New Mexico Behavioral Health
Purchasing Collaborative Meeting

Thursday, April 10, 2014

Human Services Department
37 Plaza la Prensa
Santa Fe, NM

Video Conference Sites
Albuquerque
Farmington
Las Cruces
Roswell
Thursday, April 10, 2013  
37 Plaza La Prensa  
Santa Fe, New Mexico  
1:00 p.m. – 4:00 p.m.

AGENDA

1. 1:00 – 1:30 p.m.  Call to Order  
   - Introduction of Collaborative Member/Recognize Remote Sites  
   - Review/Approval of Minutes from February 2014 (decision item)

2. 1:30 – 1:50  Vote on Criteria for Severe Emotional Disturbance  
   Secretary Deines, Children, Youth and Families Department

3. 1:50 – 2:30 p.m.  Healthy Homes, The Lifelink CSA  
   Carol Luna-Anderson, The Lifelink

4. 2:30 – 2:50 p.m.  Behavioral Health Planning Council (BHPC) Report  
   Lisa Trujillo, Chair, Behavioral Health Planning Council

5. 2:50 – 4:00  Public Input

6. 4:00 p.m.  Adjourn
Tab 1
**New Mexico Behavioral Health Collaborative**  
**February 27, 2014 • 1:00–4:00 p.m. • 37 Plaza La Prensa, Santa Fe, New Mexico**

Handouts: Copies of the NM Behavioral Health Purchasing Collaborative Meeting public hand-outs may be obtained from the website [www.bhc.state.nm.us](http://www.bhc.state.nm.us)

<table>
<thead>
<tr>
<th>Topic</th>
<th>Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Video Conferencing Sites</td>
<td>Farmington NM, Las Vegas NM, Las Cruces NM, Roswell NM, Albuquerque NM</td>
</tr>
<tr>
<td>Present were:</td>
<td>Sidonie Squier/HSD, Retta Ward/DOH, Yolanda Deines/CYFD, Aurora Sanchez/NMCD, Richard Blair/DFA, John Block/DDPC, Gino Rinaldi/ALTSD, Annjenette Torres, PED, Patrick Simpson/AOC, Daniel Roper/DVR</td>
</tr>
<tr>
<td>1. Call to Order</td>
<td>The meeting was called to order at 1:09 pm without a quorum present. The Collaborative members introduced themselves.</td>
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<tr>
<td>• Review/Approval of Minutes from February</td>
<td>Handout-DRAFT Meeting Minutes, New Mexico Behavioral Health Collaborative Meeting – August 15 and October 10, 2013</td>
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<tr>
<td>A MOTION was made by Gino Rinaldi and seconded by Yolanda Deines to approve the minutes from the August 15 and October 10, 2013 Behavioral Health Collaborative Meeting.</td>
<td>The MOTION was PASSED unanimously.</td>
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<tr>
<td>2. Crisis Systems of Care I: Community Collaboration of Action: TriCounty Community Services and Holy Cross Hospital</td>
<td>Kim Hamstra, CEO, TCCS reported on the following:</td>
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<tr>
<td></td>
<td>• TCCS provides embedded Licensed Independent Social Worker Monday through Friday; an after-hours crisis team for after hours and weekends; TCCS LISW and CCSS worker serve residents of Penasco twice a month; and 24-hour Assertive Community Treatment team.</td>
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<tr>
<td></td>
<td>• Holy Cross Hospital provides: streamlined Presumptive Eligibility for Medicaid eligible consumers; parenting classes; and advocate for behavioral health integration.</td>
</tr>
<tr>
<td>3. Crisis Systems of Care II: NM Crisis and Access Line Update</td>
<td>Rosemary Strunk reviewed the Crisis and Access Line 2013 Annual Report that included the following:</td>
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<tr>
<td></td>
<td>• Total calls answered Feb 2013-Jan 2014: 6,804</td>
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<td>• Total calls have increased from 198 in February 2013 to 423 in January 2014</td>
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<td></td>
<td>• Other statistics reported from the Annual Report to the Collaborative members included: Level of Care of Clinical Calls; Primary Presenting Problem in Calls; Clinical Disposition of All Counseling Calls; Clinical Disposition of Calls Involving Suicide; County of Residence; Consumer Receiving Behavioral Health Treatment; Consumer's Health Insurance; Consumer's Housing Status; How did the Caller Hear About NMCAL; Consumer's Primary Language; Consumer's Race/Ethnicity; Age of Consumer; Gender of Consumer</td>
</tr>
<tr>
<td>4. Trauma and Severe Emotional</td>
<td>Handout: Severe Emotional Disturbance (SED) Criteria Checklist and handouts</td>
</tr>
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</table>
### Disturbance (SED) Criteria

