New Mexico Behavioral Health Planning Council

Orientation Workbook 2012

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Behavioral Health Planning Council
Orientation Workbook

Table of Contents

➤ Introduction

➤ Who We Are....
   The Structure of the Collaborative – Systems of Care
   HB 271 Legislature of the State of NM

➤ BHPC Projects
   ❖ BHPC & Local Collaborative Summit 2012
   ❖ Behavioral Health Mapping Project
   ❖ 8 Dimensions of Wellness
   ❖ Emotional Wellness Brochure

➤ Training Activities
   ❖ Decision Making – Role Play
   ❖ Language & Communication Techniques

➤ Guiding Principles of Recovery

➤ Core Services Agencies – CSA’s

➤ Centennial Care – Medicaid Modernization Effort

➤ Legislative Memorials
   ❖ Senate Memorial 56 Adolescent Opioid Addiction Study
   ❖ House Joint Memorial 17 Task Force Recommendations

➤ 2012 New Mexico Behavior Health Collaborative Symposium

➤ The Affordable Care Act: Section 2703. Health Homes
Introduction

This Behavioral Health Planning Council Workbook is primarily intended to support the BHPC Orientation Manual as a complementary workbook for the Orientation itself. The workbook may change as the initiatives continue to roll out and further integrate into system of care framework. In addition, as mentioned in the BHPC Orientation Manual, this has been developed primarily for new BHPC members to serve as a working tool however local collaborative and communities may find this useful in helping volunteers and groups learn more about New Mexico's behavioral health system, its structure, and initiatives.

This workbook begins with Behavioral Health Planning Council Initiatives such as the Adult and Substance Abuse Subcommittee Mapping Project, 8 Dimensions of Wellness and the Annual Behavioral Health Summit. In this work we believe it is very important to honor diversity and respect each other's opinion. We have included in the workbook a couple of fun activities to help you with that by offering communication and group decision making techniques. Additionally, included in the workbook are topics on Principles of Recovery, Core Service Agencies, "Centennial Care" Medicaid Program, Senate Memorial 56 Adolescent Opioid Addiction Treatment Study, House Joint Memorial 17 Recommendations, and The Affordable Care Act: Health Homes.

A DVD was developed to further describe the work of the Behavioral Health Planning Council and its committees. The Orientation Manual, Workbook and DVD may be obtained electronically through the website. www.bhc.state.nm.us.

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Recovery is holistic. Recovery is a process through which one gradually achieves greater balance of mind, body and spirit in relation to other aspects of one's life, including family, work and community. SAMHSA
Who We Are...

collaborative
cuh-lab-uh-rey-tiv, -er-uh-tiv
1. to work jointly with others or together especially in an intellectual endeavor
2. To work jointly on an activity, especially to produce or create something

The Collaborative: Background

- GAP analysis: 2002
- Signed into law May 19, 2004
- Transformation State Incentive Grant (T-SIG) awarded by SAMHSA: October 2005
Structure of the Collaborative

• 18-member policymaking body
  – Chaired by the Secretary of Human Services
  – Alternately co-chaired by the Secretaries of Health and Children, Youth and Families

• Cross agency teams
  – Each charged with elements of implementation including contract management, administrative services, quality, capacity/service, training and local collaboratives.

Duties of the Collaborative

• Statutory Charge: HB 271
  – Identify behavioral health needs statewide
  – Create a statewide behavioral health system
  – Pay special attention to regional differences
  – Contract with a single, statewide entity
  – Monitor service capabilities and utilization
  – Make funding decisions
The Statewide Entity

• Monitored by the Collaborative
  — ValueOptions chosen in 2005
  — OptumHealth chosen in 2009

• In Partnership with the Collaborative, responsibilities include that
  — Customers get services
  — Providers get paid
  — Funds accurately managed
  — Data is accessible
Behavioral Health Planning Council

• 1998 - Established the Governor’s Mental Health Council as part of the Community Mental Health Services Block Grant
  - Membership representation required; consumers shall comprise at least 51%
• HB 271 – Established the Purchasing Collaborative and the Planning Council in 2004
  - Council is an advisory body to the Collaborative
  - 5 Statutory Sub-Committees

Purpose of the Council

• Statewide, advisory body created in statute
• All members appointed by the governor
• Serves as advocate for individuals with mental illness
• Monitors, reviews and evaluates the allocation and adequacy of behavioral health services statewide
• Oversees block grants
Local Collaboratives

- Local Collaborative Integration into BHPC Membership
- Integration into Voting Membership of Statutory Subcommittees
  - Adult, Children's and Adolescents, Native American & Substance Abuse
Local Collaboratives

Local Collaboratives (LCs):
Are made up of Behavioral Health Consumers, Family Members, Providers and Advocates
Are communities coming together to develop strong local voices for behavioral health
Are giving input about quality and coordination of services, training needs and technical assistance

Who might be at the "Local Collaborative table":
- "Consumer" - those who have or are currently using behavioral health services
- Family members
- Providers/Advocates
- Public Education
- Law Enforcement
- Courts and Jails
- Planning Groups, Councils, Advocacy Groups
- Faith Communities
- Local State Staff/Government
- Community Support
- City and County HHS
- Tribal Leaders

Fast Facts

- People with serious mental illness experience trauma in their lives more often than the general population.
- People with serious mental illness are far more likely to be victims of trauma than perpetrators.
- An estimated 500,000 people in N.M. have substance or mental health disorders.
- Nearly 90,000 adults and children have serious mental health or emotional disturbances.
The Behavioral Health Planning Council is part of New Mexico’s System of Care

What are systems of care?
Systems of Care is the overarching, value driven philosophy that guides all of our efforts to improve outcomes for adults, children, youth and their families, addressing serious emotional and behavioral health issues. System of Care is a roadmap and set of values and standard that will produce better outcomes for the people with whom we work; quality improvements in the services and support we provide; and policies and financing that support both. The Planning Council partners with state agencies, its subcommittees, local collaboratives and other stakeholders to promote education of Systems of Care and implementation.
What are Systems of Care?

System of Care is the overarching, value-driven philosophy that guides ALL of our efforts to improve outcomes for adults, and for children, youth and their families, addressing serious emotional and behavioral health issues.

System of Care is not a program or an agency or a service. System of Care is a roadmap and set of values and standards that will produce better outcomes for the people with whom we work; quality improvements in the services and supports we provide; and policies and financing that support both.

Systems of Care are community based. Communities should be organized so that a wide range of services and supports (both natural and community supports) are integrated into a network that can be drawn upon for the adult, or child/youth and family. It is no small matter to build such a network. Relationships need to be built by committed people who have a stake in improving outcomes for the people with whom they work. Stakeholders need to step up to the plate and lead the development of these relationships and the formation of this network. The network and the relationships therein need to include providers, consumers, family members, advocates, community members and others.

Systems of Care are person-centered. The adult, or child/youth and family, actively participates in assessing needs and strengths in all domains. The assessment and response should focus on the whole person so that the adult, or child/youth and family, are seen in the entire context of their lives. The adult, or child/youth and family, directs the development of a plan whereby behavioral health and other services and supports – traditional and non-traditional – are directed to individualized recovery and resiliency goals. The adult, or child/youth and family, drives this whole process.

In a System of Care, there is an agency that provides a health home for the adult, or child/youth and family. In that health home, there is active coordination through a wraparound facilitator (often a Community Support Worker) who engages the adult, or child/youth and family, and assists them in building a team to assist in building and implementing the plan.
Elements Being Developed for Systems of Care

What practice and infrastructure elements are being developed for Systems of Care?

A number of initiatives are well underway to support the practices and infrastructure necessary for behavioral health systems built on System of Care standards. These are listed below, with more information about each in the pages that follow.

**Core Service Agencies (CSAs)** are the critical infrastructure to provide a health home with care coordination delivered with fidelity to wraparound and recovery approaches. CSAs are agencies designated to provide points of entry for children and adults with intensive and complex needs, facilitating comprehensive care in system of care fashion with wraparound and recovery approaches. CSAs provide health home functions: the CSA is the site of first contact; has responsibility for clients over time; arranges for important behavioral health services for clients; coordinates care across providers; and overall supports the individual and family in coordinating and managing their care for all assessed needs and in reaching the recovery and resiliency goals they set for themselves.

