APPENDIX 2.4 d.
NM DEPARTMENT OF HEALTH (DOH), BEHAVIORAL HEALTH SERVICES
DIVISION (BHSD) REQUIREMENTS

NOTE: All findings in this document are based on FY05 contract amounts. Funding available in FY06 is contingent upon appropriations.

I. ACCESS

A. Populations/Targets

The Contractor shall provide behavioral health services in similar proportion of client characteristics and volume to the estimated targets established in SFY2005 by BHSD Region, to be adjusted to the FY06 regional reconfiguration. Special targets are required as specified below.

<table>
<thead>
<tr>
<th>(BHSD) REGION 1 (San Juan, McKinley, Cibola)</th>
<th>80% of Total = Priorities 1-3</th>
<th>20% of Total = Other Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Behavioral Health Target Population Total = 1,566</td>
<td>1,253</td>
<td>313</td>
</tr>
<tr>
<td>Regional Co-occurring Target Population</td>
<td>392, or 25% or the total target</td>
<td></td>
</tr>
<tr>
<td>Supported Employment</td>
<td>48</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(BHSD) REGION 2 (Rio Arriba, Taos, Los Alamos, Sandoval, Santa Fe, Mora, Colfax, Union, Harding and San Miguel)</th>
<th>80% of Total = Priorities 1-3</th>
<th>20% of Total = Other Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Behavioral Health Target Population Total = 3,892</td>
<td>3,114</td>
<td>178</td>
</tr>
<tr>
<td>Regional Co-occurring Target Population</td>
<td>973, or 25% or the total target</td>
<td></td>
</tr>
<tr>
<td>Supported Employment</td>
<td>121</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(BHSD) REGION 3 (Hidalgo, Grant, Luna, Dona Ana, Socorro, Sierra, Catron, Valencia)</th>
<th>80% of Total = Priorities 1-3</th>
<th>20% of Total = Other Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Behavioral Health Target Population Total = 4,056</td>
<td>3,245</td>
<td>811</td>
</tr>
<tr>
<td>Regional Co-occurring Target Population</td>
<td>1,014, or 25% or the total target</td>
<td></td>
</tr>
<tr>
<td>Supported Employment</td>
<td>74</td>
<td></td>
</tr>
</tbody>
</table>
### (BHSD) REGION 4 (Torrance, Lincoln, Otero, Eddy, Chaves, De Baca, Guadalupe, Quay, Curry, Roosevelt, Lea)

<table>
<thead>
<tr>
<th>Estimated Behavioral Health Target Population Total</th>
<th>80% of Total = Priorities 1-3</th>
<th>20% of Total = Other Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>4,302</td>
<td>3,442</td>
<td>860</td>
</tr>
</tbody>
</table>

| Regional Co-occurring Target Population             | 1,076, or 25% or the total target | 126                             |

| Supported Employment                                 |                               |

### (BHSD) REGION 5 (Bernalillo)

<table>
<thead>
<tr>
<th>Estimated Behavioral Health Target Population Total</th>
<th>80% of Total = Priorities 1-3</th>
<th>20% of Total = Other Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>4,160</td>
<td>3,328</td>
<td>832</td>
</tr>
</tbody>
</table>

| Regional Co-occurring Target Population             | 1,040, or 25% or the total target | 57                             |

| Supported Employment                                 |                               |

1. At a minimum, fifty percent (50%) of the mental health client population to be served by the Contractor shall have a Global Assessment Functioning (GAF) score of 50 or lower at registration.

2. At a minimum, fifty percent (50%) of the substance abuse client population to be served by Contractor the RCC shall have an Addiction Severity Index Drug/Alcohol Use subscale of 4 or higher at the time of registration.

3. At a minimum, twenty-five percent (25%) of all the clients served by the Contractor shall have a co-occurring disorder (mental illness and substance abuse).

### B. Priority Determination

Priority determination is the initial step in the process through which the Contractor shall ensure that consumers registered for DOH services meet the financial and clinical criteria for services.

1. The Contractor shall be required to meet regional registration targets, with 80% of consumers registered being “first priority” individuals (uninsured at 100% of federal poverty guidelines and in clinical need).

2. The Contractor shall establish a process to determine priority in accordance with the policies described in the BHSD Policy Manual, Sections Priority Determination (Priority 1-5) and Registration (Reg. 1-8), incorporated into this contract herein by reference.

3. The Contractor shall identify whether persons seeking behavioral health care are potentially eligible for Medicaid insurance coverage. If they are, the Contractor shall initiate efforts to assist those persons by making contact with the appropriate Medicaid eligibility processes; i.e., Income
Support Field Offices, within thirty (30) days of registration into the Regional Care Coordination Plan.

4. The Contractor shall ensure that consumers continuing to need clinically necessary services who no longer meet Priority I financial criteria shall not be terminated from services. Services shall be provided based on clinical necessity for these consumers.

5. The Contractor shall maintain an ongoing analysis of regional data and provider specific data.

6. The Contractor shall utilize reports and queries to monitor the progress and quality of the data entered by providers to ensure the accuracy of the data.

C. Regional Access: 24/7 Information & Referral Line (we have $20 K available)

1. The Contractor shall ensure a 24-hour, 365-day-a year toll-free referral and communication system for referrals. This system shall be staffed by behavioral health professionals who are culturally competent and are trained to screen crisis or emergency calls and to assess the caller's degree of acuity/severity and need for treatment.

2. The Contractor shall update its Service Access Plan for managing a system of consumers' access to services with various points of entry. The Plan will be reviewed during regular monthly meetings between the Contractor and the NM Interagency Behavioral Health Purchasing Collaborative (Collaborative) representatives. Customers must be allowed to self-refer to these entry points, where an evaluation of their need for treatment/supports can be conducted.

D. Coordination and Collaboration

1. The Contractor shall collaborate as appropriate with state facilities and community organizations/systems (especially with residential treatment centers) to facilitate appropriate and timely referrals and ensure smooth transitions of young adults (i.e., 18-21 years of age) into the adult treatment system.

2. The Contractor shall promote the coordination of the referral process of individuals registered with the BHSD Facilities. The Contractor shall participate in the admission and discharge planning processes at those facilities for these registered individuals as appropriate and feasible.

3. The Contractor shall have policies and procedures that ensure providers coordinate with local primary care resources, including the Public Health District Offices, to facilitate access to primary care services for BHSD clients.
E. Linkage with Criminal Justice System & Department of Corrections

The Contractor shall ensure that all behavioral health subcontractors establish continuity of care for registered clients who become detained. The Contractor shall ensure that all behavioral health subcontractors establish an education process for detention center personnel regarding subcontractor services and eligibility criteria and provide training in identification and referral of detainees for services upon release.