Yolanda Deines, CYFD Staff (Early Childhood, Protective Services, Juvenile Justice and Children’s Behavioral Health Services Division) and Dr. Bruce Perry from The ChildTrauma Academy briefed the Collaborative members on the following reports:

- CYFD has a number of initiatives aimed at addressing conflict trauma and increasing children’s wellbeing.
- CYFD and Dr. Bruce Perry have developed and are using the Neurosequential Model of Therapeutics Assessment Services Process to identify the specific parts of a child’s brain affected by neglect and abuse.
- SED Criteria Checklist was presented to the Collaborative Members for approval. The Checklist adds “B.” that includes the term “complex trauma.” Complex trauma (language developed with Federal partners SAMHSA, CSAT, CMS, ACF) exposure involves the simultaneous or sequential occurrence of child maltreatment, including psychological maltreatment, neglect, exposure to violence and physical and sexual abuse.
- The addition of “B.” and accompanying language regarding the expansion of the definition of complex trauma will be added to the April 10, 2014 Collaborative Meeting agenda as a decision item.

### 5. Update on Centennial Care Implementation

**No Handout**

Julie Weinberg/MAD and Karen Meador/BHSD

- Centennial Care started as planned on January 1.
- Primary concerns were access to care, providers getting paid and service levels.
- A Command Center (C4) was created to identify issues. Overall, about 305 issues were reported (most involved eligibility) that required follow up.
- Approximately 403,000 people are enrolled in Centennial Care managed care.
- Secretary Squier commented that the roll out of Centennial Care was better than expected.

### 6. Behavioral Health Planning Council (BHPC) Report

**Handout: Behavioral Health Planning Council Report, LC Alliance Report and LC 8 Report**

Lisa Trujillo, Chair, Behavioral Health Planning Council and Susy Ashcroft, LC Alliance, briefed the members of the Collaborative regarding the following:

- Senate Memorial 79
- Centennial Care
- Membership
- Subcommittees
- BH Day/Awards Dinner
- Mapping
- Chris Wendel has resigned as Vice Chair of the Planning Council but will continue to work on the mapping project. Her work has been invaluable and she will be missed.

#### Local Collaborative Alliance Update

Ms. Ashcroft reported the following regarding the LC Alliance:

- The vision and goals of the Local Collaborative Alliance were reviewed.
- A long range goal of the Alliance is to go out to the communities to see what their needs may be.
- Another goal is to get the Native American community to the table.

### 7. Budget Updates

**Handout: none**
8. **Public Input**

   | Secretary Squire indicated that because budgets have not been approved yet by the Governor, there is nothing to report. |

   | Delfy Roach, NM Brain Injury Alliance |

   | - Behavioral management services are being provided in the public schools and Ms. Roach believes that these services should be provided to the families at home and outside of the public school system |

   | Peggy Roberson |

   | - Ms. Roberson reported problems with MCOs and also noted that they are not returning calls. Secretary Squier asked that she send her the information and she will see that the issues are addressed. |

9. **Adjourn**

   | The meeting was adjourned at 4:05. |
Tab 2
**Severe Emotional Disturbance (SED) CRITERIA CHECKLIST**

**SED determination is based on the age of the individual, diagnoses, functional impairment or symptoms, and duration of the disorder. The child/adolescent must meet all of the following criteria:**

1. **Age:**
   - be a person under the age of 18;
   - OR
   - be a person between the ages of 18 and 21, who received services prior to the 18th birthday, was diagnosed with a SED, and demonstrates a continued need for services.