**Comprehensive Community Support Services (CCSS)** are strengths-based services that are consumer and family driven and directed to recovery and resiliency outcomes. The purpose of CCSS is to collaborate with consumers and families to coordinate and access necessary services and resources that promote resiliency and recovery. Coordination and access are achieved by operating with a wraparound approach with goals being set into a service plan. CCSS is provided by Community Support Workers in Core Service Agencies.

**System of Care networks** provide access to an array of culturally competent and community-based services and supports in all domains, and include peer, community, and natural supports as well as non-traditional services. Individuals and families need to be able to navigate this network. It is also these networks and the elements contained therein, that are “wrapped around” the adult, or child/youth and family. Networks are not naturally occurring; they need to be built by committed stakeholders willing and able to take leadership.

**Strategic planning** in conjunction with health care reform calls for the integration of behavioral health and primary care services. Many different models are being discussed, including core service agency kinds of health organizations that offer physical health and dental health services. Among the concepts being used in these health care reform discussions are health homes and trans-disciplinary care, both of which fit well with Systems of Care in communities and in the lives of individuals engaged in recovery, building their resilience, or strengthening families.

**Two financing pilots** are intended to test mechanisms for flexible financing to meet individualized goals. The Statewide Entity is working with two providers to test ways of sharing risk for adults and children/youth and their families. Under the SAMHSA System of Care grant, case rates for children/youth and their families will be developed and tested as another mechanism for flexible funding.

**Training and coaching, consumer surveys, and Quality Service Reviews**, provide assurances that services and supports are of the highest quality. The Center for Behavioral Health Training and Research (CBHTR) is the lead on developing and delivering training on System of Care principles and practices; Comprehensive Community Support Services; wraparound practices in assessment, and planning; delivery of services and supports; outcome measurement and management; and other topics. The Office of Consumer Affairs annually coordinates consumer surveys and widely disseminates results. Quality Service Reviews (QSR) are under the auspices of the Collaborative and are currently being implemented at the Core Service Agency level. QSR is a process that uses case reviews to see what is working/not working for consumers and families and aids in identifying ways to obtain better results.
Families and Organizations Collaborating for a United System (FOCUS) will work collaboratively with local communities and the state as a whole to change how services, systems, and communities support youth and families. FOCUS will identify and implement strategies to:  
1. Decrease the number of children and youth in out-of-home placements who are experiencing serious emotional and/or behavioral challenges and who may be placed in a range of community-based services and supports.
2. Increase the number of(Type:Institution) children and youth in foster care.

GOAL ONE
Youth, children, and families are engaged in community systems of care (SOC) and are better able to function in home, in school, and in the community.

GOAL TWO
System-level policies and financial strategies are in place that support local community systems of care (SOC).

GOAL THREE
Local community systems of care (SOC) are implemented statewide, beginning in

COMMUNITY STRATEGIES  
- Engage the whole community in developing systems of care for children and their families.
- Implement data-driven approaches to identify community strengths and resources as well as gaps and barriers.
- Increase community capacity to provide evidence-based and integrated services for children, youth, and their families.
- Implement practices that support community capacity building including: Quality Service Review; social marketing; and cultural and linguistic competency development.

Vista
- Children, youth, and families experiencing serious emotional and/or behavioral challenges are accessing and benefit from the community's system of care to realize resilience and other positive outcomes. By working from the core values of youth-guided, family-driven, community-focused, and culturally competent, we create a system of care that supports healthy pathways for children, youth, and families and embodies these critical core values.

Systems of Care

GOAL ONE
Youth, children and families are engaged in community systems of care (SOC) and are better able to function in home, in school, and in the community.

GOAL TWO
System-level policies and financial strategies are in place that support local community systems of care (SOC).

GOAL THREE
Local community systems of care (SOC) are implemented statewide, beginning in three anchor sites.

GOAL ONE
- Child-only with disturbing symptoms are reduced.
- Functioning is improved and resilience is increased.
- The level of healthy childhood is increased.
- Family life improves, caregiver stress is reduced.
- Children, youth and families experience less need for complexity of type, frequency, intensity, and service, e.g., decreases in out-of-home placements.
- There is an increase in the community connections of children, youth, and families.

GOAL TWO
- There is increased interagency collaboration in system design/re-design.
- There is increased youth and family collaboration in system planning.
- Financing strategies are increasingly tied to child, youth and family outcomes.
- Funding shifts to effective, community-based services and supports in accordance with state planning and local needs.
- The number of providers offering coordinated and integrated services with fidelity to SOC increases.
- The number of children, youth, and families reducing services in SOC content increases.

GOAL THREE
- Service providers and child serving systems increasingly operate in an SOC framework.
- There is an expanded network of services, supports, processes and relationships grounded in system of care values.
- Child serving systems increasingly partner with children, youth and families.

NEW MEXICO'S Systems of Care Grant
Come Celebrate Wellness
with
The NM Purchasing Collaborative
The NM Behavioral Health Planning Council
&
Local Collaboratives

*There is limited space for the event on Feb 8th & the Summit on the 9th, REGISTRATION IS REQUIRED. Contact Valeria Quintana at 505-690-6984 for more information.

**Wednesday, February 8**

Come celebrate Behavioral Health Day at our State Capitol's Rotunda in Santa Fe!
The celebration of Wellness begins in the Rotunda where there will be Exhibitors from around the state emphasizing the 8 Dimensions of Wellness. Some of the invited speakers are: Governor Susana Martinez; Department Secretaries from Human Services, the Children, Youth & Families, and Department of Health; the Purchasing Collaborative's CEO & the Chairwoman of the Planning Council. And the Main Event of Behavioral Health Day is to recognize and celebrate those who have made tremendous strides for themselves and in their communities around behavioral health, the Local Collaborative STARS of 2012!

**MORNING SCHEDULE**

- 8:30-9:00: Exhibitors set up & STARS sign-in
- 9:30: STARS to Sm. Papas & Rep. Sandofol Offices
- 10: STARS recognized on Senate/Atrium House Floors

**AWARDS CEREMONY**

- 11:30-11:50: "Hear My Story" by STARS
- 11:50-12:15: Welcome & Special Guest Speakers
- 12:15-12:50: Presentation of STAR Awards
- 12:50: Closing Remarks
- 2:00: Exhibitors take down exhibits

**Evening of Wednesday, February 8**

Come celebrate STARS & the winners of the 2nd Annual Lifetime Achievement & John Henry Awards

The Behavioral Health Planning Council and the Local Collaboratives host a special evening to honor the LC STARS, and to recognize Sam Vigil from Valencia Counseling and Betty, a Golden Retriever, who's dedicated to being a service dog at the Palmer Drug Abuse Program of Las County, Inc. Our Special Guest for this evening will be Mike Duffy, New Mexico's Regional Representative from SAMHSA. He will join us in during the Meet 'n Greet as well as speak to the group to 'kick things off' for the BH Summit.

**EVENING SCHEDULE**

- 5:00-6:30: Meet 'n Greet (Atrium)
- 6:30-9:00: Following Events

**Thursday, February 9**

Attend the Behavioral Health Planning Council/Local Collaboratives
Behavioral Health Summit, Dimensions of Wellness in New Mexico

**SUMMIT AGENDA**

- 7:00-9:00: Registration & Continental Breakfast
- 9:00-10:30: Welcome & Morning Sessions
- 10:30-10:45: Break

**MORNING WORKSHOPS**

- K-6 Relationships, Effecting Change-Panel II: 1.6 Emotional, Social, Spiritual, Occupational, & Intellectual
- The Warm Line: Victoria Baca & Shale Silverman
- 2.6 Emotional, Social, Intellectual & Environmental
- Youth Prevention Program: Youth Presentation
- 3.6 Emotional, Social, Physical & Environmental
- Walking w/Dignity: Patsy Ewing & Suzanne Pearlman
- 4.6 Emotional, Social, Intellectual & Environmental

**AFTERNOON WORKSHOPS**

- 5.6 School Based Health Care-Panel: Effective Prevention Strategies in NM: Emotional, Social, Physical, Intellectual & Environmental
- Consumer Run Wellness Center-Panel: Inside Out: Emotional, Social, Occupational, Intellectual & Environmental
- Consumer Run Wellness Center-Panel: Inside Out: Emotional, Social, Spiritual, Intellectual & Environmental
- Clarify Between Spirituality & Relig.-How Spirituality Supports Recovery: Gordon Easchert

BHPC Workbook
ADULT AND SUBSTANCE ABUSE SUBCOMMITTEE MAPPING PROJECT 2012

The Behavioral Health Planning Council's Adult and Substance Abuse Subcommittees have undertaken the task of putting together a statewide services directory. The goal of this project is to secure information from each County of our State through the Local Collaboratives (LCs) and members of the Subcommittees. The project is entitled ADULT SERVICES RESOURCE MAPPING. We are specifically looking at services available to adults (18 and older), which address substance use and mental disorders. Substance use disorders—which include misuse, dependence, or addiction to alcohol and/or legal or illegal drugs—and mental health problems—which include depression, anxiety disorders, mood disorder, post-traumatic stress disorder, and suicide. When someone is seeking or in need of help the first thing needed is awareness or knowledge of what is available in his or her community or close by. This resource is intended to help meet the need of here to find that help. This MAPPING when complete will be available to all LCs, communities, and services providers and easily accessible by individuals and families wanting help or information. In addition, the MAPPING will provide a way to share and see what is happening within your community and others throughout the State.