F. Linkages to the Judicial System Regarding Court-Ordered Treatment

The Contractor shall establish policy and procedures at the subcontractor level that address the establishment and maintenance of professional relationships with magistrate, municipal, and district judges regarding cases that contain behavioral health elements. These policies and procedures shall encourage the development and implementation of the following elements:

1. Educate the judges regarding appropriate referral procedures, client eligibility, resource availability and clinically and medically appropriate treatment alternatives;

2. Review court orders that order clients into services to ensure that the level of treatment intervention is medically and clinically appropriate to assessed client need and is within the authorized licensed capacity and resource availability of the subcontractor; and

3. Establish a mechanism by which the subcontractor can request that a judge modify court orders to match the assessed clinical need level;

G. Linkage and Coordination with Native American Programs

The Contractor shall maintain contracts with Indian Health Service (IHS) of Albuquerque and in Navajo Area IHS and with all tribal or pueblo providers, including “638 providers” that meet minimal credentialing requirements for service delivery within New Mexico.

1. The Contractor shall ensure that linkages with Tribal Courts, Indian Health Services, Bureau of Indian Affairs, and Tribal 638 programs are developed at the Contractor level and shall ensure that its subcontracted providers have established linkages with the preceding agencies in order to ensure appropriate coordination of care for Native American consumers.

2. The Contractor shall establish professional relationships with Native American programs, statewide, that provide behavioral health services and document the contacts.

3. The Contractor shall refer Native American consumers to Native American programs as appropriate, i.e. so that consumers’ needs may best be assessed and met through culturally relevant Native American treatment services.
4. The Contractor shall provide services through the Contractor's subcontractors to Native American consumers when appropriate.

II. CONTINUUM OF CARE

A. The Contractor shall manage its Network in compliance with the BHSD Policy Manual and its Appendices. This shall include use of American Society of Addiction Medicine (ASAM) levels of care as well as any nationally acceptable criteria for admission, continuation and discharge of persons with mental illness or Co-Occurring Disorders.

B. Jail Diversion through Local Forensic Networks

The Contractor shall ensure the provision of ongoing Jail Diversion through the Local Forensic Networks (LFNs). At a minimum, the Contractor shall provide the funding and supports for the following four (4) LFNs: Forensic Intervention Consortium of Doña Ana County (FIC-DAC), City of Roswell Behavioral Health Commission (Roswell BHC), Alamogordo Mental Health Intervention Consortium (MHIC), and the Forensic Intervention Consortium of Bernalillo County (FIC).

1. The Contractor shall act as fiscal agent for the Local Forensic Networks (LFNs). The Contractor shall identify an employee to act as liaison with the LFNs. The SE's specific duties as fiscal liaison include and are limited to the following:

a. The Contractor shall collect the FY06 Annual Action Plan and Budget for each of the LFNs and provide a copy of this plan to DOH. This Annual Action Plan shall include a local Jail Diversion Needs Assessment that, at a minimum, addresses:

   (1) The skill level and training needs of LFN staff in recognizing the various types of mental illness and how to handle persons with mental illness;
   (2) Cross-training of mental health personnel and law enforcement; and
   (3) Barriers or gaps in service in the current local crisis response system.

   The Annual Action Plan shall contain set measurable, time-framed goals and allocate funds for their achievement.

b. The Contractor shall, within thirty (30) days of receipt of the LFNs request, formulate professional or service contracts with LFNs approved individuals/entities, utilizing LFNs contractual language for LFN-approved sums, based on the Annual Action Plan and Budget approved by DOH. Any Executive Director contracts shall not exceed $15,000 per fiscal year. All LFN-approved contracts shall meet shall meet all applicable Comprehensive Behavioral Health Standards 7 NMAC 20.2.

c. The Contractor shall pay the request for reimbursement no later than seven (7) working days after receipt of an LFN's family or consumer members' request for mileage/per diem reimbursement.
d. The Contractor shall reimburse professional and service contractors within thirty (30) days of receipt of the request for reimbursement. The Contractor shall reimburse the LFN's for services approved under the 06 Annual Action Plan and Budget. Projects amounts are approved as follows:

<table>
<thead>
<tr>
<th>Project</th>
<th>Amount Yearly</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIC-DAC</td>
<td>$101,960</td>
</tr>
<tr>
<td>Roswell BHC</td>
<td>$74,678</td>
</tr>
<tr>
<td>MHIC</td>
<td>$89,678</td>
</tr>
<tr>
<td>IFN</td>
<td>$187,300</td>
</tr>
</tbody>
</table>

e. The Contractor shall submit to the LFN chairperson and the DOH no later than the 8th day of each month a written report that shall include but is not limited to: professional and service contract updates and family/consumer member mileage/per diem. The report shall address timely contract issuing, timely reimbursement, and budget reconciliation.

2. The Contractor shall, only upon the request of LFN, send a representative to LFN meetings.

3. The Contractor shall begin reimbursement of LFN activities upon DOH notification that the LFNs meet the following requirements:
   a. The LFN is, at a minimum, composed of representatives of all law enforcement agencies, mental health agencies, the district attorney's office, the public defender's office, district and municipal judges, hospitals that provide inpatient adult psychiatric services, the detention center, family members, and consumers.
   b. The LFN voting members are comprised of at least 25% family members and 25% consumers.
   c. The LFN confirms that the copy of their policies and procedures, which reflect the composition in d (2) above and was submitted to BHSD in FY05, has not changed.
   d. The LFN has submitted to BHSD the 05 Annual Action Plan Summary of Accomplishments, the 06 Annual Action Plan and required quarterly Action Plan Progress reports.

C. Comprehensive Women's Services

1. The Contractor shall ensure the provision of behavioral health treatment for women, their dependent children, families, and significant others. (Significant others to be defined by the customer.) Services may include, but are not limited to:
   a. Specialized groups for women to address gender-sensitive issues such as self-esteem; relationships; physical, emotional, or sexual abuse; and cultural issues;
   b. Developmental issues of children, including parent training;
c. Daycare for dependent children;
d. Family groups that may include significant others, if the service recipient so wishes;
e. Linkages to primary care that ensure customer's health needs are met, including appropriate medical testing and prescription medications;
f. Linkages to pediatric care that ensure that the health needs of dependent children are met, including appropriate medical testing and prescription drugs.
g. Provision of Opioid Replacement Treatment (ORT), if customer meets the requirements as set forth by Substance Abuse and Mental Health Services/Center for Substance Abuse Treatment (SAMHSA/CSAT) guidelines, and identifies ORT as her treatment of choice;
h. Case management to be provided by a certified case management as a component of the treatment plan;
i. Linkages to supported employment and supported housing services;
j. Transportation sufficient to ensure that women in treatment have access to the services provided;
k. Access to peer lead groups for recovery; and
l. Aftercare that provides planning and supports for continued recovery.

2. The Contractor shall develop a plan for gender-specific treatment in the approved Collaborative format. The Collaborative shall work with the Contractor in the development and implementation of this plan.