2. **Diagnoses:**
   
   Must meet **A or B.**
   
   **A.** The child/adolescent has an emotional and/or behavioral disability that has been diagnosed by a licensed psychiatrist, licensed psychologist, LISW, LMFT, or LPCC under the classification system in the *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR). Please note: Although some Axis II and other disorders are excluded as primary diagnoses, all Axis II or other disorders should be documented and are likely to affect engagement and treatment planning. In addition, please note the following:

   - Diagnoses that are included are only those providing a primary reason for receiving public system behavioral health services. Diagnoses describing a static deficit are not included, unless a qualifying Axis I disorder is also present;
   - Most diagnoses marked NOS are excluded to ensure prompt and thorough assessment. The reasons for exceptions are noted where they appear.

**Disorders usually first diagnosed in infancy, childhood, or adolescence**

Axis II Disorders; i.e. Mental Retardation, as well as Learning Disorders, Motor Skills Disorder; Communication, and Pervasive Developmental Disorders are excluded. These disorders are primarily either static deficits or disorders for which mental health or substance use treatment is secondary to primary care or specialized non-behavioral health or developmental services.

- Attention-Deficit and Disruptive Behavior Disorders — All included (except NOS Disorder 312.9): 314.00 and 314.01, 314.9, 312.81, 314.82, 314.89, 313.81
- Tic Disorders — All included (except NOS Disorder 307.20): 307.23, 307.22, 307.21
- Elimination Disorders: 787.6, 307.7, 307.6
- Other Disorders of Infancy, Childhood or Adolescence — All included (except NOS Disorder 313.9): 309.21, 313.23, 313.89, 307.3

*continued on next page*
Delirium, Dementia, and Amnestic and Other Cognitive Disorders and Mental Disorders Due to a General Medical Condition Not Elsewhere Classified (All excluded: Older age specific or, if chronic and disabling, treatment to be recommended is not behavioral health treatment or service.)

Substance-Related Disorders
All included (except the following NOS disorders: 291.9, 292.9):
303.90, 305.00, 303.00, 291.81, 291.0, 291.2, 291.1, 291.5, 292.3, 291.89, 304.40, 305.70, 292.89,
292.0, 292.81, 292.11, 292.12, 292.84, 305.90, 304.30, 305.20, 304.20, 205.60, 292.0, 304.50, 305.30,
304.60, 305.90, 305.1, 304.00, 305.50, 304.10, 305.40, 304.80, 304.90

Other Diagnostic Categories

Schizophrenia and Other Psychotic Disorders (295.00 — all subtypes, 295.40, 295.70, 297.1,
298.8, 297.3, 293.81, 293.82, 298.9). Note that 298.9: Psychotic Disorder NOS is included as it indicates the presence of significant and severe symptoms, but precise diagnosis may not occur until further evaluation and treatment commences.

Mood Disorders — All included: 296.0x, 296.2x, 296.3x, 300.4, 311, 296.40, 296.4x, 296.6x,
296.5x, 296.7, 296.89, 301.13, 296.80, 296.90

Anxiety Disorders — All included: 300.0, 300.01, 300.21, 300.22, 300.29, 300.23, 300.3,
309.81, 308.3, 300.02, 293.84

Somatoform Disorders — All included (except NOS Disorders 300.82): 300.11, 300.81,
300.82, 300.80, 300.89, 300.7, 300.82

Factitious Disorders: 300.16 (NOS Disorder 300.19 is excluded)

Dissociative Disorders — All included (except NOS Disorder 300.15): 300.12, 300.13, 200.14,
200.6

Sexual and Gender Identity Disorders — Note that some codes not usually associated with children or adolescents may be indicators of abuse or trauma. Gender Identity codes are excluded and likely to be developmental rather than requiring behavioral health treatment. All other disorders in this category are included (except NOS Disorder 302.70): 302.72, 302.79,
302.73, 302.74, 302.75, 302.76, 306.51, 625.8, 208.89, 607.84, 625.0, 608.89, 625.8, 608.89,
302.4, 302.81, 302.89, 302.2, 302.83, 302.84, 302.3, 302.82, 302.9

Eating Disorders — All included (except NOS Disorder 307.50): 307.1, 307.51

Sleep Disorders in children and adolescents are excluded and if chronic and disabling call for treatment that is not behavioral health treatment. Other primary diagnoses that do qualify for SED should be used if appropriate.

