Eastern New Mexico

# Regional Behavioral Health Facility Feasibility Study

**June 2022**

# Contents

Executive Summary ... 3
Introduction ... 9
Community Engagement ... 11
Behavioral Health Needs Assessment ... 15
- Demographics ... 15
- Substance Use Disorder ... 17
- Adult Mental Health ... 24
- Adults with Substance Use Disorder and Mental Illness ... 28
- Child/Youth Behavioral Health ... 30

Gap Analysis: Behavioral Health Services ... 34
- Introduction ... 34
- Inpatient Care ... 36
- Outpatient Care ... 42
- Crisis Care ... 45
- Existing and Future Service Demands ... 52

Recommended Facility and Services ... 59
- Proposed Facility Size and Layout ... 63
- Campus and Facility Master Plan ... 65
- Site Considerations ... 68

Financial Feasibility ... 71
- Key Metrics ... 72
- Methodology ... 77
- Projections ... 92

Funding and Ownership Considerations ... 98
- Non-Financed Options ... 98
- Financed Options ... 100

**Public/Private Funding** ........................................ 101
**Private Funding** ........................................ 102
**Ownership Models** ........................................ 104
**Staffing Feasibility and Considerations** ........................................ 107
**Partnerships** ........................................ 107
**Strategies** ........................................ 108
**Impact on the Healthcare Ecosystem and Benefits to Communities** ........................................ 109
**Potential Service Delivery Participants' Interest in Participating in a Regional Model** ...... 112
**Regional and National Precedents** ........................................ 115
**Appendix: Interview Participants** ........................................ 120

# Executive Summary

## Background

In 2021, the Cities of Clovis and Portales; the Village of Fort Sumner; Curry County, De Baca County, Quay County, and Roosevelt County joined together to address the mental health and substance use disorder (SUD) concerns of their residents. Local government leaders combined their resources in a first-of-its-kind collaborative effort and issued a request for proposal for a feasibility study for a regional behavioral health facility.

## Approach

Initium Health, a Denver-based consulting firm, conducted the feasibility study on behalf of these entities from January – June 2022. The study included:

- Needs assessment to determine the impact of behavioral health conditions – including both mental health and substance use disorders – on residents in the four-county region
- Gap analysis to identify needed services not currently available
- Solution design to meet the identified service gaps
- Financial analysis to determine financial feasibility and funding sources
- Benefit analysis to assess the projected benefits to the communities

We engaged with community members throughout the study, including regular meetings with city and county representatives; 70+ interviews with community stakeholders, providers, and individuals with lived experience and family members with behavioral health conditions; and a community listening session which attracted 50 attendees from across the region. Throughout the process, we learned about residents' behavioral health concerns and priorities, service gaps and their impact on people's lives, and what an ideal regional facility would look like according to these stakeholders.

We analyzed data from local public agencies, hospitals, and behavioral health providers, along with census, public health, and other data sources to further assess the needs and gaps in services. We evaluated the financial feasibility of a regional facility to meet the service gaps identified and examined several ownership models and funding options. Finally, we assessed the benefits of a regional facility to the communities in the region.

## Findings

### Inpatient Care

There is a significant gap in services available in the region for inpatient care for mental health and substance use disorder. Residents must travel 1.5 to 5+ hours for care outside of the region, and often across the state border to Texas. Long distances to inpatient mental health care create many challenges, including:

- Families are unable to visit their loved ones; children are separated from their families
- Individuals decline treatment because it is too far away, or because they lack transportation back home
- Burden on local EMS and law enforcement transportation resources (up to 10-12 hours round trip for a single transfer)
- For active-duty military at Cannon Air Force Base, long distances make it very difficult for the unit to provide support to the service member while they are hospitalized
- Patients experience breakdown in continuing care after returning from an inpatient facility in another community

Lack of inpatient behavioral health care is not limited to this region, and the need far outpaces what facilities across New Mexico can provide. Local hospital emergency departments often call many different facilities searching for a bed to transfer a patient in crisis, and patients can wait hours and even days to be transferred. This crisis in access impacts the entire community, but particularly those with behavioral health conditions:

- Individuals in crisis with outstanding charges are arrested and brought to jail instead of to inpatient treatment, and can remain in jail for months, even on charges as minimal as trespassing

- Individuals do not seek inpatient care when needed because of the poor experience and difficulties accessing care

- Individuals who wait in the emergency department for a long time due to limited bed availability are discharged home from the local hospital, when they should have been hospitalized

*"My nephew has needed an acute admission since mid-January. He is suicidal and homicidal- we have begged [the local hospital] to safely transport him to an acute facility. Every time he is discharged home. My family cannot safely transport him to Amarillo, Roswell, Las Cruces, Albuquerque... they can barely safely get him to the emergency room after coaxing him- to only be released."* - Resident, Clovis

### Outpatient Care

Outpatient behavioral health care is available in the region, but current capacity does not meet the enormity of the need. Specifically, there is very little ability to see psychiatrists, and psychiatrists are only available via telehealth. Consequently, getting medications for mental health is limited and gaps in access persist especially during the time period following an inpatient hospitalization, where an individual may leave with 3-7 days of medication but not be able to receive outpatient care and a new prescription for 2-3 weeks or more. This situation often results in further crisis situations and inpatient hospitalizations. Other significant gaps include medication assisted treatment for opioid use disorder, therapy for children and seniors, partial hospitalization (intense outpatient care provided during the day), and availability of Hispanic and Spanish speaking behavioral health providers.

### Crisis Care

Crisis services in the four-county region are limited to a regional crisis hotline for phone-based support and office-based walk-in care during business hours. Lack of mobile crisis response teams and crisis stabilization facilities mean that individuals in crisis often access care only once their crisis has escalated, and typically call 911, seek care at one of the local hospital emergency departments, or end up in a county detention center. None of these options improve an individual's health, and oftentimes they exacerbate the situation. However, without other alternatives, strained public safety and healthcare systems are providing the best services they can under very difficult circumstances.

### Recommendations

Based on our findings and assessment, we recommend establishing a behavioral health facility that will serve as a hub for inpatient care for the region and will meet current and future needs for behavioral health services.

In order to establish a facility that is financially sound, does not rely upon subsidies, and will be sustainable into the future, the facility needs to be adequately sized to disperse overhead costs and generate sufficient patient revenues. We recommend providing a comprehensive range of services:

- Inpatient care for mental health and substance use disorder
- Intensive outpatient and partial hospitalization programs
- Outpatient care including medication assisted treatment
- Crisis triage center for walk-in and law-enforcement drop-off

## Inpatient Care

**Table 1.** Inpatient Services

| Inpatient Services | |
|---|---|
| Category | Beds |
| Adult Psychiatric | 42 |
| Adult Detoxification | 12 |
| Adult Short-term Intensive Residential Care for SUD | 12 |
| Child/Adolescent Psychiatric | 18 |
| Geriatric Psychiatric | 12 |
| Total | 96 |

We recommend providing services and programs geared toward the specific needs of military members, considering the large military and veteran populations in the region.

### Outpatient Care

The regional facility should offer outpatient care in collaboration with current service providers in the region, to include:

- Intensive outpatient programs for substance use disorder, mental health, and co-occurring disorders
- Partial hospitalization programs for substance use disorder, mental health, and co-occurring disorders
- Outpatient visits for medication management, counseling, and individual, group and family therapy with specific services for children, adolescents, and senior populations

### Crisis Care

We recommend the facility include a crisis triage center for urgent behavioral health care needs. This center will provide short-term care for crisis needs not requiring hospitalization, with a goal of de-escalating crisis situations and connecting patients with outpatient treatment. It will be a resource for first responders and alternative to hospital emergency rooms and county detention centers in crisis situations. We recommend integration of the crisis triage center services with a robust crisis call center linked to 988, the new national emergency line for behavioral health. These services should be supplemented by mobile crisis teams that respond to behavioral health crises in community settings.

## Financial Projections and Ownership Models

Capital expenditures for a regional facility providing services outlined above are estimated at $45 million. We recommend establishing a facility that is jointly owned by the counties and municipalities involved in the study and operated by a management company. This will allow the governmental entities to have oversight of the facility, and for clinical services to be provided by organizations with the necessary expertise. Funding for capital expenditures should be sourced from federal and state funds that have recently become available. If necessary, lending should be sought from the New Mexico Finance Authority under the New Market Tax Credit program, which offers low-interest financing for public projects.

## Conclusion

The Cities of Clovis and Portales; the Village of Fort Sumner; Curry County, De Baca County, Quay County, and Roosevelt County face a unique and unprecedented opportunity to change the landscape of behavioral health care in the region by establishing much needed services to meet the growing behavioral health needs. Behavioral health care is both a national crisis and priority area, partly due to the COVID-19 pandemic having brought these concerns to the forefront of national consciousness. Reimbursement for behavioral health care is expected to increase, and the level of federal and state resources being directed to this area today exceeds any period in recent history.

National and regional behavioral health management companies are growing at a rapid pace, with construction and expansion of facilities underway in many communities. Settlement dollars from opioid litigation against companies charged with contributing to the national opioid crisis are on their way to states and counties, and hold promise of turning the tide when well invested. State, county and city representatives, community members, and providers have agreed: the time is now to bring to eastern New Mexico the behavioral healthcare that is desperately needed.

## Introduction

The Cities of Clovis and Portales; the Village of Fort Sumner; Curry County, De Baca County, Quay County, and Roosevelt County came together in 2021, pooled their resources and leveraged their strength as a group with a united cause, to find an organization that would conduct a feasibility study for a regional behavioral health facility.

New Mexico is disproportionately affected by behavioral health issues, evidenced by its rank in the top five states in the US for suicide deaths.[1] While the communities in this four-county region in rural eastern New Mexico are culturally diverse, resourceful, and collaborative, they also face severe challenges associated with poverty, isolation, trauma, and limited access to mental health and substance use services across the continuum of care.

The lack of access to care partially stems from an event in 2013, where New Mexico's former Governor Susana Martinez froze the Medicaid funding of 15 New Mexico behavioral health agencies due to "credible allegations of fraud." This event, known locally as "The Shake Up," and more widely known by a documentary of the same name, was precipitated by the state's Human Services Department hiring of Public Consulting Group to conduct an audit, which alleged almost $33.8 million in Medicaid overpayments made to providers in the state.[2] These allegations resulted in the closure of many long-standing, community-based behavioral health agencies, sending the 30,000 patients they served looking for care elsewhere.

The shuttered providers were replaced by five Arizona behavioral health companies, hired on no-bid emergency contracts that totaled $17.85 million, to provide services in New Mexico: Agave Health Inc., Valle Del Sol, La Frontera Inc., Southwest Network Inc., and Turquoise Health and Wellness, Inc. However, after only a few years of providing services in New Mexico, all five organizations ceased operations due to financial hardship and Medicaid rate reduction, leaving this vulnerable population without behavioral health care again. By 2016, all 15 of the provider agencies charged were cleared by the New Mexico Attorney General of criminal acts of fraud, but several of those agencies never reopened their business.

Lack of critical infrastructure for meeting the behavioral health treatment needs of these communities spurred local governmental leaders to band together and pool their resources collectively to help their citizens.

**Table 2.** City and County Representatives

| | |
|---|---|
| **City of Clovis** | Justin Howalt, City Manager<br>Claire Burroughes, Assistant City Manager |
| **Curry County** | Lance Pyle, Curry County Manager<br>Kristian Price, Grant Administrator |
| **De Baca County** | Amanda Lucero, Interim County Manager |
| **Village of Ft. Summer** | Jamie Wall, Clerk/Treasurer |
| **City of Portales** | Sarah Austin, City Manager |
| **Quay County** | Daniel Zamora, County Manager |
| **Roosevelt County** | Amber Hamilton, County Manager |

With assistance from the above City and County Managers, the City of Clovis issued a request for proposal, seeking a consulting firm to prepare a feasibility study relating to the development of a regional behavioral health facility to provide services to the community and the surrounding area. The City of Clovis contracted with Initium Health, a Denver based consulting firm.

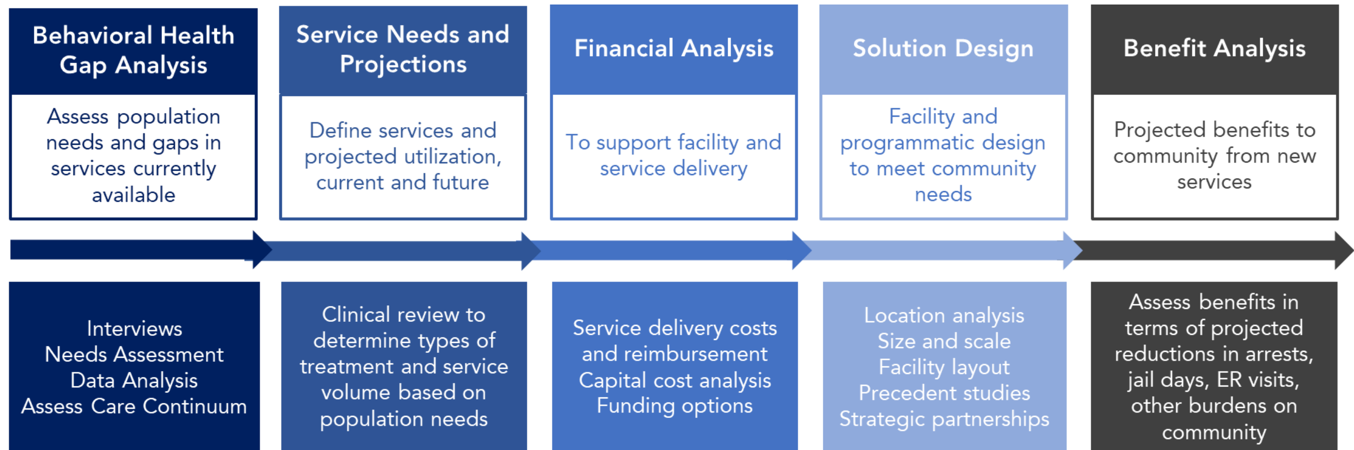
### Initium Health Team

James Corbett, JD, MDiv - Principal
Kate Bailey, MPH – Partner, VP Enterprise Project Management
Laura Bergroth, MD, MBA - Physician Consultant
Kevin Simon, MD – Psychiatrist Consultant
Elise Plakke - Executive Creative Director
Jacob Buchheim - Legal and Operational Analyst
Michael Collins – Healthcare Finance Consultant
Jacob Rasmussen, PharmD - Pharmacist Consultant

Marvin Kaiser - Graphic Designer
Feruz Mussie - Intern
Sam Braun - Web Graphic Designer
Aly Economou – Graphic Designer

We used the following approach to conduct the feasibility study:

**Figure 1.** Feasibility Study Approach




## Community Engagement

Community engagement was instrumental to a successful gap analysis and subsequent development of a vision for building a regional behavioral health facility. Individuals in this region were aware of the problems with mental health, substance use disorder, and the associated issue of homelessness and were passionate about providing insight on how community members could receive help. By actively engaging this diverse population via interviews, events, emails, and social media, we were able to garner knowledge from individuals with firsthand experience regarding behavioral health care in the region:

**Table 3.** Community Engagement by Sector

| Healthcare | Government | Community |
|---|---|---|
| Hospital Administration<br>Frontline Staff<br>Community Behavioral Health Providers | EMS<br>Sheriff Department<br>Police<br>Military<br>Fire Department<br>Public Schools<br>Detention Facilities<br>Elected Officials | Business/Landowners<br>Faith Based Organizations<br>Advocates for Underserved and/or Hard to Reach Populations<br>Individuals with Lived Experiences<br>Philanthropic Entities<br>Community Service Agencies<br>Institutes of Higher Education |

Each city and county manager provided contact information for key community stakeholders. Initium Health conducted virtual and in-person interviews with over 70 organizations from Clovis, Portales, Village of Fort Sumner, Curry County, De Baca County, Quay County, and Roosevelt County. Additional stakeholders were identified during the engagement process and subsequently engaged.

The aim of the interviews was to understand each individual's personal or professional experience with mental health and substance use disorder in their community and their perspective on community needs. To accurately determine the current state of behavioral health services in the area, the interviewees were asked how individuals would obtain treatment services and the existing gaps in care. It was important to learn the entire journey an individual takes throughout the crisis continuum of care.

In addition to qualitative data, first responders were able to provide Initium Health with the number of mental health transports from January-March 2022, as well as the number of calls related to suicidal ideation, substance use, and mental health problems from 2021-2022. The regional hospitals (with the exception of Dan C. Trigg Memorial Hospital) provided data on the number of behavioral health visits, Emergency Department (ED) length of stay, patient disposition, and payer mix. Initium Health also collected data from public sources, including census data, New Mexico state epidemiology profiles, and others.

In collaboration with the cities and counties, we held an afternoon long charette/community listening session at the Clovis-Carver Public Library in Clovis, NM in February 2022. Participants included key stakeholders, community members, and individuals with lived experiences related to behavioral health. Most attendees were already aware of this feasibility study and came to participate in this brainstorming session. The full list of interview participants and charette attendees is available in the Appendix.

The first part of the charette was focused on discussing the behavioral health care ecosystem, social determinants of health, and precedent studies of other behavioral health facilities that incorporate the architecture of recovery into the building design. Participants then broke out into four smaller groups and through an exercise led by Initium Health, the attendees brainstormed on three different topics:

- Strengths of the current mental health and SUD services available, gaps in care, needed partnerships, and top community priorities related to care
- The key attributes, qualities, and must-haves of a regional facility
- Potential sites for a regional behavioral health facility, the pros/cons of each site, and sustainable partnerships and staffing models

After brainstorming, the participants reconvened as a large group to have further discussion on each topic, which resulted in the following takeaways:

**Table 4.** Strengths and Service Needs

| Strengths and Service Needs | | |
|---|---|---|
| **Facility** | **Needs** | |
| Community support | Youth and senior services | Detox unit |
| Resourcefulness | Inpatient behavioral health care | Case management |
| Accessibility of local government officials | Crisis care | Transportation |
| Availability of local outpatient care | Dual diagnosis services | Life training/ skills |
| Mental health/SUD programs in Clovis High School | Discharge coordination | Coordinating entity to break down silos |
| Educational resources: Eastern New Mexico University (ENMU), Clovis Community College (CCC), Mesalands, etc. | Peer support | |

**Table 5.** Key Attributes of a Facility

| Facility Key Attributes | |
|---|---|
| **Facility** | **Programmatic** |
| Room to grow | 24/7 availability |
| Incorporate nature, light, views, and gardens | Transportation |
| Not institutional feel | Play, pet/animal therapy |
| Family inclusion | Providers who can treat in English and Spanish |
| Windbreaks or trees | Safe regardless of income or immigration status |
| Sprawling campus | Qualified staffing |
| Good parking | Addresses spirituality |
| Residential care & family reunification | Technology & ability to share data |
| Supportive housing / transitional housing | |
| Cross-purpose facility, i.e., primary care | |

**Table 6.** Potential Locations for a Regional Behavioral Health Facility

| Locations | | |
|---|---|---|
| **Facility** | | **Programmatic** |
| Lockwood facility | Land nearby Ned Houk Park | Integrated with the community, not tucked away |
| ENMR High School | Matt 25 | Not all neighborhoods are ideal |
| Call center | Allsup's old corporate site | Room to grow |
| Portales land near airport | Off highway between Clovis and Portales | Quiet, integrates with nature |
| Old ENMU football stadium | Hope's Children Home | Retrofitting a building may not give us the design we want and can create code issues & additional costs |
| West or north of Cannon Air Force Base | | |

Furthermore, the charette spurred new community collaboration by:

- Creating awareness of services
- Forming connections between agencies and professionals
- Raising and discussing cross-sector issues
    - Issues of crisis care and duplication of resources
    - Identified policy issues
    - Diversion from legal system for individuals with behavioral health conditions

# Behavioral Health Needs Assessment

## Demographics

The total population of the rural four-county area is approximately 78,065 persons. Located on the far eastern side of the state, three of the counties border Texas to the East. The city of Albuquerque is approximately a 3.5-hour drive to the West. The city of Clovis (population 37,765) located in Curry County, is the largest municipality and serves as a regional hub for the area.

**Table 7.** Population by County, Four-County Region (2020)

| County | Population |
|---|---|
| Curry | 48,430 |
| Roosevelt | 19,191 |
| Quay | 8,746 |
| De Baca | 1,698 |
| Total Project Area | 78,065 |

Source: US Census, 2020.

The percentage of residents who are Hispanic is 43.7%, which is more than double that of the US (18.5%) and similar to New Mexico overall (49.3%).[3]

Lack of health insurance continues to be an issue for residents, with the percentage of uninsured persons (11.50%) in our target area higher than the US (10.2%) and similar to the statewide rate (12.0%).[3]

Many residents in the region are affected by poverty. The percentage of residents living on incomes below the poverty line (16.55%) in the region is higher than the US (10.20%) and similar to New Mexico overall (16.8%). Both the per capita income ($21,823) and median household income ($42,413) are significantly lower in the region compared to the US as a whole ($34,103 and $62,843 respectively) and lower than New Mexico overall ($27,230 and $49,754 respectively).[3]

In the four-county region, educational attainment is lower than that in the state or US. There is a lower rate of individuals who have completed high school or higher (81.5%) or Bachelor's degree or higher (20.0%) compared to New Mexico (85.6% and 27.3%, respectively) and the US (88.0% and 32.1%, respectively).[3]

**Table 8.** Socioeconomic Indicators for the Region

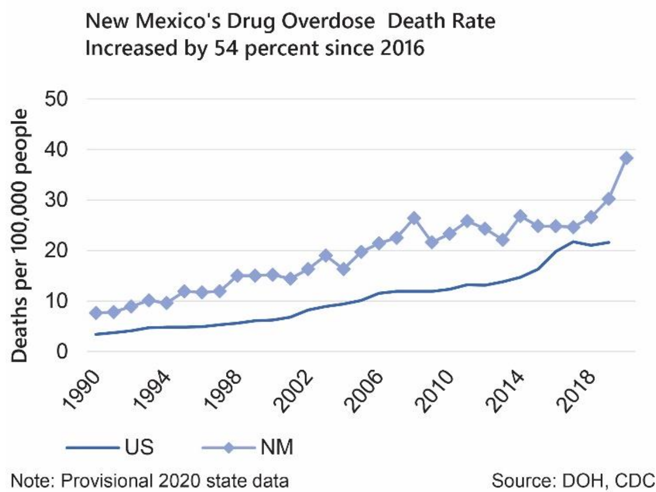
| Measure | Regional Data | | | | | Comparative Data | |
|---|---|---|---|---|---|---|---|
| | Quay County | De Baca County | Roosevelt County | Curry County | **Total Region** | New Mexico | United States |
| High School graduate or higher, percent of persons age 25+ years | 81.9% | 84.3% | 80.0% | 81.9% | **81.5%** | 85.6% | 88.0% |
| Bachelor's degree or higher, percent of persons aged 25 + years | 17.1% | 13.0% | 23.9% | 19.2% | **20.0%** | 27.3% | 32.1% |
| Median Household income (in 2019 dollars) | 29,035 | 31,625 | 42,702 | 45,092 | **42,413** | 49,754 | 62,843 |
| Per capita income in past 12 months (in 2019 dollars) | 19,784 | 17,376 | 20,123 | 23,021 | **21,823** | 27,230 | 34,103 |
| Persons in poverty, percent | 22.0% | 17.0% | 18.2% | 14.9% | **16.6%** | 16.8% | 11.4% |
| Persons without health insurance, under age 65 years, percent | 10.6% | 12.3% | 13.1% | 11.0% | **11.5%** | 12.0% | 10.2% |

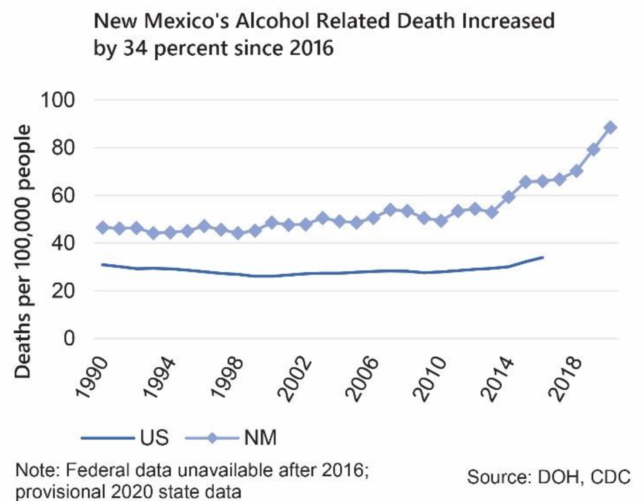
Source: US Census, 2020.

## Substance Use Disorder

Drug overdose and alcohol-related death rates in New Mexico have increased sharply in recent years. From 2016-2020, the drug overdose death rate increased by 54% and the alcohol-related death rate increased by 34%, according to the New Mexico Department of Health.[4] In the year 2020, New Mexico saw its highest numbers of these deaths ever recorded.

**Figure 2.** New Mexico Drug Overdose and Alcohol Related Death Rate.[4]




The most recent data available at the county level regarding substance use disorder-related mortality is the aggregated five-year time period 2015-2019, which is shown below, along with the comparator state rate and the national rate in 2019. Each of the four counties have rates higher than the national rate for alcohol-related deaths, and Quay County is higher than the state overall.

Drug overdose rates approach the national rate for this time period. According to local law enforcement, EMS, court compliance, and outpatient behavioral health providers, methamphetamine, opioid, and alcohol use are the top substance concerns right now.

**Figure 3.** SUD Related Mortality (2015-2019)[1]

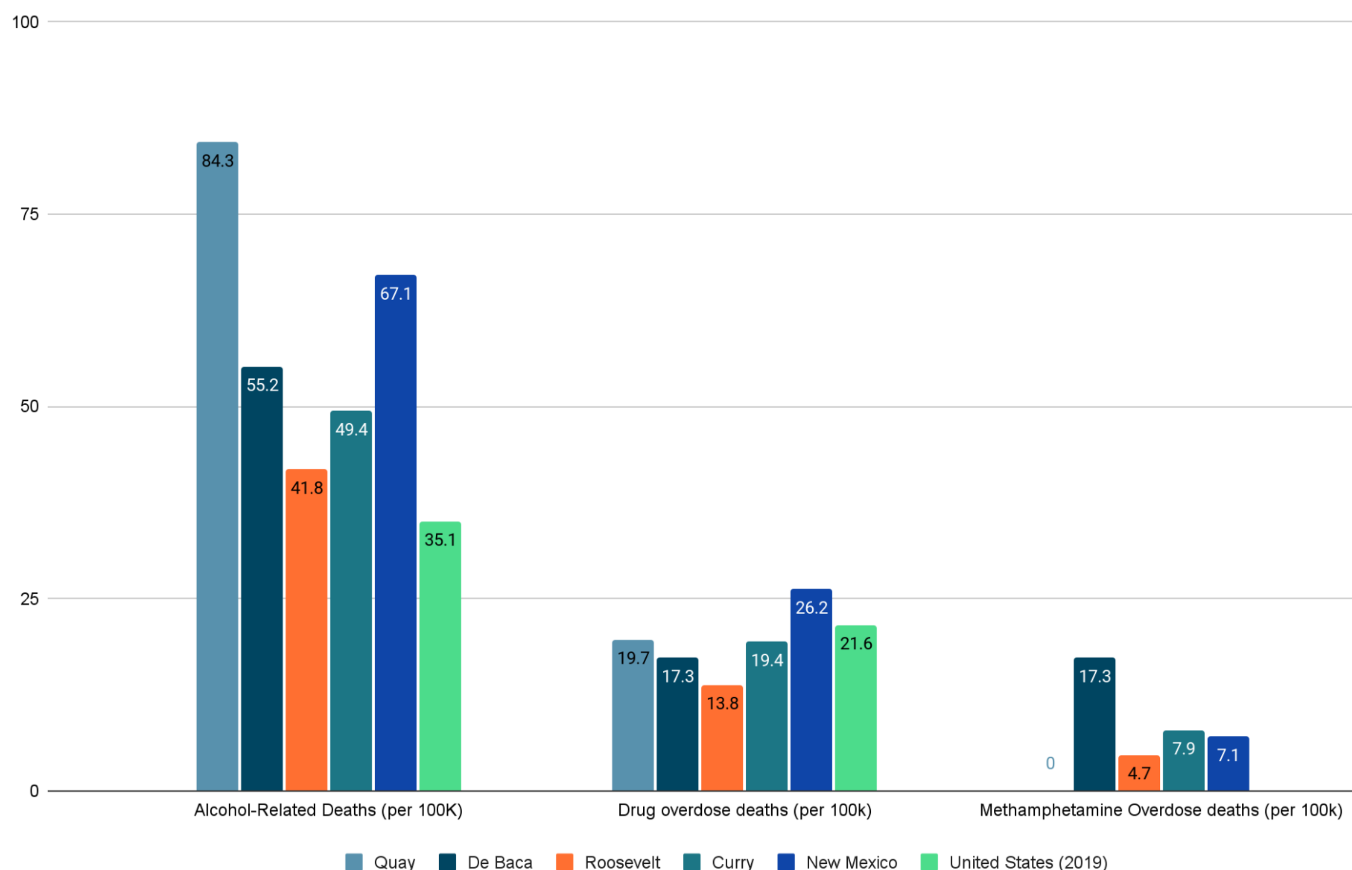



**Table 9.** SUD Related Mortality[1]

| Measure | Regional Data | | | | Comparative Data | |
|---|---|---|---|---|---|---|
| | Quay | De Baca | Roosevelt | Curry | New Mexico | United States (2019) |
| Alcohol-Related Deaths (per 100K) | 84.3 | 55.2 | 41.8 | 49.4 | **67.1** | **35.1** |
| Drug overdose deaths (per 100K) | 19.7 | 17.3 | 13.8 | 19.4 | **26.2** | **21.6** |
| Methamphetamine Overdose deaths (per 100K) | 0.0 | 17.3 | 4.7 | 7.9 | **7.1** | **Not available** |

Source: New Mexico Department of Health. New Mexico Substance Use Epidemiology Profile, 2021.

