I. PURPOSE OF THE PAPER

The purpose of this paper is to establish priorities for the next phase in the evolution of the behavioral health system in New Mexico, which has been in the process of significant transformation since September 2003. The goals of this 10 year developmental process are to increase cross-agency collaboration and care coordination, incorporate family and consumer voice, and integrate all behavioral health dollars into a single funding stream. Transformation efforts occur through a statutory entity, the Interagency Behavioral Health Purchasing Collaborative (the Collaborative), which has legal responsibility for designing and implementing the statewide behavioral health system. The Statewide Entity (SE) is charged with providing financial management and oversight (i.e., contracting with and paying providers); developing and implementing regional service plans in conjunction with local collaboratives; conducting utilization reviews and utilization management; assuring care coordination; evaluating and monitoring providers and services; conducting quality review and improvement; and collecting, managing and reporting data to meet quality management and data requirements (e.g., consumer outcomes and performance indicators). Importantly, the SE is just one component of the larger behavioral health system.

The Collaborative continues to work to achieve the vision, mission and plan outlined in the original April 19, 2004 concept paper. The current concept paper updates the activities from this original paper regarding the overall work of the Collaborative. Importantly, the current concept is broader in nature than the Request for Proposal (RFP) scheduled for release in July, 2008 (for the statewide entity for the next four years from 2009-2013), and is intended to stimulate a dialogue and set priorities for this RFP.

The vision for system transformation is to establish a behavioral health system in which consumers and family members are assisted in participating fully in the life of their communities; support of recovery and development of resiliency are expected; behavioral health is promoted; and the adverse effects of substance abuse and mental illness are prevented or reduced. The vision is also of behavioral health services that are: focused on prevention and early intervention; evidence based and promising practices; consistent with family preferences; consumer-and family-focused, strength-based, acknowledging the individual and family’s capacity for recovery and resiliency; delivered in a culturally competent, responsive and respectful manner via the most appropriate, least restrictive means; coordinated, accessible, accountable and of high quality; evaluated with system performance and consumer and family outcomes in mind; and physically and programmatically accessible. This vision is of a behavioral health system in which funds are managed effectively and efficiently; written and electronic information is uniformly available; CQI is ensured; non-interruption of service
delivery as individuals move between correctional programs to community programs and from children’s programs to adult programs is ensured; and school-based and community services are appropriately coordinated and integrated.

This concept paper will provide: (1) a brief overview of progress completed over the past three years, (2) a performance assessment based on the proposed developmental phases outlined in the 2004 Concept Paper; (3) an identification of current successes and opportunities for future improvements; and (4) a preliminary list of top priorities for the next request for proposals (RFP). This paper will be distributed widely to stakeholders throughout New Mexico’s behavioral health system, who are encouraged to provide feedback to assist with the identification of priorities for the next RFP. Comments may be sent via e-mail to bhcollaborative@state.nm.usm, by mail to: PO Box 2348 Santa Fe, NM 87504 attn: Angel Roybal; or by fax to (505) 476-7183 attn: Angel Roybal. Native American communities are encouraged to submit input directly to Kim Horan, Tribal Liaison for Behavioral Health Services Division at (505) 827-2637. There will also be opportunities for public feedback through participation in regional discussion groups scheduled over the next two months. The goal will be to document successes of the Collaborative and priority areas for further improvement. Priorities identified through this process will serve as the basis for the development of a Collaborative RFP and for further development of the single behavioral health system that is the goal of the current system transformation.

II. OVERVIEW OF THE PROGRESS COMPLETED OVER THE PAST THREE YEARS
The New Mexico Interagency Behavioral Health Purchasing Collaborative was created by State Statute in 2004, and is a pioneering effort in behavioral health system transformation. The Vision is to provide “A single behavioral health service delivery system in New Mexico in which behavioral health consumers are assisted in participating fully in the life of their communities; the support of recovery and development of resiliency are expected; behavioral health is promoted; the adverse effects of substance abuse and mental illness are prevented or reduced; and available funds are managed effectively and efficiently.”