3. The Contractor shall participate in the statewide Women's Services Advisory Group. Meetings of the Advisory Group will begin in the first quarter of FY06. Also included in the Advisory Group will be representatives of providers, the community, consumers, the criminal justice system, the courts, specialty providers of women's treatment services, and others to be identified.

4. The Contractor shall allocate funding in the following manner:

a. Carlsbad Mental Health Associates: $420,000 is allocated for Women's Residential Substance Abuse Treatment Services. Of that amount $112,166.00 is to be allocated to Women's Services from state general funds and $307,834.00 is to be allocated from the Substance Abuse Prevention and Treatment Block (SAPT) Grant.

b. UNM/HSC/ASAP: $442,336.00 is allocated for Women's Comprehensive Services. Of that total $134,502.00 shall be
allocated from state General funds, and $307,834.00 shall be allocated from the SAPT Grant.

c UNM/Milagro: $264,500 is allocated for Women's Comprehensive Services. Of that total, $34,500.00 shall be allocated from state general funds and $$230,000.00 shall be allocated from the SAPT Grant.

D. Intravenous Drug User (IVDU) Project

The Target population for this project is intravenous drug users (18 years of age and older) in Rio Arriba and Santa Fe Counties who inject or “skin pop” heroin, cocaine, and/or other drugs.

1. The Contractor shall ensure that the following providers continue to provide services for this pilot project: Hoy Recovery Program, Inc., Ayudantes, Inc., and Rio Arriba County Health and Human Services.

2. The Contractor shall ensure that outpatient substance abuse treatment services, care coordination, access to the continuum of care, and access to opioid replacement treatment, as appropriate, are provided to eligible registered customers. The target for new registrations shall be 12 per month.

3. The Contractor shall ensure that movement from a lower level of care to a higher level of care and visa versa, of any clients registered in this project, is coordinated.

4. The Contractor shall ensure that subcontractor, Hoy Recovery Program, Inc., provide outpatient substance abuse services, medically monitored detox, and residential treatment to eligible registered clients who meet the ASAM criteria for those levels of care.

5. The Contractor shall ensure that sub-contractor, Ayudantes, Inc., provide outpatient specialized ORT services in Rio Arriba County to eligible registered clients.

6. The Contractor shall ensure that sub-contractor, Rio Arriba County Health and Human Services, provide outreach services to incarcerated IV drug users in the Tierra Amarilla and Espanola Detention Centers. Outreach activities are to include but not be limited to drug education, relapse prevention, referrals into the treatment system, etc. Outreach activities shall focus on engaging IVDUs and bringing them into the treatment system. The monthly jail outreach target (outreach to eligible incarcerated individuals) is 30. The Contractor shall ensure that Rio Arriba County Health and Human Services provide case management services to eligible registered customers, as appropriate, of this pilot project. The annual target for case management is 118 unduplicated customers.
7. The Contractor shall establish linkages with the court system and law enforcement agencies in Santa Fe and Rio Arriba Counties and with probation and parole in order to bring customers eligible for this project into the treatment system.

E. Evidence-Based Practices

The Collaborative is committed to the purchasing of a continuum of services comprised of models that have been demonstrated to be effective.

The Contractor shall work with the Collaborative to continue and improve the ongoing implementation of best and evidence based practices including, but not limited to the following:

1. Integrated treatment for individuals with substance use and mental health disorders as follows:
   a. Support ongoing goals and objectives of the federal Co-Occurring State Incentive Grant (Co-SIG) to include Co-Occurring Policy Academy and Center of Excellence activities;
   b. Work with Collaborative to maintain the systems change strategies and progress currently achieved by DOH; and
   c. Work with the Collaborative to identify and implement strategies that will further and improve model application resulting in improved outcomes specific to reduction psychiatric and substance use symptomatology.

2. New Mexico Pharmacotherapy Initiative (NMPI)
   a. Examine ongoing implementation of NMPI (including application of medication algorithms and consumer education)
   b. Work with the Collaborative to identify and implement strategies that will further and improve model application resulting in improved outcomes specific to psychiatric symptoms

3. Supported Employment
   a. Examine ongoing implementation of Supported Employment initiatives
   b. Work with the Collaborative to identify and implement strategies that will further and improve model application resulting in improved competitive employment outcomes

4. Supportive Housing
   a. Examine ongoing implementation of Supportive Housing initiatives
b. Work with the Collaborative to identify and implement strategies that will further and improve model application resulting in improved housing outcomes

c. Ensure the presence of a regional housing specialist for each of the five service regions

(1) Housing specialists shall conduct regional housing needs assessments, serve as a central repository of move-in assistance/eviction prevention data, train local providers on housing/services issues, and serve as regional representative on local, regional and state homeless task forces.

d. Develop and implement Regional Housing Plans due within 90 days of start of contract. The plans shall identify regional training and education needs and strategies. The Plans will be developed in collaboration with the Collaborative to include the Mortgage Finance Authority (MFA).

F. Opioid Replacement Treatment

1. The Contractor shall work, through the Collaborative, with the Department of Health State Methadone Authority to ensure that all Opioid Treatment Programs (OTPs) meet the requirements of SAMHSA/CSAT, the regulations of State of New Mexico, national accreditation bodies, the Drug Enforcement Agency and state and local laws governing OTPs. The CONTRACTOR shall encourage providers of ORT to use national standards of care and evidence based practices in Opioid Treatment.

2. The Contractor shall ensure that the current providers of ORT continue providing such services. The publicly funded OTPs are the University of New Mexico/Health Sciences Center/ ASAP and Milagro programs, the Sixth Street Clinic, and Ayudantes, Inc.

3. The Contractor shall ensure that all behavioral health providers receive education and training in ORT and make referrals, as appropriate, to ORT services.

4. The Contractor shall abide by the Anti-Discrimination Policy of the Department of Health concerning consumers of ORT services. (See BHSD Policy Manual)

G. Harm Reduction Initiatives

1. The Contractor shall develop and implement harm reduction initiatives to reduce morbidity and mortality from drug addiction and improve the lives of addicted persons. Harm reduction herein is defined as a service delivery model and a model for behavioral change.
a. The goal(s) of harm reduction are to help customers of services to be happy, healthy, and contented with their lives as much as possible, as defined by each customer.

b. Among the principles of harm reduction are: HIV takes priority over drug problems; abstinence from drugs should not be the only goal of services to customers; harm reduction offers “safety nets” to drug users to protect themselves from serious harm; harm reduction programs are designed to be user friendly and inviting to consumers; consumers shall be treated with respect, dignity, and acceptance; drug users are competent to evaluate the choices presented to them and to make the right choices for themselves; and clinicians and workers function as consultants and facilitators in harm reduction.

c. Harm reduction initiatives and services include, but are not limited to, the following: statewide harm reduction training; development of drop-in centers for drug users; syringe exchange programs (using funding other than federal block grant allocations); and distribution and monitoring of methods of overdose prevention, such as naloxone (Narcan).