There were higher rates of alcohol-related deaths among American Indian, Asian/Pacific Islander, and Hispanic residents compared to all races in our rural target area between 2015-2019.

**Figure 4.** Alcohol-Related Death Rates by Race/Ethnicity and County (2015-2019)[1]

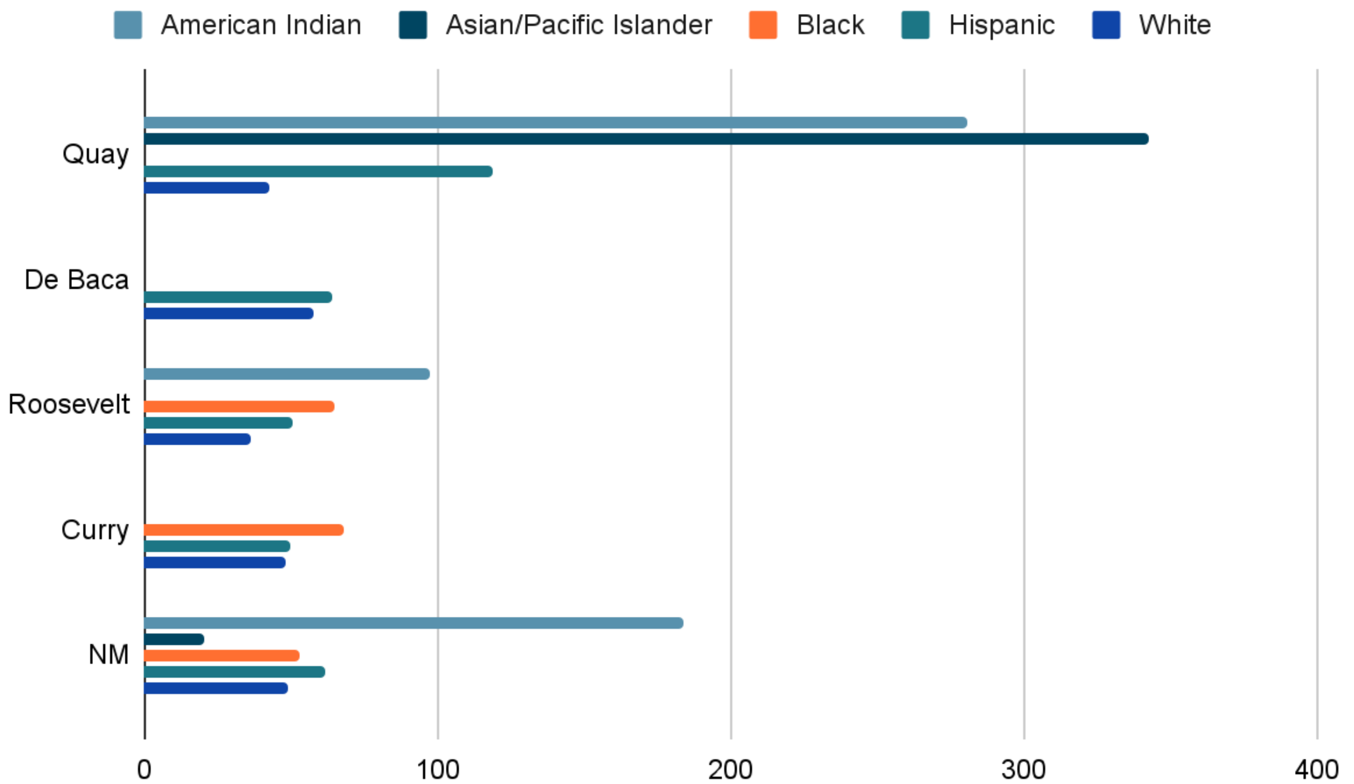


**Table 10.** Alcohol-Related Death Rates by Race/Ethnicity and County (2015-2019)[1]

| Race/Ethnicity | Regional Data | | | | Comparative Data |
|---|---|---|---|---|---|
| | Quay | De Baca | Roosevelt | Curry | NM |
| American Indian | 280.8 | 0.0 | 97.8 | 0.0 | **184.0** |
| Asian/Pacific Islander | 342.2 | 0.0 | 0.0 | 0.0 | **20.4** |
| Black | 0.0 | 0.0 | 65.2 | 68.5 | **52.8** |
| Hispanic | 118.9 | 63.9 | 50.8 | 50.0 | **62.2** |
| White | 42.5 | 58.2 | 36.2 | 48.2 | **49.2** |
| **All Races** | **84.3** | **55.2** | **41.8** | **49.4** | **67.1** |

Source: New Mexico Department of Health. New Mexico Substance Use Epidemiology Profile, 2021.

Drug overdose death rates were higher for White residents in three counties compared to all races and for Hispanic residents in De Baca County compared to all races, and for Black residents in Roosevelt County compared to all races.

**Figure 5.** Drug Overdose Deaths by Race/Ethnicity and County[1]

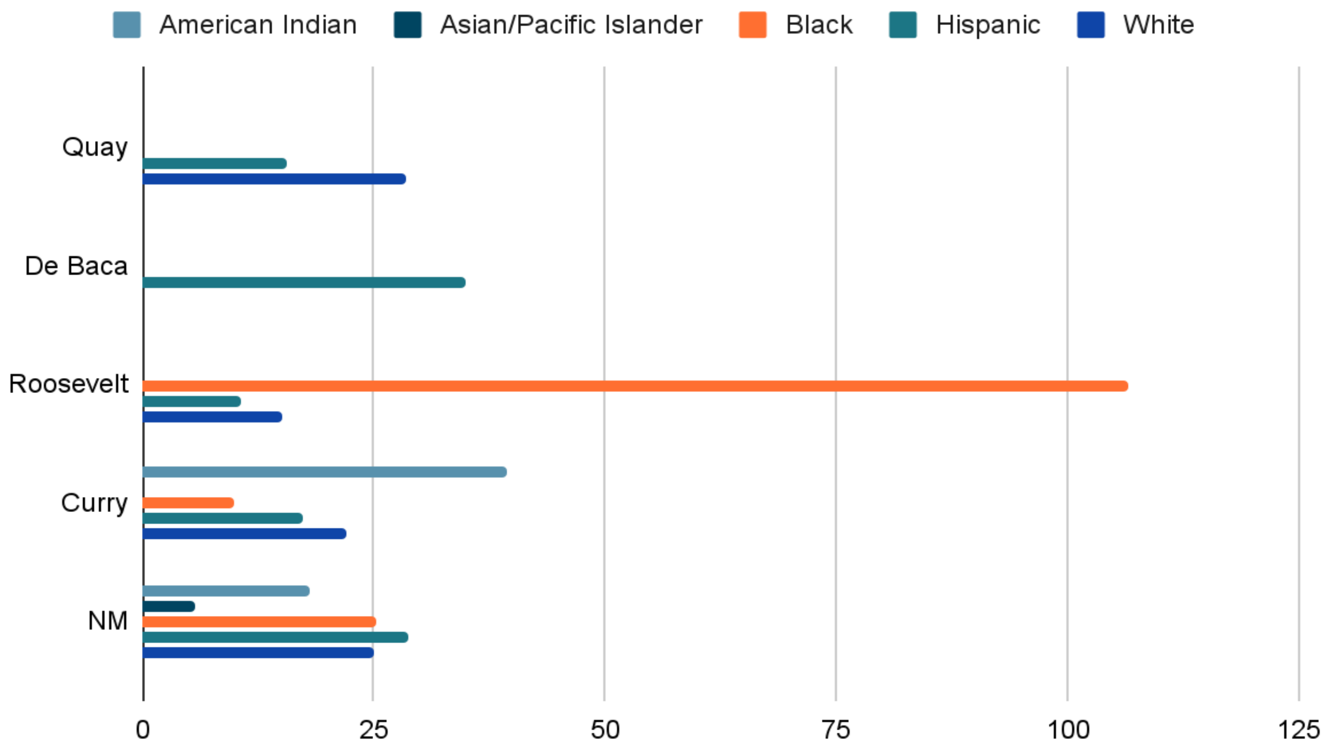



**Table 11.** Drug Overdose Death Rates by Race/Ethnicity and County (2015-2019)[1]

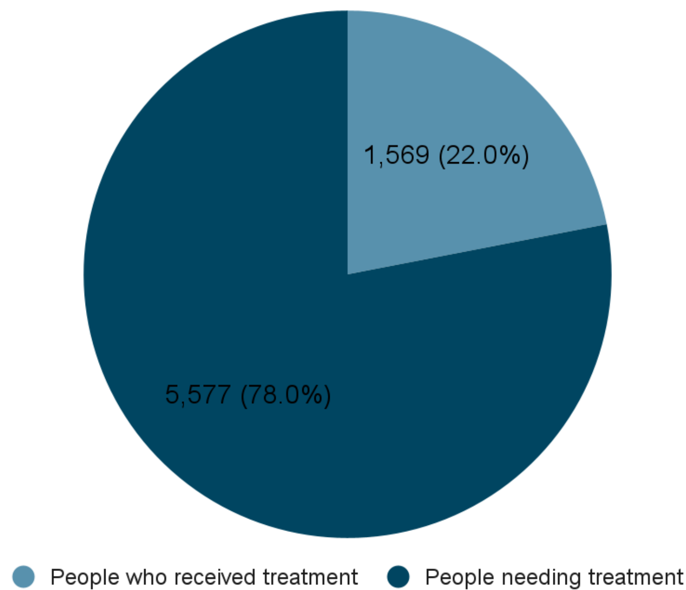
| Race/Ethnicity | Regional Data | | | | Comparative Data |
|---|---|---|---|---|---|
| | Quay | De Baca | Roosevelt | Curry | NM |
| American Indian | 0 | 0 | 0 | 39.4 | **18.0** |
| Asian/Pacific Islander | 0 | 0 | 0 | 0 | **5.6** |
| Black | 0 | 0 | 106.5 | 10.0 | **25.2** |
| Hispanic | 15.5 | 34.9 | 10.7 | 17.4 | **28.8** |
| White | 28.6 | 0 | 15.1 | 22.1 | **25.1** |
| **All Races** | **19.7** | **17.3** | **13.8** | **19.4** | **26.2** |

From a 2019 gap analysis conducted by the New Mexico Department of Health, there is a high level of unmet need for substance use treatment in our target area, with 71-81% of people with SUD not receiving any treatment in the last year, compared to 66% of people with SUD in the state overall. There are an estimated 7,146 people in our region living with a SUD. Of those, an estimated 5,577 did not receive treatment in 2019.

**Table 12.** Individuals Affected by SUD, by County and Treatment Status

| County | People living with SUD | People who received treatment | People needing treatment | % Persons with SUD not receiving treatment |
|---|---|---|---|---|
| Curry | 4,404 | 957 | 3,447 | 78% |
| De Baca | 185 | 44 | 141 | 76% |
| Quay | 835 | 245 | 590 | 71% |
| Roosevelt | 1,722 | 323 | 1,399 | 81% |
| Total | 7,146 | 1,569 | 5,577 | 78% |

**Figure 6.** Percentage of Individuals with Substance Use Disorder Receiving Treatment, 2019



## Adult Mental Health

Suicide continues to be a pressing public health issue as New Mexico ranks among the top five states in the US for suicide deaths. From 2015 to 2019, as many as 2,508 residents lost their lives to suicide. Regionally, three county rates approach the state rate, and in one county, Quay County, the suicide rate is much higher than the state rate. All of our target area county rates are much higher than the national rate for suicide deaths.

**Figure 7.** Suicide Deaths (2015-2019)[1]

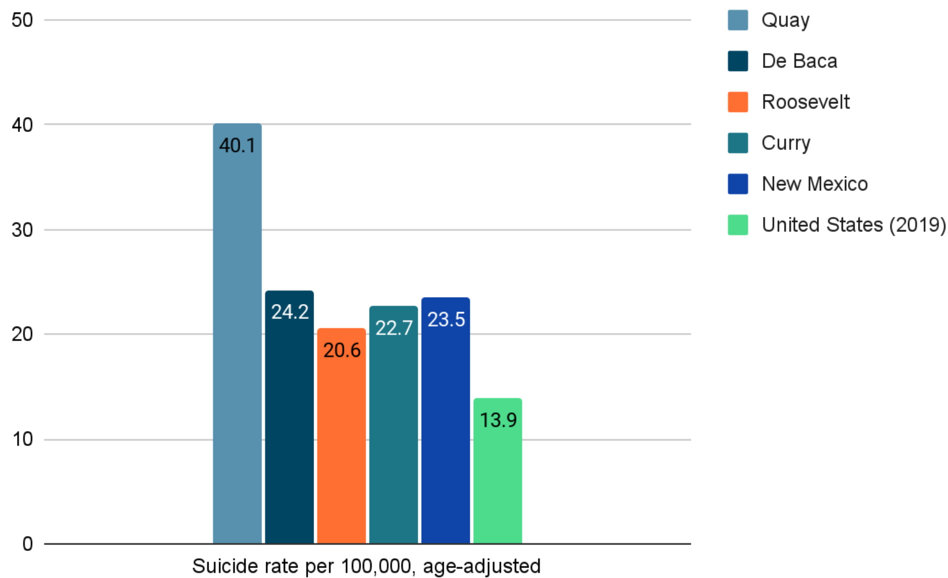



**Table 13.** Suicide Deaths (2015-2019)[1]

| Race/Ethnicity | Regional Data | | | | Comparative Data | |
|---|---|---|---|---|---|---|
| | Quay | De Baca | Roosevelt | Curry | New Mexico | United States (2019) |
| Suicide rate per 100,000, age-adjusted | 40.1 | 24.2 | 20.6 | 22.7 | **23.5** | **13.9** |

Source: New Mexico Department of Health. New Mexico Substance Use Epidemiology Profile, 2021.

The most recent data available at the state level regarding adult mental health is from the US Census Bureau Household Pulse Survey conducted from September 29 - October 11, 2021.[5] This survey estimated that 31.9% of adults in New Mexico are affected by anxiety or depressive disorder, similar to the national rate of 31.6%.

The most recent data available at the county level is self-reported 2017 Behavioral Risk Factor Surveillance Survey (BRFSS) data.[6] This survey reports the percent of adults with 6 or more days in the last month reporting their mental health as "not good." Rates are suppressed for two of our counties due to small numbers of responses, but for the other two, the overall rates appear higher than state and national rates, although the difference is not statistically significant.

**Table 14.** Adult Mental Health, 2016-2017

| Race/Ethnicity | Data for Rural Service Area | | | | Comparative Data | |
|---|---|---|---|---|---|---|
| | Quay | De Baca | Roosevelt | Curry | New Mexico | United States (2019) |
| **Adults with 6+ days in last month with mental health 'not good'** | ** | ** | 26.0 | 25.1 | **20.2** | **18.4** |

Source: Behavioral Risk Factor Surveillance System Survey Data, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, together with New Mexico Department of Health, Injury and Behavioral Epidemiology Bureau.

To estimate the number of adults affected by mental health conditions in our region, we used two approaches. First, we applied the state rate of adults with anxiety and/or depressive disorder from 2021 (31.9%) to the population of adults in the region.

**Table 15.** Estimate of Adults with Anxiety and/or Depressive Disorder, 2021

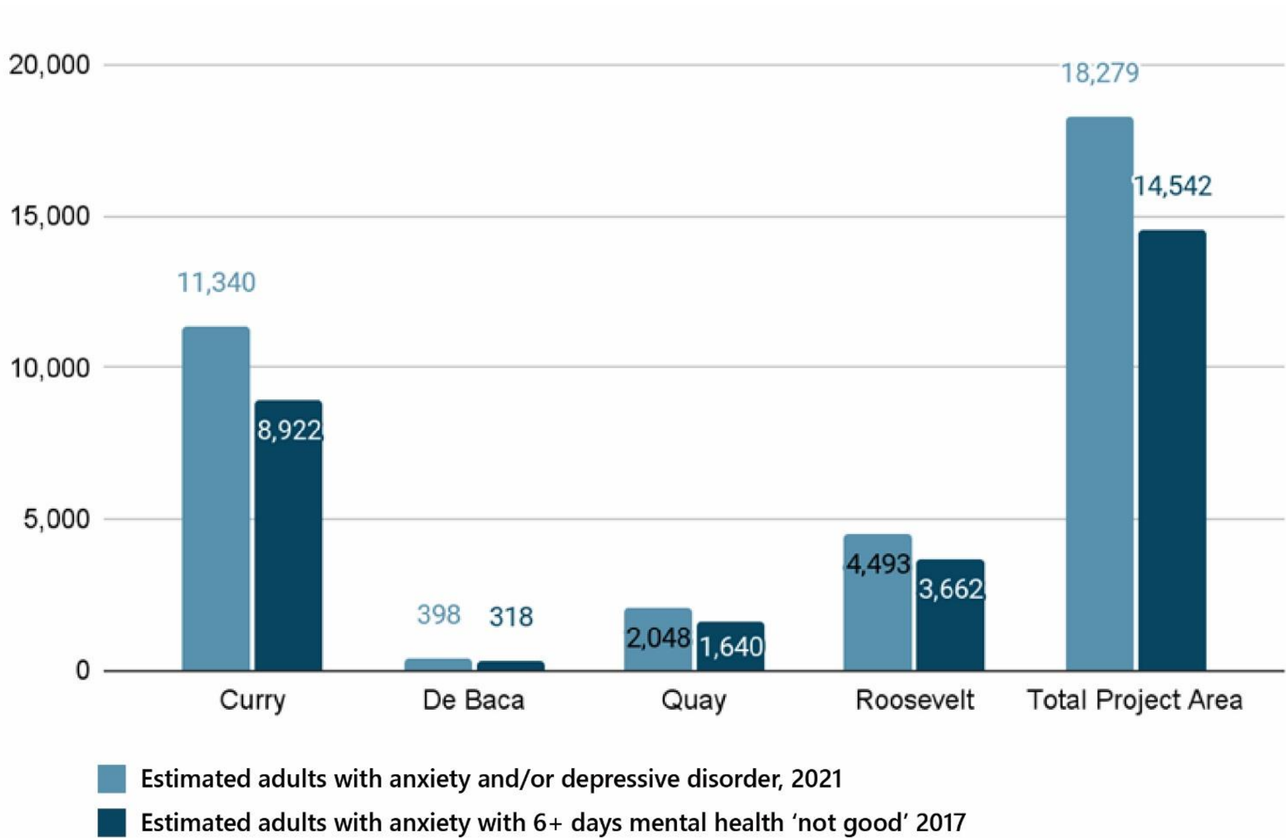
| County | Total Pop | Adult Pop (73.4%) | Est. Adults with anxiety and/or depressive disorder |
|---|---|---|---|
| Curry County | 48,430 | 35,548 | 11,340 |
| De Baca County | 1,698 | 1,246 | 398 |
| Quay County | 8,746 | 6,420 | 2,048 |
| Roosevelt County | 19,191 | 14,086 | 4,493 |
| Total | 78,065 | 57,300 | 18,279 |

Second, we applied the average rate of adults with 6+ days in the past month with mental health categorized as "not good" in Curry and Roosevelt counties (25.6%) to the population of adults in the region.

**Table 16.** Estimate of Adults with 6+ Days in the Past Month with Mental Health "Not Good"

| | Total Pop | Adult Pop (73.4%) | Est. Adults with 6+ days with mental health not good |
|---|---|---|---|
| Curry County | 48,430 | 35,548 | 8,992 |
| De Baca County | 1,698 | 1,246 | 318 |
| Quay County | 8,746 | 6,420 | 1,640 |
| Roosevelt County | 19,191 | 14,086 | 3,662 |
| Total | 78,065 | 57,300 | 14,543 |

**Figure 8.** Estimate of Individuals Affected by Mental Illness by County




Based on these analyses, we estimate approximately 14,531 - 18,279 adults in the region are affected by mental health conditions. However, this approach has several limitations. Nationally, there is an apparent increase in the prevalence of mental health conditions due to the disruptions associated with the COVID-19 pandemic, with most recent estimates showing a 25% increase in anxiety and depression worldwide.[7] The most recent county-level data is from the 2017 BRFSS which fails to capture that increase.

While the US Census Bureau survey was conducted in the fall of 2021, it is limited to self-reported anxiety and/or depressive disorder and does not necessarily reflect the rate of adults with other mental health conditions, such as schizophrenia and bipolar disorder. Even though localized data within the most recent years is limited, a variety of sources indicate that the COVID-19 pandemic has exacerbated mental health problems.[7–9] Therefore, estimates throughout this report, though lacking temporal sufficiency, should be seen as the minimum level of care required, where the actual needs of the community may be much higher. We took

this into account when projecting current and future service needs, as described in further detail below.

When we use local data to supplement the publicly available rate, it is clear that the need for behavioral health services in the region has grown rapidly in the past year. According to outpatient counselors and therapists in the area, the demand for appointments has increased and many offices have wait lists for patients to be seen. Behavioral health crises are on the rise, with crisis evaluations at the largest hospital in the four counties, Plains Regional Medical Center, up 7% in 2021 over the average of the four prior years.

**Table 17.** Crisis Evaluations at Largest Hospital in Project Area (2017-2021)

| ER Visits for Behavioral Health Crisis | | | |
|---|---|---|---|
| Year | Discharged | Transported to Inpatient Placement | Total Crisis Evaluations |
| 2017 | 323 | 180 | 503 |
| 2018 | 258 | 217 | 475 |
| 2019 | 309 | 193 | 502 |
| 2020 | 276 | 214 | 490 |
| **2021** | **322** | **205** | **527** |

Source: Hospital and Mental Health Agency Data.

## Adults with Substance Use Disorder and Mental Illness

Residents with both substance use disorder and mental illness, commonly referred to co-occurring disorders or dual diagnosis, face unique difficulties receiving care. According to several healthcare, EMS, and law enforcement representatives in the region, behavioral health patients who are transported to an inpatient mental health facility and have a substance in their system will not be admitted for treatment. Interview participants identified one facility available to community members for dual diagnosis care - Mesilla Valley Hospital in Las Cruces, NM, approximately 4.5 hours' drive from the largest population centers in the four-county region. Participants noted that it is very difficult to get into this program due to capacity constraints.

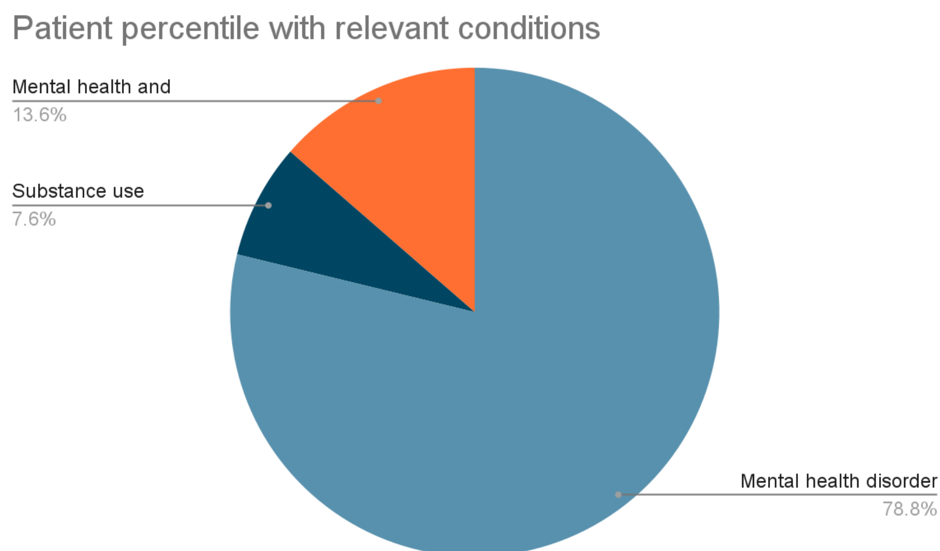
At a state level, of the 190,835 New Mexico Medicaid clients with a behavioral health diagnosis who received care in 2018-2019, approximately 13.6% had both a substance use disorder and a mental health disorder.

*"Substance abuse often goes hand in hand when people who are suffering mentally can't get the necessary help to address or cope with their symptoms. So yes, that can be part of the problem, but it is not the whole, and substance abuse does not mean that someone is less deserving of help." – Resident, Clovis*

**Table 18.** New Mexico Medicaid Clients with a Behavioral Health Diagnosis by Category (2018-2019)[10]

| Measure | New Mexico |
|---|---|
| Mental health disorder only | 78.8% |
| Substance use disorder only | 7.6% |
| Mental health and substance use disorder | 13.6% |

**Figure 9.** New Mexico Medicaid Clients with a Behavioral Health Diagnosis, by Category (2018-2019)[10]



## Child/Youth Behavioral Health

Children and youth living in the region experience a host of risk factors for substance use disorder and mental illness. The rate of child maltreatment in New Mexico is nearly twice the national rate at almost 17 children per 1,000, according to the State of New Mexico Legislative Education Study Committee Annual Report issued in January 2022.

School professionals report a dramatic increase in behavioral health issues in schools likely due to the negative impacts of school closures, isolation, and other pandemic-related experiences. As mentioned above, available data is limited to pre-pandemic surveys, and we expect the actual needs of the communities to have increased as a result of COVID-19.

Students in grades 6-8 in our target rural counties have high rates of thoughts of suicide, ranging up to 1 in 4 students. Substance use by young children less than 11 years old is prevalent. According to school counselors, youth substance use is often perpetuated by family members. Similarly, many students report improper use of prescription pain medication.

**Figure 10.** Mental Health and Substance Use Indicators, Grade 6-8 (2019)[11–14]

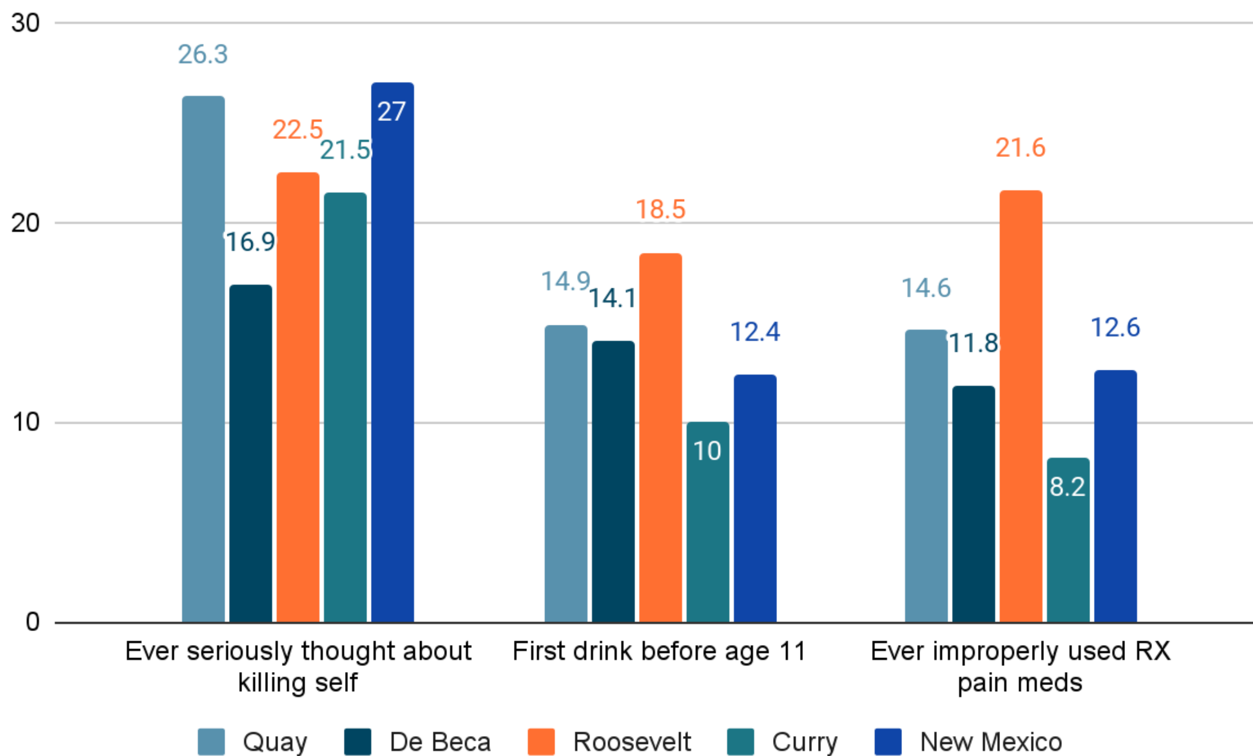



**Table 19.** Mental Health and Substance Use Indicators, Grades 6-8 (2019)[11–14]

| Measure | Data for Rural Service Area | | | | Comparative Data |
|---|---|---|---|---|---|
| | Quay | De Baca | Roosevelt | Curry | New Mexico |
| Ever seriously thought about killing self | 26.3 | 16.9 | 22.5 | 21.5 | **27** |
| First drink before age 11 | 14.9 | 14.1 | 18.5 | 10 | **12.4** |
| Ever improperly used RX pain meds | 14.6 | 11.8 | 21.6 | 8.2 | **12.6** |

Source: New Mexico Youth Risk Survey, 2019.

In New Mexico, a striking 40 percent of high school students (grades 9-12) report feelings of sadness and hopelessness. In our target counties, rates are not as high as the state overall but

still represent a significant proportion with up to approximately one-third of students experiencing these feelings. Suicidal ideation affects 9-18% of students.

Student substance use is prevalent. Between 12-25% of students report marijuana drug use, which may increase due to the recent legalization of marijuana in New Mexico in 2022. Across the four counties, 8-15% of high school students report improper pain medication use.

