis on training would have helped decrease the probability of implementation problems. Nonetheless, they attributed many of these problems to providers, criticizing them for improper billing and overbilling because they did not understand the philosophy behind CCSS. Providers, they argued, had a hard time distinguishing “dependency-producing case management” from “self-managed recovery.” In assigning blame, some state officials focused on provider resistance to recovery principles. Other state officials explained that they had not anticipated that providers might experience difficulties in “understanding conceptually” that CCSS was “not just a different kind of case management” but “a philosophy of service delivery shift” that promoted recovery.

On the other hand, the providers we interviewed focused on feasibility issues, such as acquiring revenues so that they could actually carry out new practices. Although they struggled with CCSS, most became open to the idea of “empowering” clients to take charge of their lives and the belief that they were partly culpable for fostering an unhealthy reliance of clients on the system. The problem, from their perspective, was that the state and VONM had not addressed the pragmatics of implementing recovery principles through the CCSS initiative. Providers also questioned their ability to “coach” or “teach” clients over the long term, given the stringent utilization criteria and funding restrictions on service provision, and the effects of a client's illness on his or her ability to benefit from such efforts. They genuinely felt unable to assist those clients with the greatest needs (e.g., basic subsistence and housing), who were, as one provider noted, not always “in a frame of mind to be trained on how to [get help themselves].” Owing to these concerns, many providers continued to do case management without compensation, subsidizing a conventional service that they believed enabled clients to remain in communities.

Clinical Homes

State officials explained that CHs were inspired by the historically well-funded Wraparound Milwaukee program that aimed to provide a holistic, individually tailored, community-based alternative to institutional treatment for youth (Milwaukee County 2011). Discussions about such an initiative were ongoing during 2006, and excitement among providers had begun to mount. However, as one state official reported, the program's implementation was hastily put together in 2007 as a low-cost response to a sharp decline in VONM authorizations for

inpatient treatment of youth, thus shortchanging the possibility of a prolonged preparation phase.

The CH program targeted youth at risk for institutionalization in either juvenile justice or expensive psychiatric facilities, and centered on a single behavioral health agency (“the home”) working with clients and their families to coordinate assessment, service planning, treatment, and support. The CHs were to utilize a team-based approach that brought together local professionals, including those in the juvenile justice system, clients, families, and others to develop, implement, and monitor a comprehensive plan to meet a youth's needs within the community.

According to VONM staff involved in the pilot test, CHs were “to manage clinical acuity at a more local level, thus allowing children and their families to remain in their communities and to build together the skills necessary for long-term recovery”. The state and VONM handpicked 10 provider agencies to take part in the pilot test.

In the beginning, top administrators at the CH sites were very enthusiastic about their participation, believing they would find themselves “ahead of the curve” once the initiative was rolled out on a larger scale. Yet, they quickly became frustrated with the failure of state officials and VONM to fully articulate, up front, the roles, responsibilities, and outcomes required for their agencies. The majority observed in interviews and focus groups that their input regarding these expectations and outcomes had not been solicited. Once the CHs were implemented, this lack of clarity created confusion for them and their agencies’ direct service providers, including former case managers who were now CCSS workers. As one clinical director confided, “I am not sure any of us still know what it means to operate effectively as a CH.” Providers also criticized the state and VONM for creating rules “on the fly” and not systematically disseminating them to all pilot test sites.

Paralleling concerns expressed in relation to CCSS, CH providers lamented that they had received “virtually no training,” describing the entire implementation process as putting “the cart before the horse.” When training was finally offered months into the pilot test, it focused generally on the wraparound service principles and philosophy rather than skill-building to implement the program locally on a daily basis in clinical and community settings. One provider observed, “It would've been helpful had they showed us how they facilitate a [team-based treatment planning] meeting, instead of „Here, figure it out! Because that's how you learn.”

Providers were perturbed that cogent definitions for the program and its core processes, i.e., assessment, collaborative, team-based treatment planning, and engagement, were never established, even during the training. Eventually, state officials hired consultants from the Wraparound Milwaukee program to “coach” providers. While the coaches and their advice were well received, the lack of a clearly communicated design and set of goals for the CH model complicated their jobs. They were also stunned by the extent to which communication had broken down among the state, VONM, and providers about these issues.