2. The Contractor shall monitor and document the need for local Harm Reduction strategies. The Contractor shall report identified needs to the Collaborative no later than October 1, 2005.

3. The Contractor shall ensure that outreach services to injection drug users currently provided by Ayudantes, Inc., Albuquerque Healthcare for the Homeless, and St. Martins shall continue as required by the SAPT Block Grant:

a. Outreach efforts shall include, but not be limited to, activities that encourage injection drug users in need of treatment to undergo such treatment

b. Programs shall use an outreach model that is either scientifically sound or can reasonably be expected to be effective in the local situation.

c. Outreach efforts shall include the following:

(1) Selecting, supervising and training outreach workers

(2) Contacting, communicating, and following up with high risk substance abusers, their associates, and neighborhood residents, within the restraints of Federal Confidentiality regulations 42 CFR Part 2, sections 2.1 to 2.7

(3) Promoting awareness among injection drug users about the relationship between injection drug use and communicable diseases such as HIV

(4) Recommend steps that can be taken to ensure that HIV transmission cannot occur

(5) Encourage entry into treatment
d. The Contractor shall reimburse Ayudantes, Inc. for the term of contract in the amount of $24,256.00 for the services described above.

e. The Contractor shall reimburse Albuquerque Healthcare for the Homeless as follows:

During the term of contract, $59,170 must be allocated for services for women. $21,600 of that shall be devoted to enhancing services for women prostitutes and $37,570 must be allocated to services for injection drug users as described in items 1 through 3 above.

f. The Contractor shall reimburse St. Martin’s as follows:

For the term of contract: $55,870 for services described in items 1 through 3 above.

g. Reimbursement for outreach activities is contingent upon submittal of a non-unit request for payment and a detailed description of activities performed, which the Contractor must approve.

h. Specialized outreach services are funded by Federal Block Grant funds, Federal Regulations 45 CFR Part 96.135, section 6, which state: The State shall not expend the Block Grant on the following activities: to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for AIDS.

H. Primary Care Linkages

1. The Contractor shall coordinate with the regional and statewide primary care resources including the Public Health District Offices to ensure each Behavioral Health Collaborative consumer has reasonable access to primary care services.

2. The Contractor shall educate the community medical system regarding services, coordination, and optimal consumer care.

3. The Contractor shall participate in developing and maintaining primary care linkages with community resources, including managed care organizations, as well as function in a quality assurance role routinely evaluating the effectiveness of these primary care linkages for Behavioral Health Collaborative consumers.
I. Linkages with the Department of Health/Public Health Division

The Contractor shall establish a professional relationship with the Public Health District Office(s), HIV Counseling and Testing sites and the Health Management Alliances that provide HIV/AIDS treatment statewide. The Contractor shall participate in meetings and training opportunities provided through this collaboration. The focus is to facilitate the referral of consumers of the Behavioral Health Collaborative in need of behavioral or physical health screening, assessment or treatment services. The Contractor shall develop policies and procedures that address and track the establishment and maintenance of these professional relationships at the subcontractor level.

III. CLINICAL ENHANCEMENTS FOR ASSESSMENT, TREATMENT PLANNING AND TREATMENT MATCHING

A. Process

1. The Contractor is responsible for maintaining a continuum of care, contingent upon the availability of resources. The Contractor shall guide and support the clinical decision-making throughout its Provider Network. (See the Clinical Care section of the BHSD Policy Manual for specific guidance.)

B. Required Reporting

1. The Contractor shall notify the Collaborative of any significant changes in its Continuum within thirty (30) days or during regularly scheduled meetings with representatives of the Collaborative; whichever comes first. Use required format contained in BHSD Policy Manual, Appendix H, Section XIV.

IV. TRAINING

A. The Contractor shall work with the Collaborative to identify, develop and implement training and systems change strategies that will result in the development, recruitment and retention of the behavioral health workforce.

1. The Contractor shall provide a detailed plan with goals, objectives and timelines as approved by the Collaborative

   a. Behavioral Health Treatment Training Plan: The Contractor shall collaborate with the established BHSD Interagency Treatment Training Advisory Group to develop a Treatment Training Plan for FY06 that shall identify and prioritize the training needs of the providers. The plan shall specify the type, content, and frequency of training and/or TA and shall be made available to all providers. The Contractor shall incorporate this plan, its implementation, and the training/TA outcome evaluation into its quality improvement process.
(1) In prioritizing the providers' training needs, the Contractor shall collaborate with the BHSD Interagency Treatment Training Advisory Group to identify and implement training that upgrades and maintains the clinical strength of providers.

(2) The Contractor shall ensure that all training is made available on a repetitive basis to ensure that all providers receive each training module annually, at a minimum.

B. Required Reporting

1. The Contractor shall maintain a record of these activities, which shall be made available to members of the Collaborative upon request.

V. UTILIZATION MANAGEMENT

The Contractor shall provide appropriate utilization management (UM) activities for the provision of services under this contract.

A. Compliance with Standards

1. The Contractor shall work collaboratively with the Behavioral Health Collaborative to design and develop a UM system that follows NCQA standards. The UM system shall promote quality of care and adherence to standards of care, efficient use of resources, consumer choice, and identifies service gaps within the service system.

2. The Contractor shall educate subcontractors in the UM system it develops, to clearly articulate and detail the criteria which are to be used to make utilization management decisions, and to describe the care management functions. Level of care criteria shall be disseminated to consumers, families and subcontractors playing the primary role in applying these criteria.

3. The Contractor shall develop protocols, procedures and criteria, subject to the Collaborative's approval, for service authorization and for assessing clinical necessity and making level of care determinations that are in accordance with the Comprehensive Behavioral Health Standards, the State-required Levels of Care and interim policies as issued by the Collaborative. The Contractor's criteria and protocols for making level-of-care determinations shall incorporate the ASAM patient placement. If any of the UM functions are delegated to subcontractors, the Contractor remains fully responsible for all decisions and quality of care.

4. The Contractor shall maintain records and/or information systems, which shall verify its utilization management activities and compliance with utilization management requirements.

5. The Contractor's UM plan shall specify which services will and will not require prior authorization and how it will conduct concurrent and
retrospective review. The Contractor shall describe its plan for ensuring that the level and duration of more intensive levels of care are appropriate.

6. The Contractor shall establish procedures for honoring advance directives within its UM protocols.

7. The Contractor shall establish a policy/protocol that addresses conflict of interest in the assignment of referrals and in the provision of services in cases where the Contractor is also a direct provider of care. The policy/protocol shall protect the utilization management system from excessive or inappropriate self-referral or other potential conflicts of interest that might be created in conducting the functions.

8. The Contractor's utilization management system shall:
   a. Ensure that consumers receive services based on their current condition and effectiveness of previous treatment;
   b. Ensure that services are based on the history of the problem/illness, its context and shall include an outcome focus; and,
   c. Assist consumers in choosing among providers and practitioners.