**Figure 11.** Mental Health and Substance Use Indicators, Grades 9-12 (2019)[11–14]

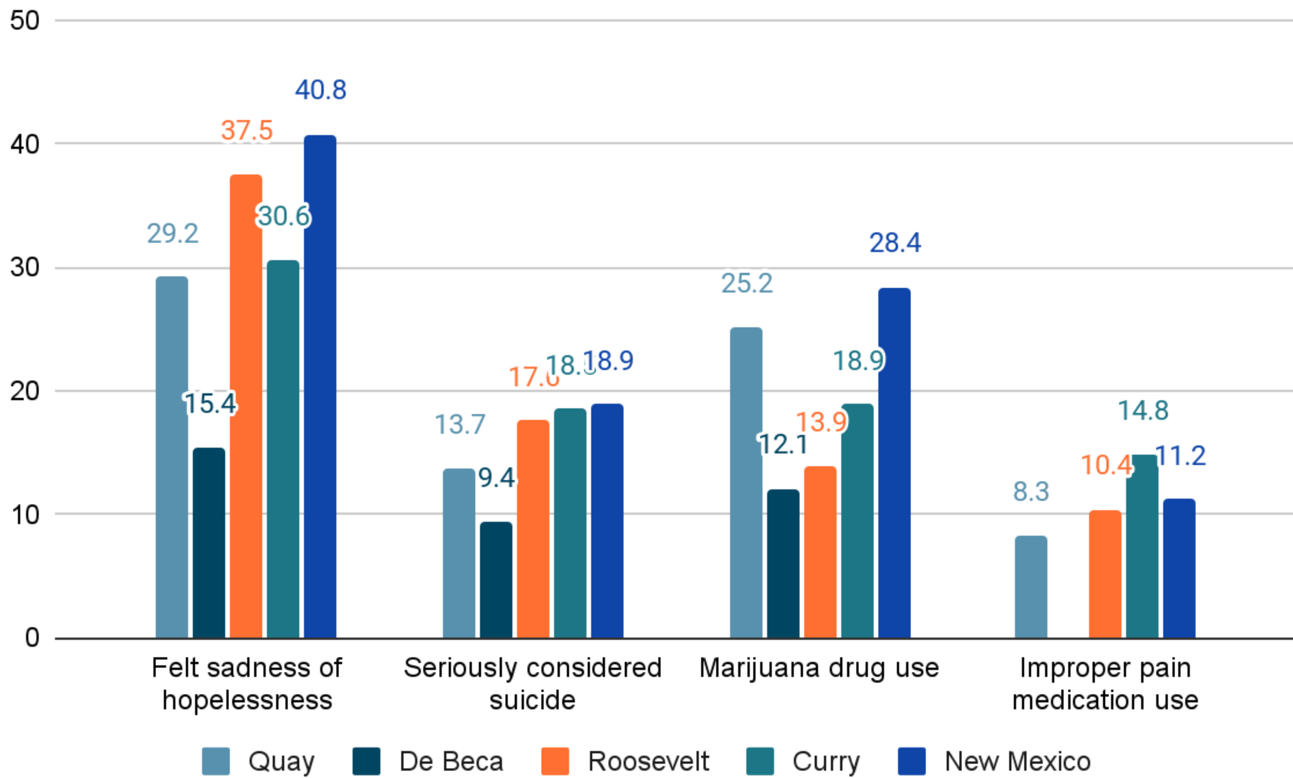


**Table 20.** Mental Health and Substance Use Indicators, Grades 9-12 (2019)[11–14]

| Measure | Data for Rural Service Area | | | | Comparative Data |
|---|---|---|---|---|---|
| | Quay | De Baca | Roosevelt | Curry | New Mexico |
| Felt sadness of hopelessness | 29.2 | 15.4 | 37.5 | 30.6 | 40.8 |
| Seriously considered suicide | 13.7 | 9.4 | 17.6 | 18.5 | 18.9 |
| Marijuana drug use | 25.2 | 12.1 | 13.9 | 18.9 | 28.4 |
| Improper pain medication use | 8.3 | - | 10.4 | 14.8 | 11.2 |

Source: New Mexico Youth Risk Survey, 2019.

There are close to 14,000 students in public schools across the region. This includes kindergarten or preschool through twelfth grade. Superintendents from each school district in the region provided the number of students enrolled in the 2021-2022 school year.

**Table 21.** Number of Students in Public Schools Per County, 2022

| County | Number of Students (all public school grades) |
|---|---|
| Curry | 8,992 |
| De Baca | 270 |
| Quay | 1,357 |
| Roosevelt | 3,239 |
| Total | 13,858 |

Source: School superintendents.

Families in the region are affected by parental substance use, parental incarceration and overdose death, and adverse childhood experiences (ACEs) which are suffered both by parents when they were children, and then by their own children. According to the June 2021 issue of

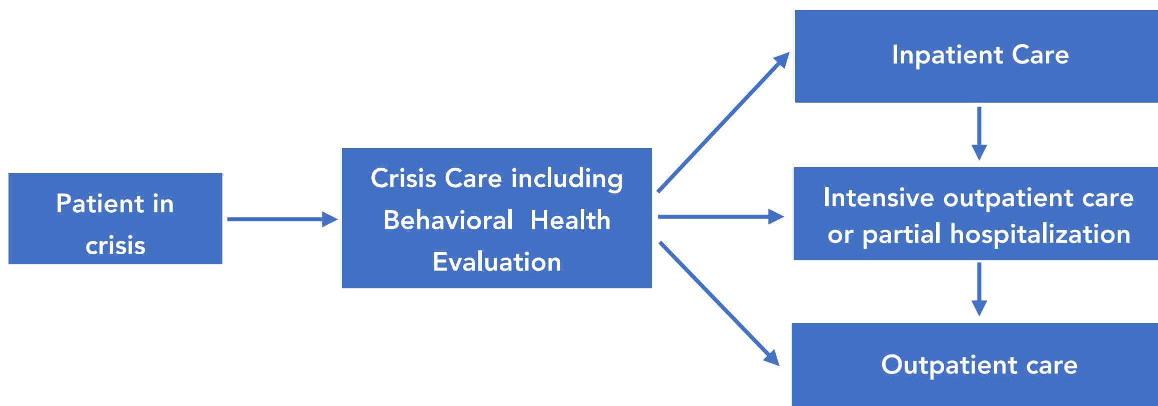
*New Mexico Epidemiology*, as many as one in seven children in the state have experienced three or more ACEs, putting them at significant risk for substance use disorders and other behavioral health conditions.[15]

## Gap Analysis: Behavioral Health Services

### Introduction

Individuals experiencing a behavioral health crisis have an urgent need for care. A behavioral health crisis can be related to an acute psychotic episode, suicidal or homicidal ideation, substance overdose or acute withdrawal, or other acute symptoms. Community members experiencing a crisis should be evaluated by behavioral health professionals and routed to the appropriate level of care based on their individual needs. Different levels of intensity and resources are required based on the individual situation. Inpatient care is provided when an individual is experiencing acute symptoms that require intensive care and 24/7 monitoring. Not all individuals in crisis need inpatient care.

**Figure 12.** Mental Health Patient Journey Example




In the inpatient setting, short-term, intensive, highly structured treatment is offered in a 24/7 residential service. Care includes therapy, medication management, education, activities, and discharge planning, and is provided by a multidisciplinary team including psychiatrists, psychiatric nurses, social workers, and other clinicians.

Intensive outpatient programs (IOP) and partial hospitalization programs are often accessed after inpatient care as a means of 'stepping down' to a less intensive level of care. They are also

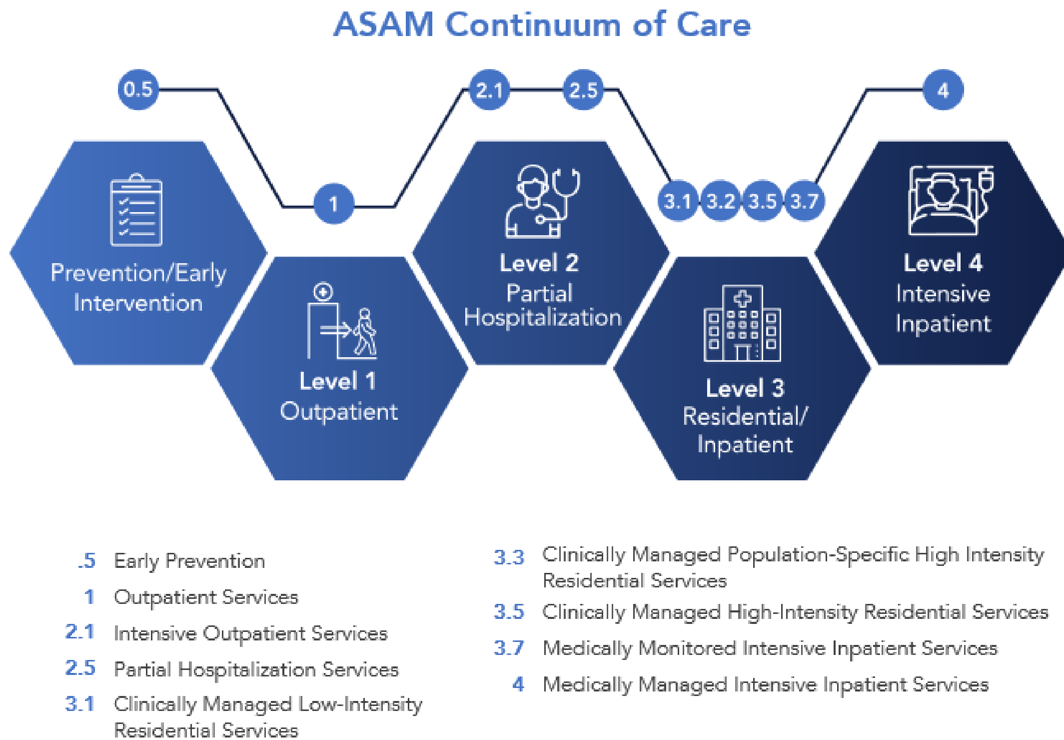
accessed directly by individuals who have not recently received inpatient care but would benefit from more intensive services than a standard outpatient appointment. IOPs and partial hospitalization programs provide intensive services during the day or evening. Individuals typically receive services up to 4 hours per day several days per week. Care may include individual and group therapy, peer support, mediation management and psychiatric consultation.

Standard outpatient care is a level of care that is typically accessed on an ongoing, longitudinal basis to manage a behavioral health condition and support an individual's recovery. Individuals may access care weekly or bi-weekly or at a frequency that suits their needs. Care may include individual and group therapy, medication management, and psychiatric consultation.

Medication assisted treatment is the use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders.[16] Medications support individuals in establishing and maintaining recovery.

For substance use disorder specifically, the American Society of Addiction Medicine (ASAM) provides a continuum of care and tools for clinicians to assess what services are needed along the continuum.[17] Services range in intensity from prevention/early intervention to intensive inpatient care.

**Figure 13.** ASAM Continuum of Care




National guidelines recommend that every community has access to three types of crisis services, [18] in addition to a continuum of behavioral health care:

- Regional crisis call center
- Crisis mobile team response
- Crisis receiving and stabilization facilities

We evaluated the availability of behavioral health services in the four-county region by comparison to national guidelines, ASAM criteria, and other benchmarks.

## Inpatient Care

*"New Mexico is in a mental health crisis and eastern New Mexico has nothing in place for acute behavioral health treatment."* – Resident, Clovis

There is a significant gap in services available in the region for inpatient mental health and substance use disorder care. Residents must travel 1.5 hours to 5+ hours for inpatient mental health care, traveling outside of the region, and often across the state border to Texas. Long distances to inpatient mental health care create many challenges, including:

- Challenges for families to visit their loved ones
- Children separated from their families
- Children and adults not receiving treatment because it is too far away or they lack transportation back home
- Burden on local EMS and law enforcement transportation resources
- For active-duty military at Cannon Air Force Base, long distances make it very difficult for the unit to provide support to the service member while they are hospitalized

Inpatient bed availability is a challenge across the state. Local hospital emergency rooms are the first point of contact with the health system for individuals in crisis. Hospitals must call many different facilities to find an inpatient bed. The lack of locally available inpatient behavioral health care causes many issues:

- Individuals do not get care they need in a timely manner
- Individuals in crisis go to the hospital ER and stay there for days until a bed opens
- Individuals in crisis with outstanding charges will be arrested and brought to jail, where they can remain for months, even on charges as minimal as trespassing
- Individuals do not seek care when they need it because of the poor experience and difficulties accessing care
- Individuals who are in need of inpatient hospitalization but are waiting for a long time due to bed availability are discharged home from the local hospital

*"My nephew has needed an acute admission since mid-January. He is suicidal and homicidal - we have begged [the local hospital] to safely transport him to an acute facility. Every time he is discharged home. My family can not safely transport him to Amarillo, Roswell, Las Cruces, Albuquerque... they can barely safely get him to the emergency room after coaxing him- to only be released."* - Resident, Clovis

On top of the uncertainty of care and long transport to a behavioral health facility, acute psychiatric patients often first experience long hospital emergency department (ED) boarding times. Psychiatric patients who experience longer boarding times are associated with increased acute antipsychotic and sedative medication use while in the ED and increased risk of admission, while also requiring additional medical staff to provide 24/7 high-level observation care.[19] In some cases, the patient is discharged from the ED, having not received any behavioral health care. The untreated or undertreated behavioral health issue inevitably

resurfaces, and patients often wind up back in the ED. The result is a cycle of expensive, yet low quality behavioral health care.

Several sources indicated that individuals are transferred to inpatient psychiatric care only when they are experiencing suicidal or homicidal ideation. Acute psychotic episodes without suicidal or homicidal ideation usually result in discharge home from an emergency room. As one interviewee stated, *"You can be actively psychotic and walk out of the hospital as long as you aren't going to kill yourself or someone else."*

Similarly, many sources reported the typical inpatient mental health length of stay is three days. This relates to the common nature of inpatient admissions, namely that individuals are put on a "72-hour hold," which is an involuntary admission deemed necessary for their safety and lasts for a duration of 72 hours. The fact that individuals do not stay to complete the typical 7-8 day inpatient stay may be due to underlying factors such as: patients do not wish to stay at the inpatient facilities based on their experience or for other reasons, or that inpatient facilities are facing such extreme capacity challenges that they aim to discharge patients after 72 hours.

Upon returning to the community, individuals struggle to get into outpatient care in a timely fashion and to get access to medications. They often leave an inpatient facility with 3-7 days of medication and need to see a provider to follow up, but due to access issues cannot be seen for 2-4 weeks. According to several interview participants from various sectors, this often results in people returning in crisis to the hospital emergency rooms only to start the cycle again.

Transportation is also a huge challenge for these communities, as EMS or law enforcement are tasked with transporting behavioral health patients to inpatient facilities that are very far away. This results in delays, emergency room boarding, and also strains these systems and resources.

Inpatient substance use care is not available within the four-county region. Individuals must be transported 1.5 to 5+ hours outside of the target rural area to Lubbock or El Paso, TX or Las Cruces, NM. Compounding this, these facilities are difficult to get into due to capacity issues. This results in a dangerous situation where Individuals in withdrawal from substances withdraw in the hospital emergency room or jail, or in the community. Tragically, we learned of one man who had died in a county detention center during withdrawal from fentanyl because the level of care he needed was not available. As with inpatient mental health care, individuals who are leaving SUD treatment programs and returning to the community face many challenges getting into outpatient care and establishing the resources they need to support their recovery.

We were able to obtain data from Roosevelt General Hospital (RGH), one of the three acute care hospitals in the region, regarding behavioral health patient transfers from the emergency room to another facility for inpatient care. In 2021, records indicate that 144 patients were transferred from the emergency room. Data was not available for 24 transfers (17%). Of the remaining 83%, patients were most commonly transferred to three facilities:  Eastern New Mexico Medical Center in Roswell, Mesilla Valley Hospital in Las Cruces, and Northwest Texas Health System in El Paso. These facilities range from 88 to 269 miles and 1.3 to 4.3 hours' drive (one-way) from the originating hospital emergency room.

**Table 22.** Behavioral Health Patient Transfers from RGH by Facility, 2021

| Facility | Number of Transfers | Distance (time) | Distance (miles |
|---|---|---|---|
| Eastern New Mexico Medical Center - Sunrise Mental Health Center | 37 | 1 hr, 19 min | 88 |
| Mesilla Valley Hospital | 35 | 4 hr, 20 min | 269 |
| Northwest Texas Health System - The Pavilion | 16 | 2 hr, 9 min | 127 |
| Peak Behavioral Health | 12 | 4 hr, 52 min | 299 |
| Covenant Medical Center | 4 | 1 hr, 47 min | 107 |
| Haven Behavioral Health Hospital of Albuquerque | 3 | 3 hr, 38 min | 228 |
| UNM Children's | 2 | 3 hr, 43 min | 229 |
| University Medical Center of El Paso | 2 | 4 hr, 38 min | 292 |
| University Behavioral Health Denton | 2 | 6 hr, 10 min | 399 |
| Central Desert Behavioral Health Center | 2 | 3 hr, 37 min | 230 |
| Gerald Champion | 1 | 3 hr, 20 min | 204 |
| Rio Vista | 1 | 4 hr, 44 min | 293 |
| Oceans Behavioral Hospital | 1 | 2 hr, 8 min | 126 |
| Presbyterian Kaseman Hospital | 1 | 3 hr, 35 min | 223 |
| Presbyterian Rust Medical Center | 1 | 3 hr, 52 min | 243 |
| Total | 120 | | |

As shown in the table below, resources available for transport of individuals to behavioral health facilities differ across the counties and municipalities. Notably, in Quay County, Tucumcari EMS does not transport behavioral health patients out of the region, only medical patients. Additionally, we learned that the Quay County Sheriff's Department is unable to transport adolescents to behavioral health care, leaving families with no option but to try to transport their young loved one themselves, which can be a very unsafe situation.

**Table 23.** Transportation to Behavioral Health Care by Entity

| Entity | Annual Volume Est. | Raw Data | Time Frame | |
|---|---|---|---|---|
| Curry County | 13 | 16 | 1/2021-3/2022 | Transports limited to prisoners, or those who require a deputy to join medical transport |
| City of Clovis | 316 | 67 | 1/2022-3/2022 | Clovis Fire/EMS transports from PRMC to behavioral health facilities |
| Roosevelt County | TBD | TBD | | Transports limited to prisoners (per data, not interview) |
| City of Portales | 423 | 423 | 1/2021-12/2022 | Police transport from RGH |
| De Baca County | 20 | 25 | 1/2022-3/2022 | EMS transports |
| Quay County Sheriff | 48 | 13 | 1/2021- 3/2022 | Sheriff transports; city EMS only transports medical transfers, not behavioral health<br><br>Sheriff is unable to transport adolescents |

Compounding this, we heard from several county and city representatives about times they transported a patient only to have them turned away from the admitting facility due to not meeting the required level of care, having a substance in their system, or the facility being full, despite the fact that the hospital called ahead of time to secure a bed.

## Residential Care

Residential care for substance use disorder is an important part of the continuum of care. There are varying levels of intensity of residential care, with different levels of clinical care available.

Individuals can move from one setting to another based on their level of need. Residential programs for individuals who need little to no medical care typically provide programs lasting 90 days to 6 months or more, to allow individuals to make progress in their recovery before living on their own.

There is one program in the four-county region, Lighthouse Mission, a faith-based program which provides separate residential programs for men and women. These programs are not certified, and do not provide healthcare, but offer a supportive environment for individuals who are seeking sobriety. The population they serve is limited to men and women who are not on psychotropic medications due to the lack of clinically trained personnel on staff, and they do not have programs for adolescents, or the ability for parents to have children with them.

Other inpatient rehabilitation facilities accessed by residents are a far distance away, in Espanola, Rio Rancho, Hobbs, Carlsbad, and Albuquerque, New Mexico. Minimum lengths of stay at these facilities vary from 30, 60, and 90 days to 6 months or 18 months. Capacity is very limited.

### Outpatient Care

Outpatient mental health services are available in the region and are concentrated in the municipalities. Outpatient services are available from various settings:

- Solo and group counselors and therapists
- One psychiatric nurse practitioner solo practice in Portales
- One hospital-based outpatient behavioral health clinic with two providers at Roosevelt General Hospital
- One community mental health agency with offices in each of the counties: Mental Health Resources, Inc
- Jail-based providers at the four county detention centers
    - Curry County: psychiatric nurse practitioner, social workers
    - Roosevelt County: psychiatric nurse practitioner, social workers, medication assisted treatment program for opioid use disorder
    - De Baca County: one social worker who provides ½ day coverage per week
    - Quay County: one group counseling agency provides counseling one day per week

Services include:

- Various providers:
  - Individual counseling for mental health and SUD
  - Family counseling
  - Telehealth counseling and therapy
  - Play therapy for children (2 providers)
- Community mental health agency (access to services are constrained by workforce shortages):
  - Group counseling for SUD, behavioral health, and anger management
  - Juvenile substance abuse group
  - Intensive outpatient program for SUD
  - Psychiatry and medication management (all psychiatry is provided via telehealth)
  - Multi-systemic therapy: intensive home and community-based treatment for adolescents and their families
  - Comprehensive Community Support Services for individuals with a serious mental illness or children with a serious emotional disturbance
  - Psychosocial Rehabilitation Services for individuals with severe and persistent mental illness
  - Certified Peer Support Services
  - Regional crisis hotline operated by the community mental health agency
  - Walk-in crisis services during business hours
- Psychiatric Nurse Practitioners and medication management (5 providers; 2 are jail-based, 2 are hospital-based, 1 solo practitioner)
- Medication assisted treatment for opioid use disorder (2 providers, 1 is jail-based)
- Crisis evaluations at hospital emergency departments provided by the community mental health agency (2 hospitals) or a group counseling agency (1 hospital)

In the most populous areas such as the cities of Clovis and Portales, there are a few peer recovery groups available such as Alcoholic Anonymous (AA), Narcotics Anonymous (NA), and Celebrate Recovery. However, according to our interviews, individuals in AA or NA have difficulty finding sponsors who can support them in their recovery.

There are no psychiatrists practicing in the region. However, some community members travel to Albuquerque or other far distances to establish care with a psychiatrist, and then see a local

psychiatric nurse practitioner regularly and travel less frequently (i.e., twice per year) to see their psychiatrist. This type of collaborative care model allows individuals with complex conditions to see local psychiatric nurse practitioners instead of having to travel 3.5 hours or more one way to see a provider on a regular basis.

Given the lack of psychiatrists in the area, access to psychiatric medications is limited. Mental Health Resources, Inc. (MHR) provides access to medication through a telehealth-based provider service. However, according to our interviews, there are limitations on this service that impede access. Individuals with certain more severe forms of mental illness may not be able to use the service due to their level of need, and there is a requirement by the agency that individuals engage in counseling in order to access their medication. This requirement can become a challenge for patients due to scheduling issues and limited availability of counselors, which can result in a gap in medication access and increased risk of a crisis event. Aside from Mental Health Resources, Inc., there are three nurse practitioners who prescribe psychiatric medications, two at Roosevelt General Hospital and one solo practitioner.

Mental Health Resources, Inc. is the sole provider of intensive outpatient programs (IOP). There are no partial hospitalization programs in the region. Partial hospitalization and intensive outpatient programs provide more hours of care per week than standard outpatient care and can be accessed directly or as a 'step down' from a higher level of care such as inpatient care. This level of care is an important part of recovery and wellness especially for those who benefit from a higher level of support after a crisis or inpatient stay as they transition back to home. We were unable to obtain data on the number of individuals served annually by IOPs. According to our interviews, these programs are valued by the community but may not provide capacity to meet the need.

There is a lack of outpatient services generally for substance use disorder. Specifically, there is a lack of Licensed Alcohol and Drug Addiction Counselors (LADAC) in the region. To the best of our knowledge, there are 2-3 LADACs who practice in the four-county area of 78,000 people. One court system professional in speaking of individuals with SUD on probation stated, "Many of them need to be seen once per week, and are lucky if they get in once a month." Mental Health Resources, Inc., provides counseling and intensive outpatient treatment for SUD. However, the agency is constrained by staffing challenges that limit access to care. For individuals referred to care from a court program, the wait can be 3-4 weeks to be seen.

*"We have MHR or Matt 25 - they are overflowing with need and not having enough counselors."* – Court compliance officer

There is very limited access to medication assisted treatment. Primary care providers offer access to naltrexone for alcohol use disorder, but do not prescribe buprenorphine for opioid use disorder. Persistent stigma, perceptions among providers about buprenorphine treatment as "substituting one drug for another," and concerns about liability if buprenorphine was sold on the street after prescribing were reported. There is just one community-based provider who prescribes MAT for opioid use disorder, at Roosevelt General Hospital. The closest methadone clinic is in Roswell, New Mexico, 1.5 hours or more drive one way for most residents, who would need to make that trip on a daily basis in order to maintain methadone treatment.

A large proportion of residents in the region are Hispanic (43% of residents, twice the national rate). As described above, Hispanic residents suffer higher rates of alcohol-related deaths and in some areas, drug overdose deaths. Despite these outcomes and the need for services, there is a lack of Hispanic providers in the region, and even a lack of providers who can provide care in Spanish. This creates a very difficult situation for Hispanic residents for whom their preferred language is Spanish.

There are additional limitations in access to services for both children and seniors. For children, there are only two counseling agencies in the region that provide play therapy, which is a key therapy for young children who have experienced trauma. For seniors, access is very limited because of Medicare reimbursement. Medicare does not reimburse services provided by social workers unless they are licensed at the independent level, and most social workers in the area are not licensed at this level. These factors result in large gaps in care for some of the most vulnerable residents in the area.

## Crisis Care

### Regional Crisis Call Center

Currently, there is one regional hotline in the region, operated by Mental Health Resources, Inc. This hotline provides telephonic support for individuals in crisis and assistance in accessing resources such as outpatient services. There is also a statewide Crisis and Access Line for individuals in crisis to speak to a counselor who can assess the situation, provide telephonic

support, and refer the caller to local resources. In July 2022, New Mexico will transition to 988, a three-digit calling system for behavioral health.

We recommend alignment between the current regional hotline provided by Mental Health Resources, Inc. and 988 such that Mental Health Resources, Inc. would receive 988 calls for the region and/or coordinate with a 988 hotline to provide follow up care for individuals who need an outpatient appointment and are calling from the Mental Health Resources, Inc. service area.

### Mobile Crisis Teams

There are currently no mobile crisis teams (MCTs) in the four-county region. This places the burden of response to 911 calls for behavioral health crises on law enforcement and emergency medical service (EMS) personnel, who are not trained in behavioral health.

Mobile crisis teams are deployed by urban and rural communities throughout the country, and are adept at resolving crisis situations. Studies suggest that MCTs are effective at diverting people in crisis from psychiatric hospitalization, connecting these people to outpatient services, and linking suicidal individuals discharged from the emergency department to services.[18,20–24] This may be due to MCTs utilization of both professional and paraprofessional staff, which includes clinicians and peer support specialists.[18] MCTs have been shown to be effective in reducing costs as well because they are able to de-escalate situations and assist individuals in avoiding inpatient hospitalization, a high-cost service. These studies have found that MCTs resulted in a 23% lower average cost per case[23] and reduced costs associated with inpatient hospitalization by approximately 79%.[25]

Several models of mobile crisis exist, including MCTs responding alone, co-responding with law enforcement, and enhanced training for law enforcement on responding to behavioral health crises. The Law Enforcement Assisted Diversion (LEAD) program is a public safety program where jail, arrest, and prosecution of individuals is diverted by police officers who turn to community-based health services instead. Eligible individuals for diversion are those suspected of low level, non-violent crime driven by unmet behavioral health needs. Instead of arrest, police officers refer these individuals into a trauma-informed intensive case-management program where the individual receives a wide range of support services. The LEAD program, currently in operation in Bernalillo County, NM, reduces reliance on the

criminal justice system and turns individuals to public health resources instead. The program helps stop the cycle of arrest, prosecution, and incarceration by addressing behavioral health issues that have been left untreated. The LEAD program also addresses homelessness and extreme poverty.[26] Notably, this program's success is dependent on the availability of resources for police officers to divert individuals.

There are resources available for establishing mobile crisis response. Following is a list of resources that set expectations and best practices for mobile crisis teams:

- SAMHSA minimum expectations to operate and best practices to operate a mobile crisis team
- University of New Mexico Mobile Crisis Team Recommendations

Given the geographical distribution of residents, travel time for a mobile crisis team to reach a person in crisis may be 1-2 hours. However, this is an improvement on current practices since currently, law enforcement is responding to these calls without the support of behavioral health professionals, meaning more time elapses before a person in crisis has access to services.

Additionally, we interviewed the Behavioral Health Services Division of the New Mexico Department of Human Services, which indicated interest in piloting a program in New Mexico that would provide crisis support via telehealth. In this model, a trained lay person or first responder would be equipped with a tablet and the ability to connect a person in crisis to a behavioral health professional via videoconference.

### Crisis Receiving and Stabilization Facilities

There are currently no crisis stabilization centers in the four-county region or in nearby counties. Mental Health Resources, Inc. offers walk-in crisis services during business hours whereby individuals can speak with a behavioral health clinician. However, the full range of crisis stabilization services such as in a crisis triage center are not available.

Crisis triage centers were established via New Mexico statute in 2015 and updated in 2018 to provide stabilization of behavioral health crises as outpatient stabilization or short-term residential stabilization in a residential rather than institutional setting, which may provide an

alternative to hospitalization or incarceration.[27] In 2019, Centennial Care, the New Mexico Medicaid program, began reimbursing for crisis triage center services. These facilities are relatively new to the state but similar facilities have been established in other states for many years.