On a pragmatic level, many sites lacked the staff and infrastructure to operate effectively as CHs and were not funded to maintain youth successfully in communities. Site administrators

and their staff complained that the program consumed limited financial resources resulting in monetary losses. One provider deemed CHs as a “classic unfunded mandate.” Traditional payment rates for Medicaid and children's services, for instance, insufficiently compensated the CHs for their added coordination, community engagement responsibilities, and the legal liabilities of ensuring that all aspects of a client's care were covered. Auditing problems also arose because directions were not provided on how to bill appropriately for CH activities, such as coordination. The CH site directors voiced concerns regarding these increased administrative and service delivery costs to officials early in the pilot test, but claimed that the state and VONM were slow to address them.

Core Service Agencies

Despite the impression that CHs would become permanent additions to the service array for children and adolescents notwithstanding implementation problems, the state and OHNM began to phase them out CSAs in 2010. In official discourse and at public meetings, state officials characterized the program as a success that paved the way for an even better initiative, the CSAs. They were seen as a more ambitious, larger-scale health home model for behavioral healthcare that targeted youth and adults, a “one-stop shop” that would assume the coordination functions fulfilled by the CHs and offer 24-hour crisis management, diagnostic assessment, access to psychiatric services (evaluation and medication management), and outpatient treatment. Consistent with the ACA, the state government promoted CSAs as the first step toward integrating behavioral health and primary care. The CSAs were to supersede traditional community mental health centers, which, unlike CSAs, lacked wraparound service coordination.

Administrators and providers of direct service agencies had concerns that initial implementation plans were, once again, “poorly conceived.” No new state funding had been allocated for the initiative, despite the increased service coordination and delivery expectations placed upon CSAs. Nevertheless, most agencies underwent the formal application process to demonstrate their capacity to fulfill all CSA requirements, in part because their leadership feared losing access to needed sources of public funding. In early 2011, 22 agencies were selected to serve as CSAs; smaller agencies specializing in a limited array of services were not chosen. The state granted 41 CSA designations to these 22 agencies; some received the designation of “youth” CSA or “adult” CSA, but the majority held both simultaneously. Of these, two large organizations were granted the 13 separate CSA designations (7 and 6, respectively) in multiple counties. While urban regions might count on having two or three CSAs, rural counties were lucky to have one; in some communities, well-established provider agencies were denied CSA designations. Instead, they were awarded to agencies from different communities lacking a local presence.

Unlike the CH program, the CSA initiative incorporated limited local input through two work groups organized by OHNM and composed of providers, clients, and families. Even though the groups were largely advisory, with state officials making final decisions, they had some early impact on defining target populations, developing an evaluation tool, and creating training strategies for providers. Nonetheless, similar structural factors and top-

down decision making that plagued the CCSS and CH initiatives tended to undermine this bottom-up input.

As part of their coordination function, CSAs were intended to generate referrals to specialty providers when needed services were not provided in-house. Yet, months into the implementation, it was clear that several CSAs were not doing so, which meant that the non-affiliated providers were left out, as they could not seek reimbursement for clients assigned to CSAs without the referral. In one community, providers were baffled why the local CSA, which lacked several specialty services for youth, would not generate referrals to their organizations.

State officials contended that CSAs would not put providers “out of business,” but simultaneously instituted new rules that further cut into the bottom line of the smaller agencies. For example, a new state-sponsored training program to certify providers in CCSS was open only to CSA staff. Without this credential, non-CSA sites could not bill for CCSS and thus lost access to an important funding stream. The decision affected 17 smaller agencies; one agency that started specializing in CCSS—delivering this service to 173 rural families—had to terminate 22 CCSS workers, eventually closing its doors. Critical of the aftermath of this policy decision, one state official commented: “We are creating Wal-Mart vs. Walgreens, [which] is creating divisiveness [among providers] and taking away consumer choice.” In effect, this decision undercut the state government’s emphasis on “consumer-driven care” by reducing the number of community-based outlets where one could access providers and services.