For questions about completing the MAPPING please contact the LC – Cross Agency Team (CAT) leader. You may also contact your LC Representative to the Adult and Substance Abuse Subcommittee. Once the information has been gathered and the MAPPING forms completed give to the CAT staff and he or she will forward by email to Meador, Karen, HSD at Karen.Meador@state.nm.us

Definitions: Services being offered within each County will be divided into three parts, prevention programs, treatment services and self-help or peer support programs. These are defined as follows:

Prevention Programs = Alcohol, tobacco, and other drug abuse prevention is an active process that promotes the personal, physical, and social well-being of individuals, families, and communities to reinforce positive behaviors and healthy lifestyles. The term “prevention” is reserved for interventions that occur before the initial onset of a drug or alcohol related disorder.

Treatment Services = the process of providing care to a person or taking action to modify a symptom, an effect, or a behavior. Also the process of interacting after assessment with a person who is substance addicted to present a diagnosis and recommend and negotiate a treatment plan. Also frequently used as a synonym for intervention. Types of treatment can include crisis intervention, brief intervention, and long-term intervention. Substance abuse treatment is an organized array of services and interventions with a primary focus on treating substance abuse disorders. Mental health treatment is an organized array of services and interventions with a primary focus on treating mental disorders, whether providing acute stabilization or ongoing treatment. These programs may exist in a variety of settings, such as traditional outpatient mental health centers (including outpatient clinics and psychosocial rehabilitation programs) or more intensive inpatient treatment units.

Self-Help and Peer Support Programs = Peer support has been defined by the fact that people who have like experiences can better relate and can consequently offer more authentic empathy and validation. People with similar lived experiences offer each other practical advice and suggestions for strategies that others may not offer or even know about. For Peer run or directed programs maintaining its peer-to-peer vantage point is crucial in helping people rebuild their sense of community when they’ve had a disconnecting kind of experience.

Resource = name of service or program within the County provided to adults with behavioral health needs.
Contact Information = address, phone number and contact name.
Target Population = who the service is aimed at, as identified by the agency.
Services Provided = a brief description of what is being offered.
Eligibility Requirement = a description of what is required to receive the services. State if service is free or requires Medicaid or insurance. Capacity = How many can receive service at any given time, i.e., 30 per month with no waiting list; 1 warm line call at a time, etc.
Behavioral Health Mapping
Mental Health and Substance Abuse Treatment Programs

Examples:

### Prevention Programs

<table>
<thead>
<tr>
<th>Resource (Service or Program)</th>
<th>Contact Information</th>
<th>Target Population</th>
<th>Services Provided</th>
<th>Eligibility Requirement</th>
<th>Capacity (number served)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern New Mexico Human Development-</td>
<td>820 Highway 478 Anthony, NM 88021 575-882-5101</td>
<td>Parents and their children in three age groups-5-6 year olds, 6-10 year olds and 10-14 year olds.</td>
<td>Strengthening Families – designed to improve family relations and to reduce the risk of negative behaviors and substance abuse.</td>
<td>Registration with SNMHD Prevention Department</td>
<td>10 to 14 sessions held with children and parents separately and family sessions together in a group format.</td>
</tr>
</tbody>
</table>

### Treatment Programs

<table>
<thead>
<tr>
<th>Resource (Service or Program)</th>
<th>Contact Information</th>
<th>Target Population</th>
<th>Services Provided</th>
<th>Eligibility Requirement</th>
<th>Capacity (number served)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Connection Sobering Center Santa Fe County</td>
<td>2052 Galisteo Street Santa Fe, NM 87505 505-913-4330</td>
<td>Adults 18 yrs and older volunteering for a supported detox experience</td>
<td>Residential short term 3 to 5 days for an acute abstinence episode from alcohol and/or other drugs</td>
<td>Services by referral only, Medical clearance, required by any physician</td>
<td>15 beds (10 for men and 5 for women)</td>
</tr>
</tbody>
</table>

### Self-Help or Peer Support Programs

<table>
<thead>
<tr>
<th>Resource (Service or Program)</th>
<th>Contact Information</th>
<th>Target Population</th>
<th>Services Provided</th>
<th>Eligibility Requirement</th>
<th>Capacity (number served)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catron County Help Line</td>
<td>575-533-6000 or 877-533-6456</td>
<td>Anyone in need</td>
<td>Warm line/referrals</td>
<td>None</td>
<td>1 call at a time 3 hours per day, 6 days per week (Sunday through Friday)</td>
</tr>
</tbody>
</table>
Want to do something/know more/spread the word? Contact your Behavioral Health Planning Council Representative

8 Dimensions of Wellness

**Emotional**
Developing skills and strategies to cope with stress.

**Environmental**
Good health by occupying pleasant, stimulating environments that support well-being.

**Financial**
Satisfaction with current and future financial situations.

**Intellectual**
Recognizing creative abilities and finding ways to expand knowledge and skills.

**Social**
Developing a sense of connection and a well-developed support system.

**Physical**
Recognizing the need for physical activity, diet, sleep, and nutrition.

**Spiritual**
Search for meaning and purpose in the human experience.

**Occupational**
Personal satisfaction and enrichment derived from one's work.
What else can you do to nurture your Emotional Wellness?
Write ideas down here:
1. 
2. 
3. 
4. 
5. 

Please take three of these brochures:
1. Keep one
2. Give one away
3. Have one somewhere for someone else
(like in a waiting room or office)

REMINDERS: Talk about the Emotional Dimensions of Wellness at your Local Collaborative/Club meeting/group/family gathering!

For more information about the Behavioral Health Planning Council:
http://www.bhc.state.nm.us/BHPC/BHPC.html

BHPC Workbook Page 18
Training Activities

Activity 1: Decision Making – Team building Role Play

Questions for Consideration in Preparation of a collaborative response

The intention of having conversation with the Behavioral Health Planning Council at this time is to learn from experience what has worked best, what will continue to serve communities in coordinating and enhancing local service delivery, and how the BHPC can best provide input to the state to continue to move the overall behavioral health system forward.

BHPC members are the advisory body to the Governor and to the Purchasing Collaborative. It is important to stress that members represent communities from across New Mexico primarily through the Local Collaborative (LC) structure, which brings a geographic and cultural diversity to the table. As such, BHPC act as a conduit and a catalyst for information flowing up from communities to the Collaborative and correspondingly down from the Collaborative to communities.

Role Play:

Volunteers: BHPC Chair; BHPC consumer; BHPC family; BHPC Local Collaborative Rep; State staff representative:

1st Identify Facilitator

2nd Identify Volunteers from audience to fill the above roles or any other role.

3rd Discuss briefly each of the questions that follow

4th As a group identify top two priorities your group would like the State CEO to hear from your Behavioral Health Planning Council/or sub-committee.

You have a Cross Agency Staff and Administrative Coordinator available to you as resources for this activity.

Name Tags, Flip Chart and markers will be available

To guide the conversations with this BHPC members will brainstorm and identify priority response as requested to the state in the two areas which follow:

- External to the BHPC
  - In what areas is advice from BHPC needed from the state? (The state will be asking the same question of them.)
o What is the best approach for providing input to the state? Based upon experience over the past few years which requests from the state did you feel were reasonable, meaningful and manageable to complete?

- Internal to the Behavioral Health Planning Council

o How should BHPC function as the mechanism for facilitating BHPC sub-committees? What are the best approaches for ensuring participation of the voices of those who don’t participate in meetings?

o What is the most meaningful thing that BHPC can do to improve Behavioral Health Initiatives?