A. INFRASTRUCTURE DEVELOPMENT ACTIVITIES
Over the past three years, the New Mexico Interagency Behavioral Health Purchasing Collaborative (the Collaborative) has launched several critical infrastructure development initiatives, including the establishment of a 17 member policy-making virtual organization that meets monthly to manage the uniquely integrated funding and staffing structure. The Collaborative has also consolidated over $300 million state and federal behavioral health dollars and its management through a single statewide entity under contract with the State of New Mexico, replacing multiple contracting mechanisms and administrative infrastructures. In addition, the Collaborative has created the Local Collaborative structure, comprised of 15 local stakeholder groups that address behavioral health system change within their communities, and provide input and recommendations to the Collaborative. Finally, the Collaborative has established the Behavioral Health
Planning Council, a statewide Governor-appointed advisory body that assists with planning and policy development, and oversees the mental health and substance abuse federal block grants.

In September 2003, Governor Bill Richardson directed all agencies tasked with the delivery, funding or oversight of behavioral health care services in New Mexico, to work collaboratively to create a single statewide behavioral health service delivery system. The combination of tight government budgets and the growing demand for coordinated services for consumers and families encouraged New Mexico to seek a better behavioral health care system which would foster increased responsiveness to the needs of New Mexican behavioral health consumers and their families. House Bill 271 was introduced and passed the State Legislature in 2004 and signed into law by Governor Richardson. The law took effect May 2004, and created an Interagency Behavioral Health Purchasing Collaborative consisting of the secretaries and/or directors of 17 state departments and agencies (See Appendix A). The Collaborative is charged with: (1) inventorying all expenditures for mental health and substance abuse services; (2) Creating a single behavioral health care system that promotes mental health; emphasizes prevention, early intervention, resiliency, recovery and rehabilitation; manages funds efficiently; and ensures statewide availability of services; (3) Paying special attention to regional, cultural, rural, frontier, urban and border issues, and seeking and considering suggestions from Native American communities; (4) Contracting with a single, Statewide services purchasing entity [SE] to ensure availability of services; (5) Monitoring service capacities and utilization in order to achieve desired performance measures and outcomes; (6) Making decisions regarding funds, interdepartmental staff, grant writing and grants management, comprehensive planning, and meeting State and federal requirements; (7) Overseeing systems of care data management, performance and outcome indicator selection, rate setting, service definition establishment; and (8) Monitoring training, assuring that evidence-based practices receive priority, and providing oversight for fraud, abuse, licensing and certification.

The Collaborative created nine Cross Agency Teams (CATs) established to move the behavioral health system from development to implementation. These CATs operate as a “virtual department” across the Collaborative. The CATs include: the Cross Agency Coordinating Team (Steering Group), SE Contract Oversight, Administrative Support, Local Collaboratives and Planning, Policy Development, Capacity Service Development, the Consortium for Behavioral Health Research and Training (CBHTR), Quality and Evaluation, and Communications. Descriptions of these CATs are provided in Appendix B.

The Collaborative relies on the Behavioral Health Planning Council (BHPC) to serve as an advocate for individuals with serious mental illnesses, children and youth with
severe emotional and behavioral disturbances, and other individuals with mental illnesses and/or emotional issues. The BHPC monitors, reviews and evaluates the allocation and adequacy of behavioral health services within the State. The goals of the BHPC are to: (1) Improve the continuum of behavioral health services statewide; (2) Ensure that behavioral health services are consumer and family driven; (3) Increase behavioral health education and training to individuals, families, providers and the general public; (4) Increase judicial system educational opportunities; (5) Increase substance abuse and co-occurring mental health services; (6) Improve the behavioral health workforce capacity in New Mexico, including providing input into the peer certification process and all other proposed certifications; (7) Ensure smooth transitions for consumers within the behavioral health continuum; (8) Promote adequate funding to address the needs of the behavioral health continuum; (9) Ensure the availability of appropriate pharmaceuticals; (10) Ensure that behavioral health services are provided in a culturally competent manner; (11) Utilize data and information in their decision-making processes; and (12) promote the development of appropriate employment and housing opportunities to consumers in the State.