While still a young initiative, the future of the CSAs remains unsettled, in part due to the lack of state financial support for wraparound coordination and the internal administrative tools to track and monitor referrals to non-CSA providers. Rural CSAs were also impacted by a lack of funds for travel to facilitate coordination and defray the costs of providing CCSS in non-office settings. Throughout FY 2011–2012, the state and its then current managed care contractor, OHNM, pressured the CSAs, across the board, to assume additional responsibilities with very little guidance. One clinical director stated that the transition to CSAs had been “pretty stressful” for her staff. As a CSA, her agency had been “asked to do a lot of things” based on “sketchy implementation plans with unrealistic timeframes.” Another director said, “They say that the state and OptumHealth have a 5-year plan for CSAs, but no one has ever seen it.”

Discussion

Since 1997, NM has had a poor track record of system-wide reforms to improve behavioral healthcare. Key findings from this work (Table 1) replicate those reported in our earlier analyses of reform (Semansky et al. 2012; Waitzkin et al. 2002; Watson et al., 2011; Willing et al. 2013). Collectively, our studies illustrate that top-down planning shaped by outer context considerations, insufficient concern for ensuring innovation fit, minimal preparation at the system and organizational levels, and inadequate delineation of key expectations and implementation processes, create challenges for service agencies and providers. In terms of this work specifically, limited funding and cost-cutting at the outer

context also drew the ire of stakeholders situated within the inner context, who consistently cited reduced agency revenue as a consequence of muddled CCSS, CH, and CSA implementation efforts.

Application of the EPIS model or other comprehensive conceptual frameworks can prompt attention to these and other issues during the earliest stages of planning (Aarons et al. 2011). From the perspective of the administrators and providers we studied, state officials and their managed care contractors had excluded them from the exploration process, which subsequently stymied their ability to identify and seek solutions to potential problems as they oriented their agencies to the new initiatives. The preparation phase for each initiative was also truncated, resulting in the repeated occurrence of potentially avoidable implementation problems.

The EPIS model demonstrates why that new programs require scrutiny to determine whether goals and objectives are being met and to inform quality improvement during both the implementation and sustainment phases. However, there was little in the way of data collection to formally evaluate and then improve upon implementation processes related to CCSS, CHs, and CHs. Importantly, this pattern has dominated system change efforts within NM since 1997 (Waitzkin et al. 2002; Willging et al. 2013). Other states, however, have successfully engaged in purposeful, data-driven planning related to systems change. Maryland, for example, has made inroads in reforming its public system by creating and enacting long-term, holistic behavioral healthcare plans, and adopting structures that facilitate “bottom-up” planning, promotion of “shared leadership” with inner context stakeholders, and ongoing evaluation (Semansky 2012).

Use of the EPIS model demands that outer and inner context stakeholders must collaborate to assess reform efforts broadly. Indeed, the three initiatives described in this case study were not implemented in isolation but were in keeping with national trends to build a recovery orientation into public-sector services for persons with serious mental illness (The President's New Freedom Commission on Mental Health 2003; Jacobson 2004), particularly through wraparound approaches (Walker & Bruns 2006; Winters & Metz 2009; National Wraparound Initiative 2013). In interviews and official written discourse, state officials optimistically heralded CCSS, CH, and CSAs as important steps in reducing system fragmentation, coordinating community-based support services, utilizing multidisciplinary teams that include clients and families as active players rather than passive recipients of care, and preparing the public sector for the eventual integration of behavioral health and primary care.