9. The Contractor shall establish, maintain and monitor a utilization management system which includes an efficient decision making process; utilize a clear criteria for admission, continued stay and discharge; and applying those criteria to both prior authorization and concurrent review processes.

10. The Contractor shall involve physicians and professionally trained and appropriately licensed practitioners in the authorization and review process. Staff who make service authorization decisions must be Master's prepared clinicians with a minimum of five (5) years of clinical experience in the mental health and/or substance abuse fields. This group would include Master's equivalent Certified Nurse Practitioners and Clinical Nurse Specialists, in addition to other licensed Master's level clinicians, such as LISWs, LPCCs, or psychologists. Proportionate to the number of consumers with substance abuse problems, a subset of care coordination staff shall be licensed as Alcohol and Drug Abuse Counselors (LACs, LDACs, or LADACs). Similarly, the Contractor shall demonstrate that staff have been trained and are competent in working with co-occurring psychiatric and addictive disorders.

11. The Contractor's UM Plan shall describe the criteria to be used by the Contractor in offering case management services to mental health and/or substance abuse clients, as well as identifying the methods to be used for providing case management and the expected outcomes of this service. The Plan shall also describe any and all special approaches they would employ in providing care management for adults with serious mental illness, persons with chronic addictive disorders, and adults with co-occurring psychiatric and addictive disorders.
12. The Contractor shall educate customers and provide them with information to enhance their ability to make informed choices of effective treatment and supports. This includes changes in treatment milieu/environment that addresses the long-standing issue of an institutionalized customers mindset and learned helplessness. The UM system shall be structured to honor advance directives and to emphasize relapse and crisis prevention, not just crisis intervention. Customers should have an optimal choice of provider agencies and practitioners consistent with their treatment needs. For each level of care, the Contractor shall describe the amount and type of choice customers will be offered in provider organizations and practitioners, in services, and in time and location of the same. The Utilization Management Plan shall also describe the options customers will have when their initial selection of provider(s) proves unsatisfactory to the consumer.

B. Management of Customer Status

1. The Contractor shall establish policies and procedures that identify consumers who have not received billable services for 120 days from providers who have submitted claims for the client

   a. The Contractor shall develop and implement procedures to ensure that utilization reports identify consumers who have not received billable services for more than 120 days and will identify those consumers as inactive in the system.

   b. The Contractor shall ensure that providers adhere to policies and procedures to identify inactive status for those clients who have not received billable services for more than 120 days.

VII. QUALITY ASSURANCE AND QUALITY IMPROVEMENT

A. Provider Credentialing

Credentialing requirements and processes shall be streamlined and enable practitioners to move across agencies and settings without unnecessary restrictions once credentialing has been granted. The requirements shall be developed in ways that promote non-traditional approaches to service such as customer-run programs.

1. The Contractor shall ensure that subcontractors meet the credentialing and re-credentialing requirements of the Comprehensive Behavioral Health Standards and/or interim policies issued by the Collaborative. Procedures shall be implemented to credential both existing as well as new staff.

2. The Contractor shall ensure that subcontractors, including individual practitioners, are competent to provide the services they offer. The Contractor shall utilize quality management data in conducting
subcontractor re-credentialing, re-contracting and/or performance evaluations.

3. The Contractor shall maintain records and/or information systems that will verify its credentialing activities, including primary source verification, and compliance with credentialing requirements.

4. The Contractor shall ensure that subcontractors are responsive to the uniqueness of special populations, linguistic and cultural minorities, and other populations that would be underserved, or inappropriately served without focused attention.

5. Contractor shall maintain and, upon request, submit to the Collaborative, a roster of all subcontractors by type, expertise, geographical location, disability population access, and language abilities.

B. Quality Management/Quality Improvement

1. The Contractor shall have a current quality management plan for tracking and improving quality in access, appropriateness of care, consumer satisfaction, provider relations, and outcomes. The plan must outline the relationship between the utilization management system and quality improvement findings. The plan must describe the roles of subcontractors, consumers and family members in development and implementation. The Contractor's CQI Committee membership must include, at a minimum, a representative from a provider agency and a representative from a specialty provider agency.

2. The Contractor shall conduct quality management activities in accordance with the Comprehensive Behavioral Health Standards (7 NMAC 20.2) and/or interim policies issues by the Behavioral Health Collaborative, and shall maintain records and/or information systems which will verify quality management activities and compliance with quality management requirements.

3. The Contractor's quality management plan must have procedures for monitoring operations, including telephone access, linkage to clinical services, quality of the service, authorization decisions, and implementation of the complaints and grievances and incident management systems. When the Contractor is a provider of mental health or substance abuse services in New Mexico, the quality management system must address the avoidance of conflict of interest.

4. The Contractor shall establish and maintain a statewide morbidity and mortality review process that identifies and corrects case specific issues and promotes the development of a more effective system. The Contractor shall follow guidelines for this process as established through consensus and policy with the Behavioral Health Collaborative.

5. The Contractor's quality management functions shall include conducting data-driven evaluations of clinical practices to improve quality of care.
The quality management activities shall demonstrate how that system has influenced/changed provider practice patterns and produced corresponding improvements in consumer functioning and well-being.

6. The Contractor shall ensure that its subcontracted providers have a current quality management plan for tracking and improving quality in access, appropriateness of care, consumer satisfaction, quality of care, and outcomes. The plan must describe the roles of provider agency staff, consumers, and family members in development and implementation.

7. The Contractor shall monitor the Continuous Quality Improvement (CQI) Process at the provider level. Monitoring shall include, but not be limited to, annual on-site clinical audits of providers.

C. Incident Management

1. The Contractor shall develop and implement an incident management system in accordance with the DOH/CYFD Community Agency Incident Management System Guide, the Comprehensive Behavioral Health Standards, and the incident management protocols as developed by the Behavioral Health Collaborative.

2. The Contractor shall ensure that all incidents of abuse, neglect, exploitation, death, law enforcement intervention and emergency service which involve a registered consumer and occur during or in between episodes of care either at a subcontractor site or which occur at the Contractor's site are reported to the Behavioral Health Collaborative within the appropriate timeframe.

3. The Contractor shall submit a quarterly report to the Collaborative summarizing all such incidents in accordance with the Collaborative's directives.

D. Medical Director

1. The Contractor shall hire or contract for the services of a Medical Director who is licensed to practice medicine in New Mexico, with preference giving those that are Board Certified in Psychiatry. This individual shall perform integral functions in the development and maintenance of the behavioral health service system. A single individual shall be identified as the Contractor's Medical Director. This person shall have the authority to delegate activities to other physician/psychiatrists, but the Medical Director remains responsible for coordination, management, oversight, and reporting of these activities. The Medical Director may provide both indirect and direct services.