By providing urgent behavioral health services in an appropriate environment, Crisis Triage Centers can de-escalate and stabilize patients within 24 hours or during a short (24-72 hour) stay, avoiding unnecessary psychiatric inpatient admissions. In alignment with the New Mexico Administrative Code 7.30.13.9, patients receive comprehensive medical history and physical examination at admission, and crisis stabilization services to include, but not limited to, crisis triage, screening and assessment, de-escalation/stabilization, brief intervention and psychological counseling, and peer support.[27]

Lack of behavioral health crisis resources in the community means individuals in crisis are either taken to the local hospital emergency room or to jail. For people in crisis, these locations provide safety but are not conducive to improving their mental health. In our interviews with law enforcement, detention center, EMS, and hospital personnel, many expressed similar concerns that they were unable to meet the behavioral health needs of people in crisis and instead felt they were making the crisis situation worse.

*"Too often have we had to run in circles, from one crisis hotline to the next, back to mental health resources, over to police who then direct us to the hospital that directs us back to the police, and so on. In the end, very little help came, and we were dismissed to wait it out."*–
Resident, Clovis

These conditions result in a significant use of public safety resources, with unfavorable impact to the systems and the people served. Public safety data related to emergency calls for behavioral health situations were provided to us by city and county representatives.

**Table 24.** Behavioral Health Related Emergency Calls, Annual Volume Estimates

| Mental Health / Overdose / Suicide Attempt Emergency Calls | Annual Volume (est.) |
| --- | --- |
| Curry County | 45 |
| City of Clovis | 261 |
| Roosevelt County & City of Portales | 92 |
| De Baca County | 100 |
| Quay County | 112 |
| Total Calls/Responses | 610 |

## Behavioral Health and Justice Systems

*"Not surprisingly, the prevalence of mental illness and substance use disorders (SUDs) in jails and prisons are three to four times that of the general population. Once in jail, people with mental illness are incarcerated twice as long, and few receive needed treatment. Upon release, with Medicaid benefits interrupted and a criminal record, they are likely to be unemployed, homeless, and arrested. Thus, the cycle continues."*

- SAMHSA Executive Order: Safe Policing for Safe Communities: Addressing Mental Health, Homelessness, and Addiction Report.

Data from the Curry County Detention Center, the largest detention center in the region, indicate that many detainees need behavioral healthcare.

- 65% of individuals have a mental health condition, including major disorders
- 45% of individuals are on psychotropic medications
- Recidivism rate within 90 days: 70% of detainees come back

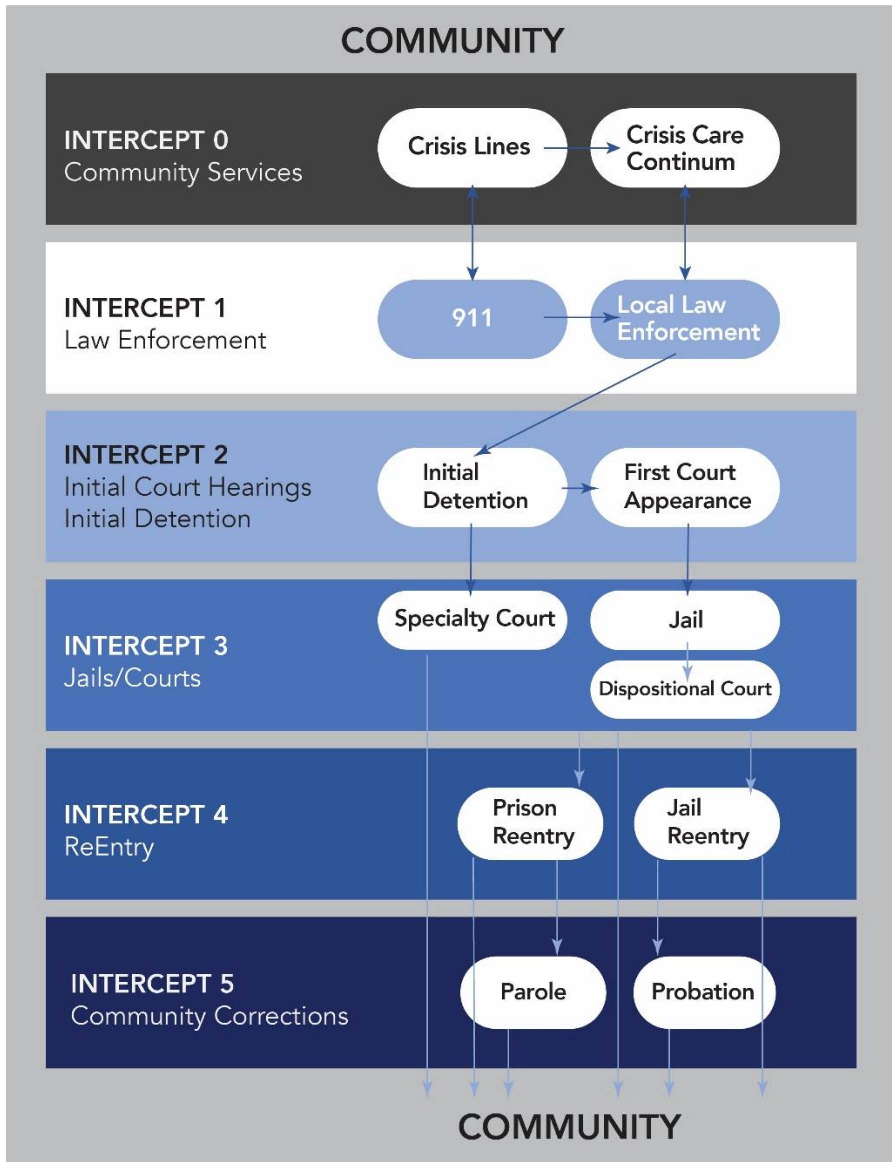
Behavioral health service availability within the county detention centers varies across the counties. Curry County Detention Center has a psychiatric nurse practitioner and full-time social worker and can become the de facto mental health service for many individuals with no other options. Roosevelt County has a social worker and a medication assisted treatment program. De Baca County Detention Center has one part-time social worker. In Quay County, the community mental health agency performs an initial assessment, and a separate group counseling agency provides counseling once per week to those who qualify.

Lack of crisis stabilization resources in the community often leads to the incarceration of individuals needing behavioral health care. For example, when law enforcement is called to respond to individuals who are in a behavioral health crisis and have a warrant or have committed a misdemeanor such as criminal trespassing, law enforcement will charge individuals with a crime and bring them to the detention center.

The average length of stay in the detention center is 7.8 days, upon which an individual is released and needs to transition to community-based care. However, after incarceration, individuals face challenges in accessing outpatient care due to transportation, long wait times to be seen, and reportedly, resistance to being seen by outpatient providers due to their criminal history. This results in an unfortunate cycle where individuals who are released will often return to the detention center due to untreated behavioral health conditions.

New Mexico, like many states and counties across the county, is in the process of using the sequential intercept model to establish programs and services to divert people with behavioral health conditions from the criminal justice system and into treatment. This model describes how individuals with mental health conditions and substance use disorders come into contact with and move through the criminal justice system. It is used to identify resources and gaps in services at each intercept to enable cross-sector collaboration to develop strategies to divert people with behavioral health conditions away from the justice system and into treatment. [28]

**Figure 14.** Sequential Intercept Model




Investment in behavioral health crisis care, connected to a continuum of inpatient, outpatient, and community-based services, will improve the diversion of residents into treatment at Intercept 0 and Intercept 1. Programs such as the medication assisted treatment program at Roosevelt County Detention Center which facilitate access to care and services for individuals being released, are important to addressing Intercept 4 and should be expanded.

ARISE Sexual Assault Services, a local agency serving the four counties, also provides support and assistance to individuals within detention centers in upon re-entry. According to ARISE, individuals often face delays in accessing outpatient services after release. Additionally, we

learned from ARISE and probation officers there is a lack of support groups such as Narcotics Anonymous and difficulty finding sponsors.

## Existing and Future Service Demands

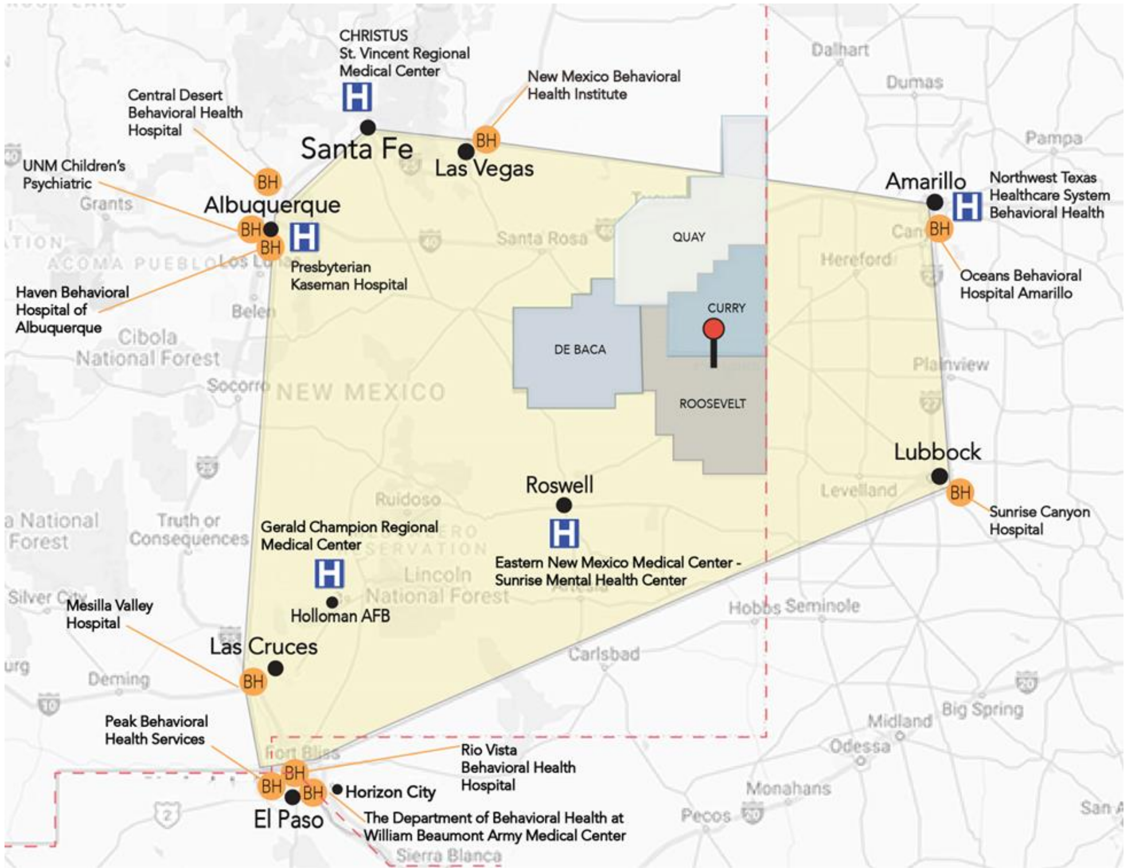
As described above, an estimated 14,000-18,000+ adults in the region have a mental health condition. While these conditions range from mild to serious mental illness, none of these residents have access to inpatient behavioral healthcare when a crisis occurs, and many residents face challenges in accessing outpatient care, especially psychiatric care. Additionally, this number does not include adolescents or children.

There are an estimated 7,126 individuals (adolescents and adults) with a substance use disorder in the four-county region. Of these, only 1,569 (22%) received any treatment for their SUD in 2019. Clearly, many residents are going without needed care, with detrimental effects on them, their families, and their communities.

## Geographic Distance and Demand

Due to the lack of inpatient behavioral health care, we anticipate high demand for an inpatient facility. We mapped the locations of the facilities to which patients were transferred from the Roosevelt General Hospital emergency room. We verified that this list includes all inpatient behavioral health facilities within 5 hours drive of Roosevelt General Hospital. The map illustrates the lack of services from a geographic perspective, and the long distances currently traveled.

**Figure 15.** Facilities Accessed by Patients of Roosevelt General Hospital, 2021




Cannon Air Force Base in Curry County uses additional facilities for transfer of active-duty service members, which are at an even farther distance than those represented above. Representatives from Cannon provided the data outlined in the table below. The Air Force Base reported difficulties with using certain facilities due to lack of collaboration and communication regarding a service member's care. This factor, as well as capacity issues, underlie the need to transfer service members up to nearly 700 miles away for care.

**Table 25.** Behavioral Health Facilities/Units Used by Cannon Air Force Base

| Facility | Distance (miles) | Distance (time) | Frequency |
|---|---|---|---|
| Rio Vista Behavioral Health, El Paso, TX | 312 | 4-5 hours | Most often |
| Northwest Texas Healthcare System – The Pavilion, Amarillo, TX | 116 | 1-2 hours | Fairly often, when space is available |
| Laurel Ridge Treatment Center, San Antonio, TX | 493 | 7-8 hours | Use fairly often |
| El Paso Behavioral Health System, El Paso, TX | 315 | 4-5 hours | Used less frequently |
| Red River Hospital | 302 | 4-5 hours | Utilized 4-5x so far for Alcohol Use Disorder |
| The Meadows of Wickenburg | 676 | 10-11 hours | Utilized 1-2x so far |

Note: in our interview with Cannon Air Force Base, it was also discussed that service members are transferred to the Colorado Mental Health Institute in Pueblo, CO.

## Comparison to Expert Guidelines

There is a lack of behavioral health beds statewide in New Mexico. A widely used expert guideline for psychiatric inpatient beds per capita is a minimum of 50 beds per 100,000 residents.[29–32] With a population of approximately 2.6 million, this guideline would require 1,300 beds in New Mexico. However, there are only an estimated 858 beds, with a gap of 442 beds. The proposed facility, as outlined below, would add 72 psychiatric beds to help close this gap.

## Demand Outside of the Region

The four-county region has a population of approximately 78,000, which, according to the expert guideline cited above, would require approximately 39 psychiatric beds. However, based on the lack of facilities in this region of the state, we expect this facility will serve patients from neighboring counties as well.

There are 18 general hospitals without behavioral health units outside of the four-county region and within a four-hour drive of Clovis. We surveyed these hospitals and two hospitals responded, confirming the need for additional inpatient capacity, especially for children and adolescents.

**Table 26.** Survey of Behavioral Health Inpatient Demand from Acute Care Hospitals Outside of the Region

| General Acute Care Hospital | Demand for inpatient behavioral health beds | Would use inpatient behavioral health facility in Clovis (Yes/No) | If yes, approximation on transfers per month |
|---|---|---|---|
| **Alta Vista Regional Hospital** | High demand. Very difficult to admit to New Mexico Behavioral Health (psych) which is near them. When they can't admit to New Mexico behavioral health they have to transfer out of the city. | Yes | Changes month to month, but estimate 5-15 transfers per month. |
| **Lincoln County Medical Center** | High demand. Currently transfer to Peak, Mesilla Valley, Sunrise (Roswell), and use telehealth. | Yes (if services include pediatrics) | Would probably transfer 1 a day, but depends on the season |

## Geriatric Care

To better understand the demand for geriatric psychiatric care, we surveyed nursing homes, skilled nursing facilities, home health care providers, and assisted living facilities in the four-county region and within a 30-mile radius of Clovis (including Texas). While seniors can be admitted from home through a hospital emergency department, nursing homes are often the highest users of inpatient psychiatric units. Of 33 providers, 16 responded, with 11 indicating that they would admit residents to the proposed facility in Clovis. Total estimate of admissions per year according to respondents is 271-377.

## Future Needs

We anticipate that the behavioral health needs in the region will continue to grow, as the prevalence of mental health and substance use disorders increases in line with national trends and the impact of COVID-19 on behavioral health. Behavioral health concerns were growing prior to the pandemic, as illustrated below for youth in particular. According to a response to the New Mexico legislature from the Legislative Education Study Committee in January 2022, "The Department of Health reports the long-term mental health consequences of the pandemic will be significant for children. In a national survey included in *COVID-19 and Education: The Lingering Effects of Unfinished Learning*, by the international business consultant McKinsey & Company, parents reported an increase in mental health symptoms and behaviors, an indication, the Health Department concludes, that children have suffered a "mega [Adverse Childhood Experience]" as a result of the pandemic."[33]

In New Mexico, approximately 150 of the 858 psychiatric beds are designated for children or adolescents.[34] Due to this very limited number of beds to serve 357,583 children and adolescents in the state, it is even more difficult to find inpatient care for pediatric patients. This leaves families in a lurch, where they are facing long distances for care and the potential of being separated from their child during a psychiatric inpatient stay, which is not optimal for the child or the family.

**Figure 16.** Trends in Mental Health Over Time for Youth[35]

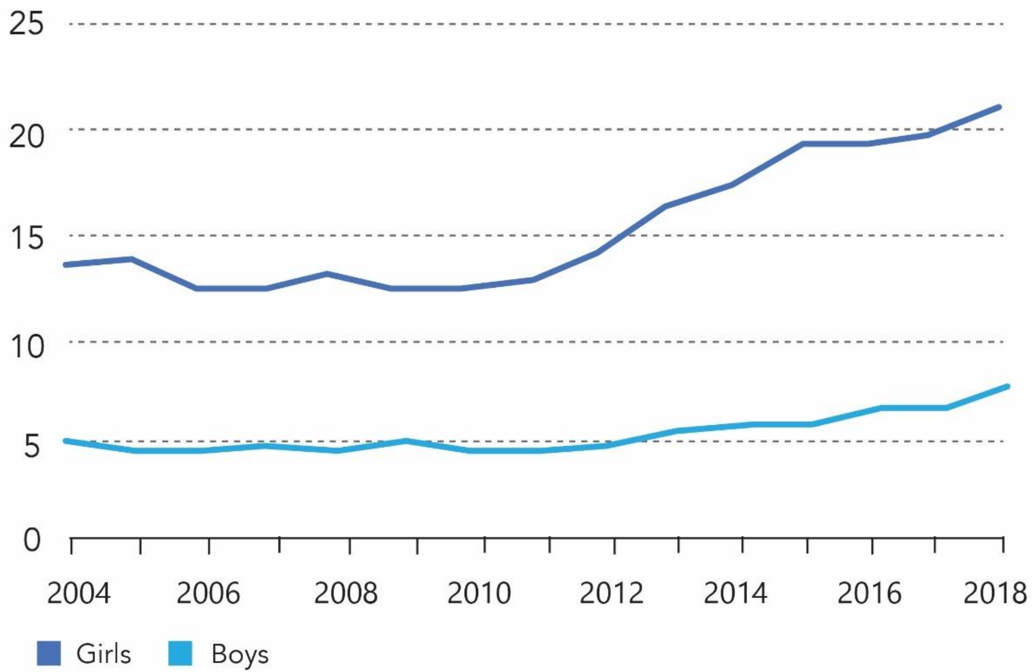
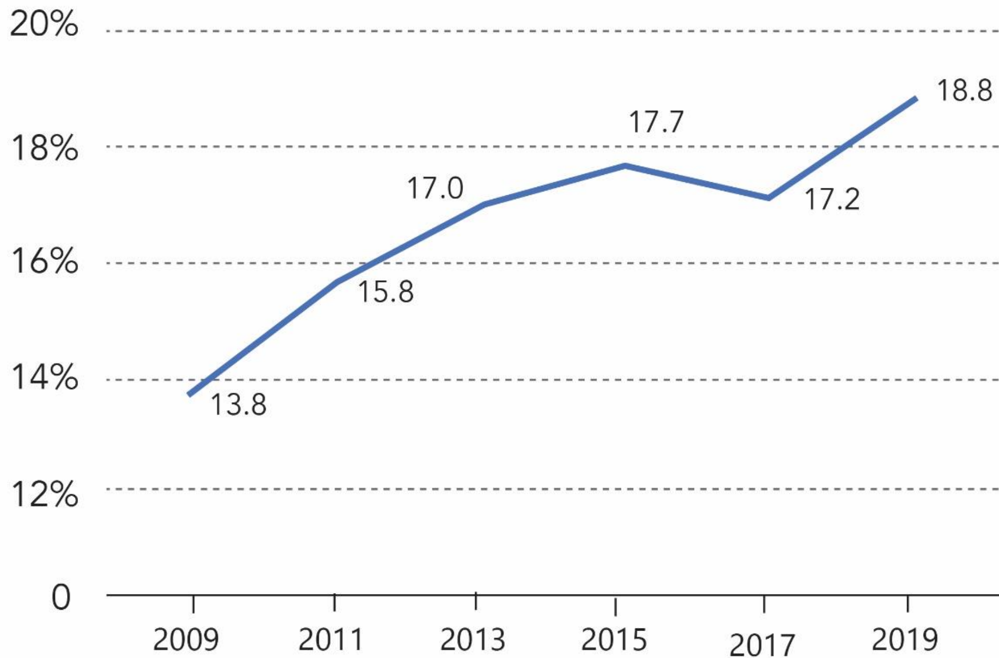


**Figure 17.** Suicidal Tendencies of High School Students Over Time[36]




## Alignment with State Initiatives

Establishing a regional behavioral health facility in the four-county region aligns with the future direction of the New Mexico Behavioral Health Services Division (BHSD). We spoke with the BHSD Director and several staff members regarding this study, and they expressed their support of an inpatient behavioral health facility in this region, and indicated that it would align with future statewide direction for BHSD.

BHSD is developing a statewide hub-and-spoke model for behavioral health, which will establish referral relationships between outpatient sites of care in smaller communities with larger, acute care sites such as the proposed regional facility. The model will coordinate care for individuals with behavioral health conditions between providers at the spokes and regional hubs when a higher level of care is needed, with ongoing care provided by the spokes after an acute care admission. A similar model has already been developed for opioid use disorder treatment, and is being broadened to include all behavioral health.

## Recommended Facility and Services

In order to meet the current and future needs for behavioral health services, we recommend establishing a behavioral health facility that will serve as a hub for inpatient care for the region and neighboring communities. To establish a facility that is financially sound and will be sustainable into the future, the facility needs to be sized appropriately to disperse overhead costs and generate adequate patient revenues.

### Services Recommendations:

Inpatient care for mental health and substance use disorder

Intensive outpatient and partial hospitalization programs

Outpatient care including medication assisted treatment

Crisis triage center for walk-in and law-enforcement drop-off

### Inpatient Care

We recommend the following inpatient services in the proposed facility. The number of beds in each category is based on several factors, including population distribution in the region (child and adolescent / adult / geriatric), existing bed capacity and bed demand, and operational factors including regulatory nursing ratios. A behavioral health facility of this size would provide capacity for 3,159 inpatient admissions annually, assuming a 90% occupancy rate and an average length of stay of eight days.

**Table 27.** Facility Size and Services Recommendations

| Inpatient Services | |
|---|---|
| **Category** | **Beds** |
| Adult Psychiatric | 42 |
| Adult Detoxification | 12 |
| Adult Short-term Intensive Residential Care for SUD | 12 |
| Child/Adolescent Psychiatric | 18 |
| Geriatric Psychiatric | 12 |
| **Total** | **96** |

We recommend facility design and operational flexibility that also allows beds to 'flex' from one specialty to another as the need arises. For example, if the facility consistently has a full adult service, but a less-than-full geriatric service, beds may be allocated from the geriatric service to account for added need in the adult service.

In addition to inpatient psychiatric services for adults, seniors, and children/adolescents, we recommend a 12-bed detoxification unit to provide intensive inpatient withdrawal management care at an ASAM level 4. Complementary to this is a unit for short-term intensive residential care for substance use disorder, which can serve as the next level of care for individuals who have undergone detoxification and need further residential care (ASAM level 3.5). The projected length of stay on this unit is 30 days.

## Outpatient Care

We used a proportion of the projected inpatient admissions to estimate the number of admissions to outpatient programs annually. We projected 1,267 admissions to intensive outpatient or partial hospitalization programs, and 1,312 patients served with standard

outpatient care annually, taking into account the availability of outpatient services which exist in the area already.

- Intensive outpatient programs for substance use disorder, mental health, and co-occurring disorders
- Partial hospitalization programs for substance use disorder, mental health, and co-occurring disorders
- Outpatient visits for medication management, counseling, and individual, group and family therapy
- Medication assisted treatment for substance use disorder

Recommended child/adolescent outpatient services:

- Behavior management and cognitive behavioral therapy
- Coordination of care with schools and medical providers
- Family therapy and parent education
- Individual and play therapy
- Psychiatric consultation and evaluation
- Medication management

Outpatient services may be provided through relationships with existing community-based providers and are discussed further below in the section on Potential Service Delivery Participants' Interest.

## Crisis Triage Center

We recommend including a Crisis Triage Center (CTC) in the regional behavioral health facility to address the immediate crisis care needs of the four-county region. The CTC will provide an open door for individuals in crisis to access the level of care they need. It will also provide an avenue for law enforcement and EMS to get immediate care for an individual in crisis, and be able to return to their public safety and emergency response duties. Under the medical supervision of the facility psychiatrists, the CTC will provide emergency behavioral/mental health triage and evaluation for patients undergoing acute behavioral health crises.

In addition to guideline-directed treatment strategies, the CTC will also utilize structural and interior design strategies to help achieve its goal. For example, a noise-reducing design and recliners in the waiting room will provide a calming environment, allowing natural stress

reduction and stabilization to start before the patient is even seen by a provider, leading to improved stabilization rates and reduced patient duration of stay.[37] If a patient requires an escalation of care, they can be easily transferred to the attached inpatient psychiatric facility for further treatment.

We recommend sizing the CTC to meet the needs of the immediate four-county region. The surrounding communities are less likely to use the CTC due to distance. We anticipate the CTC will provide 1,680 admissions through five reclining chairs (up to 24 hour stay) and four short-term beds (24-72 hour stay).

The CTC will also provide an important entry point for intensive outpatient and outpatient programs. For example, individuals may receive short-term services at the CTC for a substance use disorder crisis and be immediately connected with an SUD intensive outpatient program during their stay.

### Supportive Services

In addition to the clinical care services provided at the facility, we recommend providing supportive services that will support the success of individual clients and families. The first of these is care coordination, a key component of successful behavioral health care. These services include communication with all providers involved in a patient's care, and ensuring services and follow-up care is arranged for individuals leaving inpatient care. These services can be provided by licensed social workers and supplemented by social work interns who are completing their education and training. They should include assisting individuals with accessing resources to address social determinants of health, such as housing, employment, and food assistance.

During our interviews, we heard from community members several times about two additional services that would be critical to the success of a regional behavioral health facility: transportation and childcare. Transportation to the facility for outpatient care can be arranged in advance for Medicaid-covered individuals at no cost. Currently, there are two community health workers (CHWs) at Roosevelt General Hospital's behavioral health clinic who provide this support along with assistance in accessing other services.

Additionally, community members thought it would be important to provide childcare on site, to support parents who would otherwise find it difficult to maintain their appointments. This could be particularly helpful for single parents and for those who need to attend multiple days per week, such as an intensive outpatient program. Other services identified desired by community members include spiritual care and pet/animal therapy.

### Future Services

Community members and interview participants from various human service organizations expressed the desire for longer term residential care for behavioral patients. Our initial recommendations include short-term residential care for substance use disorder (including co-occurring disorders). We recommend that the facility campus be sized and positioned to allow for future growth and construction for longer term residential care for adults and for adolescents, as there is a lack of residential treatment programs in the region and in the state, and Medicaid reimbursement is available for these services.

## Proposed Facility Size and Layout

The proposed facility will include crisis care and inpatient and outpatient care for both mental health and substance use disorder patients. Based on the services estimates above, the proposed facility will be just under 80,000 square feet in size. This estimate was gathered from two separate methodologies.

### Size Projections

Relying on experts in the field, we first gathered a general estimate of facility size based on square footage needed per patient bed. Based on advice from experts in the field, the lowest estimate utilized was 666 square feet per bed, and the highest was 1,000 square feet per bed.[38] This gave a range of total size between 51,000 square feet and 96,000 square feet This estimate guided the rest of our research as a broad range from which we could narrow actual size needs.

### Space Allocation

We conducted extensive research into the requisite spaces within a behavioral health facility, adopting best practice standards when deciding what to include within a proposed facility.

Using several sources,[38–41] we modeled a behavioral health facility and concluded that the following would be the best break down of space:

**Table 28.** Proposed Facility Square Feet Allocation

| Inpatient Care | | Outpatient Care & Crisis Stabilization | | Staff Support | | Logistics | |
|---|---|---|---|---|---|---|---|
| *Resource* | *Sq. Ft.* | *Resource* | *Sq. Ft.* | *Resource* | *Sq. Ft.* | *Resource* | *Sq. Ft.* |
| Patient Rooms (72) | 25,350 | Crisis Triage Center | 6,000 | Nurse/Doctor Workrooms | 2,000 | Corridors | 3,400 |
| Interview Rooms (6) | 1,500 | Outpatient (2) Interview Rooms | 1,000 | Team Rooms | 2,100 | Dining Room | 1,250 |
| Group Therapy (4) | 1,000 | IOP rooms (2) | 1,000 | Medication Rooms | 1,000 | Public Restrooms | 500 |
| Dayrooms | 2,000 | Seclusion Rooms (4) | 1,000 | Open Nurse Station | 4,000 | Security Office | 200 |
| Patient Lounge | 2,000 | Recreational Therapy Room | 1,800 | Administrative Offices | 1,792 | Food Prep | 2,500 |
| Intake/Reception | 2,000 | Short-term residential care for SUD | 8000 | | | Environmental Services | 400 |
| Common Room | 1,000 | Crisis Triage Center | 6,000 | | | Misc. | 2,000 |
| Detox unit (12 beds) | 6,000 | | | | | | |
| Total | 39,900 | Total | 18,800 | Total | 10,892 | Total | 10,250 |

Total space allocated for patient care is 39,900, for non-intensive Patient Care is 18,800, for staff support is 10,892, and for logistics is 10,250. This brings the total facility size to 79,842 square feet.