Other states' experiences attest to the myriad of issues that stakeholders within outer and inner contexts must navigate when incorporating wraparound approaches and interventions to achieve such goals. Research shows that implementing and sustaining these approaches is “complex and difficult” and requires “a renegotiation” of the state's relationship with providers, in addition to ongoing adaptation at the agency and system levels (Bruns et al. 2006; Walker & Koroloff 2007). The use of conceptual frameworks to guide wraparound implementation at multiple levels is a vital asset to this systems-change process (Walker & Koroloff 2007). Four basic activities proven useful to advance wraparound approaches in the

demographically similar state of Nevada include: (1) formal assessments of unmet need conducted at the outset of the planning phase; (2) pilot studies of outcomes and cost benefits of the service process during the preparation phase; (3) a study of fidelity and quality improvement strategies during the implementation phase; and (4) systems-level data collection to support continuous improvement in the sustainment phase (Bruns et al. 2006). The types of negotiation and activities to facilitate the transference of potentially expensive wraparound models in NM were glossed over in planning for CCSS, CHs and CSAs.

Regarding behavioral health and primary care integration, state officials, providers, and clients outside of NM have seen the benefits of medical homes in promoting holistic, coordinated approaches to treating complex conditions that require interdisciplinary intervention (Reid et al. 2010; Schoen et al. 2011; Takach 2011). Early evidence from states involved in testing patient-centered medical home models points to reduced *per capita* costs to care for Medicaid recipients, high provider and client satisfaction, and increased access to care (Takach 2011). However, as illustrated in other states, transitioning an existing practice into a medical home model is a lengthy, complex process, especially for solo and small group providers (as often found in rural areas) who have fewer staff and resources (Schoen et al. 2011). These providers may need additional support and incentives to implement these changes and to explore creative ways to share resources (Abrams et al. 2010; Nutting et al. 2011; Rittenhouse et al. 2011).

The historical separation between behavioral health and physical health services also presents special challenges that can impede implementation if they are not tended to during the exploration and preparation phases of planning. These challenges are engendered by outer context factors, i.e., separation of funding streams, licensure laws that govern the scope of practitioner activities, reimbursement barriers, and inner context factors, i.e., different practice styles, culture, and language of behavioral health and primary care professionals (Lambert & Gale 2012). Strategies to ameliorate the inherent disadvantages faced by providers in rural states include technical assistance tailored to agency characteristics and organizational readiness, training through webinars, and infrastructure grants for improved IT systems to facilitate information exchange about clients (Alakeson & Frank 2010; Merrell & Berenson 2010). Ongoing assessment is essential to identify strengths and weaknesses of this transition process, develop context-relevant strategies to bolster organizational climate and culture, facilitate change, and determine required support and incentives (Arrons et al. 2011; Willging et al. 2013).

Planning must consider mechanisms for collaboration with non-medical home providers (Alakeson & Frank 2010; Merrell & Berenson 2010). Without them, providers offering comprehensive services may be incentivized to direct clients to their agencies, thus optimizing their financial compensation and marketplace share. This approach could result in monopolies that deteriorate community-based systems of care. Notably, implementation of the CSA initiative in NM has already constrained the ability of small provider agencies to participate in enhancing these systems, as outer context decisions have restricted their range of reimbursable services.

Although conceptual models can raise awareness of issues to consider when planning for service innovations, the reality is that state officials in NM and elsewhere may find they cannot invest the time to implement them, given the constant pressures they reportedly are under to curtail costs for public service delivery systems while simultaneously moving forward with gubernatorial agendas (Garfield 2009; Roebuck 2010). Research must focus on factors facilitating or inhibiting state governments from using such potentially fruitful models.

Given NM's multiple transitions in behavioral healthcare over two decades, it is clear that major shifts in the outer context can thwart use of the EPIS model and other frameworks. For example, a change in gubernatorial administrations in 2011 ushered in another reform in the administration of Medicaid funds at the state level. Unburdened by the state's past experience with reform, new political appointees recruited from outside NM set out to "modernize" the Medicaid system to increase administrative efficiencies and decrease state spending on recipients (NMHSD 2013). Despite public protest, they applied for and were awarded a Section 1115 demonstration waiver from the CMS to revert to a managed care delivery system (called "Centennial Care" in recognition of NM's 100th year of statehood) that resembled the 1997 MMC program, except that four rather than three MCOs deliver Medicaid-funded services.