2. The Contractor shall ensure that the Medical Director functions include, but are not limited to:
a. Assisting the Contractor with behavioral health system development;

b. Oversight of medical and psychiatric practices, including participating in the development and maintenance of the UM system and quality improvement processes;

c. Assist with the development and maintenance of a morbidity/mortality review process, including monitoring implementation of corrective actions through a CQI process;

d. Assist with development, implementation, maintenance and monitoring of Statewide Practice Guidelines/Best Practice Initiatives, including but not limited to NMPI, integrated treatment for co-occurring disorders, supported employment, and supported housing.

e. Provide consultation to the Contractor regarding development of services for individuals with complex medical, psychiatric, and/or addiction issues, including individuals with cognitive impairment, traumatic brain injury and/or developmental disabilities.

f. Coordination with the DOH Public Health Division regarding collaborative management of public health concerns. The Medical Director shall assist the Contractor in seeking and employing technical assistance from the Public Health Division (Public Health District Offices) regarding linkages to primary care across the region, identification and management of infectious diseases including tuberculosis and HIV, and other areas where collaborative efforts can improve the health care of clients. The Medical Director will participate in developing and maintaining primary care linkages with community resources, as well as function in a quality assurance role routinely evaluating the effectiveness of these primary care linkages for clients.

VII. CUSTOMER INVOLVEMENT

A. The Contractor shall collaborate with BHSD's Office of Customer Affairs (OCA). Customer initiatives shall include but are not limited to the following services, which are further defined in the BHSD Policy Manual and the BHSD Service Codes and Definitions:

1. Customer and family advocacy.
2. Customer-run self-help groups; e.g., Double Trouble in Recovery (DTR), mood disorders, alumni groups, co-occurring, post traumatic stress disorder, women's issues, etc.
3. Drop-in Centers (staffed and administered by customers)
4. Customer-developed "Warm Lines" as an adjunct to Crisis Lines
5. Informational and educational activities conducted by customers; e.g., Motivation for Recovery, Leadership Academy, etc.

B. The Contractor shall support customer-directed services. Such efforts shall involve identifying, engaging, ensuring, and supporting customers in the maintenance of customer-staffed services.

C. The Contractor shall participate in and collaborate with the OCA to keep informed about customer issues and activities.

D. The Contractor shall participate in and collaborate with the Recovery Empowerment Specialists (RES) on the annual NM Customer Satisfaction Project.

E. The Contractor shall ensure that all initiatives and activities available are open to all customers.

F. The Contractor, in collaboration with the OCA, shall ensure recruitment, training, and orientation of customer representatives to participate in its Quality Improvement Committee and shall require those representatives to attend the Leadership Academy.

G. The Contractor is expected to foster open communication and a collaborative relationship with the Recovery Empowerment Specialist (RES). At minimum, this shall involve developing monthly mechanisms for briefing one another on customer issues in their regional, coordinating training and TA to customer and/or Network programs, and exploring additional opportunities for coordination.

H. The Contractor is expected to participate in and collaborate with the “regional survey teams” that conduct the annual Customer Satisfaction Project in its Region. This includes participating in the state-level monthly meetings that steer the statewide process, assisting with selection of sample programs, participating in the regional team and customer survey representative trainings, and assisting the regional survey teams who are overseeing the annual data collection.

VIII. COMPLAINTS AND GRIEVANCE

A. The Collaborative shall require the Contractor to develop and implement a complaints and grievances resolution system with definition, procedures and timeframes in accordance with the standards issued by the Collaborative. The system shall afford both customers and subcontractors adequate opportunity to disagree with the SE’S service authorization decisions and/or other decisions or policies.

B. The Contractor shall ensure that the system shall be easily understood, user friendly, standardized and reviewed periodically so that improvements can be made. Information about the process of filing complaints and grievances shall be developed in many forms so that all customers using the system will be able to understand the process; translated into languages spoken by the population served at each facility; and read to and explained to customers with learning
disabilities and/or who are not able to read. This information shall be provided to all customers at the time of first contact or during the initial treatment sessions.

C. The Contractor shall provide for settlement of customer complaints and grievances at the lowest possible administrative level, as well as provide a formal process for dispute resolution.

D. The Contractor shall maintain records and/or information systems that will verify application of the complaints and grievance system, and compliance with complaints and grievance requirements including confidentiality requirements.

E. The Contractor Complaints and Grievances System shall have the following components:

1. Procedures for informing consumers and providers of the steps to take to file complaints and grievances, including time frames for responses and parties to be involved at each level of the grievance/resolution process;

2. Procedures for continuing services under dispute;

3. Availability of expedited reviews of emergency and urgent situations;

4. Availability of expedited grievance procedures for consumers who need assistance with understanding or communicating in the process;

5. Procedures to ensure that practicing peer professionals, who are trained or who practice in the same specialty, will be included as part of the resolution process. These professionals should have no involvement in the treatment being grieved.

6. An explanation of how families and significant others will be involved, where appropriate

7. A provision for consumers and providers to register complaints and have them resolved before grievances need to be filed.

F. The Contractor shall monitor subcontractor grievances and corrective action plans for trends, as well as to address appeals. The Contractor shall train subcontractors on the complaint/grievance policy and its implementation.

G. Reporting Requirements

The Contractor shall notify the Purchasing Collaborative of any significant changes in the Complaints and Grievance System during FY06.

The Contractor shall submit quarterly regional Complaints and Grievances Reports to the Purchasing Collaborative using the format required by the Collaborative.

The Contractor shall submit a Complaint/Grievance Report to the Purchasing Collaborative quarterly. The report should indicate the number of complaints/grievances received, the type of each complaint/grievance, the status of each complaint/grievance, and the outcome of each complaint/grievance. The
report must also be received within forty-five (45) calendar days of the last day of each quarter. In addition, all complaint/grievance records and files shall be available to the Collaborative for on-site monitoring and review.

X. NETWORK/SYSTEM DEVELOPMENT

A. Requirements for developing supported housing

1. The Contractor shall maintain a move-in assistance/eviction prevention loan fund to ensure access to housing for consumers who are homeless or at risk of becoming homeless. The Contractor shall update and submit local move-in assistance and eviction prevention loan fund management plans that include eligibility criteria, loan agreements, and loan repayment schedules by July 31, 2005.

2. The Contractor shall coordinate with BHSD and assist network providers to increase the types and number of stable housing options for persons served by the Contractor through federal, state, and local entities. The Contractor shall document regional housing efforts in the monthly report to BHSD, including housing needs assessments, status of regional housing plans, utilization of the move-in assistance/eviction prevention loan fund, and any planning and training efforts.

XI. INDICATORS OF PERFORMANCE

A. Performance Indicators and Measures

1. The Contractor shall cooperate with BHSD in generating reports required to meet the behavioral health measures in the Department of Health Strategic Plan as well as the Legislative measures outlined in House Bill 2.