Impulse-Control Disorders not elsewhere classified — All are included (except for NOS Disorder 312.30): 312.34, 312.32, 312.33, 312.31, 312.39

Personality Disorders — All are Axis II and excluded. An Axis I primary diagnosis must be included to qualify for SED. However, Axis II diagnoses should be documented and affect engagement and treatment planning.

continued on next page
B. The term “complex trauma” describes children’s exposure to multiple or prolonged traumatic events, which are often invasive and interpersonal in nature. Complex trauma exposure involves the simultaneous or sequential occurrence of child maltreatment, including psychological maltreatment, neglect, exposure to violence and physical and sexual abuse. [Dear State Director letter, July 11, 2013, from CMS, SAMHSA, ACF.]

In order to qualify as a complex trauma diagnosis the child must have experienced one of the following traumatic events:
- Abandoned or neglected;
- Sexually abused;
- Sexually exploited;
- Physically abused;
- Emotionally abused; or
- Repeated exposure to domestic violence.

In addition to one of the qualifying traumatic events above, there must also be an exparte order issued by the children’s court or the district court which includes a sworn written statement of facts showing probable cause exists to believe that the child is abused or neglected and that custody is necessary.

3. Functional Impairment:

The child/adolescent must have a Functional Impairment in two of the listed capacities:

- **Functioning in self-care:**
  Impairment in self-care is manifested by a person’s consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs.

- **Functioning in community:**
  Inability to maintain safety without assistance; a consistent lack of age-appropriate behavioral controls, decision-making, judgment and value systems which result in potential out-of-home placement.

- **Functioning in social relationships:**
  Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults. Children and adolescents exhibit constrictions in their capacities for shared attention, engagement, initiation of two-way effective communication, and shared social problem solving.

- **Functioning in the family:**
  Impairment in family function is manifested by a pattern of significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents and/or caretakers (e.g., foster parents),
disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable expectations that may result in removal from the family or its equivalent). Child-caregiver and family characteristics do not include developmentally based adaptive patterns that support social-emotional well-being. For early childhood functioning, major impairments undermine the fundamental foundation of healthy functioning exhibited by:

- rarely or minimally seeking comfort in distress
- limited positive affect and excessive levels of irritability, sadness or fear
- disruptions in feeding and sleeping patterns
- failure, even in unfamiliar settings, to check back with adult caregivers after venturing away
- willingness to go off with an unfamiliar adult with minimal or no hesitation
- regression of previously learned skills

**Functioning at school/work:**
Impairment in school/work function is manifested by an inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others); identification by an IEP team as having an Emotional/Behavioral Disability; or inability to be consistently employed at a self-sustaining level (e.g., inability to conform to work schedule, poor relationships with supervisor and other workers, hostile behavior on the job).

4. **Symptoms:**

**Symptoms in one of the following groups:**

- **Psychotic symptoms:**
  Symptoms are characterized by defective or lost contact with reality, often with hallucinations or delusions.

- **Danger to self, others and property as a result of emotional disturbance:**
  The individual is self-destructive, e.g., at risk for suicide, and/or at risk for causing injury to self, other persons, or significant damage to property.