B. SERVICE DEVELOPMENT AND ENHANCEMENT

Infrastructure development activities provided a unique opportunity for system development and enhancement for children, youth, and adult services. Examples of service development and enhancement initiatives that resulted from this infrastructure development and that support the goals outlined above are provided in the following section. Initiatives described relate to consumer and family services, housing, substance abuse services, community-based services (for children, youth, and adults), the interface between primary care and behavioral health, and disaster preparedness.

Consumer and Family Services

Increased consumer and family voice is a major priority for the collaborative. In September 2006 Local Collaborative membership was finalized, ensuring strong consumer and family participation in planning and policy development. In addition, the Collaboratives’ Office of Consumer and Family Engagement (CAFÉ), was broadened to focus on all consumers, including adults, children, youth, and families statewide. In 2007 fifty seven Certified Peer Specialists were trained throughout New Mexico, and more have been trained in 2008. In addition, a curriculum to train Certified Family Peer Specialists is currently underway, with the goal of training the first cohort by early 2008. Importantly, both Certified Peer and Family Specialists meet staffing qualifications for the Community Support Worker position covered in the Comprehensive Community Support Services model for qualified provider organizations.

Housing
Another example of a service enhancement activity is the development of a ten-year permanent supportive housing plan that includes an aggressive goal of creating 5,000 new supportive housing opportunities, locally based supportive housing partnerships, a supportive housing pipeline with public and private funders and developers, rental assistance opportunities, and best practice housing supports and services. Two related initiatives are already underway, including the Housing First: Permanent Supportive Housing for Youth pilot project designed for youth transitioning out of foster care or juvenile justice, and the NM Linkages Permanent Supportive Housing Pilot to provide up to 110 rental subsidies and support services for adults who are homeless or at risk of homelessness and living with behavioral health issues.

**Substance Abuse Services**

Substance Abuse Service expansion is also underway, including the Total Community Approach (TCA) projects, with the goal of developing effective substance abuse prevention, treatment and law enforcement service systems in local communities. In addition, legislative dollars have been allocated to develop the Los Lunas Community Treatment and Training Center, a state-of-the-art substance abuse treatment and training facility that will serve New Mexican’s across the State. The Co-Occurring Disorder (COD) State Incentive grant implemented evidence-based practices in co-occurring disorders at four sites (First Nations, Life Link, Rehoboth McKinley, and Youth Development Incorporated); partnered with UNM to train approximately 500 behavioral health providers statewide on Traditional and Western Approaches to Co-Occurring Disorders; developed an adolescent model for COD treatment, implemented a COD track in five rural area drug courts; created a re-entry pilot project for the Corrections system; and trained justice system professional on COD in coordination with the GAINS Center. Substance abuse service dollars have also shifted away from social detox and toward intensive outpatient treatment. The State has received a second Access to Recovery Grant intended to assist with the design and implementation of a voucher program to pay for an expanded array of community-based clinical substance abuse treatment and recovery support. Finally, the Office of Substance Abuse Prevention has become part of the Public Health Division of the Department of Health, working to provide training to preventionists seeking certification, to collaborate with other state entities on prevention activities, and to oversee the Prevention Information Management System.