However, in the waiver application, state officials affirmed their intent "to establish health homes as an integral step in the integration of care" for Medicaid clients "with a behavioral health condition" and indicated that these "Behavioral Health Homes," or BHHs, would be based in CSAs (NMHSD 2013). Under Centennial Care, the CSAs would work under the direction of the MCOs and in concert with "Primary Care Practitioner/Patient-Centered Medical Homes." As BHHs, the CSAs are eventually to assume responsibility for comprehensive care management and coordination, transitional care from inpatient settings, individual and family support, referral to community and social support services, and using IT to share data and link services.

"Full implementation" of the newly revamped MMC program occurred on January 1, 2014, the same date when major provisions of the ACA were put into effect. As of this writing, behavioral health providers are grappling with the change from a single BHO managing services statewide to multiple MCOs managing these services; movement on the BHH front remains at a standstill. Training for providers to collaborate with their counterparts in primary care to achieve integration of care for individuals with comorbid conditions has yet to take place. Moreover, the state has not introduced efforts to fully enable provider organizations to function effectively as BHHs. Notably, the language of recovery and transformation, so prominent in the framing of the previous reform in NM, is largely absent in the official discourse concerning Centennial Care, which is instead focused on the neoliberal ideals of cost containment and efficiency, despite the possibility of adding new and expensive bureaucracy to public-sector behavioral healthcare.

Recent outer context decisions may also undermine efforts to base BHHs in CSAs. In the months before Centennial Care, NM's gubernatorial administration unexpectedly reduced access to behavioral healthcare statewide. In June 2013, the administration accused 15

nonprofit agencies that operated three quarters of the CSA network and cared for upwards of 88,000 New Mexicans of “egregious mismanagement,” “fraud,” and “corruption.” The administration based its allegations on an audit undertaken at its request by the Public Consulting Group of Massachusetts, and abruptly suspended reimbursement for services rendered by the agencies. State officials contended that Section 6402(h) of the ACA allows them to halt payment “when there is pending an investigation of a credible allegation of fraud against an individual or entity as determined by the state” (Willing & Semansky, 2014). Audit findings were never disclosed either to the inculpatated agencies or the state legislature, let alone the public (LFC 2013).

The administration gave leaders of the nonprofit agencies two choices: (1) submit to a “takeover” by five Arizona companies or (2) face closure. Because of “pay holds” surpassing \$13.5 million in early November 2013, dwindling reserves, and no new state financing for the foreseeable future, most agency leaders consented to the assumption of management and clinical care functions by the Arizona companies. As a result of this forced transition, CCSS and other basic services for Medicaid recipients were disrupted (Centers for Medicare and Medicaid Services 2013; LFC 2013). The survival of crucial safety-net providers is now threatened because most agencies running the CSAs were community mental health centers in rural areas. Thus, NM embarks upon national healthcare reform during a period in which state-funded behavioral health services are again in flux, and without a publicly supported and workable blueprint for turning the idea of BHHs into reality.

Limitations

This research occurred in a single state, which constrains generalizability. For Study 1, we drew from a purposive sample and thus only interviewed a relevant subset of state officials, managed care employees, and provider agency personnel knowledgeable about, involved in, or otherwise affected by the CCSS and CSAs initiatives. Not all participants were able to speak in-depth about the nuances of each initiative described here. Although we did interview or conduct focus groups with the majority of provider agency personnel taking part in the CH initiative, we did not interview state officials for Study 2. Because the voices of state officials are often absent in published research on system transformation in the public sector, further study of their decision-making processes and experiences is needed. In addition, we relied on a relatively small sample of individuals and mostly on document review findings to construct our description and analysis of the CSA initiative. Finally, this research does not describe the perspectives of individuals and families that relied on CCSS, CH, and CSA services during the study period. Such perspectives will be considered in future articles concerning behavioral health reform in NM.