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**Activity 2: Language and Communication Techniques**

Communication skills are the ability to communicate with people. Many things are involved in communication. Some is nonverbal and this is body language, eye contact, how a person sits, moves, and gestures. Another form of communication is verbal when someone speaks to another person. Then, there is written communication through letters and now email.

**Different Forms of Communication**

**Verbal Communication:** Verbal communication includes sounds, words, language and speaking. Language is said to have originated from sounds and gestures. There are many languages spoken in the world. The bases of language formation are: gender, class, profession, geographical area, age group and other social elements. Speaking is an effective way of communicating and is again classified into two type’s viz. interpersonal communication and public speaking. Good verbal communication is an inseparable part of business communication. In a business, you come across people from various ages, cultures and races. Fluent verbal communication is essential, to deal with people in business meetings.

**Non-Verbal Communication:** Non-verbal communication involves physical ways of communication, like, tone of the voice, touch, smell and body motion. Creative and aesthetic non-verbal communication includes singing, music, dancing and sculpturing. Body language is a non-verbal way of communication. Body posture and
physical contact convey a lot of information. Body posture matters a lot when you are communicating verbally to someone. Folded arms and crossed legs are some of the signals conveyed by a body posture. Physical contact, like, shaking hands, pushing, patting and touching expresses the feeling of intimacy. Facial expressions, gestures and eye contact are all different ways of communication. Reading facial expressions can help you know a person better.

**Written Communication:** Written communication is writing the words which you want to communicate. Good written communication is essential for business purposes. Written communication is practiced in many different languages. E-mails, reports, articles and memos are some of the ways of using written communication in business. Written communication is used not only in business but also for informal communication purposes. Mobile SMS is an example of informal written communication.

**Visual communication:** The last type of communication is the visual communication. Visual communication is visual display of information, like topography, photography, signs, symbols and designs. Television and video clips are the electronic form of visual communication. Effective communication is essential for the success of any type of business. Informally too, nothing can be achieved without proper communication. Communicative media is growing day by day to ensure clarity and to eliminate the ambiguity in communication. (By Aarti R)

**Activity:** Think of a time you disagree with someone. Write a short letter to that person using negative language (Do not sign it).

All letters will be exchanged with others in the orientation. Now rewrite the letter you have received in a more positive way.

- What if you were the recipient of the negative letter?

- How did it make you feel to read the negative letter?

- How did you want to respond to the person who wrote the negative letter?

- Would you want to respond differently to the person if the letter were more positive? In what way would your reaction or response be different?
Research Supporting the Principles of Recovery & Systems of Care

Previous research efforts have outlined principles of effective addictions treatment. In 1999, the National Institute on Drug Abuse (NIDA) produced a research-based guide entitled Principles of Drug Addiction Treatment. It identified 13 principles that research has found to be associated with effective addictions treatment:

1. No single treatment is appropriate for all individuals.
2. Treatment needs to be readily available.
3. Effective treatment attends to multiple needs of the individual, not just his or her drug use.
4. An individual’s treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person’s changing needs.
5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
6. Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.
7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
8. Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.
9. Medical detoxification is only the first stage of addictions treatment and by itself does little to change long-term drug use.
10. Treatment does not need to be voluntary to be effective.
11. Possible drug use during treatment must be monitored continuously.
12. Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at the risk of infection.
13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.

The National Summit on Recovery’s 12 principles of recovery provides guidelines on the process of and outcomes associated with recovery. The NIDA principles relate most closely to the following principles of recovery:

- There are many pathways to recovery. The pathway to recovery may include one or more episodes of psychosocial and/or pharmacological treatment. For some, recovery involves neither treatment nor involvement with mutual aid groups. Recovery is a process of change that permits an individual to make healthy choices and improve the quality of his or her life.

- Recovery is holistic. Recovery is a process through which one gradually achieves greater balance of mind, body, and spirit in relation to other aspects of one’s life, including family, work, and community.

- Recovery exists on a continuum of improved health and wellness. Recovery is not a linear process. It is based on continual growth and improved functioning.

- Recovery involves a process of healing and self-redefinition. Recovery is a holistic healing process in which one develops a positive and meaningful sense of identity.
  - Recovery is a reality. It can, will, and does happen.
Guiding Principles of Recovery

- There are many pathways to recovery.
- Recovery is self-directed and empowering.
- Recovery involves a personal recognition of the need for change and transformation.
- Recovery is holistic.
- Recovery has cultural dimensions.
- Recovery exists on a continuum of improved health and wellness.
- Recovery is supported by peers and allies.
- Recovery emerges from hope and gratitude.
- Recovery involves a process of healing and self-redefinition.
- Recovery involves addressing discrimination and transcending shame and stigma.
- Recovery involves (re)joining and (re)building a life in the community.
- Recovery is a reality. It can, will, and does happen.

To all CSAs:

1. **CSA Eligibility Criteria for target populations.** The Collaborative has approved new CSA Eligibility Criteria for both Youth and Adults. The new criteria more appropriately focuses the population eligible to receive CSA core services to those individuals with intense and complex behavioral health needs in need of a “clinical home” function. As such, the new eligibility criteria are now aligned with the original intent of the CSA initiative and supersede any prior communication concerning target populations for CSAs including language in the Request for Proposals for CSAs for Phases I-III.

   In a Clinical Home model, a provider (selected by the consumer) works jointly with the consumer to coordinate and manage behavioral health care and other support systems. The goal is to empower individuals, families, and providers to work as partners in a spirit of personal and organizational accountability. The intended outcome is a holistic and well-monitored treatment experience. This requires services to be accessible, family-centered, integrated, and culturally appropriate.

   CSAs are designated “clinical home” points of entry for children and adults with intensive needs, assuring comprehensive care in system-of-care fashion with wraparound and recovery approaches. In time, (the CSA initiative is in year one of a three to five year implementation) these agencies will help to bridge treatment gaps in the child and adult treatment systems, promote the appropriate level of service intensity, ensure that community support services are integrated into treatment, and develop the capacity for consumers to have a single point of accountability for identifying and coordinating their behavioral health, health and other social services.

   The CSA eligibility criteria are summarized as follows:

   - Children experiencing Serious Emotional/Neurobiological/Behavioral Disorders (SED)  
     plus other criteria
Adults with Severe Mental Illness (SMI) plus other criteria
- If SMI, a substance use disorder.
- If SMI or CSD, a developmental disability.
- If CSD, a mental health disorder.

Persons with chronic substance dependence (CSD) plus other criteria

Persons with a co-occurring disorder:

The new definitions with all requisite criteria for CSA eligibility for both Youth and Adults can be accessed through the following links:

https://www.optumhealthnewmexico.com/provider/csaSupplementalInformation.html

Please note the removal of “at risk for SED” for CSA Youth Eligibility. Although “at risk for SED” is no longer deemed a target population for CSA eligibility, any youth referred to a CSA will receive a CSA Eligibility Determination as follows:

2. Comprehensive Community Support Services (CCSS) – As a provider type eligible to provide CCSS services under Medicaid (see also FQHCs, CMHCs, 638/Tribal organizations), CSAs may provide CCSS to any consumer clinically and medically in need of such service. Provision of CCSS by a CSA is not limited to CSA eligible consumers.

3. CSA Geographic Coverage & Responsibility. Selection of a CSA for CSA core services is driven by consumer choice not by geographic boundary. While a CSA is responsible for serving CSA eligible consumers within its designated geographic area, eligible CSA consumers outside its geographic area may also be served. Should such cross-boundary service be desired, it is expected that the consumer chosen CSA and the designated CSA for that geographic region dialogue and work together to insure consumer choice is honored and necessary services are timely and appropriately delivered.

Please contact Elizabeth Martin if you have any questions or need further clarification at 505-428-6564 or elizabeth.a.martin@optumhealth.com
FACTS AT A GLANCE:

CORE SERVICE AGENCY NO REJECT; NO EJECT

As Long as funding is available

Core Service Agencies (CSA) serve as the support base and point of service coordination for all individuals meeting the CSA eligibility regardless of presenting behavior.