- **Trauma symptoms:**
  Children experiencing or witnessing serious unexpected events that threaten them or others. Children and adolescents who have been exposed to a known single event or series of discrete events experience a disruption in their age-expected range of emotional and social developmental capacities. Such children may experience:
  - a disruption in a number of basic capacities such as a sleep, eating, elimination, attention, impulse control, and mood patterns
  - under-responsivity to sensations and become sensory seeking, physically very active, aggressive and/or antisocial
  - under-responsivity to sensations but not sensory seeking and may shut down further and become lethargic or depressed and difficult to arouse
  - over-responsivity to sensations and become hypervigilant or demonstrate fear and panic from being overwhelmed
  - episodes of recurrent flashbacks or dissociation that present as staring or freezing

5. **Duration:**

- The disability must be expected to persist for six months or longer.
Tab 3
THE LIFE LINK
THE LIFE LINK

• Founded in 1987 as La Luz de Santa Fe Family Shelter

• 501(c)(3) nonprofit status

• Licensed Community Mental Health Center and Core Service Agency.

• HUD-approved Housing Agency

• Funded by a combination of city, state, federal funding, grants, and private donations.
MISSION

The Life Link helps hungry, homeless, and displaced individuals and families achieve self-sufficiency through emergency assistance, housing, employment services, and other supportive programs including advanced addiction and mental health treatment services.
PHILOSOPHY

We Believe...

• that people function best in an environment where they are treated with dignity and respect.
• that people function best in an environment where they are supported, challenged and have the opportunity for self-renewal and growth.
• that people function best in an environment where they are rewarded and recognized for their contributions.
• we have the responsibility for identifying and meeting individual and family needs and expectations. We strive to provide services of consistent high quality that are cost effective and beneficial.
• our ability to meet those needs is directly related to having motivated, dedicated and skilled staff.
PROGRAMS AND SERVICES

- Comprehensive Community Support Services (CCSS)
- Supportive Housing
- Psychosocial Rehabilitation
- Peer Support Services
- Outpatient Clinical Services
- Intensive Outpatient Program
- Psychiatric Services
- Integrated Medical Services
- Supportive Employment
- Sojourners Advocacy Café
- Human Trafficking Aftercare Services
CCSS

- Coordination of housing, finances, entitlements, employment, healthcare, and other community resources to support recovery and independent living.
PEER SUPPORT SERVICES

- Oldest and largest peer support program in New Mexico
- Provide clients access to trained professionals with personal experience with mental illness and addiction issues
- Certified Peer Support Specialists have completed extensive training and provide outreach, CCSS, treatment, and other support services.
- Fully integrated members of the multidisciplinary team.
OUTPATIENT CLINICAL SERVICES

- Commitment to evidence-based practices
- Individual and group therapies
- Trauma-informed and trauma-specific services
- Gender-specific services
- Advanced addiction and co-occurring services, including Suboxone clinic
- Integrated psychiatric services and primary care clinic
SUPPORTIVE HOUSING

• Stable permanent housing is essential for people to become integral members of the community

• The Life Link oversees 6 different permanent supportive housing programs
  • La Luz provides 24 permanent supportive housing units for severely mentally ill clients
  • 135 permanent housing vouchers for individuals and families
  • Provides rental assistance to an average of 20 transitional housing households per month
PSYCHOSOCIAL REHABILITATION

• Supported Employment
• Competitive employment placement
• Psychoeducation about mental illness
• Life Skills training (e.g. stress management, budgeting, computer lab, GED classes)
• Santa Fe Clubhouse
HUMAN TRAFFICKING
AFTERCARE

• Long-term, comprehensive services for victims of human sex trafficking

• Partnership with cities of Albuquerque and Santa Fe, local and State law enforcement, FBI, ICE, NMAG

• Complex clinical profile involving severe prolonged trauma exposure, serious mental illness, substance addiction.

• 505-GET-FREE hotline/textline

• National profile, serving victims from 7 different states
SUCCESSFUL LIVING INITIATIVE

• Final year of a 5-year SAMHSA grant designed to provide intensive services to co-occurring and traumatized homeless individuals

• Human Trafficking victims have all received services under SLI.