Both our modeling of a sample behavioral health facility, and a more general per patient estimate generate a square footage estimate near the midpoint of the ideal per patient range.

Units will have a combination of single and double-occupancy rooms to provide flexibility for patient gender and acuity levels. Additionally, we recommend designing the units to provide flexibility in terms of the numbers of beds per unit to account for seasonal and other fluctuations.

## Campus and Facility Master Plan

When planning the layout of a behavioral health facility, it is important to understand that architectural design can help with a patient's recovery process. Aggressive behavior can be reduced by using specific environmental factors, which ultimately improves both patient and staff experience and patient outcomes.

Architectural manipulation of structures and space can allow for environmental factors such as sound, color, views, smell, and light to contribute to a therapeutic environment for healing purposes. The principles of the architecture of recovery incorporate the following:

- Public architecture philosophy aligned with a public health approach
- Landscape architecture used to engender a transformative relationship with the natural environment
- Space which supports a holistic treatment approach is calming, soothing and creates connections with clinical programs
- An ecosystem of resources is available to patients (clinical, residential, social services, family wellness, etc.)

Having a facility that does not have an institutional feel and is patient-centered was a priority to the community and key stakeholders. Designing for dignity creates a social connection where people feel like they have a safe place to come that fosters a community-mind-body connection where people are seeking the same type of care.

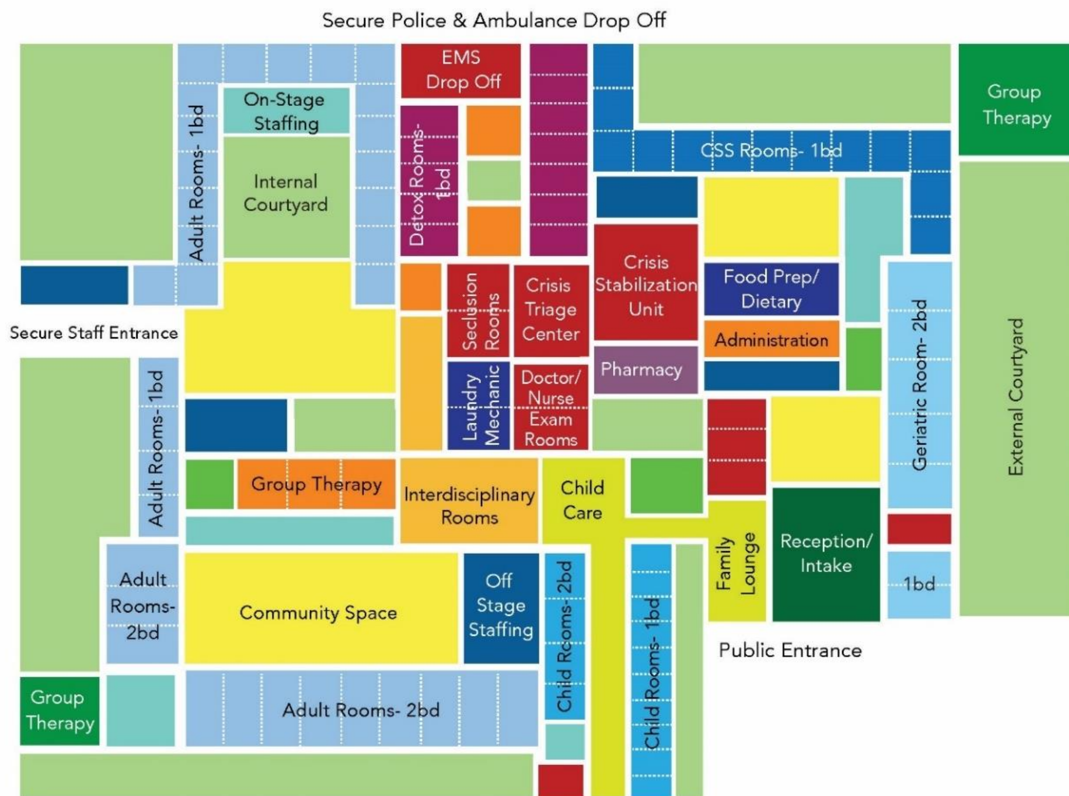
Additionally, it shifts the paradigm from a traditional staff-centered design to patient-centered. Healthcare has been very provider-centric historically, which is reflective of a medically based model of care. Patient-centered care is an active partnership between patients, families, and staff that ensures optimal outcomes for the patient throughout their journey. Aesthetics are very significant when it comes to behavioral health hospitalization. It is difficult for a patient to start thinking about recovery when enclosed in a tiny space with limited access to sunlight and other things humans need to feel positive.

Nature plays a significant role in positive distraction which fosters healing. Studies have repeatedly demonstrated that viewing natural scenery provides a range of benefits for human health and well-being, such as reduced anxiety and stress, shorter hospital stays, lower heart rate, and increased directed attention.[42] Natural lighting and views in common spaces, such as utilizing floor-to-ceiling windows reduces feelings of institutionalization that can inhibit individual growth and healing. By incorporating both open and glassed-in courtyards into the facility, in addition to walking paths and gardens, patients can have access to daylight and a calming natural environment.

Autonomy and independence in a facility creates a sense of control and choice. Certain features in patient rooms like adjustable lighting and temperature can help patients feel more in control of their environment. By incorporating welcoming day/community areas with areas to relax as well as congregate and socialize, the facility can facilitate peer connection and support. This approach encourages patients to not isolate themselves in their rooms. It provides both privacy and the opportunity to create a sense of community.

The architecture of recovery principles of design, nature, and autonomy influenced our preliminary conceptual sketch of the facility layout. Instead of having nursing stations located centrally, they are placed where there is a clear line of sight to all rooms and gathering areas. Patient rooms are grouped together by age (child, adolescent, adult, and geriatric) and the associated group areas promote interaction among similar aged peers. It is cooperative recreation that allows for informal gathering. Residents are encouraged to relate to others and foster a feeling of safety that helps them focus on their recovery and learn about their diagnosis.

**Figure 18.** Conceptual Sketch of a Regional Behavioral Health Facility




Key

**Bedroom Type**
- 1 Bed or 2 Beds-Child Room
- 1 Bed or 2 Beds-Adult Room
- 1 Bed or 2 Beds-Geriatric Room
- 1 Bed- Detox Room
- 1 Bed-Crisis Stablization Services

**Staff Spaces**
- Administration Room
- Interdisciplinary Rooms
- On-Stage Staffing
- Off-Stage Staffing
- Laundry/Mechanic
- Food Prep/Dietary
- Pharmacy/Lab

**Public Spaces**
- Community Spaces/Living/Dining
- Internal/External Courtyard
- Group/Recreational Therapy
- Group Therapy Garden
- Play Area/Child Care/Family Lounge
- Reception/Intake
- Restrooms

**Clinical Spaces**
- EMS Drop Off/Seclusion/Triage Center
- Crisis Stabilization Unit
- Doctor/Nurse Exam Rooms

Based on feedback from the community engagement session and best practices, the following are key attributes and considerations for a regional behavioral health facility:

### FACILITY

- Room to grow
- Incorporate nature, light, and views
- Not institutional feel
- Family inclusion
- Windbreaks or trees
- Sprawling campus
- Good parking
- Garden
- Residential care & family reunification
- Supportive housing / transitional housing
- Cross-purpose facility, i.e., primary care

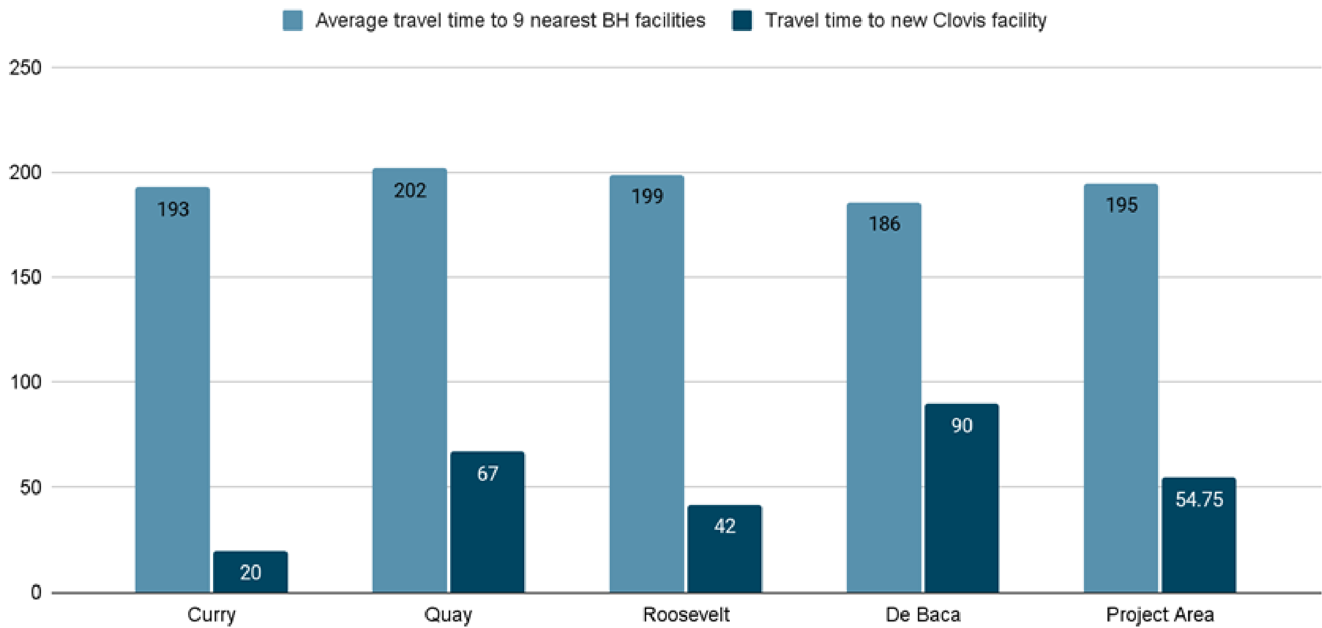
### PROGRAMMATIC

- 24/7 availability
- Transportation
- Play, pet/animal therapy
- Providers who can treat in English and Spanish
- Safe regardless of income or immigration status
- Qualified staffing
- Addresses spirituality
- Technology & ability to share data

## Site Considerations

We recommend locating the proposed facility in Clovis, the municipality with the greatest population density in the region. By constructing a new facility in Clovis, the average travel time from population centers within the four-county area reduces to less than an hour, with a range of approximately 20-90 minutes. As shown above, there are currently no facilities accessible from any population centers within the target area, which can be reached in under an hour.

**Figure 19.** Difference in Travel Time Between Current and Proposed Locations




During the community engagement process, the community identified core criteria for the site of a future behavioral health facility:

- Proximity to hospital
- Close to the population hub
- Room to expand
- Access to natural space
- Non-institutional feel
- Patient privacy and proximity to busy areas

Additional factors to consider included the cost associated with a new build versus remodeling an existing structure, adequate parking, and access for first responders.

The following locations were identified as potential sites for the regional behavioral health facility based on the community's priorities:

- Land adjacent to Plains Regional Medical Center (PRMC)
- Land nearby Ned Houk Park

- Hope Children's Home
- Matt 25 Building
- Allsup's old corporate headquarters

Additional sites suggested by community members included:

- Land donation
- Lockwood facility
- ENMRSH
- Call center
- Land near Portales airport
- Old ENMU football stadium
- Land west or north of Cannon Air Force Base
- Off the highway between Clovis and Portales

**Table 29.** Core Criteria Utilized to Evaluate Primary Sites for a Regional Behavioral Health Facility

| | Hospital Proximity | Population Hub | Room to Expand | Access to Nature | Non-Institutional Feel | Patient Privacy |
|---|---|---|---|---|---|---|
| Land adjacent to PRMC | Yes | Yes | Yes | Yes | Yes | Yes |
| Ned Houk Park | No | No | Yes | Yes | Yes | Yes |
| Hope Children's Home | Yes | Yes | Yes | Yes | No | Yes |
| Matt 25 | Yes | Yes | No | No | No | No |
| Allsup's old headquarters | Yes | Yes | No | No | No | No |

We also arrived at an agreement that building a new facility versus remodeling an existing structure would be preferred based on feedback received from the community and key

stakeholders. A new building would allow for innovative design that promotes healing through the architecture of recovery model, the opportunity to grow in the future, and have room to provide a wide array of services. Furthermore, the above identified existing structures have an institutional feel about them and would be costly to remodel, expand, and get up to code.

This is a preliminary evaluation of potential locations in Clovis, NM. A more comprehensive analysis should be conducted when the development phase commences.

## Financial Feasibility

Thorough financial analysis was an integral part of our feasibility study. While the behavioral health facility requires significant capital expenditure up front, the facility has healthy operational profit margins, and our projections show the facility to be financially self-sufficient. The primary driver of shortening the time to profit and the time to break even is the source of capital funds and the terms associated with their acquisition.

**Figure 20.** Executive Summary

| Capital Expenditure | | Annual Revenue | | Annual Costs | |
|---|---|---|---|---|---|
| Land | $500K | Inpatient Treatment | $16.4M | Salary/Wages | $22.3M |
| Construction | $38.7M | IOP Treatment | $6M | Interest | $1.9M |
| Initial Inventory | $250K | Partial Hospitalization | $1.4M | Depreciation | $850K |
| Pharmacy | $500K | CTC | $150K | Pharmacy | $600K |
| Lab | $100K | Outpatient Treatment | $89K | Other | $1.2M |
| FF&E | $4.5M | Pharmacy | $1.98M | | |
| | | Detox | $1.97M | | |
| | | CSS | $1.38M | | |
| Total | $45M | Total | $29.4M in Y1 | Total | $28.9M in Y1 |

The estimated capital expenditure necessary to open a behavioral health facility is $45 million. This mainly accounts for a high construction cost, at $500 per square foot. Additionally, Furniture, Fixtures and Equipment (FF&E) are notoriously expensive for behavioral health

applications.[43] Annual Revenue in year 1 is projected to be $29.4 million; the methodology used to reach this number is explained in depth below. Annual Costs in year 1 are projected to be $28.9 million, where salary and wages account for the largest portion of costs.

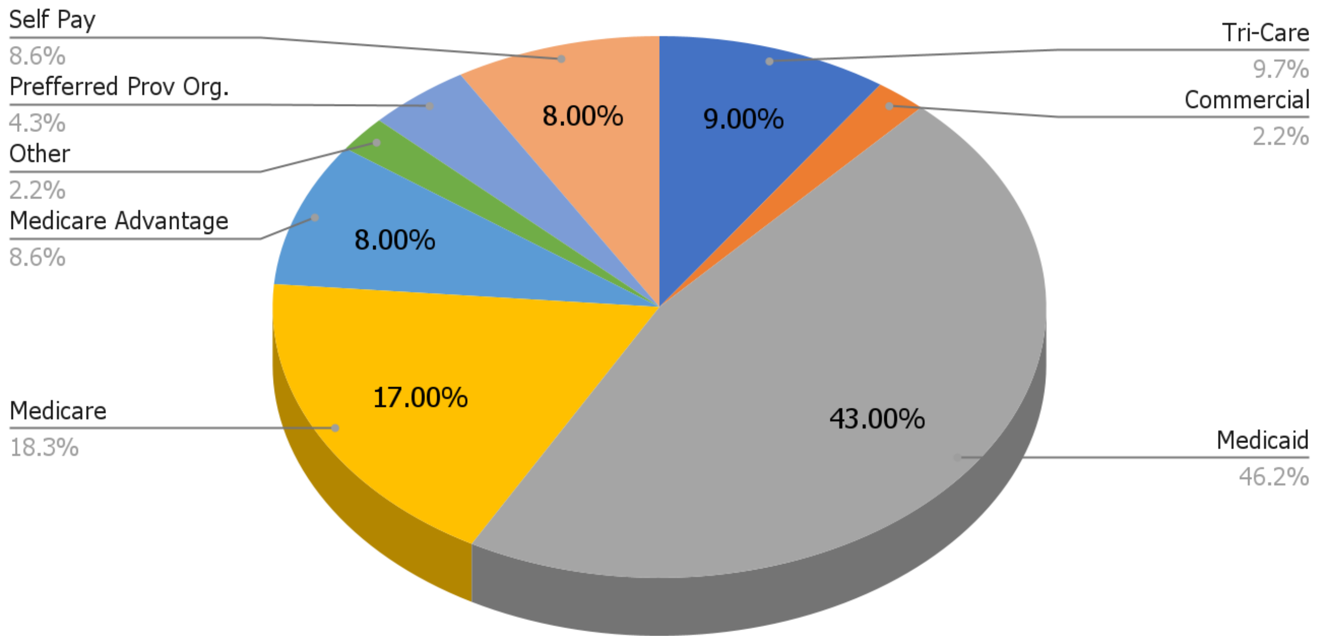
### Key Metrics

The financial success of the proposed behavioral health facility comes into focus with 6 key metrics that form the foundation for our financial projections. The payer mix, average length of stay, and per diem reimbursement rates inform the projected revenue of the facility, demonstrating healthy revenue sources. The monthly cost and revenue breakdowns demonstrate the ultimate profitability of the facility.

### Payer Mix

Before revenues could be calculated for relevant categories, an accurate payer mix must first be established. This informs the makeup of insurance amongst the expected patient population. Based on payer mix data from local hospitals, the top two payers are projected to be Medicaid and Medicare, respectively.

**Figure 21.** Payer Mix Breakdown




## Average Length of Stay (ALOS)

Two of the main factors that predict facility revenue are the average length of stay and the per patient, per diem reimbursement rate. Where the patient population, the average length of stay, and the daily reimbursement rate are all known, a rough estimate of projected revenue can be applied to a patient population.

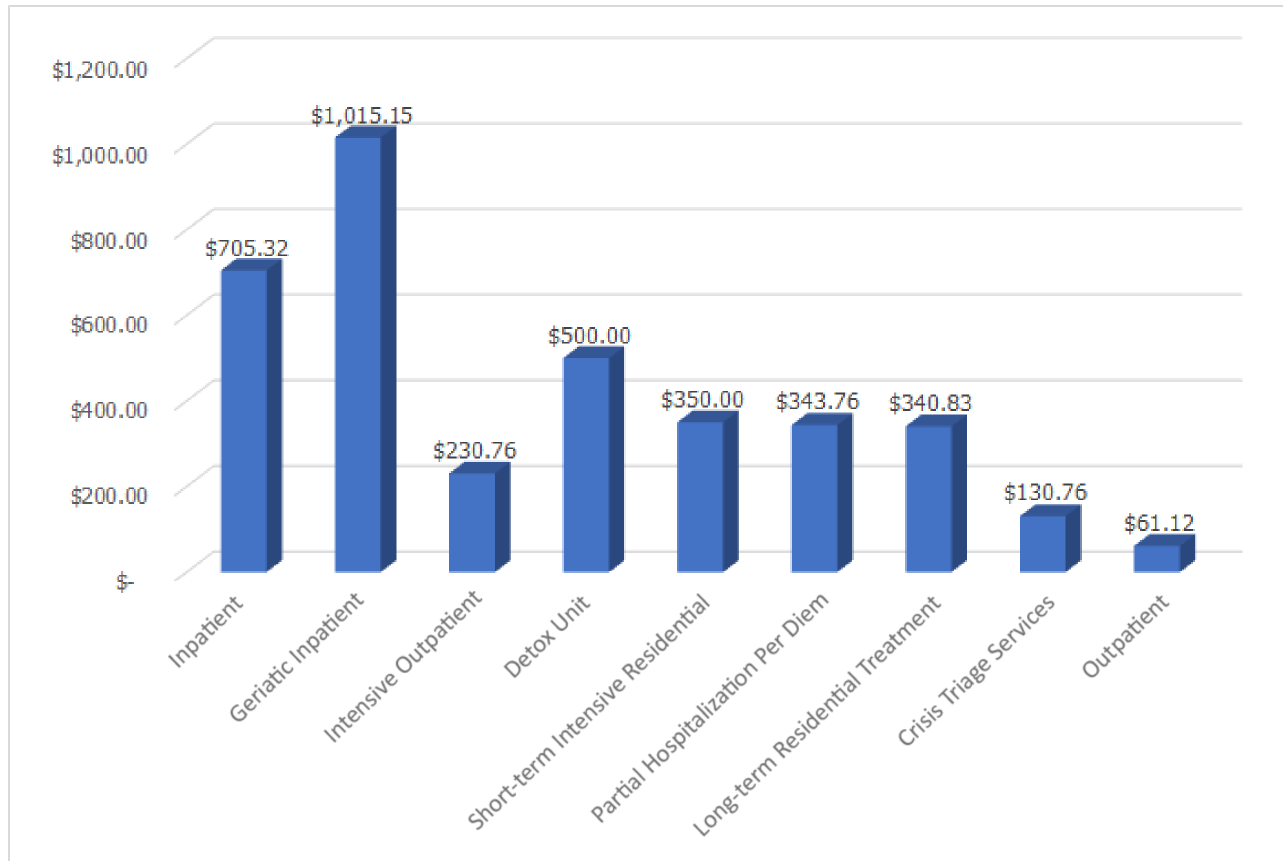
**Table 30.** Average Length of Stay by Treatment Type

| Service | ALOS (days) |
|---|---|
| Inpatient | 8 |
| Geriatric Inpatient | 12 |
| Intensive Outpatient | N / A |
| Detox Unit | 5 |
| Short-term Intensive Residential | 21 |
| Partial Hospitalization Per Diem | 28 |
| Long-term Residential Treatment | 30 |
| Crisis Triage Services | 4 |
| Outpatient | N / A |

The average length of stay for different services was estimated based on expert advice, internal experience, and industry accepted standards.

## Per Diem Revenue

**Figure 22.** Weighted Average Reimbursement by Service Type

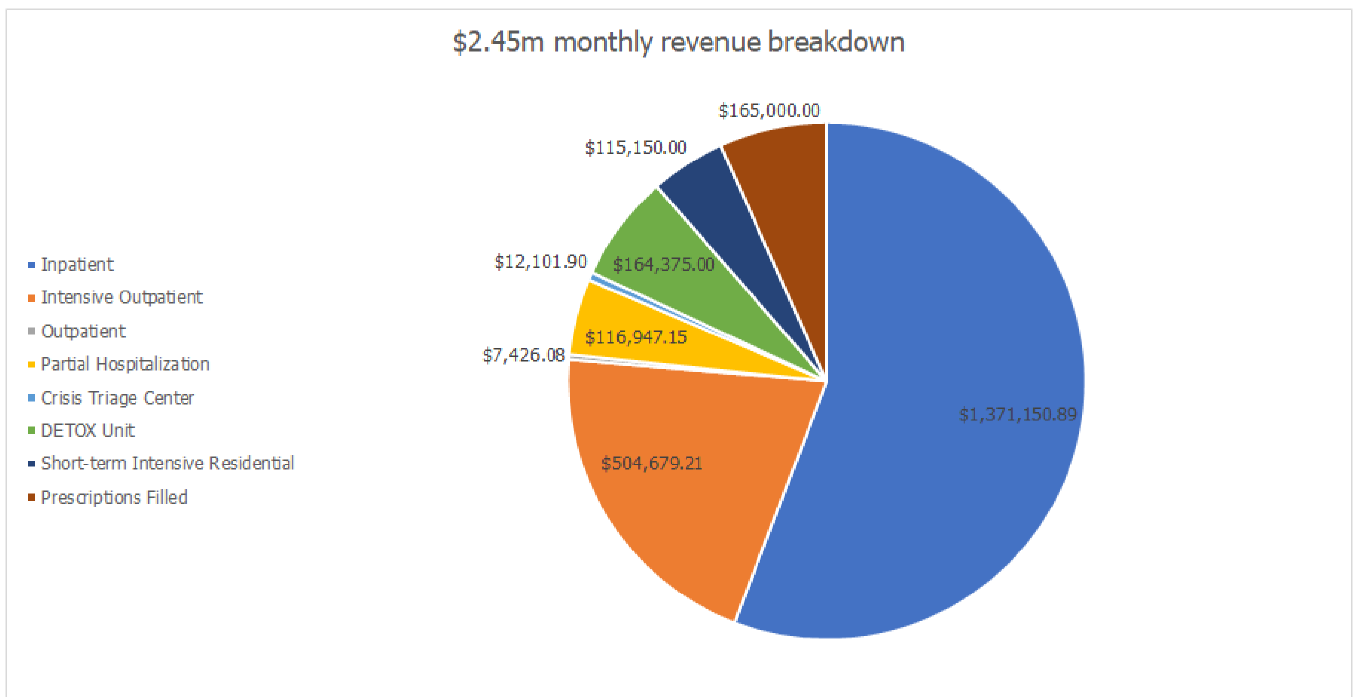



The per diem reimbursement for each treatment provided above was gathered from local providers of those services to mimic the real-world expectations of the behavioral health facility. These per diem reimbursement rates reflect the per diem reimbursement rate for one day of billed services (the minimum billable unit of time varies between the services).

## Revenue Breakdown

The key metrics above lead to an accurate estimate of monthly revenue for all services provided by the behavioral health facility.

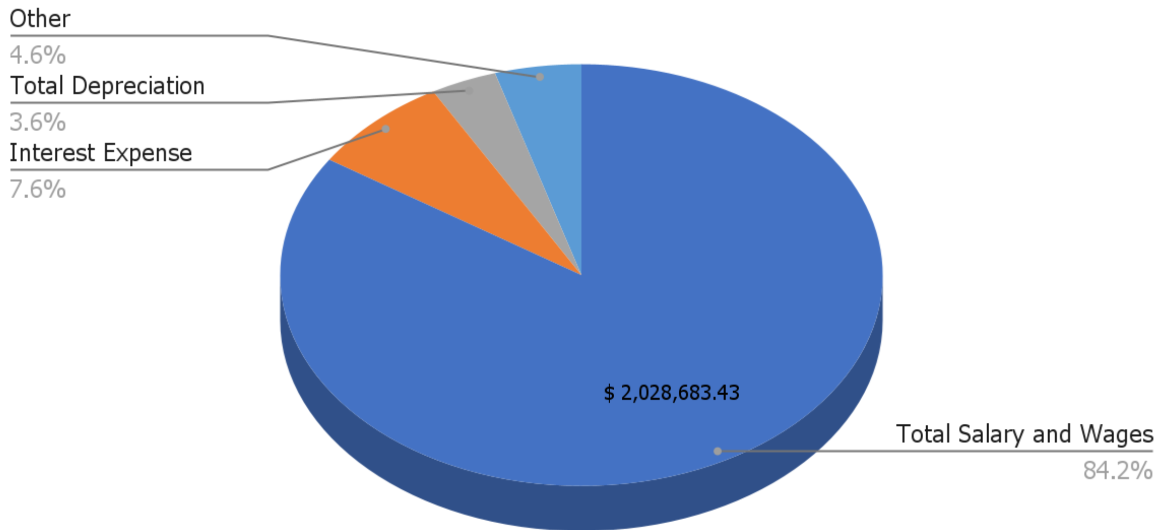
**Figure 23.** Representative Categories of Total Revenue



### Costs Breakdown

**Figure 24.** Representative Categories of Total Costs

Monthly Costs ($2.25M) Breakdown by Category




## Methodology

This section describes the methodology and the significant assumptions within this financial model.

### Capital Expenditures

The capital expenditures will require an initial outlay of approximately $45 million dollars. The majority of this cost comes from construction.

**Table 31.** Capital Expenditures

| Capital Expense | Cost |
| --- | ---: |
| Land | $500,000 |
| Construction | $38,700,000 |
| Pharmacy | $500,000 |
| Lab | $100,000 |
| FFE | $4,500,000 |
| Initial Inventory | $250,000 |
| Total | $44,550,000 |

### Construction Estimate

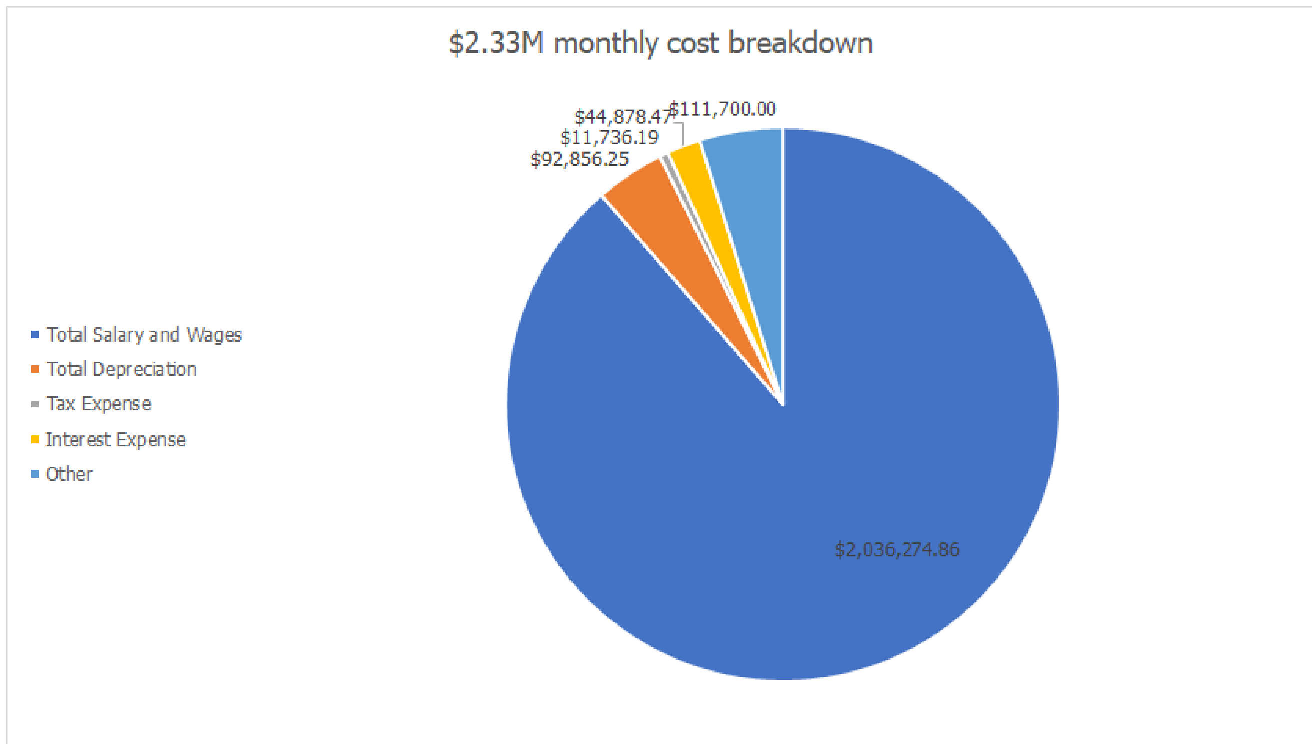
Due to the substantial fluctuation in construction costs that stem from supply chain issues and the broader COVID-19 pandemic, a range of potential construction costs was first established, and then an explicit cost per square foot was adopted from within that range.