Core Service Agencies (CSA) embody the true spirit of recovery and resiliency as exemplified by:
- Individual and Family Empowerment
- Shared Decision-Making
- Personal Choice

Core Service Agency will:
- Make an eligibility determination for each individual referred
- Complete assessments in a timely manner
- Provide crisis services

Individuals enrolled in a Core Service Agency (CSA) can:
- Enroll in a CSA of their choosing
- Actively engage in their own recovery
- Not be ejected or rejected because of presenting behavior
- Be referred to another appropriate agency for services

NO REJECT, NO EJECT

A CSA will not "reject" or "eject" individuals who meet the definition of "target population" within the designated area.

No "Reject" means the agency must accept the referral for eligibility determination, and if eligible, provide/coordinate services within funding availability.

No "Eject" means that the agency must continue to follow the consumer through all levels of care and movements within the system(s).

APPROPRIATE REASONS FOR A CSA TO END TREATMENT THAT DO NOT VIOLATE THE NO REJECT, NO EJECT POLICY:

**Does not respond** — attempt to respond means that there has been at least three attempts to contact the consumer, in a 30 day period, which has included at least one visit to last known address as well as phone calls to last known phone number.

CSA's door is always open and Individuals will be welcomed back to a CSA upon return.

Published by the CSA Communications Team

April 2011

BHPC Workbook
### FACTS AT A GLANCE: **BASIC INFORMATION**

**Key:** Adult=A; Children’s=C

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**Published by the CSA Communications Team**

**August 19, 2010**
NEW MEXICO HUMAN SERVICES DEPARTMENT
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

Susana Martinez Sidonie Squier
Governor Secretary
Media Contact: Matt Kennicott (505) 827-6236 or (505) 819-1402
matt.kennicott@state.nm.us
February 22, 2012
For Immediate Release

Behavioral Health Funding Finds Parity In Centennial Care
Domenici: “Good step forward for behavioral health in New Mexico”

SANTA FE – In November, the New Mexico Behavioral Health Collaborative (BHC) voted to integrate physical and mental health in the state’s new “Centennial Care” Medicaid program. This will be instrumental in helping New Mexicans achieve a higher quality of life, as individuals with mental illness often also struggle with serious chronic physical health conditions.

"While serving as New Mexico's Senior Senator I was privileged to work on legislation designed to improve health care for millions of Americans by ensuring mental health parity in the law. The Centennial Care plan is a good step forward for behavioral health in New Mexico," said Senator Pete Domenici (R-NM). “I am confident that recipients of behavioral health services in New Mexico will continue to receive quality care for years to come with the Human Services Department putting a fence around this funding. This will put behavioral health on the same footing as physical health in our state with regard to how we Fund these services."

The life span for individuals with mental illness may be shortened by up to 25 years and for those with both addiction and mental illness, life span may be shortened by as much as 37 years. Treating the entire spectrum of illness for individuals – both physical and mental – will help to increase wellness, recovery, and resilience.

“It makes sense for us to move forward with the integration of behavioral and physical health services in order to better serve New Mexicans in need,” said Behavioral Health Collaborative Co-Chair and Secretary of Human Services Sidonie Squier. “These patients will face better outcomes with increased wellness, better recovery, and longer term resilience. We will put a fence around the behavioral health dollars in order to protect this crucial funding stream.”

The Managed Care Organizations (MCOs) will be required to have behavioral health administrative leadership equal to that of physical health under Centennial Care. Behavioral health administration must demonstrate knowledge, experience, and commitment to implementing Core Service Agencies (CSAs) and Behavioral Health Homes. Potential savings from the improvement of mental health will likely be reinvested back into additional behavioral services. For additional information on Centennial Care and the concept paper, visit the HSD website at http://www.hsd.state.nm.us/MedicaidModernization
Currently, the Medicaid program is 16% of the state budget.

Health care costs continue to increase.

- 5.8% a year through 2020 according to the Centers for Medicare and Medicaid Services actuaries. This rate is faster than the economy is expected to grow this decade.

- Even with three years of 100% federal funding for newly eligible enrollees under the Federal Health Care Reform, the State's Medicaid bill will continue to rise dramatically.
Four Goals

- Assuring Medicaid recipients receive the right amount of care at the right time, in the most cost-effective settings
- Assuring the care is measured for quality, not quantity
- Slowing the rate of growth of program costs (bending the cost curve) without cutting services, eligibility or provider rates
- Streamlining and modernizing the program in preparation for January 2014

Statewide Listening Tour

- Five Public Meetings
- One Tribal Consultation
- Small Workgroups
  - Advocates
  - Providers
  - Native Americans
  - Health Plans
- Written and Verbal Comments
Principle 1: A Comprehensive Service Delivery System

- Manage Care
  - Focus on health literacy with and for recipients
  - Comprehensive care coordination process
  - Include behavioral health to maximize integration of care
  - Protect behavioral health funding in the system
  - Maximize technology for rural and frontier regions
  - Better use of school health clinics

Principle 2: Personal Responsibility

- Engage recipients in their personal health decisions
  - Reward recipients for engaging in healthy behaviors
    - Gift card to recipients who engage in quantifiable healthy behavior (e.g. well-child visits)
    - Gift card for recipients with chronic illnesses who follow a specific plan of care
    - Debit card that earns points for additional healthy behaviors
  - Targeted cost sharing strategies
    - $3.00 co-pay for any legend/brand drug dispensed when there is a generic drug available – exception of psychotropic drugs
    - Sliding scale co-payment on recipients with incomes above 100% of the Federal Poverty Level (FPL) who use emergency room for non-emergency care
Principle 3: Payment Reform

- Rewarding plans and providers who practice cost-effective medicine targeted at outcomes rather than process
  - Use pilot project approach to produce the desired result
    - Pediatric asthma
    - Readmissions to hospitals within 30 days of discharge
    - Peer-to-Peer Physician effectiveness reporting

Principle 4: Administrative Simplification

- Combine all Medicaid waivers (except for the Developmental Disabilities waiver) into a single, comprehensive 1115 waiver
- Reduce the number of managed care plans from seven to a more manageable number
  - Reduce costs
  - Focus on managing and monitoring our private contractors
Native American Participation

- Improve Health Outcomes and Promote Economic Opportunities for Native American Communities
  - Native Americans will fully participate in the Managed Care service delivery structure
  - Encourage and promote greater involvement by and with the Native American community
    - Health plans will contract with the Tribes for on-reservation case management and transportation services, where such services are available and offered by the Tribes
    - Encourage and incentivize Tribes to develop care coordination teams and health homes that meet state requirements to provide integrated care for their members with chronic medical/behavioral health conditions; and
    - Explore the concept of “mini block grants” to Tribes who are willing to provide an array of services to their members for a set amount of money.

Implementation of the Affordable Care Act

- “Newly eligible” individuals (below age 64 with incomes up to 133% of the FPL) will become eligible to receive health care services through Medicaid
  - The benefit package can be less comprehensive than the current Medicaid benefit
    - Enroll Federal health care expansion population into Medicaid
    - Offer the federally required benchmark benefit package for the expansion population
CENTENNIAL CARE

- Creative, Innovative Approaches to Create a Modern and Flexible Delivery System:
  - Maximize chances of a healthier population
  - Purchase quality care rather than quantity of care
  - Slow the rate of growth of the program costs by maximizing administrative simplicity and focusing on better outcomes
  - Require that plans, providers, recipients and the State, all move together to slow the rate of growth the cost of the program while avoiding cuts, improving quality, and modernizing our system
- Centennial Care will continue delivering benefits for those most in need, now and into the future, while avoiding cuts

CENTENNIAL CARE

Process Timeline

- June through October 2011:
  - Public stakeholder meetings and subject specific workgroups

- October 2011 through January 2012:
  - Finalize concept paper, “vet” with the Governor, organize internal workgroups to begin putting additional operation details on the design

- February 2012 through June 2012:
  - Submit waiver to the U.S. Center for Medicare and Medicaid Services (CMS), develop Request for Proposals (RFP) for plans, finalize new contract to be used with plans
    - Procurement on the street mid to late June 2012

- July through September 2012:
  - Procure new plans and award contracts

- October 2012 through September 2013:
  - Prepare for “Go Live”
CENTENNIAL CARE

The State has a several ways for people to submit suggestions and ideas for our Centennial Care concept.