• Significant findings have included:
  • Decrease in serious psychological distress
  • Decrease in binge drinking
  • Decrease in homelessness/increase in stable living environment
  • Decreased incarcerations
  • Increase in education/employment
  • Increased social connectedness
  • Increased overall functioning in everyday life
HEALTHY HOMES

• Fourth year of a 5-year SAMHSA grant for providing Permanent Supportive Housing to adults with SMI and COD
• Primary intervention is CCSS provided by Certified Peer Support Specialists.
• Has thus far enrolled 170 clients, predominantly from Hispanic and Native American populations
• 74% of the active clients are in permanent housing.
• Client-specific outcomes have included
  • Increased housing stability
  • Increased ability to manage crises
  • Improved relationships with family
  • Increased social connectedness
  • Increased overall quality of life
NEXT OPPORTUNITY

• Applying for SAMHSA supported employment grant

• “What Works!: New Mexico Supported Employment” is a partnership between HSD/BHSD, The Life Link, and Mental Health Resources
  • The Life Link will provide services in Santa Fe and Rio Arriba Counties
  • Mental Health Resources will provide services in Curry and Roosevelt Counties
SAMHSA’S Mental Health Transformation Grant Profile: 
Healthy Homes: 
The Peer Experts Supportive Housing Program 
New Mexico Human Services Department 
The Life Link (Direct Services) 
University of New Mexico Center for Rural and Behavioral Health (Evaluation) 

Mission: 
to expand and enhance New Mexico’s behavioral health system to provide evidence-based Permanent Supportive Housing to adults with serious mental illness and co-occurring disorders who are homeless or at risk of homelessness

Primary Focus: 
Supportive Housing & Comprehensive Community Support Services provided by Certified Peer Support Specialists

Peer Involvement 
86% of all Advisory Groups are Peers or Family Members

Employ Certified Peer Support Specialists and Peer Site Evaluators

Program Impact: Direct Services & Infrastructure Development
79 organizations and communities have implemented supportive housing EBPs

Key Collaboration: with State Housing Finance Authority to amend LIHTC Qualified Allocation Plan to incentivize rental subsidies for supportive housing units

Cumulative Enrollment
<table>
<thead>
<tr>
<th>Year</th>
<th>Enrollment</th>
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<tbody>
<tr>
<td>Year 1</td>
<td>54</td>
</tr>
<tr>
<td>Year 2</td>
<td>162</td>
</tr>
<tr>
<td>Year 3</td>
<td>191</td>
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</table>

new supportive housing units built from 2011-2013

66% of formerly homeless active clients are housed

client impact from baseline to 6-month follow-up
increased ability to deal with crisis
improved relationships with family
increased housing stability
increased social connectedness
increased overall quality of life

*San Juan County active for years 1 & 2 only

SAMHSA’s GAINS Center March 2014
Tab 4
MEMBERSHIP

We have a new Chair of our Medicaid Subcommittee, Alicia Bernal. We are glad of the appointment from HSD, and for Kim Carter’s help getting her up-to-speed on her important role in the Council’s functions.

Gail Falconer has been elected as our Interim Vice Chair. We will have elections for the positions of Chair and Vice-Chair at our June 18th meeting. Gail has vacated the position of Co-Chair of the Children and Adolescents Subcommittee, which has left us with only one person who can, by dint of membership on the Council and on the subcommittee, be co-chair.

We are aware of several applications either completed or due for completion soon, at the Governor’s office. We are still out of compliance with federal and state statute and need to have new members that are consumers, family members, and advocates to bring us into compliance. We now need a minimum of four appointees to put us back into compliance. There is concern voiced within the council about whether we can fairly represent the varied populations in the state that we are accustomed to hearing from, rural and urban, Native and non-Native, Hispanic and non-Hispanic, and across the age continuum.

ROLE OF THE COUNCIL

For several reasons, we have found ourselves discussing the role of the Council. We have found ourselves visiting the law that created the Council, and our Bylaws and Policies and Procedures during these discussions. To that end, we will be visiting the two of the above-mentioned documents that are in our purview to change, and are hoping to arrange a training for our members on our role, including our Block Grant work and an effort to be more data-informed. The training would be on June 19th, if we find that our finances allow us.