2. The Contractor shall cooperate with BHSD in generating reports required to meet the National Outcomes Measures, including:
   a. Abstinence from drug/alcohol use
   b. Decreased mental illness symptomatology
   c. Increased/retained employment or return to/stay in school
   d. Decreased criminal justice involvement
   e. Increased stability in housing
   f. Increased access to services (service capacity)
   g. Increased retention in treatment—substance abuse
   h. Reduced utilization of psychiatric inpatient beds—mental health
   i. Increased social supports/social connectedness
   j. Customer perception of care
   k. Cost effectiveness (average costs)
Use of evidence-based practices

3. The Contractor shall track performance on the following measures:
   a. The percentage of consumers who report that they were informed at registration and at regular intervals about the range, length and availability of services, so that they can make informed choices. Measurement should examine the following elements:
      (1) Initial and ongoing information about services
      (2) Peer support mechanisms for self management
   b. The percent of customers who actively participate in decision-making concerning their treatment.
   c. The number of persons who are self-identified adult customers or family members who actively serve on policy boards or advisory groups, participate in or implement quality improvement activities, or who hold paid staff positions as part of the SE’s activities or its direct service system.
   d. Percent of registered adults with seriously disabling mental illness who are placed in protective custody and are screened and assessed by a crisis worker within eight (8) hours of notification by the facility.
   e. Percentage of customers who indicate an improvement in the quality of their lives and increased independent functioning in their community, as a result of their treatment experience.

B. Required Reporting

1. The Contractor shall notify BHSD of any significant changes in its ability to collect information on tracking its performance on the above listed measures during FY06.

2. The Contractor shall submit progress on Performance Indicators as indicated above.
DOH School-Based Behavioral Health

A. The SE in collaboration with the DOH Office of School Health (OSH), is required to expand the continuum of school based behavioral health programs and services by developing and implementing prevention (Phase 2), screening, assessment, early intervention, and treatment services, including those provided by community mental health providers working in schools, those working as part of school-based health centers (SBHCs), and those provided by schools and school behavioral health professionals.

1. Components of this requirement include:
   a. Increasing school-based behavioral health screening for youth in schools as part of a needs assessment and track this data.
   b. Improve access to behavioral health care delivered in a school setting by recruiting additional network providers as needed to provide behavioral health screening and services in schools as well as continuing to reimburse all service codes used in the delivery of school-based behavioral health care (per RFP response) and track this data.
   c. Work with the Collaborative to identify a primary behavioral health care provider to work in any school district that requests the assistance. (per RFP response)
   d. Assuring coordination and integration of behavioral health care with health care services delivered in school-based settings, including BIA and tribal schools, broadly and through 504 plans, IFSPs and IEPs specifically.
   e. Participate in the development and expansion of school-based suicide prevention and response program activities in partnership with the Collaborative, including screening, training and protocol development and implementation for public, tribal, and BIA schools (per RFP response)
   f. Ensure a smooth school transition for student moving between inpatient, RTC, and community-based settings.
   g. Fully participate in the development and implementation of policies, procedures and methods designed to improve implementation, delivery and funding for school-based behavioral health services and track that data.
   h. Effectively link data collection systems between SBHC Pro and the overall behavioral health data collection system. The SE in collaboration with DOH will develop a code for those SBHC who do not use SBHC Pro. The code should be used for billing purposes and should allow for tracking clinical information as well as reimbursement. It should identify the place (school) where services were delivered then be specific as to which school.
   i. Encourage the development of and equitably work with and reimburse school-based health centers for behavioral health services delivered in these settings.
   j. Provide for the integration of services into the school culture.
   k. Work with student assistance teams, school-based positive behavioral support teams, local community health care systems and local collaboratives to coordinate the behavioral health services provided in and out of schools.
I. Improve the sustainability of school behavioral health services through diversification of funding [including increased financial and in-kind support from the served school district(s) and foundation and government grants] and the development of community partnerships.

m. Partner with the Collaborative on the appropriate use of behavioral health screening, assessment, and evidence-based interventions and school-based services as related to Section 504 and Special Education Services.

n. Assist schools to increase their capacity to access Medicaid reimbursements and other funding sources within the control of the SE and the Collaborative for behavioral health services.

o. Partner with the Collaborative on the development of a regional mentorship model for schools with effective school behavioral health services mentor schools in the earlier stages of service development. (per RFP response).

p. Fully participate with the Collaborative in the development and implementation of state standards for mental health services provided in schools.

q. Partner with the Collaborative and the state Behavioral Health Institute to support training for school staff, students and families on multiple behavioral health issues (per RFP response).

r. Support the development of and participate in school crisis response teams for critical incident debriefing and counseling (per RFP response).

s. Participate in the development of telehealth models of behavioral health consultation, including reimbursement mechanism for school-based behavioral health services.

t. Prepare to work in Phase 2 for the appropriate use of prevention funds and evidence-based prevention programs in schools, appropriate use of safe and drug-free school funds for behavioral health programs, crisis response planning and implementation, and training around behavioral health issues. Provide data regarding collaboration with Title IV, health educators, school nurses and school counselors, implementation of prevention/intervention/post intervention strategies and identification of programs.

B. The SE in collaboration with the DOH Office of School Health (OSH), shall ensure the following is included in Exemplary School-Based Behavioral Health Services (E-SBHC):

1. The SE shall ensure the following eligibility criteria is used for students served:

   a. Federal funds target students determined to have a serious emotional disturbance (SED). Eligible individual: 1) has a mental, emotional or behavioral disorder defined under DSM-IV; 2) are at risk of out of home placement; and, 3) have a current functional impairment which significantly disrupts the student's ability to maintain age appropriate family, school or community relationships. Students are not currently eligible for Special Education services.

   b. SG Funds target other high-risk students that are not currently eligible for Special Education services.
c. Funds may not be used to pay for services which Special Education departments are legally required to provide.

2. The SE shall ensure the following services are available for students served:
   a. General health and behavioral health screening, crisis intervention, behavioral health assessment, individual, group and family counseling and treatment services, and case management providing linkage and referral to other services or resources particularly needed health care service are provided to students and their families.
   b. Administration of CFARS, Consumer Satisfaction, Teacher/Student rating and case studies at designated times/timeframes as indicated by outside evaluator of the E-SBHC sites in Collaboration with OSH.
   c. E-SBHC services are delivered in school-based settings and integrated with health care services where appropriate. Staff must participate in School Health Advisory Committee (SHAC) meetings, school behavioral health service planning meetings, in teacher or other school staff meetings and provide consultation and school staff training to enhance behavioral health care delivery.
   d. Number of service hours per site are determined by contract (Minimally 10 hrs. of treatment services a week is required to be provided at the school-based site with provisions for year round access to services during hours when the E-BHC is closed. For sites where new SBHC expansion funds are designated, the hours of service will follow the applicable level of service found in the Guidelines for Models of School-Based Health Centers. The SE shall collaborate with the DOH OSH to coordinate this initiative.