› Website: www.hsd.state.nm.us/medicaid.modernization
› E-mail Address: medicaid.comments@state.nm.us
› Phone: 1–855–830–5252
› Regular Mail: Centennial Care Comments - Human Services Department P.O. Box 2348, Santa Fe, New Mexico 87504
SENATE MEMORIAL 56
Adolescent Opioid Addiction Treatment Study

New Mexico Behavioral Health Collaborative
Opioid Dependence Core Group

October 2011

Senate Memorial 56
Senate Memorial 56 Vision

Senate Memorial 56 Adolescent Opioid Addiction Treatment is requesting the Interagency Behavioral Health Purchasing Collaborative to develop a comprehensive statewide plan for treatment of opioid addiction among adolescents, including steps for implementation of the plan. The service system design within this report has a focus on opioid addiction but it has been built to be applicable to all substance addictions. The Collaborative's intent within this Memorial is to design a system of care that provides a platform upon which persons with addictions can use to build their sustained recovery. The service system shall be inclusive of evidenced-based, scientific practices tempered by the experiences of persons contending with addictions and their families. It is tailored to cultural and geographic diversity in order to create a New Mexico best practice for the treatment of addiction disorders. Critical to the endeavor is collecting and analyzing performance outcomes according to resource allocation to determine best value in practice. As best value practices are identified the behavioral health workforce shall receive the training and mentoring needed to increase service efficacy and statewide access and capacity.

Statement of Problem

New Mexico has the highest rate of fatal unintentional drug overdoses in the country. New Mexico adolescents are using drugs at younger ages than other youth in the United States (age 12), and are more likely to have tried heroin than their national counterparts (Youth Risk and Resiliency Survey, 2011). An increasing number of high school students report using painkillers to get high: In 2007, 11.7% of students reported this usage, and the percentage increased to 14.3% in 2009 (YRRS, 2011). In a study conducted in 2009 by the Center for Disease Control, 4.7% of New Mexico high school students reported lifetime heroin use, compared to 2.5% of students in the United States. Confirmed unintentional fatal drug overdose deaths in Albuquerque alone have increased from 5 in 2005 to 20 in 2009 with the number is still increasing (Shah, 2011).
The Legislature
of the
State of New Mexico

49th Legislature, 2nd Session

LAWS 2010

CHAPTER

HOUSE MEMORIAL 56, as amended

Introduced by
REPRESENTATIVE JEFF STEINBORN

REPRESENTATIVE MIMI STEWART
REPRESENTATIVE JAMES EDGAR MADALENA
REPRESENTATIVE DANICE PICRAUX
A MEMORIAL

REQUESTING THE INTERAGENCY BEHAVIORAL HEALTH PURCHASING
COLLABORATIVE TO DEVELOP A COMPREHENSIVE, STATEWIDE PLAN FOR
TREATMENT OF OPIOID ADDICTION AMONG ADOLESCENTS.

WHEREAS, in 2005, New Mexico had the second-highest
drug-induced death rate in the United States, with nearly
thirty deaths for every one hundred thousand persons,
compared to a rate of just over eleven deaths for every one
hundred thousand persons in the United States; and

WHEREAS, the total unintentional drug overdose death
rate in New Mexico increased by one hundred eighty percent
between 1990 and 2005; and

WHEREAS, adolescent deaths from opioid overdose
accounted for twelve percent of all opioid deaths in New
Mexico in 2009, up from two percent prior to 2004; and

WHEREAS, a 2007 national survey, conducted by the
federal substance abuse and mental health services
administration, indicated that New Mexico teens between the
ages of twelve and seventeen use illicit drugs more heavily
than the United States average; and

WHEREAS, according to data collected from the 2009 youth
risk and resiliency survey, fourteen and three-tenths percent
of New Mexico students used prescription painkillers to get
high that year, an increase of nearly two percent from 2007;
and

WHEREAS, New Mexico lacks a system of coordinated and
effective care for treatment of opioid-addicted adolescents;
and

WHEREAS, there are virtually no outpatient facilities in
New Mexico that offer combined medical and psychological
treatment of adolescent opioid addiction; and

WHEREAS, there are no inpatient facilities in New Mexico
that offer combined medical and psychological treatment of
adolescent opioid addiction; and

WHEREAS, a November 4, 2009 study, conducted by the
department of health in response to House Memorial 9, which
was passed in the first session of the forty-ninth
legislature, acknowledged the seriousness of opioid use among
adolescents; and

WHEREAS, despite the report's numerous recommendations
for an ongoing commitment to addressing this problem, no
comprehensive plan for treatment of adolescents has been
developed;

NOW, THEREFORE, BE IT RESOLVED BY THE SENATE OF THE
STATE OF NEW MEXICO that the interagency behavioral health
purchasing collaborative be requested to develop a
comprehensive, statewide plan for treatment of opioid
addiction among adolescents; and

BE IT FURTHER RESOLVED that the interagency behavioral
BE IT FURTHER RESOLVED that the task force assess the
economic savings, if any, that may result from coordinating or
consolidating governmental direct caregiver training programs
across all disability programs and their respective state
agencies; and

BE IT FURTHER RESOLVED that the task force include
representatives from the department of health, the higher
education department, the human services department, the
children, youth and families department, the aging and long-
term services department, the developmental disabilities
planning council, the arc of New Mexico and disability rights
New Mexico; three New Mexicans with a disability, or their
legal representatives; and other members chosen on an ad hoc
basis as the secretary of health deems necessary; and

BE IT FURTHER RESOLVED that the task force research
direct caregiver training models that are in use in other
states, as well as the merits of models such as the college of
direct support; and

BE IT FURTHER RESOLVED that, by November 1, 2010, the
task force report to the legislative health and human services
committee its findings and recommendations regarding the
possibility of coordinating or consolidating governmental
training programs for direct caregivers across all disability
programs and their respective state agencies; and

BE IT FURTHER RESOLVED that copies of this memorial be
transmitted to the secretary of health; the secretary of higher education; the secretary of human services; the secretary of children, youth and families; the secretary of aging and long-term services; the executive director of the developmental disabilities planning council; the public policy director for the arc of New Mexico; and the executive director of disability rights New Mexico.
Introduction

One of the greatest challenges facing law enforcement agencies and detention centers in New Mexico and across the nation is how to respond to people who have mental health disorders. House Joint Memorial 17 addresses this challenge and charges the Interagency New Mexico Behavioral Health Purchasing Collaborative with convening stakeholders to develop humane and effective strategies to serve people with mental health disorders in order to reduce the number of people with mental health disorders who are in detention or require law enforcement intervention.

Representative Rick Miera sponsored HJM 17 in 2011. Senators Papen and Baffort sponsored similar memorials in 2009 and 2010. Their collective support and commitment to finding answers shines a light on this critical issue and sets the stage for solutions.

The task force members and participants (listed on page 17) represent a broad range of disciplines and perspectives, as well as urban, rural, and frontier communities. The full task force met five times during the summer of 2011 to review current services and to vet critical components of a statewide crisis system. Their thoughtful effort and generous commitment to discussing and working through these difficult issues was humbling to us. The task force reached consensus on the five Guiding Principles and nine Recommendations contained in this report.

We are especially grateful to the task force steering committee members who met faithfully every Friday afternoon from May through October (350 labor hours) to guide the process and develop this report. In addition to planning the task force meetings and synthesizing the task force recommendations, the steering committee reviewed and incorporated the many written comments received from the Local Collaboratives, stakeholders, advocates, clients, and community members who were not always able to attend the full task force meetings. The complete record of the HJM 17 task force activities including minutes, research, presentations, and written submissions is at:  
https://sites.google.com/a/nmcounties.org/hjm17/home

These recommendations set forth a road map to reduce the number of people with mental health disorders who are in detention or require law enforcement intervention through improving our mental health system. Each recommendation will require further work to implement. It will take commitment and resources.

Grace Philips, Co-Chair  Daphne Rood-Hopkins, Co-Chair  
NM Association of Counties  NM Human Services Department

Jails were made to house the people you are afraid of; but now you want us to house the people you are mad at, the neighbor that frustrates you, the drug addict who won’t get well, and the mentally ill.

Ramon Rustin, Chief  Metropolitan Detention Center

Bernalillo County

On a given day approximately 31% of the inmates at MDC are on the mental health case load. 728 of these are taking psychotropic medications and 129 are acutely mentally ill.

Matt Elwell  Operations Administrator  Metropolitan Detention Center
Guiding Principles

Peer led and peer driven services are critical to any effective and humane statewide mental health system.

Services should employ the least restrictive environment and maximize client choice.