**Community-Based Services**

Children, Youth, and Family Services

Enhancing and expanding community-based services is another top priority of the Collaborative. The Clinical Home/Wraparound pilot was initiated with 10 provider agencies. A clinical home is a single case management provider that coordinates all behavioral health services, including clinical supports (intake, assessment, treatment, service planning), community supports (school, social activities, housing), and existing supports (family, neighbors, friends). Integrated into the clinical home pilot is the wraparound training pilot, which promotes the effective identification
and use of available supports. Other community-based service expansions for children include CCSS, juvenile justice reentry services (JJRS), and Multi-Systemic Therapy (MST), all of which aim to keep youth in communities. JJRS uses regional transition coordinators to provide behavioral health case management to youth and families upon admission to CYFD facilities. MST provides home and community-based services to youth and family, with the goal of improving relationships and building supports and resources. Both CSS and MST were included as a new benefit in the State's Medicaid Plan.

Expanding behavioral health services in schools is another priority. This has included the development of the “Success in Schools” workgroup of the Collaborative that is working to identify and ultimately implement standards for school-based behavioral health care and track participation in behavioral health related training by school personnel. In addition, local collaboratives (LC) across the State received allocated dollars to increase school district involvement in their LCs and generate behavioral health awareness across their school district. The Department of Health’s Office of School and Adolescent Health (OSAH) has also launched a statewide crisis line in 2005, and received a federal SAMHSA grant to develop and implement a suicide identification, prevention, and treatment model for youth with depression who are at risk for suicide. OSAH also sponsored several statewide trainings on suicide prevention, awareness, and response; and implemented mandatory screening, crisis planning, intervention, and post-intervention activities for all OSAH-funded school-based health centers. OSAH is currently spearheading a statewide teen dating violence awareness and prevention initiative. In addition to these trainings, the New Mexico Institute for Early Childhood Mental Health Training is currently offering high level advanced behavioral health training for clinicians working with infants and young children.

Adult Services
Adult-focused services are being enhanced through Comprehensive Community Support Services (CCSS), with the goal of coordinating and providing recovery-based services, including independent living, learning, working, socializing, and recreation. CCSS supports consumers and family members in crisis situations and provides individual interventions to develop and enhance skills necessary for independence. The Collaborative, in partnership with the cities of Albuquerque and Las Cruces, also established Assertive Community Treatment (ACT) programs designed to provide multidisciplinary psychosocial treatment in community-based settings to adults with severe and persistent mental illnesses. In addition, community-based services are being enhanced for active military, veterans, and their families through a services pilot developed to provide case management and clinical support in coordination with the VA and the current behavioral health system. The Collaborative is also working with SBIRT sites and Aging and Long Term Services in training behavioral health and primary care providers on a national model of suicide prevention. Another critical training initiative is the Compulsive Gambling Training Plan under development, with the goal of enhancing providers’ abilities to deliver compulsive gambling assessment, diagnosis, and treatment.
Interface between Primary Care and Behavioral Health

Improving the interface between behavioral health and primary care is another current effort of the Collaborative. The Screening, Brief Intervention, Referral, and Treatment (SBIRT) grant provided a mechanism for offering substance abuse services through primary care settings, with a particular focus on rural and traditionally underserved communities. In addition, there is currently a common referral process and monthly case consultation meetings between ValueOptions and the managed care organizations (MCOs) in an attempt to coordinate care for people with both physical and behavioral health needs. Finally, there have been two pilot projects involving psychiatrists training primary care practitioners and providing case consultation, both of which have been very successful. The next step is to determine strategies for improving this important interface.

Disaster Preparedness

The Collaborative is also currently working on protocols regarding roles and responsibilities of partnering departments, agencies, and organizations in the event of a disaster. The Collaboratives’ network of behavioral health providers worked cohesively to provide disaster care during the Hatch Floods in August 2006, where FEMA dollars were accessed and behavioral health outreach services were expanded to Hatch and Alamogordo, demonstrating an effective disaster preparedness plan.