The cost to construct a behavioral health facility ranges from $200 to $680 per square foot. The lower end could be achieved through repurposing a decommissioned hospital while the higher end accounts for luxury preferences within a facility.[44] Ultimately, $500 per square foot was employed as a conservative–yet accurate–estimate of construction costs. This value was informed by experts who are currently engaged in hospital construction.

### Operational Costs

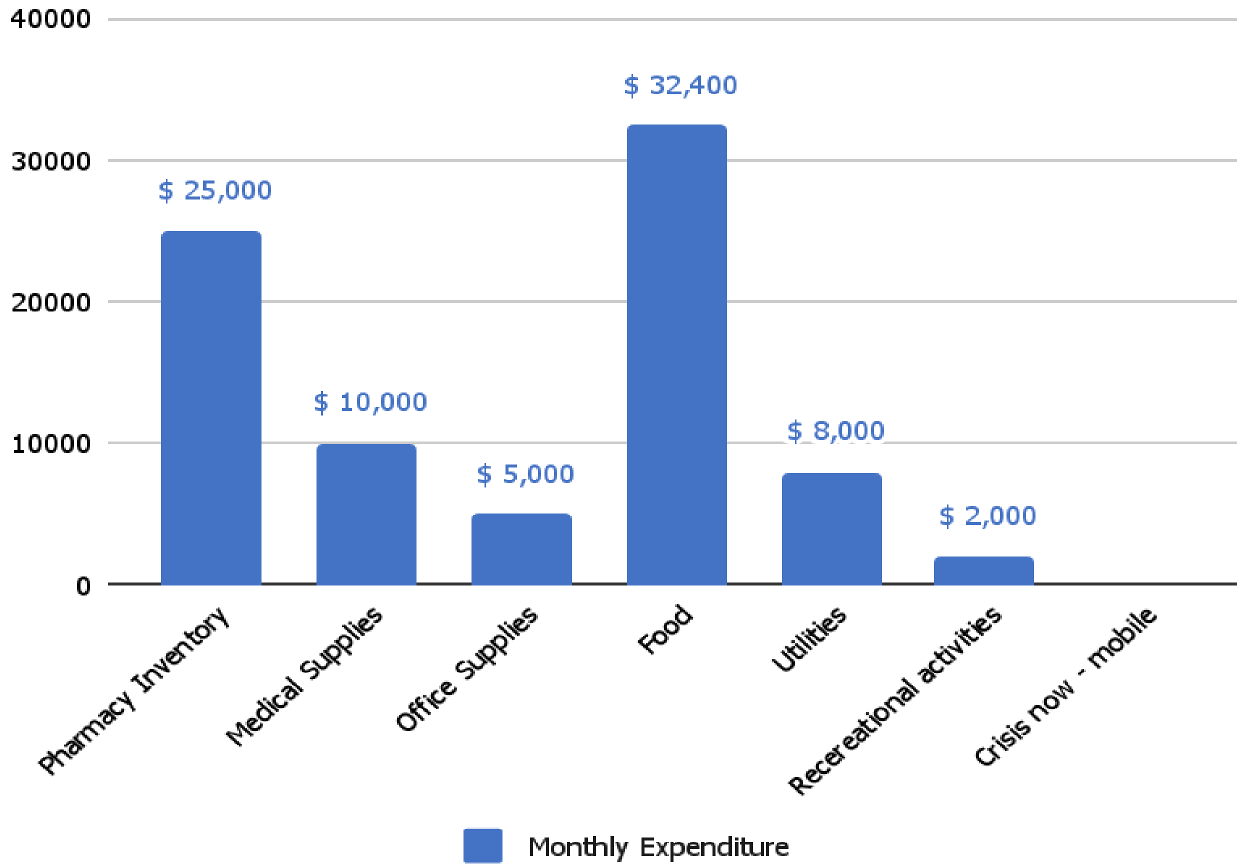
Operational costs will average $2.3 million dollars monthly, with roughly 85% of the monthly operating expenses stemming from salary and wages. When possible, expenses were calculated as fixed annualized averages, based on the annual expenditure expected from any given category. Aside from this "top-down" approach, the salary/wages were estimated with a "bottom-up" approach on an employee level.

**Figure 25.** Monthly Cost Breakdown




Fixed expenses within the "other" category are logistical and operational expenses that keep the facility functioning.

**Figure 26.** Fixed Expenditures




## Salary and Wages

We estimated 259 full time staff will be necessary to operate the proposed facility.

**Table 32.** Full Time Employee Count

| Staff Base | |
|---|---|
| **Position** | **Count** |
| CEO | 1 |
| Certified Pharmacy Technician | 4 |
| CFO | 1 |
| Charge Nurse | 4 |
| Environmental Services | 4 |
| Finance | 3 |
| Food Service | 6 |
| Human Resources | 3 |
| IT Department | 2 |
| Nurse (LPN) | 76 |
| Nurse Manager | 4 |
| Nurse Practitioner | 8 |
| Peer Support Specialist | 14 |
| Pharmacist | 2 |
| Psychiatric Technician | 63 |
| Psychiatrist | 4 |
| Receptionist | 4 |
| Recruiter | 2 |

| | |
|---|---|
| Security | 4 |
| Social Worker | 50 |
| Total | 259 |

**Table 33.** Base Salary and Salary after Benefits by Position

| Staff Position | Base Salary | Salary with Benefits |
|---|---|---|
| Administrators | $200,000 | $284,000 |
| Charge Nurse | $71,593 | $101,662 |
| Environmental Services | $40,000 | $56,800 |
| Finance | $48,301 | $68,587 |
| Food Service | $30,000 | $42,600 |
| Human Resources | $80,000 | $113,600 |
| IT Department | $67,700 | $96,134 |
| Nurse (LPN) | $48,375 | $68,693 |
| Nurse Manager | $131,094 | $186,153 |
| Nurse Practitioner | $104,843 | $148,877 |
| Peer Support Specialist | $41,600 | $59,072 |
| Pharmacist | $130,151 | $184,814 |
| Pharmacy Technician | $38,000 | $53,960 |
| Psychiatric Technician | $45,000 | $63,900 |
| Psychiatrist | $375,000 | $532,500 |

| | | |
|---|---|---|
| Receptionist | $45,000 | $63,900 |
| Recruiter | $50,000 | $71,000 |
| Security | $35,000 | $49,700 |
| Social worker | $55,640 | $79,009 |

We gathered local salary ranges for each position, and used the 75th percentile of those ranges for the majority of positions, as a base salary. For a few high-level positions, or positions where we expect difficulty in hiring employees, we used higher percentiles. This assumption seeks to pay not just a living wage but a wage that will keep employees happy and retain expertise at the facility.

Additionally, a 20% benefits estimate, 12% retention estimate, and 10% incentivization was added onto this base salary. This rather significant add-on of 42% to the base salary acknowledges the barriers that will be faced when hiring an employee base of 250+ full time employees. By including higher-than-average salaries, incentives, and benefits, the facility will be better prepared to encourage the relocation of essential staff to the area.

### Revenue Sources

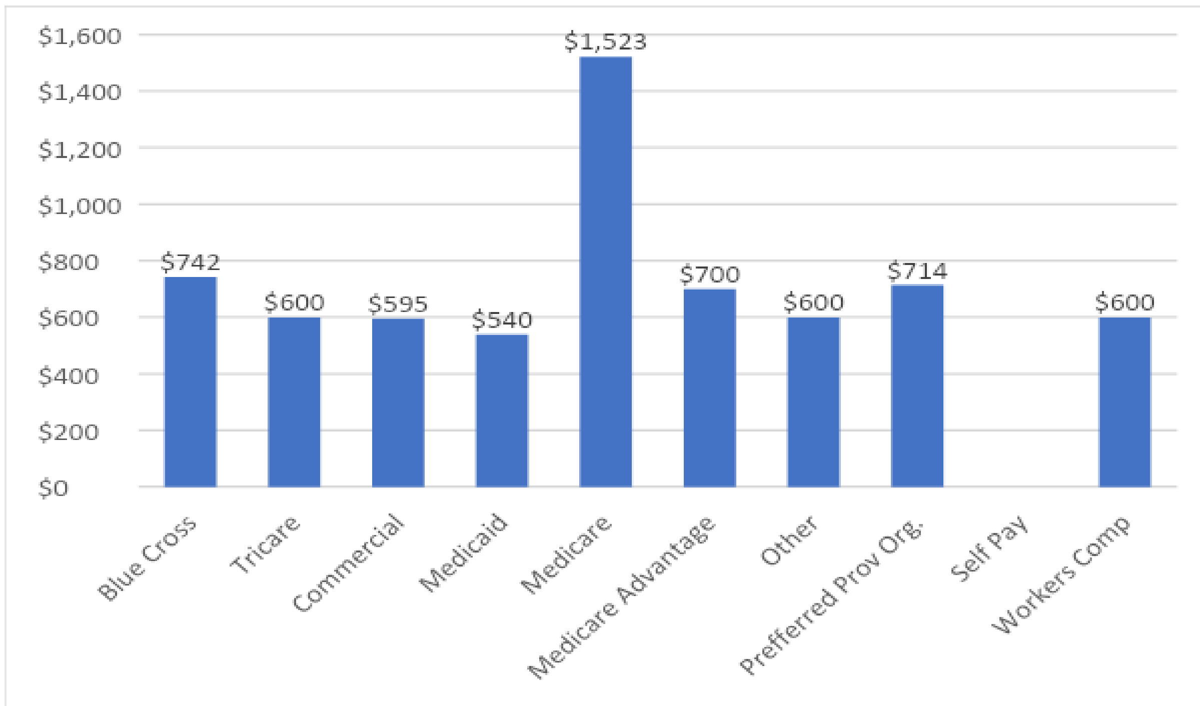
With the goal to produce a self-sufficient facility in mind, we analyzed the projected revenue of the facility by category.

With an accurate payer mix established, the revenues per service were then gathered for each payer. Inpatient reimbursement rates, especially for new facilities, are negotiated individually with several payers, including Medicaid, which assesses based on cost, and Medicaid Managed Care Organizations, which use the Medicaid rate as a starting point for negotiations. We verified our inpatient revenues using publicly available data for other New Mexico facilities of similar size to account for variations.

The same methodology was adopted for each service at the facility. First, a per diem reimbursement rate per minimum billable unit was obtained for each payer in the payer mix. Then the reimbursement rates for all expected payers informed a weighted average

reimbursement rate for that service. Lastly, the weighted average was applied to the average length of stay for the respective service. By multiplying the weighted average per diem by service with the average length of stay for each service for each, expected revenue could be extrapolated and annualized based on our projected patient population. The following section illustrates this methodology for inpatient psychiatric care.

**Figure 27.** Estimated Reimbursement for Inpatient Psychiatric Care by Payer Per Diem




The per diem revenue per patient was then applied across the average length of stay (ALOS) of 8 days, a common length of stay for inpatient psychiatric care.

**Table 34.** Inpatient Psychiatric Reimbursement Rates by Payer, per Admission

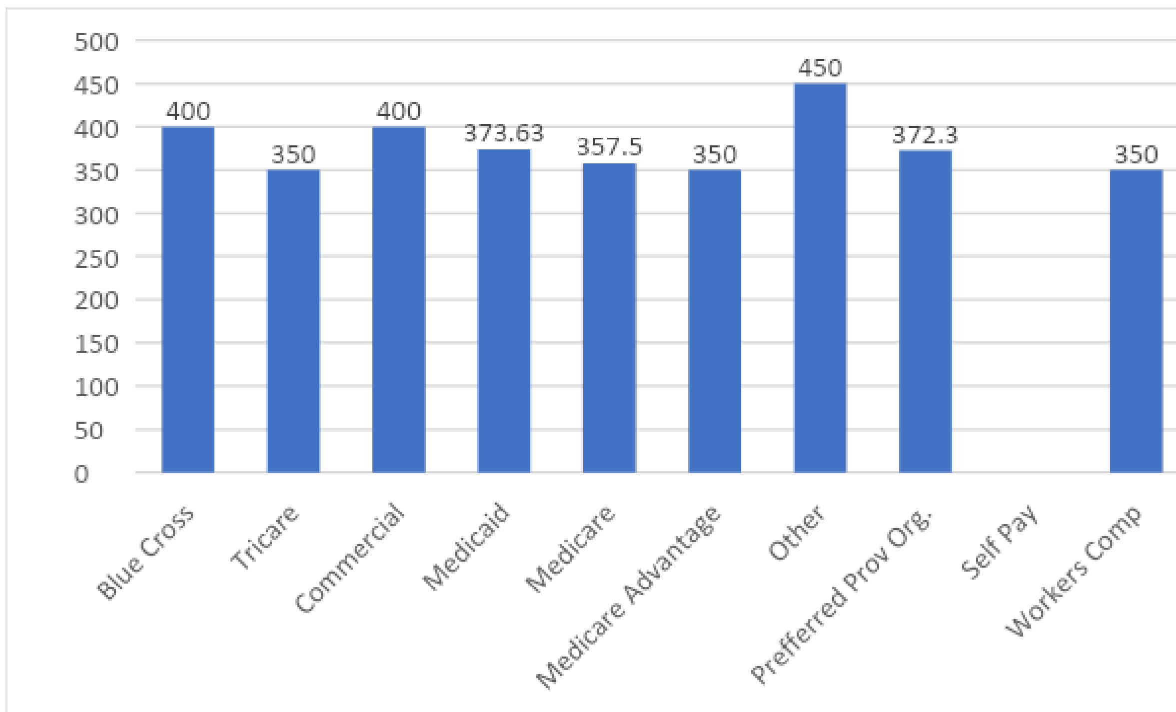
| Payer Mix | Payer Mix | Inpatient (Summation) |
|---|---|---|
| Blue Cross | 7.00% | $5,936.00 |
| Tricare | 9.00% | $4,800.00 |
| Commercial | 2.00% | $4,760.00 |
| Medicaid | 43.00% | $4,317.44 |
| Medicare | 17.00% | $12,181.75 |
| Medicare Advantage | 8.00% | $5,600.00 |
| Other | 2.00% | $4,800.00 |
| Preferred Prov Org. | 4.00% | $5,712.00 |
| Self Pay | 8.00% | $ - |
| Workers Comp | 0.00% | $4,800.00 |
| TOTAL (WEIGHTED) | 100.00% | $5,642.60 |

A weighted average was calculated to net the average reimbursement rate per inpatient stay at the behavioral health facility. This average was then applied to the projected inpatient population to net the average inpatient revenue.

### Short Term Intensive Residential Treatment

Short Term Residential treatment would be utilized by patients needing more intensive treatment than intensive outpatient programs or partial hospitalization. We followed the methodology outlined above to project revenue per patient.

**Figure 28.** Short Term Intensive Residential Treatment Reimbursement Rates by Payer, Per Diem




Reimbursement rates were applied to the average length of stay per residential patient (30 days).

**Table 35.** Residential Treatment Reimbursement by Payer, per Admission

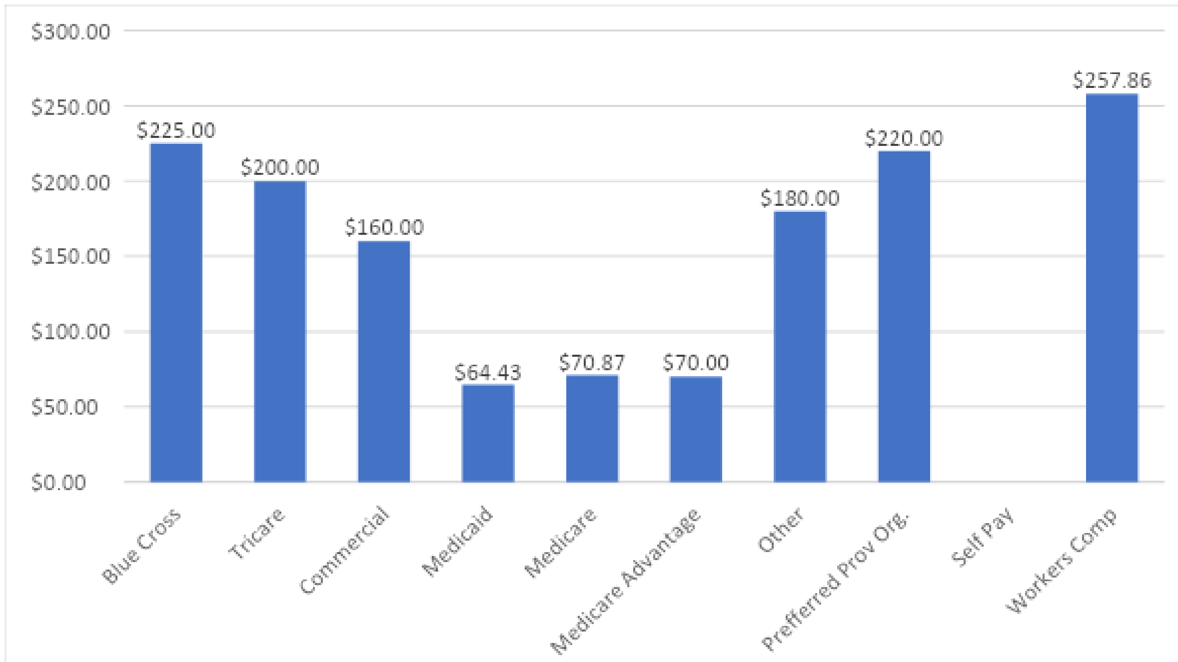
| Payer Mix | Payer Mix |
|---|---|
| Blue Cross | $12,000.00 |
| Tricare | $10,500.00 |
| Commercial | $12,000.00 |
| Medicaid | $11,208.90 |
| Medicare | $10,725.00 |
| Medicare Advantage | $10,500.00 |
| Other | $13,500.00 |
| Preferred Prov Org. | $11,169.00 |
| Self Pay | $ - |
| Workers Comp | $10,500.00 |
| **TOTAL (WEIGHTED)** | **$10,224.84** |

This netted a weighted average of reimbursement rates per patient per stay which we applied to the projected residential patient population.

### Intensive Outpatient (IOP)

Intensive outpatient revenue was calculated in a similar fashion to that above. WE modeled a sample IOP program using industry accepted standards. The program utilized to project IOP revenue represents a 4 hour a day, 3 day a week program which lasts six weeks.

**Figure 29.** IOP Revenue by Payer, Per Diem




We applied daily reimbursement rates to our program model to obtain a per patient, per program rate.

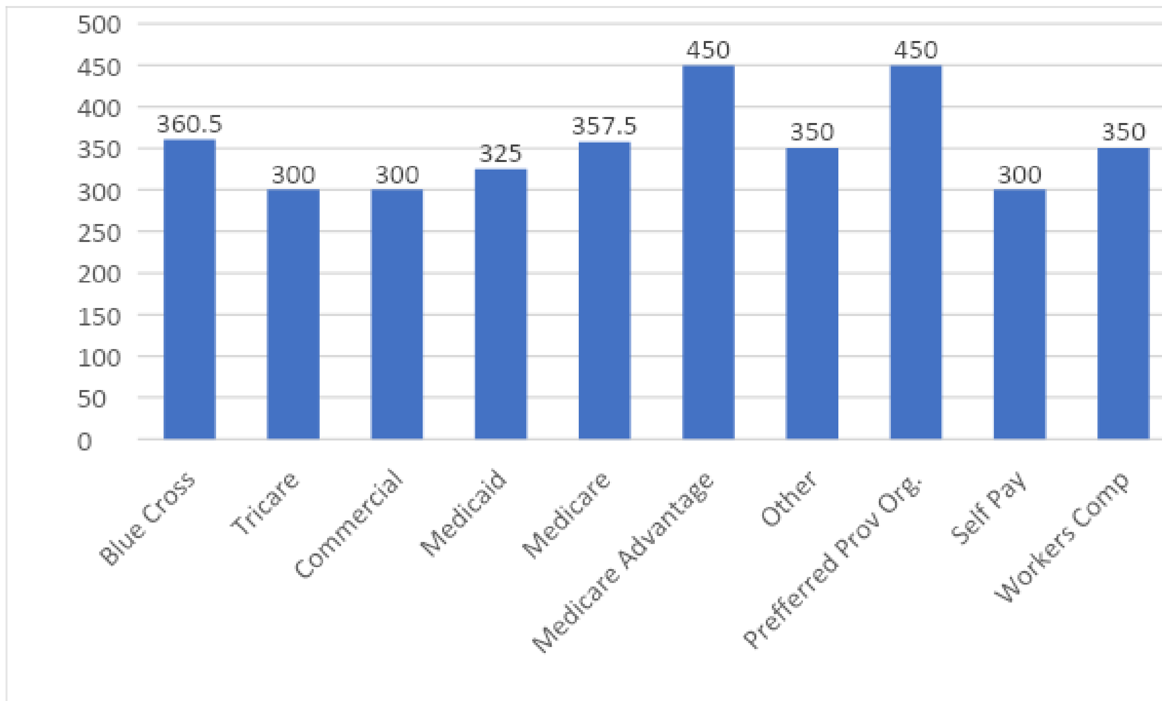
**Table 36.** IOP Revenue by Payer per Program

| Payer Mix | Intensive Outpatient (Summation) |
|---|---|
| Blue Cross | $ 4,050.00 |
| Tri-Care | $ 3,600.00 |
| Commercial | $ 2,880.00 |
| Medicaid | $ 4,638.96 |
| Medicare | $ 5,102.86 |
| Medicare Advantage | $ 5,040.00 |
| Other | $ 3,240.00 |
| Preferred Prov Org. | $ 3,960.00 |
| Self Pay | $ 4,641.48 |
| Workers Comp | $ 4,641.48 |
| **TOTAL (WEIGHTED)** | **$ 4,525.06** |

We applied this weighted average to the projected IOP patient population to arrive at an annual revenue projection.

## Partial Hospitalization

**Figure 30.** Partial Hospitalization Revenue by Payer, Per Diem




We used a partial hospitalization program with services provided 4 days per week for 7 weeks to obtain a per patient revenue estimate.

**Table 37.** Partial Hospitalization by Payer, per Program

| Payer Mix | Partial Hospitalization (Summation) |
|---|---:|
| Blue Cross | $10,094.00 |
| Tri-Care | $8,400.00 |
| Commercial | $8,400.00 |
| Medicaid | $9,100.00 |
| Medicare | $10,010.00 |
| Medicare Advantage | $12,600.00 |
| Other | $9,800.00 |
| Preferred Prov Org. | $12,600.00 |
| Self Pay | $8,400.00 |
| Workers Comp | $9,800.00 |
| **TOTAL (WEIGHTED)** | $9,625.28 |

### Crisis Triage Center

Not all private insurers in New Mexico have adopted reimbursement rates for Crisis Triage Services, due to Crisis Triage Centers being a new service offered in the state. Due to this, the minimum expected reimbursement rate (Medicaid) has been adopted for the entire Crisis Triage Center patient population. The maximum billable time for Crisis Triage Services is one hour, with a reimbursement of $130.76 for that time. This informs our revenue estimate for Crisis Triage Services and was applied to the patient population.

### Detox Unit

The Detox unit will generally be used by patients experiencing withdrawal symptoms and will house patients suffering from a substance use disorder that will normally stay for 5 days. We were unable to obtain reimbursement rates for Detox services for all private payers. Similar to Crisis Triage services, we used an estimated Medicaid reimbursement rate for Detox services of $500 per day. This reimbursement rate, multiplied across the 5-day ALOS, informs the projected revenue from Detox services.

### Outpatient

Traditional outpatient treatment varies patient to patient by length, frequency, and cost of service. Outpatient revenue is one of the smallest categories of revenue for the behavioral health facility, and volume projections will be further informed by future discussions with potential collaborating providers. We used a very conservative revenue estimate of $16,085 per month.

### Pharmacy

The last revenue estimate included in operational financial projections is pharmacy revenue. In order to promote continuity of care and ease of access to medications, we recommend including a small retail pharmacy onsite at the facility. For pharmacy revenue we utilized a different methodology, focusing first on industry standards for revenue and profit margins, instead of on reimbursement rates by payers. This recognizes that prescriptions will vary in dosage, frequency, cost and length by patient, so it is more feasible to adopt a single underlying standard to apply to all prescription revenue. We utilized an average revenue of just over $55 per prescription, with a profit margin of 20%, informed by acceptable industry standards. This yields a monthly pharmacy revenue of $165,000.

## Projections

With an accurate estimate of capital expenditures, annual costs, and annual revenue, we projected the financials of the facility across 5 years, assuming a 5% annual growth rate in revenue year over year. This assumption is tied to the unprecedented changes we are seeing in

national and political attention to this issue, which is expected to drive reimbursement rate increases for both public and private payers.

The following financial projections adopt a capital loan structure of $45 Million at 2.5% interest to be paid back over 30 years. This model was utilized because it is conservative, in that it assumes all capital expense must be financed, and uses a typical interest rate and typical payback term.

### Operational Ramp-up

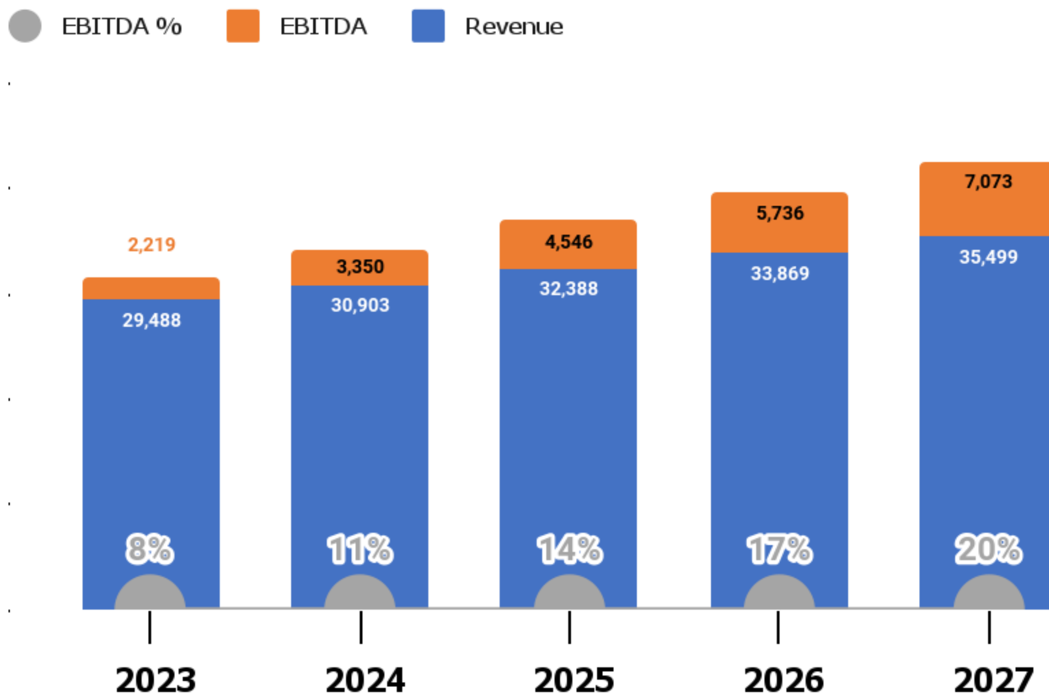
In our model, we estimated that the vast majority of employees will be hired by 6 months from when the facility opens. If it takes longer than six months to hire the majority of employees, this could increase operational losses during the startup period, potentially lengthening the time to break even. If full operational capacity can be achieved prior to six months, operational losses would be decreased, and the behavioral health facility may become self-sufficient sooner than the estimated break even point.

This operational ramp-up period presumes that roughly 50% capacity will be achieved by month three and 90% capacity, the facility's estimated maximum, will be achieved by month six.