Conclusion

This chapter of public behavioral health services reform in NM has seemingly come full circle, with the award of the federal waiver to reinstate the previous and widely-criticized care delivery system dominated by multiple MCOs (Waitzkin, 2002). Behavioral health homes for persons with serious mental illness and substance use problems will remain more

in the realm of rhetoric than reality, unless there is a concerted and collaborative planning effort involving state officials, service providers, and intended service recipients, with primacy accorded to “a highly local developmental” transition process (Alakeson & Frank 2010). The *de facto* policy decision to replace the management of local NM agencies with a handful of out-of-state contractors attests to the influence of the outer context over inner context dynamics. Without long-term commitment across gubernatorial administrations and state governments to ensure stable leadership, provide better funding and resources, manage transition processes, and build capacity (Garfield 2009), behavioral health services cannot truly be transformed in underserved states such as NM. Implementation efforts will falter, and those most in need of comprehensive, coordinated care will continue falling through the cracks of fragmented behavioral healthcare systems.

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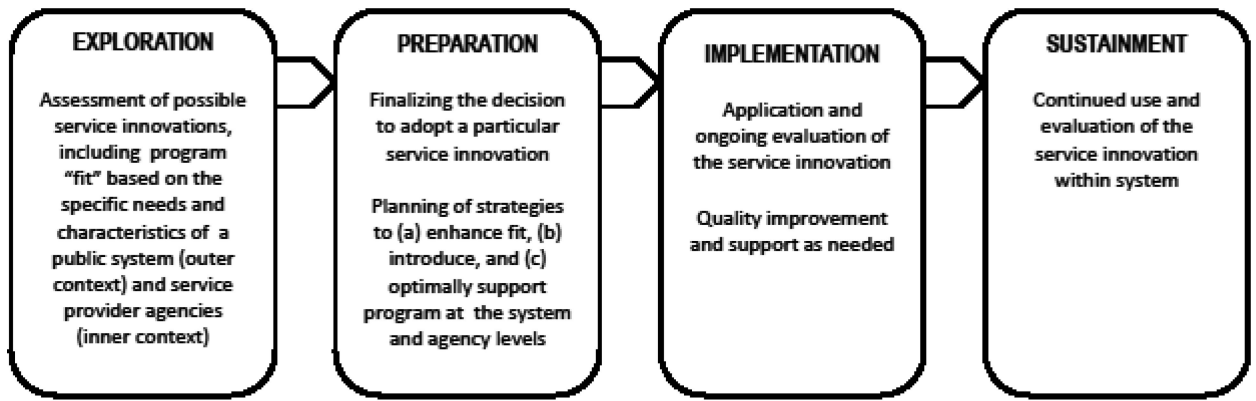
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Note: Adapted from Aarons, Hurlburt, & Horwitz, 2011.

Figure 1.
The EPIS Framework

Table 1

Common themes and issues encountered across CCSS, CH, and CSA initiatives organized according to the EPIS Model

	Exploration	Preparation	Implementation	Sustainment
Outer context action:	Decision to advance recovery-oriented systems Neglect of system- & organizational-conditions in assessing “fit” of service innovation	Insufficient attention to organizational capacity & readiness, & provider training Failure to determine realistic expectations related to program implementation	Ambiguously defined expectations Decision to restrict service provision Inadequate articulation & evaluation of intervention processes	Cost cutting
Inner context consequence:				
CCSS	Lack of provider involvement in determining service logistics & design	Providers unclear about new expectations & unfamiliar with key CCSS skills related to recovery-oriented care & wraparound planning	Lack of clarity about CCSS practice Billing problems Limits placed on use of CCSS during first 5 months of implementation Loss of case management revenue	Providers experience difficulties carrying out CCSS, especially in rural areas Perpetuation of uncompensated case management
CHs	Lack of provider involvement in determining service logistics & design	Providers lack new skill sets to implement model on day-to-day basis & uniformly	Parents do not understand care options under CH Billing problems Agencies with insufficient infrastructure unable to offset the costs incurred to transition to new model of care	Model replaced by CSAs in 2010
CSAs	Minimal provider involvement in determining service logistics & design	Select providers could take part in trainings to deliver specific CSA services, i.e., CCSS	Referrals not generated to non-CSA providers Lack of coordination with non-CSA providers Non-CSA sites prohibited from billing for CCSS, leading to loss of agency revenue Community-based care outlets/ service options restricted Imposition of increased but ill-defined agency responsibilities	To be determined

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