A crisis system must serve both individuals with mental illness who have insight into their condition and those who do not.

Mental health services must be trauma informed, gender specific, age appropriate, culturally sensitive, language appropriate, and accessible to anyone regardless of literacy level.

These recommendations are for services that would be available to all persons with serious mental illness, their families, and their natural supports regardless of age, socio-economic, or insured status.

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Two-thirds of boys and three-quarters of girls in the juvenile system meet the diagnostic criteria for mental illness and/or substance use disorders. The majority are victims or witnesses to traumatic events and respond to threats self-protectively, sometimes with violence.

Jeffrey Tinstman
Senior Behavioral Health Administrator
NM Children, Youth, & Families Department

\[1\] In order to accord respect and dignity to individuals living with a diagnosable mental illness, the HM Task Force has elected to refer to these individuals as “clients” for the purpose of this document.
## Recommendations

### System Improvements
Develop flexible funding streams and payment mechanisms to compensate providers for the critical services described in these recommendations.

### Regional Crisis Triage Centers
Fund regional crisis triage sites to conduct mental health evaluations and provide up to 23 hours of diversion.

### Respite Services
Develop and fund respite care locations throughout the state to serve as a non-clinical alternative to reduce need for hospitalization or incarceration.

### Training
Establish peer training programs and training for family members, natural supports, teachers, students, and first responders.

### Call Centers
Establish a centralized, statewide call center with a single telephone number that is connected to local authorities and behavioral health agencies throughout the state.

### Warm Lines
Expand warm line services statewide that are client-run or client-staffed to provide telephone-based peer support.

### Community Crisis System Planning
Develop broad community coalitions in all communities or counties of the state to enhance and integrate local capacity to respond to mental health crises.

### Peer Services
Use peer services whenever possible to provide and enhance services.

### Criminal Laws
Review criminal statutes to determine whether there are sensible changes that can be made which would reduce costly and often unnecessary, lengthy, and ineffective incarceration of individuals with mental illness.
HOUSE JOINT MEMORIAL 17

50TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2011

INTRODUCED BY

Rick Miera

A JOINT MEMORIAL

REQUESTING THE INTERAGENCY BEHAVIORAL HEALTH PURCHASING COLLABORATIVE AND ITS MEMBER DEPARTMENTS TO STUDY THE NEEDS OF AND AVAILABLE RESOURCES FOR PEOPLE WITH MENTAL HEALTH DISORDERS IN CRISIS SITUATIONS AND TO DEVELOP STRATEGIES TO IMPROVE SERVICES, TREATMENT AND CARE OUTSIDE OF LAW ENFORCEMENT AND DETENTION IN ORDER TO REDUCE THE NUMBER OF PEOPLE WITH MENTAL HEALTH DISORDERS WHO ARE IN DETENTION FACILITIES OR REQUIRE LAW ENFORCEMENT INTERVENTION.

WHEREAS, one of the greatest challenges facing law enforcement agencies and detention centers is how to respond to people who have mental health disorders; and

WHEREAS, law enforcement agencies are the first-line responders to people with mental health disorders who are not receiving necessary treatment and care; and
WHEREAS, current statute permits people with mental health disorders to be taken to detention facilities for protective custody regardless of whether they have committed criminal acts warranting arrest; and

WHEREAS, many people with mental health disorders are held in detention facilities for misdemeanor charges due to a lack of available treatment or community support; and

WHEREAS, the burden for addressing mental health issues in New Mexico communities has been left to counties where detention centers have become de facto mental health facilities; and

WHEREAS, few detention centers are equipped to deal with this population; and

WHEREAS, individuals with mental health disorders can be traumatized by incarceration; and

WHEREAS, the current situation exposes the state and local governments to substantial liability; and

WHEREAS, individual agencies cannot provide the solution to this problem because it is a systemic problem that requires collaboration and development of strategies among federal, state, county and municipal governments as well as health care providers and advocacy organizations;

NOW, THEREFORE, BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO that the interagency behavioral health purchasing collaborative, through the behavioral health planning council, be requested to convene stakeholders to develop humane and effective strategies to serve people with mental health disorders in order to reduce the number of people with mental health disorders that require law enforcement intervention and to reduce the number of people with mental health disorders in detention centers; and
BE IT FURTHER RESOLVED that stakeholders include but not be limited to representatives from the New Mexico association of counties; the New Mexico municipal league; the department of health; the human services department; the training and recruiting division of the department of public safety; the aging and long-term services department; the corrections department; the New Mexico behavioral health institute at Las Vegas; the New Mexico hospital association; disability rights New Mexico; the national alliance on mental illness, New Mexico; and two individuals living with serious mental illness identified by the interagency behavioral health purchasing collaborative; and

BE IT FURTHER RESOLVED that the interagency behavioral health purchasing collaborative be requested to report its findings to the appropriate interim legislative committee by December 1, 2011; and

BE IT FURTHER RESOLVED that copies of this memorial be transmitted to the directors of the New Mexico association of counties, the New Mexico municipal league, the New Mexico behavioral health institute at Las Vegas, the New Mexico hospital association, disability rights New Mexico and the national alliance on mental health, New Mexico; the chief executive officer of the interagency behavioral health purchasing collaborative; and the secretaries of health, human services, public safety, aging and long-term services and corrections.
The Behavioral Health Collaborative, in cooperation with a broad range of stakeholders and partners, plan to support the enhancement of practice over the next 12 to 24 months within four broad behavioral health domains through the support of Practice Improvement Collaboratives and the development of Learning Communities. The four domains are:

1. **Crisis System of Care**: Many people with serious mental illness have contact with law enforcement and are subsequently held in detention centers, primarily due to a lack of crisis response services. The Collaborative plans to phase-in a crisis system of care building on the work of HJM 17 (Resources for Persons with Mental Illness).

2. **Recovery-Oriented System of Care (ROSOC)**: Federal statistics consistently show New Mexico as having the highest rates of fatal and debilitating addiction disorders. Building on the work of SM 56 (Adolescent Opioid Addiction Study) the Collaborative is promoting the nationally recognized model, Recovery Oriented System of Care.

3. **Trauma**: Trauma is extremely prevalent and significantly exacerbates or precipitates both behavioral health and physical health conditions. Focuses for practice enhancement include trauma informed care, military trauma spectrum disorders, multigenerational trauma and other related areas.

4. **Integrated Behavioral and Physical Health**: New Mexico is quickly moving towards the integration of physical and behavioral health within the Health Homes initiatives.

**Supporting Enhancement of Practice**

- **Practice Improvement Workgroup**: A Practice Improvement Workgroup (Workgroup) is a consortium of stakeholders working together to promote the implementation of evidence-based and promising practices for targeted health concerns. Each of the four domains has Workgroups in various levels of development. For example, the Workgroup for the Recovery Oriented System of Care is coming together from the team that crafted Senate Memorial 56 “Adolescent Opioid Treatment” and the Workgroup for integrated behavioral and physical health is being formed through the various stakeholders tasked with developing Behavioral Health-Health Homes.

- **Symposium**: The Collaborative will host a two day Symposium on August 15th and 16th that will include a track for each of the four domains. The Symposium audience will be by invitation by the Workgroups to the champions, leaders and committed stakeholders that form the core of the Workgroup to enhance practice. Symposium track subcommittees are currently crafting presentations by nationally recognized leaders and state champions on best practices within the four domains to help the Workgroup leads come together, develop a common perception of best practices and practice enhancement, and to formulate next steps to support the PIC’s and to create Learning Communities.
Collaborative Symposium cont...

- **Learning Communities**: Learning Communities are a practice improvement method, in which a group of practitioners work together to improve their skills in evidence-based and promising practices. The learning communities are structured to provide the ongoing feedback, peer-support, and coaching necessary to develop proficiency. The PIC’s will be identifying the best and promising practices to be enhanced and with its partners (UNM-CBHTR, UNM-CASAA, UNM-Project ECHO and Partners in Wellness) are developing strategies on how to create learning communities to provide ongoing education, training and interactive support through a variety of very creative modalities including interactive teleconferencing and social media in addition to traditional approaches.

**Summary**: The Collaborative plans to promote the enhancement of practice within the domains of trauma, recovery oriented system of care, regional crisis response and integrated behavioral health by supporting the ongoing organization of leaders, champions and other committed stakeholders within Practice Improvement Workgroups. One activity tasked to the Workgroups is to identify best and promising practices that lead to desired service outcomes within their respective domains and to create Learning Communities. A Symposium will be held on August 15th and 16th bring the Workgroup leaders and together, develop a common perception of best practices, practice enhancement and formulate next steps to support the workgroups and to create Learning Communities. A Website for this project to facilitate communication should be operational in April.