MARCH COUNCIL MEETING

Much of what happened at this meeting is discussed elsewhere, but we wanted you to know about a presentation we had by Everette Hill, on the continuing Community Conversations that are going on in Albuquerque. They are successfully bringing the advice of community members to their city government on the topic of behavioral health.

CENTENNIAL CARE

We continue to have updates on the implementation of Centennial Care. Two of our subcommittees have plans to discuss scenarios with representatives from our Centennial Care MCO’s to help us gain an understanding of Care Coordination in our behavioral
health system. So far we don’t have a lot of information and there is a lot of concern over how it will work with our CSA’s who are the agencies most involved, by definition, with the consumers with the most complex needs.

SUBCOMMITTEES

Adult, Substance Abuse, and Medicaid – Much of what these committees have been doing has been discussed already, as it has focused primarily on Centennial Care and the changes it brings. There was a review of legislative results, including budget impacts. We had a presentation on an Employment Supports grant that is currently being pursued.

Children and Adolescent – There is a complete report from this subcommittee attached which I recommend that you read. It explains all the work being done, focused on the handful “standing items of interest and partnership”: Infant Mental Health, Transition Age Youth 18-24, Detention Centers for Youth, To support Communities of Care, Children’s Cabinet: support and advise, MH First Aid.

The Native American Subcommittee – This subcommittee continues to be well informed on Centennial Care implementation efforts in the Native world. There has been good representation there from the four MCO’s. Of interest is the possibility that this year’s Tribal Leadership Summit may have a focus on Behavioral Health issues.

MAPPING – Work continues on this with the Aging and Long Term Services folks and a refocusing of effort on collecting information.

ATTACHMENTS:

CHILDREN AND ADOLESCENT SUBCOMMITTEE REPORT
BUDGET VARIANCE (March 31, 2014)
## BEHAVIORAL HEALTH PLANNING COUNCIL

### Budget Variance YTD

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<th>Category</th>
<th>Frequency</th>
<th>Line Item</th>
<th>Budget</th>
<th>Current Month</th>
<th>Previous Months</th>
<th>TOTAL</th>
<th>BALANCE</th>
<th>% Utilized</th>
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<td>Council Meetings</td>
<td>4 per year</td>
<td>Stipends</td>
<td>$5,000.00</td>
<td>$570.00</td>
<td>$1,425.00</td>
<td>$1,995.00</td>
<td>$3,005.00</td>
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<td>Mileage</td>
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<td>Food</td>
<td>$3,000.00</td>
<td>$0.00</td>
<td>$1,430.76</td>
<td>$1,430.76</td>
<td>$1,569.24</td>
<td>48%</td>
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<td>Per Diem</td>
<td>$1,000.00</td>
<td>$170.00</td>
<td>$522.92</td>
<td>$692.92</td>
<td>$307.08</td>
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<td>Statutory Sub-Com</td>
<td>5 Committees</td>
<td>Stipends $15/hr</td>
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<tr>
<td></td>
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<td>Adult/SA/Medicaid</td>
<td>$9,500.00</td>
<td>$690.00</td>
<td>$5,265.00</td>
<td>$5,955.00</td>
<td>$3,545.00</td>
<td>63%</td>
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<tr>
<td></td>
<td></td>
<td>Children</td>
<td>$3,500.00</td>
<td>$300.00</td>
<td>$1,397.50</td>
<td>$1,697.50</td>
<td>$1,802.50</td>
<td>49%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Native American</td>
<td>$3,500.00</td>
<td>$225.00</td>
<td>$1,935.00</td>
<td>$2,160.00</td>
<td>$1,340.00</td>
<td>62%</td>
</tr>
<tr>
<td>Mileage</td>
<td></td>
<td>All Subcommittees</td>
<td>$500.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$500.00</td>
<td>0%</td>
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<tr>
<td></td>
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<td>Food Subcommittees</td>
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<td>$281.93</td>
<td>$281.93</td>
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<td>Ad Hoc Committees</td>
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<td>Block Grants</td>
<td>stipend / mileage</td>
<td>$12,500.00</td>
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<td>$377.60</td>
<td>$377.60</td>
<td>$12,122.40</td>
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<td></td>
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<td>Others</td>
<td></td>
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<tr>
<td>Behavioral Health Day</td>
<td>Annually</td>
<td>All costs</td>
<td>$5,700.00</td>
<td></td>
<td>$4,258.64</td>
<td>$4,258.64</td>
<td>$1,441.36</td>
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<td>Misc. Operational</td>
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<td>All costs</td>
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<td>$625.74</td>
<td>$625.74</td>
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<td><strong>Total Operations</strong></td>
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<td></td>
<td>$53,500.00</td>
<td>$2,516.20</td>
<td>$20,045.55</td>
<td>$22,561.75</td>
<td>$30,938.25</td>
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<table>
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<th>Revenue</th>
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<th>Fiscal Agent</th>
<th>Operations</th>
<th>Total</th>
<th>Expended</th>
<th>% Utilized</th>
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<td>Contracts Funds BHSD July 13-June 14</td>
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<td>$3,100.00</td>
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<td>Optum Health FY 10,11,12, 13</td>
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<td>Optum Health FY 14 6-months</td>
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<tr>
<td></td>
<td>$56,600.00</td>
<td>$3,100.00</td>
<td>$53,500.00</td>
<td>$56,600.00</td>
<td>$25,876.75</td>
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Greetings Behavioral Health Purchasing Collaborative Members. It is a pleasure to provide all of you an update report on the current activities of the Children and Adolescent Subcommittee. Since the last report the subcommittee has continued our focus on our priority areas. Please see updates in each area.