III. PERFORMANCE ASSESSMENT BASED ON THE PROPOSED DEVELOPMENTAL PHASES

A. ORIGINAL PLAN OF ACTION

The Collaborative anticipated three planning and implementation phases needed to transition to a single behavioral health delivery system. Phase One began in July, 2005 with the awarding of a contract to the single statewide entity (SE) selected through a competitive procurement process. The Collaborative would then work with the SE to ensure that all services continued to be delivered and providers were appropriately paid for these services. The goals of this phase were to work out potential issues that arose during the transition, implement initial data requirements and processes, and develop goals for Phase Two. Phase One goals also included the development of expectations for local systems of care, and the development of such systems with the help of teams of State and SE staff. In addition, the first comprehensive statewide plan for behavioral health would be completed by the Collaborative with the help of the Behavioral Health Planning Council and the SE.

Phase Two was anticipated to last up to two years (July 2006-June 2008) and focus on the identification of effective ways of combining multiple funding sources and funding mechanisms to support the desired outcomes of local systems of care and the Collaborative. An important goal of this phase was to develop performance indicators and outcome measures for subsequent phases in order to track progress toward the goals of the Collaborative. In addition, local systems of care were to be formed and effectively operating; and additional resources were to be identified to
address unmet needs and identify priorities for service expansion. Finally, it was anticipated that Phase Two might also include the securing of additional funding streams and other resources not included in the initial RFP.

Phase Three was anticipated to begin no later than July 1, 2008. The belief was that the system would be mature, performance and outcome measures would be clear, and adjustments to the system could then be undertaken based on the results of the previous years. During this phase additional funding streams included in the SE responsibilities would be included, and the coordination of other related resources would be accomplished. The goal of Phase Three would be to revise the initial comprehensive statewide plan for behavioral health, with input from local collaboratives, the SE, and the Collaborative. New funding streams would also be identified and secured.

B. PROGRESS TO DATE
To date, many goals of Phase One, Two, and Three have been actualized. For instance, the SE contract was awarded to ValueOptions on July 1, 2005, and the Collaborative worked with this SE over the course of Phase One to ensure that all services continued to be delivered and providers were appropriately paid for these services. Potential issues during the transition were identified during Phase One, and the Collaborative worked with the SE to rectify these issues (e.g., developing over 35 common service definitions and implementing some initial steps to ensure commonality of reimbursement rates for these services). In addition, initial data requirements and processes were identified during Phase One, including 21 performance measures for the Collaborative. However, considerable work is needed to enhance the data infrastructure of the Collaborative, including the creation of a uniform data system. Expectations for local systems of care were developed during Phases One and Two, with the creation of fifteen Local Collaboratives (LCs) within five common geographic regions (13 judicial districts) and a sixth common “region” for two Native American populations. In addition, several Collaborative staff members were hired to support the newly developed Cross Agency Teams (CAT) charged with implementing the Comprehensive Plan, including one CAT focused solely on supporting LCs in their development. The first comprehensive statewide plan for behavioral health was completed during Phase I by the Collaborative with the help of the Behavioral Health Planning Council and ValueOptions. This work included town hall meetings and stakeholder retreats to identify goals, strategies, and priorities, and resulted in a plan that includes the Governor's performance measures, recommendations from the Legislative Finance Committee, and goals of the Purchasing Collaborative (see Appendix C). During this phase, the State also applied for and received a SAMHSA Transformation Grant to support the efforts of the Collaborative.