For more information contact Harrison Kinney at: harrison.kinney@state.nm.us
The Affordable Care Act: Section 2703. Health Homes – An Opportunity for New Mexico

Expert Panel Presentation
December 9, 2011
Albuquerque, New Mexico

Background

- Health Homes is a new Medicaid State Plan Option that provides a comprehensive system of care coordination for Medicaid individuals with chronic conditions.
- Goals of implementing Section 2703 will be:
  - To expand upon the traditional and existing medical home models to build linkages to community and social supports; and,
  - To enhance the coordination of medical, behavioral and long-term care to treat the “whole person.”

Health Homes: What are they?

- New opportunity for Medicaid programs to provide and pay for six new and previously unreimbursed services:
  1. Comprehensive care management;
  2. Coordination and health promotion;
  3. Comprehensive transitional care/follow-up;
  4. Patient and family support;
  5. Referral to community and social support services;
  6. Use of Health Information Technology to link services.

Health Homes: What are they?

- Opportunity to enhance integration and coordination of primary, acute, behavioral health, and long-term care services and supports across person’s lifespan.
  - HH provide significant coordination of behavioral and physical health care.
  - Funding: 90/10 federal/state dollars for the first 8 fiscal quarters that a State plan amendment is in effect.

Who would receive HH services?

- Medicaid beneficiaries with:
  - Two or more chronic conditions (mental health, substance abuse, asthma, diabetes, heart disease, being overweight); or
  - One chronic condition and at risk for a second; or
  - Serious and persistent mental health condition.
- Cannot exclude dual eligibles (Medicare/Medicaid)

Health homes can differ based on needs of different subpopulations

<table>
<thead>
<tr>
<th>Subpopulation</th>
<th>Potential Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronically ill</td>
<td>Primary care as “home”</td>
</tr>
<tr>
<td>Dual eligibles</td>
<td>LTC, Medicare provider networks</td>
</tr>
<tr>
<td>Serious and Persistent Mental Illness (SPMI)</td>
<td>Mental health system as “home”</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Relationship to TCM</td>
</tr>
</tbody>
</table>
Who provides HH services?

- States have flexibility in deciding who can provide HH services
- Potential HH providers include:
  - Individual providers like physicians, community and rural health clinics, community mental health centers, home health agencies, and others
  - Interdisciplinary teams of health professionals that include physicians, nurse care coordinators, BH professionals, social workers, pharmacists, dietitians, chiropractors, licensed complementary and alternative medical practitioners, physician assistants, and others
- Providers can be within walls of a practice or virtual

Phased-In Approach

- Phase 1: Provide HH services to eligible Medicaid beneficiaries with serious mental health diagnoses and other behavioral issues through selected Care Service Agencies (CSAs)
- Phase 2: Provide HH services to beneficiaries with complex physical health diagnoses via primary care infrastructure
- Phase 3: Provide HH services to beneficiaries with long-term care needs

Overview of Medicaid Population 2011

<table>
<thead>
<tr>
<th>Population</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>215,599</td>
<td>4.0%</td>
</tr>
<tr>
<td>Children &amp; Youth (Under 18)</td>
<td>520,724</td>
<td>60%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>540,594</td>
<td>100%</td>
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</table>

Populations with SMI or Any Behavioral Health Problem

<table>
<thead>
<tr>
<th>Population</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>25,641</td>
<td>12.4%</td>
</tr>
<tr>
<td>SMI</td>
<td>25,641</td>
<td>12.4%</td>
</tr>
<tr>
<td>Any Behavioral Health</td>
<td>91,910</td>
<td>14.2%</td>
</tr>
<tr>
<td>All Adults</td>
<td>215,599</td>
<td>100%</td>
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</tbody>
</table>

Populations with SED or Any Behavioral Health Problem

<table>
<thead>
<tr>
<th>Population</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children &amp; Youth (Under 13)</td>
<td>8,928</td>
<td>9.9%</td>
</tr>
<tr>
<td>SED</td>
<td>80,926</td>
<td>9.5%</td>
</tr>
<tr>
<td>Any Behavioral Health</td>
<td>19,982</td>
<td>4.1%</td>
</tr>
<tr>
<td>All Children &amp; Youth</td>
<td>104,877</td>
<td>100%</td>
</tr>
</tbody>
</table>

Chronic Conditions

<table>
<thead>
<tr>
<th>Chronic Condition</th>
<th>SED 2011</th>
<th>SMI 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>730</td>
<td>480</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>540</td>
<td>3,779</td>
</tr>
<tr>
<td>Diabetes</td>
<td>243</td>
<td>4,897</td>
</tr>
<tr>
<td>COPD</td>
<td>751</td>
<td>3,784</td>
</tr>
<tr>
<td>Obesity &amp; other hypertension</td>
<td>1,683</td>
<td>3,946</td>
</tr>
<tr>
<td>Chronic Liver Disease</td>
<td>101</td>
<td>1,481</td>
</tr>
<tr>
<td>Inflammation</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>Reversing Conditions</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Asthma &amp; Obstructive</td>
<td>300</td>
<td>5,886</td>
</tr>
<tr>
<td>All Chronic Conditions</td>
<td>4,721</td>
<td>32,757</td>
</tr>
</tbody>
</table>

BHPC Workbook Page 54
So our initial focus will be on:
Persons with SMI, SED or other behavioral health problems and one of the following chronic conditions:
- Asthma
- COPD
- Hypertension
- Hyperlipidemia
- Heart Disease
- Diabetes
- Obesity

Next steps in preparing the Medicaid State Plan Amendment
- Further examining the data for patterns in expenditures by populations and chronic conditions;
- Developing a budget and analyzing where the cost savings will be achieved;
- Developing financial payment methodologies and incentives;
- Studying where and how many health homes will be needed;
- Developing a statewide implementation plan.

Time Frames
- March, 2012: Submit a State Plan amendment for health homes for persons with behavioral health problems;
- July, 2012: Implement initial Health Homes in Bernalillo County
- By July 2013 – will have gone statewide
- By July 2014 – initiated health homes for other chronic conditions
Health Homes

The Health Home is an alternative approach to the delivery of health care services that promises better patient experience and better outcomes than traditional care. The Health Home has many characteristics of the Patient-Centered Medical Home but is customized to meet the specific needs of low-income individuals with chronic medical conditions. There are two types of Health Homes that states can implement: Behavioral Health-Health Homes (BHHH) and Primary Care Health Homes (PCHH). New Mexico chose to develop both types and will be bringing up the BHHH in the next year. Individuals with Behavioral Health disorders have a shortened life span than the average person and have great difficulty managing medical conditions. Health Homes are designed to treat the whole person, taking into account the individual's preferences, goals and life situation. A comprehensive treatment plan is developed with the person and family, as appropriate, that includes both behavioral and physical health care as well as social and community resource needs.

There are six new Health Home services that are designed to overcome the obstacles these consumers often face accessing health care and develop the health literacy and skills necessary to improve health status and outcomes. The specific services include: comprehensive care management, care coordination, health promotion, comprehensive transitional care, peer and family support and referrals to community and social support services.

The specific chronic conditions found to be significant in the data for New Mexico include: asthma, chronic obstructive pulmonary disease (COPD), hypertension, hyperlipidemia, heart disease, diabetes and obesity. It is not uncommon to see individuals with more than one of these conditions which can further compromise their health. There is a strong lifestyle component to these chronic conditions that requires sustained attention and motivation by the individual and the health team. The use of motivational enhancement strategies by all members of the Health Home team is a critical piece of the practice transformation of Health Homes. The development of a trusting relationship and bond between the Health Home team members and the individual is seen as the driver of change, necessary to meet the goals of the Health Home: improved health outcomes, stability of the chronic conditions and a life of recovery and good health for the Health Home members.

The other component of the Health Home is the use of health technology and information to track individuals over time, ensure all necessary screenings, tests and services are occurring in a timely manner. There is also information that the Health Homes must report regarding their systems and specific client outcomes. The exchange of vital health information between the Health Home, hospitals and involved providers is designed to increase communication within the health community and allows integration of the individual's medical record.