PRIORITY AREAS:
- Substance abuse services, Statewide for youth-identify gaps/prevention and treatment effective advance based services. What kinds of services are available?
  **Update:** We will have in the month of April 2014, a guest presenter Micheal Hock M.A. Staff Manager with CYFD to present the current work being done by Justice and Mental Health Collaboration Program. This group is focused on supporting youth who have co-occurring mental health and substance abuse challenges.
- Schools Roles and Regulations, School Based Health Centers
  **Update:** Continuous discussion on how to best address this area. Any suggestion are welcome. Our goal is to engage schools in our group and have continuous collaboration with this system.
  - Look at legislative interim subcommittee-What are our legislators considering regarding our children?
  **Update:** We have spent time informing the group of legislature priorities of CYFD and the priorities of Members of the CASC. We will continue to meet with Valerie Palombi, who is a member of the CYFD Task force whose goal is to review and revise the Children’s Law Code for 2015. We will work with her to learn the current code and advice to the Task Force of recommendations moving forward.

Standing Items of Interest and Partnership
- Infant Mental Health
- Transition Age Youth 18-24
- Detention Centers for Youth
- To support Communities of Care
- Children’s Cabinet: support and advise
- MH First Aid

Moving Forward:
1. **Youth Engagement Plan:** Adhoc Transitional Youth Subcommittee of the Children’s and Adolescent Subcommittee. Led by Gail Falconer and also At Large member Joe Harris, has had its first official meeting March 25th. Gail and Joe will continue to meet with youth at Families ASAP, a non-profit organization that provide Parent Peer Support. A special thanks to Families ASAP for their support.
2. We were pleased to have Amber Parker, Director of the Juvenile Citation Program out of Las Cruces NM. She presented the great work they are doing with youth who are at risk of entering the juvenile justice system, keeping youth out of the facility and in their home, in their communities by providing an alternative to detention program and referring out to local providers to address the underlining needs of the youth and their family. The CASC has voted to write a Letter of Support and submit that to the Planning Council, and the Purchasing Collaborative. It is our goal that members of the Collaborative will be presented the information as a best practice of what a successful diversion program can do for youth and their families.

Thank you for taking the time to read this update, if you or someone you know is interested in participating in the CASC please contact me at Erica.Padilla@state.nm.us (505) 827-3991.