3. The SE shall ensure that the E-SBHC comply with all applicable NM School-Based Health Centers Standards attached to the RFP.

a. Demographic and encounter data reported through the SBHC-PRO! coordinated by SE with the DOH OSH. The SE shall ensure the current level of services are provided.

b. Report currently entered on a secure web site monthly to include: 1) Monthly Level of Operations (MLO) reporting service hours by practitioner and other staff. Insufficient levels of service for 3 consecutive months will result in reduced monthly reimbursement. 2) narrative project report, reporting the unique number of students seen, the number of groups conducted and the average number of persons attending groups at each site, E-SBHC staff participation in School Health Advisory Committee (SHAC) meetings, planning meetings, organizational activities, consultations, and teacher/school staff training/meetings. Staff changes, need for new services, barriers to program implementation and strategies identified to address any impediments are included in the month they occur.

c. Request for payment submitted electronically for 1/12 draw-down.
5. The SE shall ensure that all current providers are offered subcontracts relatively at the FY05 contract amounts as follows:

a. Socorro Mental Health, Inc. $78,141
b. Valencia Counseling Services, Inc. $57,300
c. UNM/HSC ACL Teen Center $100,275
d. Healthcare Foundation of Southern New Mexico $50,138

6. The SE shall track and report the E-SBHC subcontract funding sources as follows:

a. CYFD Federal funds (CMHS) $117,000
b. DOH BHSD SG Funds $168,853
 Coordination with DOH State-operated Care Facilities.

1. The Contractor shall continue existing medically necessary inpatient services maintaining current state operated “safety net” resource utilization of services while instituting facility liaison treatment teams to ensure proper utilization of 24 hour, inpatient DOH facilities.

2. The Contractor shall collaborate with DOH Senior Management and Hospital Administrators monthly in defining characteristics of all levels of inpatient care and utilization management of facilities.

3. The Contractor shall use the ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders in pre-admission and discharge of clients from DOH Specialty Hospitals or Units.

4. The Contractor shall interact with DOH State Operated facilities in the care and management of individuals referred for medically necessary inpatient care. DOH facility admissions units will determine admission criteria for patients and levels of care.

5. The Contractor shall collaborate with DOH State Operated facilities in the discharge planning review process for individuals transitioning into community-based services to ensure proper discharge management. In concurrence with DOH facility managers, criteria for determining when a patient can be discharged to a different level of care will be documented.

6. The Contractor shall continue the current funding for residential care services with Turquoise Lodge specialty hospital in the amount of $750,000.00 of Substance Abuse Federal Block Grant dollars.

7. The Contractor will consider these transitional Phase One requirements. Phase Two requirements will be negotiate during Phase One.
Phase Two Special Grants

The Contractor shall work with the Collaborative to ensure coordination of activities specific to the ongoing implementation of specialized Substance Abuse and Mental Health Services Administration (SAMHSA) grants including but not limited to the following:

**Substance Abuse Screening, Brief Intervention, Referral and Treatment Grant (S-BIRT)**

A. Support goals and objectives of the New Mexico S-BIRT initiative in accordance with federal requirements

B. Upon approval by SAMHSA and successful completion of key benchmarks, to be identified by the Collaborative in Phase I, work with the SBIRT implementation team to identify strategies regarding the potential transition of S-BIRT activities to the Contractor

**Access To Recovery (ATR) Grant**

A. Support goals and objectives of the New Mexico ATR initiative in accordance with federal requirements

B. Upon approval by SAMHSA and successful completion of key benchmarks, to be identified by the Collaborative in Phase I, work with the ATR implementation team to identify strategies regarding the potential transition of ATR activities to the Contractor

Upon approval by SAMHSA and successful completion of key benchmarks, to be identified by the Collaborative in Phase I, work with the ATR implementation team to identify strategies regarding the potential transition of ATR activities to the Contractor
Phase Two Prevention Activities

Upon the successful completion of key benchmarks, to be identified by the Collaborative in the Phase One, the Contractor shall work with the Prevention Services Bureau to ensure a successful transition of evidence-based prevention services to the Single Entity.

Phase Two
Substance Abuse Prevention Programs:

Goal: The State Entity (SE) shall continue to purchase evidence-based prevention programming in New Mexico.

Objective: The Contractor shall become proficient with evidence-based practices as described by the Center for Substance Abuse Prevention (CSAP) and will coordinate a smooth transition of Prevention services into fiscal year 2007 at the 2006 level of programming, including the same number of individuals, families and communities receiving services.

1. The Contractor shall designate a specific staff point person who shall be the direct line of communication with the Bureau Chief of the Prevention Services Bureau.

2. The SE’s designated staff shall meet with the staff of the DOH Prevention Services Bureau and prevention advocates on a monthly basis throughout the first year of phase 1 implementation to plan for the successful transition of evidence based prevention programming in phase 2.

3. The SE’s designated staff shall coordinate services into fiscal year 2007 insuring that the current prevention providers continue to provide services and that the level of services continue without lowering the number of people who received services in fiscal year 2006.

4. Beginning in fiscal year 2007, the Contractor shall ensure that the quality of services provided at the local level are being delivered with fidelity and are the highest quality possible.

5. The SE’s designated staff shall work with the staff of the DOH Prevention services bureau to ensure that technical assistance is delivered at the community level on an as needed bases. Technical assistance needs shall be met at the local level within one week of the request.

6. The SE’s designated staff shall meet with representatives of the Southwest and Western Centers for the Application of Prevention Technology (CAPT) at least quarterly to become familiar with the services provided by the CAPT’s.

7. The SE’s designated staff shall meet with, Behavioral Assessment Inc., the external evaluation team at least quarterly to develop an understanding of the current protocols in place used to evaluate evidence-based prevention services.
8. The SE’s designated staff shall attend four meetings of the sub-recipient team (current providers of local substance abuse prevention programs).

9. The SE’s designated staff shall attend at least one of each of the six regional meetings to learn about local prevention initiatives and work with the regions to implement evidence based environmental strategies beginning in fiscal year 2007.

10. The SE’s designated staff shall become familiar with all aggregate reports used to outline outcomes produced by the sub-recipients.

11. The SE’s designated staff shall meet with the Epi-work group on a monthly basis to gain an understanding of the current profile of the State of New Mexico with regards to the leading indicators of substance abuse.

12. The SE’s designated staff shall meet with the Training Advisory Committee (TAC) on monthly bases to gain an understanding of the prevention training initiatives in New Mexico.

13. The SE’s designated staff shall meet with the New Mexico Credentialing Board for Behavioral Health Professionals to become aware of the process for certifying Prevention Specialists.

14. The SE’s designated staff shall meet with representatives of Region 6 to continue to build capacity in Native American Communities.

15. The SE’s designated staff shall attend the state-planning meeting to learn about the needs expressed by communities across the State of New Mexico and participate in the ongoing development of the New Mexico Prevention System.