During Phase Two, LCs continued to evolve, and worked toward more stakeholder involvement. For instance, LCs throughout the State were allocated dollars to gain greater participation by their local school districts. In addition, resources were identified during Phase Two to address some of the unmet needs and priorities for
service expansion. For instance, service dollars were allocated for several pilot projects, including the clinical home/wraparound services, CCSS, the TCA, the Veterans and Family Support Services (VFSS), and the JJRS. In addition, dollars were allocated to support statewide implementation of evidence based practices such as MST. Dollars were also allocated to support the development of CBHTR, which now leads several evaluation projects (e.g., TCA, VFSS), has submitted several federal grant proposals (e.g., NIMH grant to develop a multimedia approach to evidence based practice training, the SAMHSA Comprehensive Children's Mental Health Grant- Systems of Care), and is in the process of developing training curriculum for several statewide service initiatives (e.g., CCSS, Wraparound). Thus, there has been an effort in Phase Two to secure additional funding and other resources not included in the initial RFP. In addition, several statewide training initiatives have been completed in order to enhance local provider capacity (e.g., Traditional and Western Approaches to Co-Occurring Disorders, Suicide Prevention Training, Early Childhood Behavioral Health Training, and Integration with Primary Care). Identifying effective ways of combining multiple funding sources and funding mechanisms to support the desired outcomes is an ongoing effort; as is the development of performance indicators and outcome measures to track progress toward the goals of the Collaborative.

Other accomplishments of Phase Two include: (1) Obtaining an Executive Order to address licensing and credentialing of the professional workforce, including psychologists, social workers and counseling professions; (2) Enhancing Medicaid Service coverage for Assertive Community Treatment, Multi-Systemic Therapy, and Comprehensive Community Support Services; (3) Conducting a residential treatment services study for children and adolescents; (4) Commissioning a provider capacity survey and implementing recommendations from this survey to enhance provider development; (5) Working collaboratively between CBHTR and the new Department of Higher Education to address workforce development on evidence-based practices; and (6) Creating a coordinated legislative process among Collaborative agencies.

Phase Three is anticipated to begin July 1, 2008. The Collaborative is currently working on revising the initial comprehensive statewide plan for behavioral health, with input from LCs, ValueOptions, and other stakeholders. Several documents are being developed to inform the comprehensive statewide plan, including both the Children's and Adult's Purchasing Plans (both of which identify services to be developed, where services should be developed, cost, etc.). In addition, data from the Network Development Plan, the Implementation of Priority Work Plans, and the final reports from the Success in Schools and Co-Occurring State Incentive Grant (COSIG) will be incorporated. The Collaborative will expend concerted effort during Phase Three on ensuring service development for children and adults in custody, supervision, and/or Protective Services, including Adolescent Transition; Core Service Agencies; Quality Improvement; and MIS Data, Reporting, and Accountability. In addition, the development of a Uniform Rate Plan and a Fee-for-Service Conversion
Plan for BHSD providers will be critical. New funding streams will also be identified and secured in Phase Three.

C. GAPS
Although tremendous accomplishments have occurred over the past three years, some identified goals have not been met. For instance, while initial data requirements and processes were identified during Phase One, considerable work is needed to create a uniform data system that routinely reports core data to the Collaboratives’ partners. In addition, LCs continue to need support in their development, as many have struggled over the past few years to recruit members and achieve goals. This is particularly true in rural communities, who are widely dispersed, and therefore have limited access to LC meetings and difficulty completing requests on short time frames. Although CBHTR has been established and begun to work on critical training and research initiatives, it still lacks a permanent structure, including staffing to support the mission of the consortium. Therefore, it will be important to finalize decisions about where CBHTR is housed, how it will function across the partnering agencies, and who hires the director. Many of the pilot projects developed during Phase II have been very successful, and it will be important to consider obtaining and/or allocating resources for further statewide implementation. Similarly, the training initiatives to date have helped to enhance local provider capacity, and dollars will be needed to continue these training efforts. Therefore, it will be critically important to obtain additional dollars to support service enhancement and expansion; and to identify and implement effective ways of combining multiple funding sources and mechanisms. Additionally, although several performance indicators and outcome measures have been selected to track progress toward goals, the creation of a fully functioning uniform data system and accompanying reporting process is necessary to obtain the core data needed to accurately track these measures. In addition, the number of measures is currently unwieldy, and it will be necessary to define a core set of dashboard indicators for tracking the success of the Collaborative.