### EBITDA

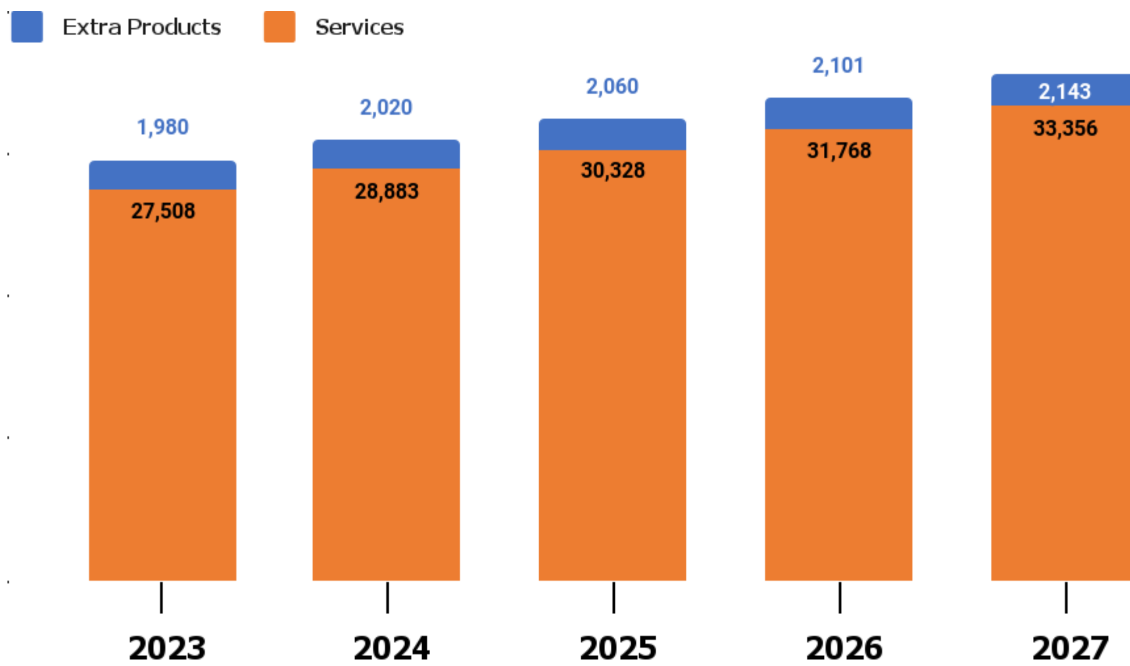
EBITDA, or earnings before interest, taxes, depreciation, and amortization, looks at the operational profitability of the behavioral health facility. EBITDA projections show strong profitability and growth over time, starting near 8% margins and growing to 20% by year 5.

**Figure 31.** EBITDA Projections




Similarly, revenue projections are also strong with a growth of 5% annually, topping $30 million in year 5.

**Figure 32.** Revenue Projections




Lastly, although the facility has a negative cash flow initially, it returns a positive cash flow in year 4 (Cash Flow), and has a break even point between years 5 and 6 (Cumulative Cash flow– only five years are projected here).

**Figure 33.** Cash Flow Projections

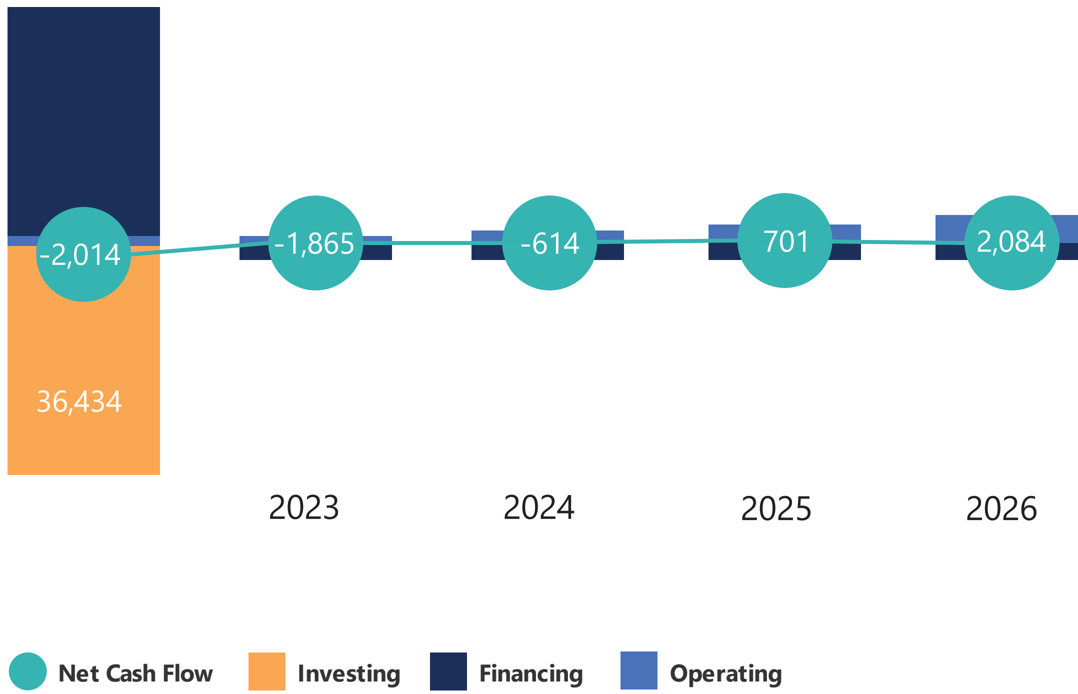
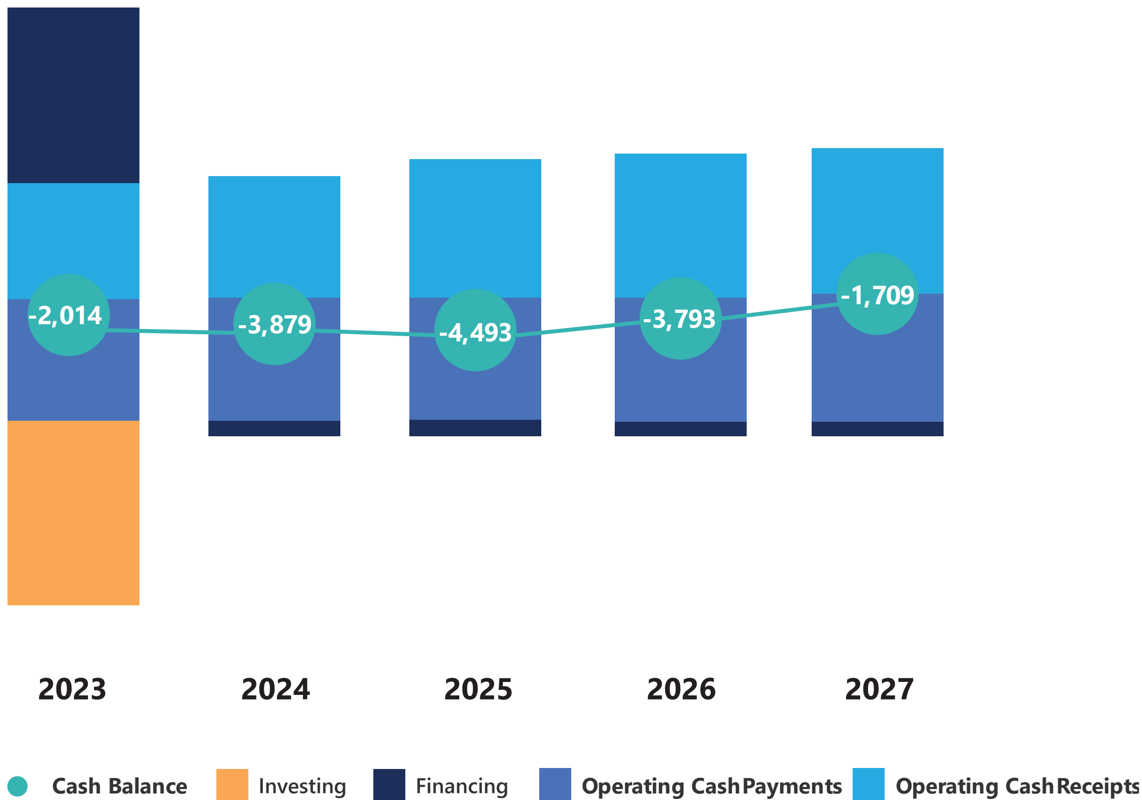


**Figure 34.** Cumulative Cash Flow Projections




## Uncertainties

Although the financial outlook is strong, there are uncertainties present which should temper the expectations of the proposed facility. Primary uncertainties include patient utilization, and operational ramp-up time. The former refers to the percentage of patients in an affected population who will utilize behavioral health services, while the latter acknowledges that the behavioral health facility will not be 100% efficient on day one. Due to the high demand and pent-up needs, we anticipate the facility will fill quickly, and that staffing will be the primary restraint to reaching 90% capacity.

According to industry experts, we anticipate the time to hire, onboard, and train staff will decrease our revenue in the initial months of operation. This is due to the inability to hire, train and deploy all 250+ full time employees by day one. On the low end, five months was estimated to be a sufficient ramp up time – where most staff are present by month five. At the high end, 26 months was estimated to be a sufficient ramp up time – where 50% of the staff is

present by month 17 and the vast majority is hired by month 26. These estimates come from different regions nationally, and do not account for the local fluctuations in available workforce.

### Feasibility

The behavioral health facility, as envisioned, is financially feasible. Assuming low interest rates on capital expenditures can be procured, and the facility can meet or exceed the expectations above which demonstrate the facility will be self-sufficient and profitable by year 5.

## Funding and Ownership Considerations

We considered a variety of funding sources and options to acquire capital for a new behavioral health facility. Generally, funding options can be divided into two categories: financed and non-financed options. The pros and cons of each possible capital funding option is discussed below.

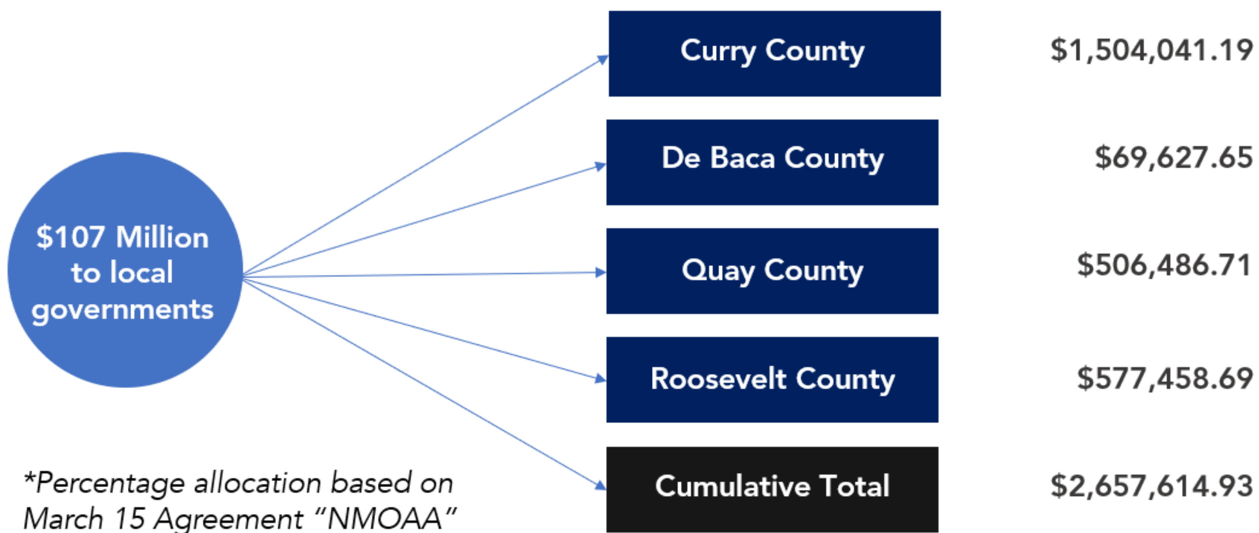
## Non-Financed Options

Among the first funding sources explored were existing funds available to the cities and counties. The largest benefit to using these funds to pay for behavioral health services is that it requires no new expenditure on the entities' behalf, and is completely within the control of the entities to employ. However, this comes with the drawback of potentially using funds earmarked for other purposes, and with the notable drawback of requiring a higher tax rate on taxpayers.

### Opioid Settlement Dollars

Opioid settlement dollars provide perhaps the best source of no-interest funds. Opioid settlement dollars available to the counties stem from a large pool of money that defendant manufacturers and distributors of opioid medication agreed to pay out to governmental agencies across the nation, for contributing to the opioid epidemic. Roughly $200 million dollars are available in the total settlement fund for New Mexico, and this pool has been distributed to state entities – to be further distributed to counties and towns based on population size. Of the $107 million dollars allocated to local governments Clovis, Curry, De Baca, Quay, and Roosevelt will be receiving $2,657614.93, collectively.

**Figure 35.** Opioid Settlement Fund Distribution




Opioid settlement funds can be used for the expansion of hand-off programs and recovery services, treatment for incarcerated populations, prevention programs, treating opioid use disorder, support for people in treatment and recovery, and to prevent overdose deaths and other harms (among a multitude of other uses). In short, a new behavioral health facility, and its operation, falls within the purview of acceptable opioid funds use.

### Tax Mill or Levy

We considered the institution of a tax mill or levy to fund the regional behavioral health facility. This is a model being employed by other communities across the country, such as Larimer County, CO. This is perhaps the surest method to ensure a new behavioral health facility is built, and continues operating successfully far into the future. This is because the institution of a tax mill or levy is entirely within the discretion of the local governments, and does not rely on external approval. However, it comes with the notable downside of raising taxes on the affected public. Therefore, although a tax mill or levy is traditionally a great option for funding infrastructure projects, in this case it may not make the most sense, and was not supported by city and county managers.

### Governmentally Directed Spending

Governmentally directed spending involves requesting funds from the state or federal government for a specific purpose, generally for a public benefit. In this case it would involve reaching out to New Mexico's senators and representatives to request funding for the behavioral health facility. Given the increased focus on behavioral health, state-level sources in New Mexico expressed significant confidence in the prospect of funds allocation from the state legislature. The risks inherent in relying on these funds are that the process is entirely within the discretion of the spending committee to which the proposal is submitted. While governmentally directed spending could be an excellent source of funding, we are unable to guarantee a certain amount will be allocated.

### Credit Tenant Lease

The last option pursued under non-financed options was a Credit Tenant Lease structure. This option is akin to a "rent to own" mortgage on a home. In this scenario, the counties would apply for a loan for the development of the behavioral health facility from one of a variety of lenders. The cost of the behavioral health facility would then be fronted by the development entity in exchange for a lease agreement on behalf of the counties. The counties would then have the right to purchase the facility after an agreed upon amount of time.

Under this structure, the counties would pay an agreed upon lease payment every month, for the right to use, operate, and eventually own the facility. This model is beneficial because it requires no capital expenditure. While it does require counties to take on risk, by agreeing to a long-term lease, this lease payment could be covered by the revenue of the facility. However, this funding option is not the most ideal because there is still an 'interest' payment tacked onto the lease payment. While no capital expenditure is required, the counties would end up paying for the investment over time through a higher-than-mortgage lease payment.

## Financed Options

Financed options share common characteristics with a home mortgage. Capital funding is secured through a loan, where the source of the funds generally sets the term length, interest rate, and other key language of the loan. Financed options should be seen as a backstop to other more favorable forms of financing. Financed options require payback, assign risk to the

cities and counties, and limit the entities' addition of more debt services. We pursued all available options, and the summation of each financed option is discussed below.

### NMFA Public Funding

The New Mexico Finance Authority (NMFA) has several public funds which are used to loan capital funds to projects in service of the public benefit. Unfortunately, only one fund qualifies for use on a behavioral health project, the New Mexico Primary Care Fund, which has only $500,000 left in it. This source also requires an in-depth application procedure. It is more feasible to pursue one source of funding through the NMFA, so the fund that could potentially fund the entire project is preferable to one that may only cover a fraction of a percentage of the cost of the project.

Additionally, publicly available funding *must* be allocated to counties that demonstrate a historical need based on national criteria. At this time *only* De Baca County and Quay County qualify. This means that De Baca or Quay County would need to secure funds and negotiate the construction of a facility either in their respective counties or in a separate county.

### Grants

Grants represent the last form of no-interest funding pursued within the public category. Federal and state grants for behavioral health largely focus on funding programs and services, not capital or construction costs. In the context of a non-profit facility, grants may provide additional revenue to hire staff and support programmatic expenses. Grants should also be explored as a strategy to support services that are not reimbursable, such as childcare at the facility, or other wraparound services.

## Public/Private Funding

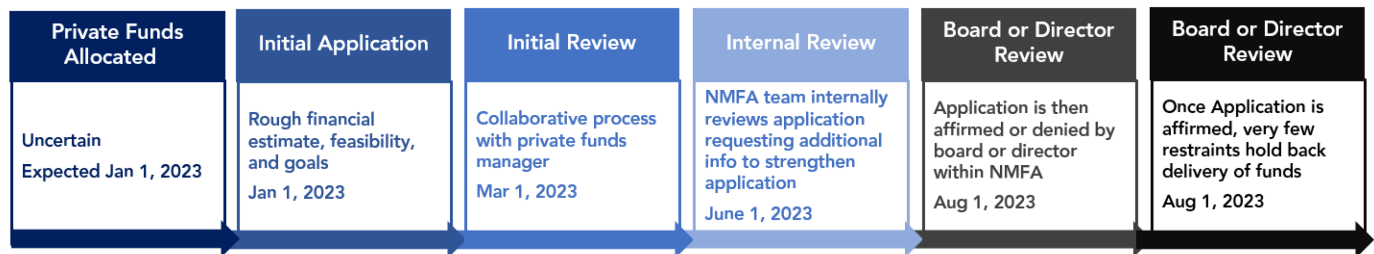
Public/private funding involves private equity as investors, with a public entity allocating the equity. For example, just as a homeowner could secure a mortgage through a private bank (private equity, private allocation), homeowners with a greater need may qualify for state or federally-sponsored mortgage programs (private equity, public allocation). Generally, the success of these funds relies on the tax benefits that flow to the owners of the private equity. In our case, the NMFA has a new market tax credit fund, which allocated private equity towards

publicly beneficial projects, but gives the owners of the private equity a tax break, so the interest rates are lower for the loanee.

### NMFA New Market Tax Credit

The NMFA new market tax credit offers perhaps the best opportunity to fund the entirety of a behavioral health facility at a low interest rate. Securing a loan through the NMFA new market tax credit fund involves a collaborative application process. At the start of the process, a loan manager is assigned to help strengthen the application, and works closely with the application to garner support for the application as it is reviewed internally.

**Figure 36.** Potential timeline to secure funds through the new market tax credit fund.




The several loan directors we spoke with informed us that a typical interest rate on the size of loan we are projecting would be needed would be in the range of 6%, which is very reasonable given the large amount.

The greatest drawback to this option is the currently dormant nature of the new market tax credit fund. Currently, the new market tax credit fund is waiting for approval of funds to be allocated to it. The directors we spoke with assured us that $100 million dollars would be available in the fund by Jan. 1, 2023, however we have no way to verify this with certainty. Given this uncertainty, there is a possibility that the total funding available is less than required to construct a new behavioral health facility.

## Private Funding

The last sources of funding explored concerned purely private funds. Private equity is akin to asking for a loan from your local bank. Generally, private funding has a higher interest rate, as the owners of private equity expect a return on their investment. However, private funding also has the fewest obstacles to securing capital funds. Where public funding generally comes with

substantial oversight and requirements, while offering lower interest rates and cheaper capital, private funding generally comes with less oversight and requirements at the cost of higher interest rates. Opportunity zone (OZ) funds, private development funds, and local partnerships could help pay for a new behavioral health facility.

### Opportunity Zone Fund

An opportunity zone fund functions similarly to public/private equity. Opportunity zone funds encourage investment in underserved communities by providing tax incentives to the fund manager. However, unlike public/private funds, the oversight imposed on an OZ fund applies more directly to the fund manager than to any individual developer. There are fewer application hurdles to clear to qualify for acceptance into an OZ fund, but generally the strength of the proposed business/project is the primary factor when considering acceptance into an OZ fund. Generally, an OZ fund will rely on historical revenue for the project involved to determine whether it is a solid investment. Unfortunately, no historical revenue exists for a new behavioral health facility in the project area. Thus, any OZ fund manager would likely require a guarantor of any loan provided to the project area.

### Private Development funds

Among private funds, we pursued private development funds, which are smaller operations that focus almost exclusively on the projected success of the proposed project and the return on investment it could expect. Private development funds generally do not include tax benefits like an OZ fund or public/private spending, and so charge a marginally higher interest rate to account for their added risk. However, in our experience, private development funds have been the most collaborative source of funding to date. Several funds, including Signet, Leon Capital, Sabra, and Quadrangle Partners, have expressed interest in partnering with the cities and counties to construct a new behavioral health facility. All private funders have recognized that a dire need exists for behavioral health services, and factor this into their consideration of whether constructing a new facility would be a sound investment.[45]

### Family Foundations

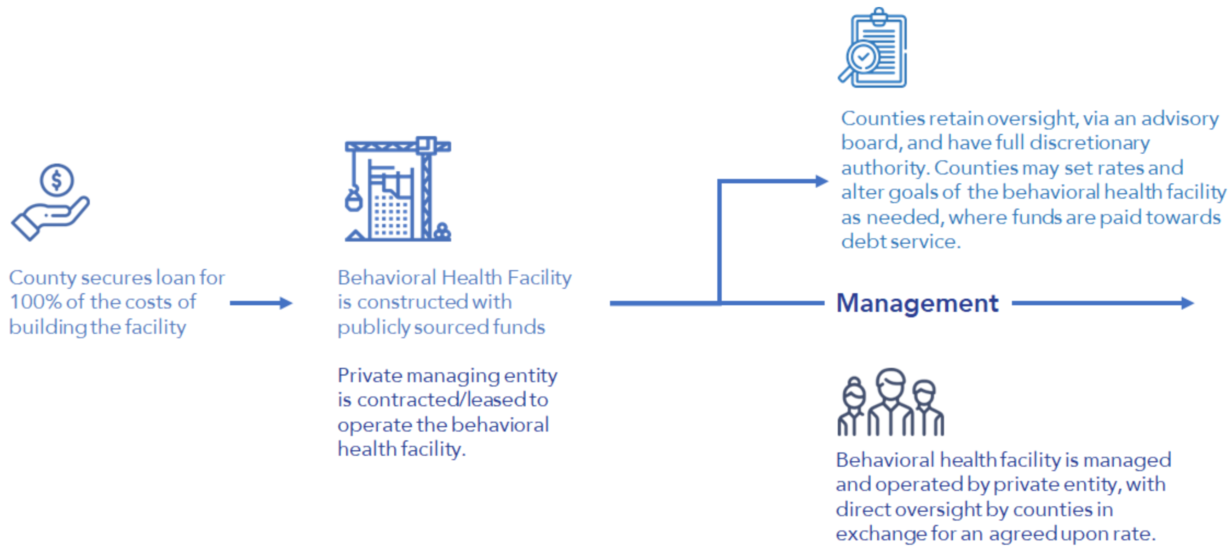
Last within the funding sources we pursued are family foundations. These are the most variable entities from which the entities could seek capital funding. We met with family foundations who expressed interest in substantial investment in a new behavioral health facility.

Family foundations should be one of many sources in a capital campaign. While family foundations would not provide the entirety of capital funding necessary to build a behavioral health facility, their contributions could help lower the funds necessary at the time of start-up.

## Ownership Models

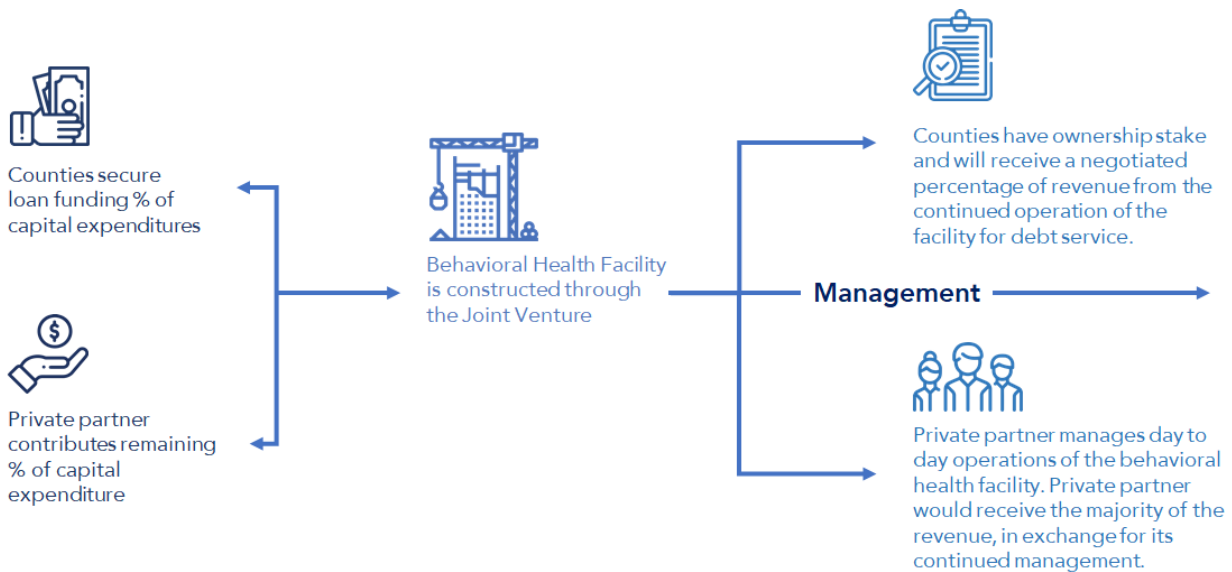
After exploring funding options, it became apparent that not all options are available under any given ownership structure. Instead, certain funding options will necessitate a private or public partnership. Similarly, for counties to remain in a position of authority and oversight, certain funding options become less practical because they do not allow for sufficient oversight or advisory throughout the operation of the facility. There are three likely ownership models which could result from the above funding options; county financed, joint venture, and State and Federally funded models. These models are purely representative and should be considered alongside a capital campaign to reduce capital expenses to the maximum extent possible.

**Figure 37.** Public Model (City/County Financed)



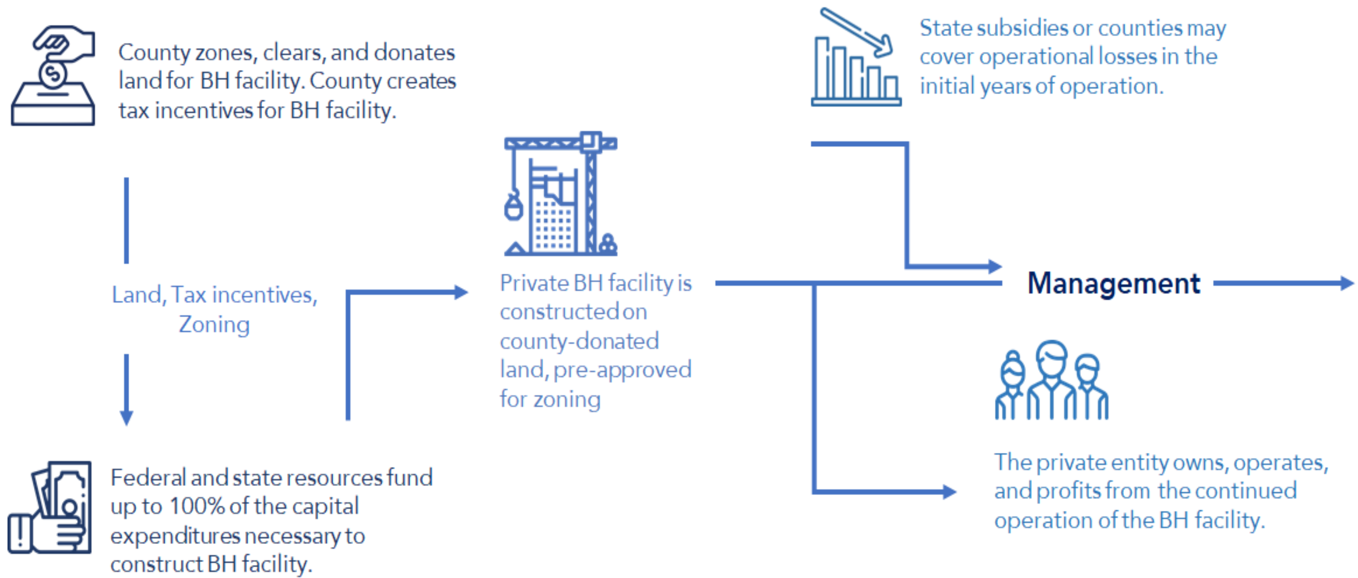

Under a city/county financed option, the cities and counties would secure a loan for the entirety of the behavioral health facility. This would assign risk to the entities, as they become responsible for the payback of capital. However, this scenario provides the entities with a substantial place of authority to hire a private management firm to operate the facility – ensuring the treatment goals of the community are always aligned with those of the managing entity.

**Figure 38.** Private/Public Model (Joint Venture)



In a joint venture model, the cities and counties would partner with a private entity both to reduce capital expenditures and secure a long-term partner that would manage the behavioral health facility. This model incentivizes private partners to come forward by allocating resources towards the development of a behavioral health facility.

**Figure 39.** Public Model (State and Federal Resources)




Lastly, a city/county owned, but state and federally funded model is the most ideal scenario for counties, private partners, and patient treatment. Under this model, the cities and counties would lobby for support from the state or federal government, securing most of the capital funding from non-financed sources that do not require payback. Cities and counties would clear, zone, and donate land to be used for the behavioral health facility. Then, a private development group could quickly start construction of the facility.

Similar to the city/county financed option, the cities and counties would have significant authority and oversight over the operation of the facility. However, unlike the City/County financed option, in this scenario, the entities do not need to take on a loan to achieve that oversight. Instead, state and F\federal governments would allocate funds directly to the cities and counties for the construction of the facility, negating the need for a large loan.

## Staffing Feasibility and Considerations

Throughout our interviews and listening session, community members emphasized the challenge of recruiting and retaining the behavioral health staff in the region. Current national workforce issues compound the existing workforce challenges of this rural area. Healthcare has seen drastic measures in staffing in the past two years particularly in nursing, with extremely high wages being paid to contract or "travel" nurses due to shortages and related impacts of COVID-19. Staffing should continue to be a key consideration in the planning for a regional behavioral health facility and partnerships and strategies outlined below can be advanced while the facility is still in development.

## Partnerships

We recommend establishing partnerships with several colleges and universities to strengthen the workforce pipeline for behavioral health. Specifically, we recommend partnering with Eastern New Mexico University (ENMU) and Clovis Community College (CCC) to provide internship opportunities and clinical supervision for students and new graduates. These two schools are working to develop a 2+2 program for students in the Associates in Behavioral Sciences degree program at CCC to go on to obtain a Bachelor's in Social Work (BSW) at ENMU. Additionally, we learned from ENMU that many of their BSW graduates go on to complete their Master of Social Work online while continuing to live in the area. By working with these local schools, the facility will be able to attract students who have strong ties to the area and are more likely to stay.

In addition, ENMU is launching a Licensed Substance Abuse Associates program in the fall of 2022, to fill a much-needed gap in outpatient substance use disorder care in the region. Currently, there are only one or two clinicians in the region who provide the clinical supervision necessary for LSAA graduates to obtain their Licensed Alcohol and Drug Addiction Counselor (LADAC) certification. ENMU will expand access to this opportunity by providing this clinical supervision. The regional behavioral health facility should partner with ENMU to provide an opportunity for clinical experience and supervision for LADAC candidates.

Additional partnership opportunities that should be explored include West Texas A&M in Canyon, TX, and Texas Tech in Lubbock, TX, which both offer psychiatric mental health nurse practitioner (PMHNP) programs. These advanced practitioners can prescribe medication and

provide psychiatric care to inpatients, outpatients, and via telehealth. The employment of this type of nurse practitioner is a key element in our facility model. Advanced practitioners will collaborate with psychiatrists to expand access to psychiatric care and reduce the need for more psychiatrists, who are especially difficult to recruit due to low numbers of these providers nationally.

In a similar effort in Omaha, NE, a $50 million behavioral health facility for child and adolescent behavioral health with 36-40 beds is under development on the campus of Immanuel Medical Center. Nearby schools including Metropolitan Community College, the University of Nebraska at Omaha, Creighton University, Bellevue University, and Iowa Western Community College, are collaborating on ways to expand their output of mental health care workers. Insights from these collaborators and similar coalitions may be useful to informing partnerships in eastern New Mexico and should be explored.

## Strategies

During this study, we heard from several sources that public recreation facilities and other amenities are lacking in the region, which can hinder the ability to retain professional staff. In order to recruit and retain the staff necessary to deliver quality care in a regional facility, we recommend the counties and municipalities in the four-county region collaborate to develop strategies to invest in infrastructure that will attract top talent to the area.

While the four-county region is home to a population that is 43% Hispanic, there are very few Hispanic behavioral health clinicians, or even clinicians who are Spanish speaking. This disparity makes it difficult for residents to access care and develop therapeutic rapport with clinicians. We heard heartbreaking stories of individuals in need of behavioral health care who could not find a clinician who could speak their language. It is imperative that staffing strategies at the new facility include recruitment and retention of Hispanic clinicians as part of an overall recruitment strategy that emphasizes diversity.

Given the current staffing challenges nationally and the rising number of millennials in the labor market, it is important for any organization to be purpose-driven and to give employees a sense of fulfillment in their work. In conjunction, the facility should offer competitive salaries, benefits, and working conditions. It should provide incentives such as sign-on and retention bonuses, including student loan repayment subsidies tied to each month of working within the

facility. Staffing strategies such as these should be considered and discussed when selecting a management company to provide services at the facility as this entity would be responsible for recruiting, hiring, and retaining staff.

## Impact on the Healthcare Ecosystem and Benefits to Communities

As our gap analysis shows, there is a large unmet need for behavioral health care in the four-county region. Due to the current lack of nearby behavioral health facilities, the current health system infrastructure is simply unable to provide adequate care for residents experiencing behavioral health crises. Local hospitals do not have the capability to properly treat behavioral health patients and are forced to rely on EMS and law enforcement to transport them to distant behavioral health facilities or county detention centers for treatment.

Establishing a regional behavioral health facility that offers immediate access to crisis care would result in many benefits to the community. By providing a range of crisis services, a regional facility will be able to provide the most appropriate care needed to individuals in crisis. As community members grow accustomed to utilizing the facility and services, we can expect that the impact on law enforcement, EMS, and local hospital emergency departments will lessen.

A 2019 study evaluating the effects of stand-alone psychiatric emergency services in Alameda County, CA, implemented between 2011-2016, found that *"Ten percent of all EMS encounters were for involuntary psychiatric holds. With an EMS-directed screening protocol, 41% of all such patient encounters resulted in direct transport of the patient to the psychiatric emergency service, bypassing medical clearance in the ED. Overall, only 0.3% of these patients required re-transport to a medical ED within 12 hours of arrival to psychiatric emergency services."*[46]

Access to crisis services can also reduce the need for inpatient behavioral health care. A *Psychiatric Times* article reviewing current psychiatric ED practices reported that the Crisis Response Center in Tucson, Arizona, which sees over 1,250 patients every month, can stabilize over two-thirds of patients without needing inpatient admissions.[47] From a cost-specific perspective, a 2013 study that evaluated mental health crisis stabilization programs in

Minnesota, concluded that due to lower utilization of ED and hospital inpatient services, the net financial benefit for mental health crisis stabilization was a return of $2.16 for every dollar invested. Notably, this total did not include cost-savings from reduced justice system utilization, which are likely to be significant.[48]

### Health Services Quality Impact

In accordance with *SAMHSA National Guidelines for Behavioral Health Crisis Care - Best Practice Toolkit,* we recommend deploying mobile crisis response teams capable of stabilizing and transporting behavioral health patients to the regional behavioral health facility.[18] This would significantly reduce the current EMS transport burden. Additionally, in those cases where EMS is called and/or required, transportation will be much shorter. Appropriate patients can be transported directly to the crisis triage center at the behavioral health facility, instead of a local hospital ED. When a hospital ED visit is required for medical clearance, transport to a behavioral health facility in Clovis instead of elsewhere will alleviate countless hours of EMS transport.

The proposed facility will act as the main regional behavioral health treatment facility responsible for most, if not all, behavioral health patients who would otherwise end up in a local hospital ED, dramatically reducing the current burden on local EDs while improving quality of behavioral health care. Together with the mobile crisis response teams, crisis triage center, and inpatient facility, the regional behavioral health facility's interdisciplinary medical teams will provide quality behavioral health care to residents, leading to improved patient and community outcomes.

### Criminal Justice System Impact

Our interviews and data received from law enforcement showed high utilization of justice system resources for behavioral health crises. Police and sheriff deputies respond to crisis events and provide patient transport services when EMS is unavailable, while the county detention centers provide behavioral healthcare to patients awaiting transfer to a behavioral health facility, which can take months. The result is another example of expensive, yet low quality healthcare, where patients rarely receive proper care in a timely manner due to a lack of system capacity and resources.

A common problem arising from depending on law enforcement for behavioral crisis interventions is a higher incidence of arrests during crisis situations. Representatives from county sheriffs and EMS services confirmed this is an issue in the four-county region, leading to excessive criminal justice system costs and poor patient outcomes. From January 3, 2021 to September, 28, 2021, the Portales City Police Department reported 94 suicide attempt/threat calls, utilizing 168 responding police officers across 73 Portales Police dispatch events. We are unable to provide an exact number of avoidable behavioral health arrests from the data provided, but based on feedback from our interviews, anticipate that a crisis triage center would be an appropriate service for a large proportion of these events.

A 2015 report from the *Ella Baker Center, Forward Together, Research Action Design* found that the average court costs associated for a single arrest was $13,607.[49] This does not account for the indirect costs to the criminal justice system including policing, prosecuting, and incarcerating, which together reach far beyond this sum. For a mental health patient arrest, the total escalates further due to the additional healthcare costs. A 2013 study evaluated the impact of a jail diversion program for people with serious mental illness on taxpayer costs.[50] Due to reductions in criminal justice costs, diversion to a mental health treatment facility was associated with approximately $2,800 lower taxpayer costs per individual experiencing a crisis event.

Co-locating a mobile crisis service with a regional behavioral health facility would promote well-coordinated care, as the facility would work side by side with city and county services to ensure patients get the care they need. In turn, crisis patient arrests will be reduced, removing the detention centers from the treatment continuum unless absolutely necessary. This will also increase the capacity of county detention center behavioral healthcare professionals to care for the true detainee population. With the regional facility up and running, the overall justice system can expect significant cost-savings and reduced workloads associated with behavioral health crisis events.

The current and ever-rising need for acute behavioral health crisis services in the eastern New Mexico region is overwhelming. A regional behavioral health facility including a crisis triage center is a vital solution that will lead to significant improvement in behavioral crisis patient

outcomes, reduction of hospital ED burden, cost-savings, and better overall quality of life for the citizens in the four-county region.

## Potential Service Delivery Participants' Interest in Participating in a Regional Model

Behavioral health care services are often provided by several different provider groups within the same facility. For example, in Johnson County, Iowa, the Guidelink Center offers urgent mental health and substance use care through collaboration of several entities. In this example, a single managing entity oversees operations across the center, while each provider organization offers its unique expertise.

**Figure 40.** Organizational Relationships at the Guidelink Center

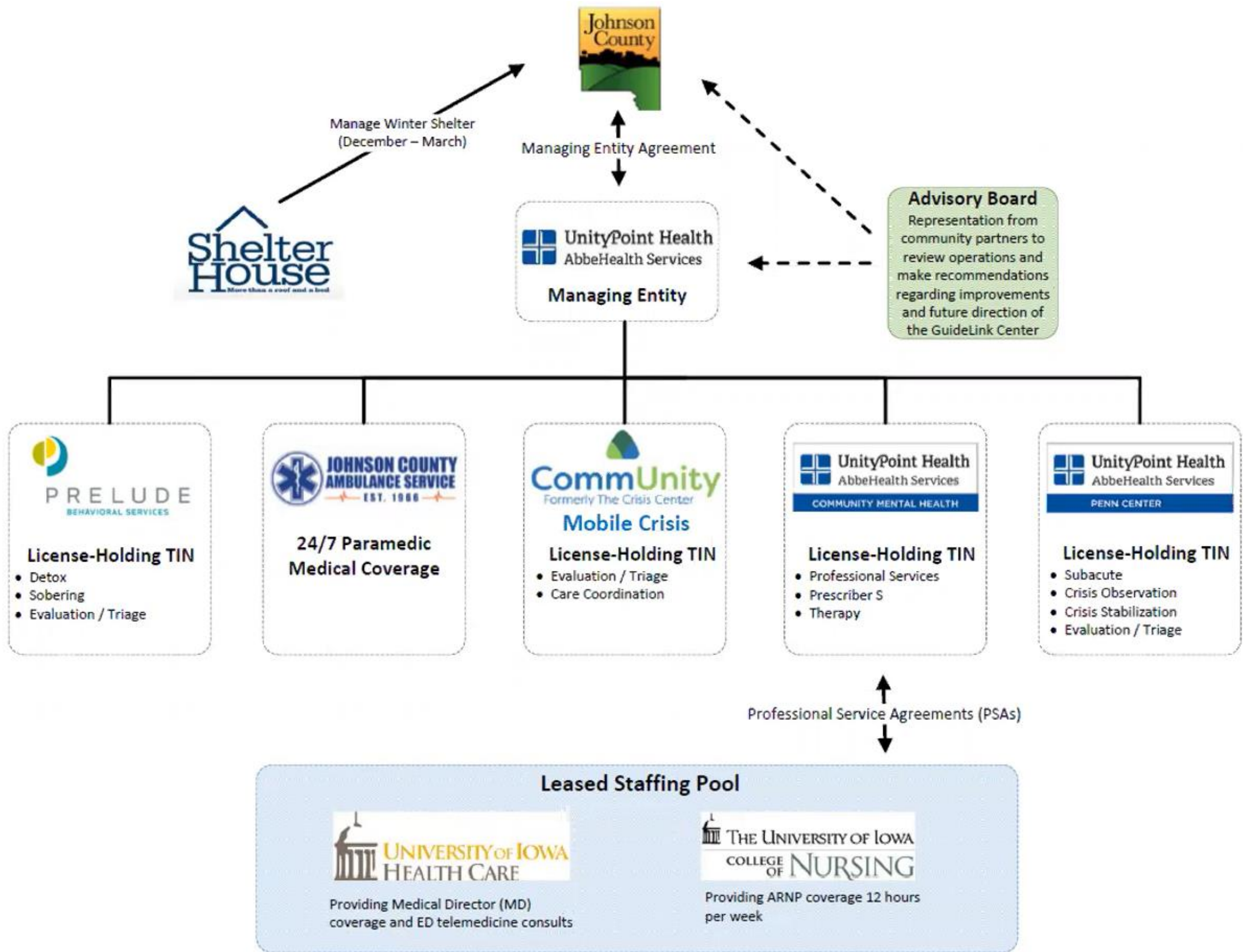


**Figure 41.** The Guidelink Center, Johnson County, IA

While our gap analysis demonstrated that there are currently not enough outpatient behavioral health services to meet the need, it is also important to consider how current providers can

work with a regional facility to avoid duplication of services, especially given the staffing challenges addressed above. Integrating and co-locating current service providers with the new facility may improve coordination of care between crisis, inpatient, and outpatient settings and maximize resources. Further exploration of these relationships is recommended, including exploration of this topic during discussions with potential managing entities.

During this study, we interviewed eight behavioral health agencies, including counseling agencies, solo practitioners, the community mental health agency, and providers from Cannon Air Force Base. We asked providers about their ideal working relationship with a regional behavioral health facility, and how they would participate with this service delivery model. Most providers were very supportive of a regional facility and indicated their interest in collaborating on patient care.

Preferred components of partnership between community-based behavioral health counseling agencies and providers and a new regional facility:

- Availability to reach a liaison at the facility to alert them of a patient coming to the crisis triage center and provide patient information
- Inpatient providers confer with outpatient providers / counseling agencies during inpatient care as needed
- Upon discharge, providers receive a phone call, fax with discharge medication list, and outline of expectations for the patient regarding medication management
- Collaboration regarding ongoing patient care for those who receive medication management at the facility and counseling elsewhere
- Ability to see their own patients during inpatient care (Cannon Air Force Base)

Additionally, Mental Health Resources, Inc. expressed concern regarding a regional behavioral health facility pulling staff from other agencies, leaving a deficit in the availability of outpatient care in the region.

## Regional and National Precedents

We examined regional and national precedents with a focus on how new construction, expansions, and recently acquired behavioral health facilities are owned, operated, and

funded, to inform the cities and counties involved of other facilities that could serve as models for a regional facility.

The first facility in Milwaukee County, MN is a county joint venture (JV) with state and federal support. The JV is between Milwaukee County (50%) and four health systems (50%): Advocate Aurora Health, Ascension Wisconsin, Children's Wisconsin, and Froedtert Health. The facility is a Mental Health Emergency Center that includes 24/7 crisis mental health assessment, stabilization, treatment, and transition care management for children, adolescents, and adults. The facility is targeted to open September 2022 and will be 12,000 square feet. There was $18M in construction and start-up expenses. The facility received $5.7M in state funding allocated by Gov. Tony Evers from ARPA funds, $2.5M in federal appropriation dollars secured by Sen. Tammy Baldwin, and $1M from national private, nonprofit behavioral health provider Rogers Behavioral Health.

**Figure 42.** Milwaukee County Mental Health Emergency Center Rendering

The Larimer County Behavioral Health Facility in Fort Collins, Colorado is county-owned with a contracted provider organization. The facility includes a crisis stabilization unit, behavioral health urgent care, two levels of withdrawal management (detox), medication assisted treatment, short-term intensive residential treatment (IRT), and on-site pharmacy and lab service. The target open date for the facility is mid-2023 and will have 64 beds. The provider for the facility is SummitStone Health Partners (private, nonprofit).

**Figure 43.** Larimer County Behavioral Health Facility Rendering

Peak Behavioral Health Services in Santa Teresa, NM is owned by private equity and managed by a for-profit company. This 119 bed facility was purchased by Summit BHC in January 2022. It is owned by Patient Square Capital and managed by Summit BHC.

**Figure 44.** Peak Behavioral Health Services

Rio Vista Behavioral Health in El Paso, TX is owned by private equity and managed by a for-profit company. This 80-bed facility opened in 2019 and is owned and managed by publicly-traded company Acadia. The facility is investing to build out 38,000 square feet to add 40 beds, an outpatient center, and outdoor recreation space.

**Figure 45.** Rio Vista Behavioral Health Expansion Rendering

A 43-bed Child and Adolescent Behavioral Health Center is under development in Peoria County, IL. The facility will offer inpatient and outpatient care, family housing, and adolescent substance use treatment. The facility will be jointly operated by UnityPoint Health Behavioral Health Services, Human Service Center, and Tazwood Center for Wellness. It will be located on a 13-acre property which was formerly a nursing home.

The Peoria County Board approved sale of the property to UnityPoint health, a non-profit health system, for $8-10M, which is dependent on how much state assistance will be provided. The facility replaces the child/adolescent unit of the UnityPoint inpatient hospital to double the inpatient capacity in the area. UnityPoint Health-Central Illinois Foundation launched the Young Minds Project (capital campaign) to raise $24M toward the capital needs of the project. Of the $24M goal, $12M will be raised from community sources. Recently, the project secured $2M from federal appropriations under the leadership of US Congressman Darin LaHood.

# Appendix: Interview Participants

| | |
|---|---|
| Arise Sexual Assault Services | |
| Be Well Counseling | |
| Cannon Air Force Base | * |
| Casey Turnbough, PMHNP | |
| Christian Believers Education | * |
| City of Clovis Grants, Marketing, & Communications | * |
| Clovis City Commission | * |
| Clovis City Manager’s Office | * |
| Clovis Community College | |
| Clovis Fire Department | * |
| Clovis Municipal Schools | * |
| Clovis Police Department | * |
| Connect Counseling | |
| Curry County Adult Detention Center | * |
| Curry County CYFD/Juvenile Justice System | * |
| Curry County DWI Court Compliance | |
| Curry County Manager's Office | * |
| Curry County Sheriff’s Office | |
| Dan C. Trigg Memorial Hospital | |
| De Baca County Assessor | |

| | |
|---|---|
| De Baca County Communications Center | |
| De Baca County Detention Center | * |
| De Baca County Sheriff's Department | * |
| De Baca Family Clinic | * |
| De Baca Manager’s Office | * |
| Dora Municipal Schools | |
| Eastern New Mexico University | |
| Elida Municipal Schools | |
| Floyd Municipal Schools | |
| Licensed Social Worker, Former Clovis Resident | |
| Fort Sumner EMS | * |
| Fort Sumner Municipal Schools | |
| Grady Schools | |
| Hartley House | * |
| House Municipal Schools | |
| Integrated Resilience | * |
| Juvenile Probation Office | * |
| La Casa Family Health Center | * |
| Lighthouse Mission | |
| Logan Municipal Schools | |
| Matt 25 | * |
| Melrose Municipal Schools | |

| | |
|---|---|
| Mental Health Resources | * |
| Mesa Counseling | |
| New Mexico Human Services Department | |
| New Mexico State University | * |
| Ninth Judicial District Court | * |
| New Mexico Association of Counties | |
| Plains Regional Medical Center | * |
| Portales Manager's Office | * |
| Portales Fire Department | * |
| Portales Municipal Schools | |
| Portales Police Department | * |
| Portales Professional Social Work Services | * |
| Professor, Odessa College, Former Clovis Resident | * |
| Quay County Detention Center | |
| Quay County Fire Department | |
| Quay County Health Council | |
| Quay County Manager’s Office | * |
| Quay County Sheriff's Office | |
| Roosevelt County Chamber of Commerce | |
| Roosevelt County Detention Center | * |
| Roosevelt County Health Council | * |
| Roosevelt County Manager's Office | |
| Roosevelt County Misdemeanor Compliance Programs | |
| Roosevelt County Sheriff's Office | * |
| Roosevelt General Hospital | * |
| Rose H. Hurst, LPCC | |
| San Jon Municipal Schools | |

| | |
|---|---|
| State of New Mexico County Emergency | * |
| Texico Municipal Schools | |
| The Psychiatric Care Center | |
| Tucumcari EMS | |
| United Way of Eastern New Mexico | * |

* Attended the Community Listening Session

## Bibliography


1. New Mexico Department of Health. New Mexico Substance Use Epidemiology Profile. Accessed June 22, 2022. https://www.nmhealth.org/data/view/substance/2457/

2. Timeline: New Mexico's Shake Up Of Behavioral Health Providers. Accessed June 27, 2022. https://www.kunm.org/public-health-new-mexico/2013-09-13/timeline-new-mexicos-shake-up-of-behavioral-health-providers

3. 2020 Census Results. Accessed June 27, 2022. https://www.census.gov/programs-surveys/decennial-census/decade/2020/2020-census-results.html

4. https://www.nmlegis.gov/Entity/LFC/Documents/Program_Evaluation_Reports/Progress%20Report%20-%20Addressing%20Substance%20Use%20Disorders.pdf

5. Week 39 Household Pulse Survey: September 29 – October 11. Accessed June 27, 2022. https://www.census.gov/data/tables/2021/demo/hhp/hhp39.html

6. CDC - 2017 BRFSS Survey Data and Documentation. Accessed June 27, 2022. https://www.cdc.gov/brfss/annual_data/annual_2017.html

7. COVID-19 pandemic triggers 25% increase in prevalence of anxiety and depression worldwide. Accessed June 27, 2022. https://www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide#:~:text=In%20the%20first%20year%20of,Health%20Organization%20(WHO)%20today.

8. The Implications of COVID-19 for Mental Health and Substance Use | KFF. Accessed June 27, 2022. https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

9. COVID-19's toll on mental health. Accessed June 27, 2022. https://www.bc.edu/bc-web/bcnews/campus-community/faculty/anxiety-and-stress-spike-during-pandemic.html

10. https://hsc.unm.edu/medicine/departments/psychiatry/cbh/docs/2020-bh-resource-mapping-and-needs-assessment.pdf. Accessed June 27, 2022.

11. 2019 Middle School County Report – De Baca – New Mexico Youth Risk & Resiliency

Survey. Accessed June 27, 2022. https://youthrisk.org/publications/county-reports/2019-middle-school-county-report-de-baca/

12. 2019 Middle School County Report – Curry – New Mexico Youth Risk & Resiliency Survey. Accessed June 27, 2022. https://youthrisk.org/publications/county-reports/2019-middle-school-county-report-curry/

13. 2019 Middle School County Report – Roosevelt – New Mexico Youth Risk & Resiliency Survey. Accessed June 27, 2022. https://youthrisk.org/publications/county-reports/2019-middle-school-county-report-roosevelt/

14. 2019 Middle School County Report – Quay – New Mexico Youth Risk & Resiliency Survey. Accessed June 27, 2022. https://youthrisk.org/publications/county-reports/2019-middle-school-county-report-quay/

15. Whiteside C. Adverse Childhood Experiences (ACEs)Among New Mexico Adults: Results from the NM BRFSS, 2019. *New Mexico Epidemiology*. Published online June 11, 2021.

16. Medication-Assisted Treatment (MAT) | SAMHSA. Accessed June 27, 2022. https://www.samhsa.gov/medication-assisted-treatment

17. ASAM Criteria. Accessed June 29, 2022. https://www.asam.org/asam-criteria

18. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf. Accessed June 27, 2022.

19. Lane DJ, Roberts L, Currie S, Grimminck R, Lang E. Association of emergency department boarding times on hospital length of stay for patients with psychiatric illness. *Emerg Med J*. 2022;39(7):494-500. doi:10.1136/emermed-2020-210610

20. Currier GW, Fisher SG, Caine ED. Mobile crisis team intervention to enhance linkage of discharged suicidal emergency department patients to outpatient psychiatric services: a randomized controlled trial. *Acad Emerg Med*. 2010;17(1):36-43. doi:10.1111/j.1553-2712.2009.00619.x

21. Guo S, Biegel DE, Johnsen JA, Dyches H. Assessing the impact of community-based mobile crisis services on preventing hospitalization. *Psychiatr Serv*. 2001;52(2):223-228. doi:10.1176/appi.ps.52.2.223

22. Hugo M, Smout M, Bannister J. A comparison in hospitalization rates between a community-based mobile emergency service and a hospital-based emergency service. *Aust N Z J Psychiatry*. 2002;36(4):504-508. doi:10.1046/j.1440-1614.2002.01042.x

23. Scott RL. Evaluation of a mobile crisis program: effectiveness, efficiency, and consumer satisfaction. *Psychiatr Serv*. 2000;51(9):1153-1156. doi:10.1176/appi.ps.51.9.1153

24. Dyches H, Biegel DE, Johnsen JA, Guo S, Min MO. The Impact of Mobile Crisis Services on the Use of Community-Based Mental Health Services. *Res Soc Work Pract*. 2002;12(6):731-751. doi:10.1177/104973102237470

25. Bengelsdorf H, Church JO, Kaye RA, Orlowski B, Alden DC. The cost effectiveness of crisis intervention. Admission diversion savings can offset the high cost of service. *J Nerv Ment Dis*. 1993;181(12):757-762. doi:10.1097/00005053-199312000-00008

26. https://nmsc.unm.edu/reports/2018/the-santa-fe-law-enforcement-assisted-diversion.pdf. Accessed June 27, 2022. https://nmsc.unm.edu/reports/2018/the-santa-fe-law-enforcement-assisted-diversion.pdf

27. New Mexico State Legislature. *New Mexico Administrative Code*.; 2018.

28. The Sequential Intercept Model (SIM) | SAMHSA. Accessed June 29, 2022. https://www.samhsa.gov/criminal-juvenile-justice/sim-overview

29. Mental health. Accessed June 27, 2022. https://www.who.int/health-topics/mental-health#tab=tab_1

30. https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/bed-supply-need-per-capita.pdf. Accessed June 27, 2022.

31. Hudson CG. Benchmarks for needed psychiatric beds for the United States: A test of a predictive analytics model. *Int J Environ Res Public Health*. 2021;18(22). doi:10.3390/ijerph182212205

32. Shortage of Psychiatric Hospital Beds for Mentally Ill (Summary TAC Report) : Mental Illness Policy Org. Accessed June 27, 2022. https://mentalillnesspolicy.org/imd/shortage-hospital-beds.html

33. https://www.nmlegis.gov/Entity/LESC/Documents/Reports_To_The_Legislature/LESCReportToLegislature_2022.pdf. Accessed June 28, 2022.

34. https://www.nmlegis.gov/entity/lfc/Documents/Health_Notes/Health%20Notes%20-%20Cost,%20Use%20and%20Effectiveness%20of%20Inpatient%20Behavioral%20Health%20Services%20for%20Adults.pdf. Accessed June 27, 2022.

35. Haidt J, Allen N. Scrutinizing the effects of digital technology on mental health. *Nature*. 2020;578(7794):226-227. doi:10.1038/d41586-020-00296-x

36. Mental Health and Substance Use Considerations Among Children During the COVID-19 Pandemic | KFF. Accessed June 27, 2022. https://www.kff.org/coronavirus-covid-19/issue-brief/mental-health-and-substance-use-considerations-among-children-during-the-covid-19-pandemic/

37. Ulrich RS, Bogren L, Gardiner SK, Lundin S. Psychiatric ward design can reduce aggressive behavior. *J Environ Psychol*. 2018;57:53-66. doi:10.1016/j.jenvp.2018.05.002

38. https://leg.mt.gov/content/Committees/Interim/2013-2014/Children-Family/Committee-Topics/HJR16/hjr16-building-operating-16-bed-facilities-may2014.pdf. Accessed June 27, 2022.

39. https://www.cfm.va.gov/til/dGuide/dgMH.pdf. Accessed June 27, 2022.

40. Design guidelines for short-stay patient units | 2017-05-03 | Health Facilities Management. Accessed June 27, 2022. https://www.hfmmagazine.com/articles/2841-design-guidelines-for-short-stay-patient-units

41. Designing to “right-size” patient rooms - Architecture. Accessed June 27, 2022. https://www.healthcarefacilitiestoday.com/posts/Designing-to-right-size-patient-rooms--15746

42. Franco LS, Shanahan DF, Fuller RA. A review of the benefits of nature experiences: more than meets the eye. *Int J Environ Res Public Health*. 2017;14(8). doi:10.3390/ijerph14080864

43. Furniture for Psychiatric, Mental and Behavioral Health Facil... Accessed June 27, 2022. https://www.anchortex.com/collections/bh-behavioral-healthcare-furniture

44. 2022 Cost to Build a Hospital | Hospital Construction Cost. Accessed June 27, 2022. https://www.fixr.com/costs/build-hospital#:~:text=The%20average%20cost%20to%20build,cost%20depends%20on%20several%20factors.

45. https://www.cbre.us/-/media/cbre/countryunitedstates/media/files/services/healthcare-capital-markets/2022-investor-developer-survey.pdf. Accessed June 28, 2022.

46. Trivedi TK, Glenn M, Hern G, Schriger DL, Sporer KA. Emergency Medical Services Use Among Patients Receiving Involuntary Psychiatric Holds and the Safety of an Out-of-Hospital Screening Protocol to “Medically Clear” Psychiatric Emergencies in the Field, 2011 to 2016. *Ann Emerg Med*. 2019;73(1):42-51. doi:10.1016/j.annemergmed.2018.08.422

47. https://www.psychiatrictimes.com/view/hospital-level-psychiatric-emergency-department-models. Accessed June 27, 2022.

48. https://www.wilder.org/sites/default/files/imports/Crisis_stabilization_technical_report_4-13.pdf. Accessed June 27, 2022.

49. http://whopaysreport.org/wp-content/uploads/2015/09/Who-Pays-FINAL.pdf. Accessed June 27, 2022. http://whopaysreport.org/wp-content/uploads/2015/09/Who-Pays-FINAL.pdf

50. Cowell AJ, Hinde JM, Broner N, Aldridge AP. The impact on taxpayer costs of a jail diversion program for people with serious mental illness. *Eval Program Plann*. 2013;41:31-37. doi:10.1016/j.evalprogplan.2013.07.001