IV. SUCCESSES AND OPPORTUNITIES FOR IMPROVEMENT
Initial information regarding successes of the past three years and opportunities for improvement are provided in the following section. This information is not meant to be complete, but instead to begin the dialogue in the public meetings about what others see as successes and opportunities for improvement.

For instance, pilot projects such as the clinical home/wraparound services pilot have been a tremendous success, and there is an eagerness to expand these services statewide. In addition, several federally funded grants have enhanced service capacity (e.g., COSIG, SBIRT), and there is interest in ensuring sustainability. The need for the accurate reporting of core data to determine effectiveness of services and identification of consumers served is critical; as is the need to move from coordinating funding to blending/braiding funding.
Several opportunities for improvement will occur in the next phase of maturation for the Collaborative. These include the need to enhance the development of the provider networks (i.e., determining service needs, developing provider competencies), and the need to develop more consumer operated services, a clear directive in the original RFP that was not fully implemented in the first two phases. In addition, the next phase needs to better serve individuals not covered by Medicaid, and be clear about defining the target population (i.e., who is a collaborative consumer). In addition, better clarity regarding the role of the SE in relation with the Collaborative is needed on issues such as care coordination, grant oversight, policy development, prevention, ensuring consumer and family involvement, and compliance with block grant requirements. Operational issues include the need to: (1) ensure better coordination between the Collaborative and the SE; (2) develop a process for the Collaborative to receive and manage statewide data; (3) clarify the role of SE vs. CBHTR for training, and (4) complete the implementation of the fee for service system. Other issues include the need to: improve communication across the system, organize the Collaborative so that it is positioned to monitor the SE, align the Collaboratives' vision with the realities of providing services in New Mexico, align the benefit package with consumer eligibility and need (not who is paying the bill), and ensure that the SE is culturally competent and prepared to follow the Collaboratives' prioritized needs. Finally, implementing systems of care for children, youth, and adults is vital to New Mexico's transformation.

V. TOP PRIORITIES FOR THE NEXT RFP
Based on preliminary input from various stakeholders discussions the following have been identified as possible top priorities:
- Create a uniform data system for collecting and reporting core data
- Continue to support the development of local collaboratives
- Determine a structure for CBHTR
- Identify funding to expand service pilots statewide
- Identify funding to sustain workforce development training efforts
- Identify and Implement ways to combine multiple funding sources and mechanisms
- Create capacity to track identified performance indicators and outcome measures
- Identify 10 concise performance indicators and outcome measures
- Develop consumer and family operated services; and increase consumer and family voice in system development, evaluation and oversight
- Develop the model for systems of care; and train and implement system of care for children and youth, adults and elders statewide

VI. NEXT STEPS
The goal of this concept paper is to provide a brief overview of the vision for system transformation, identify progress completed over the past three years, and consider future priorities for the SE and the system as a whole. Over the next few months,
stakeholders will meet to identify needed changes and priorities in order to set the standards for the competitive RFP. As noted in this concept paper, several of the activities originally planned for phases one and two have been actualized, while others are either in process or in need of review. For instance, the original vision was to draw down dollars from nontraditional funding sources (e.g., DWI), and it will be important to clarify if these efforts are still desired and/or appropriate. A major lesson learned over the past three years is that the plan and accompanying RFP must be flexible and adaptable to an ever-changing behavioral health system. The best source for identifying needed changes is at the local level, thus, stakeholder input is critical. Stakeholders are encouraged to provide written feedback regarding:

- Successes of the Collaborative;
- Opportunities for improvement; and
- Priority areas to focus on in the next phase of this developmental process.

Comments should be provided either in person at one of the upcoming regional stakeholder meetings or via e-mail to bhcollaborative@state.nm.us, by mail to: PO Box 2348 Santa Fe, NM 87504 attn: Angel Roybal; or by fax to (505) 476-7183 attn: Angel Roybal. Native American communities are encouraged to submit input directly to Kim Horan, Tribal Liaison for Behavioral Health Services Division at (505) 827-2637.