I: State Information

State Information

<table>
<thead>
<tr>
<th>Plan Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start Year: 2014</td>
</tr>
<tr>
<td>End Year: 2015</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>State SAPT DUNS Number</th>
</tr>
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<tbody>
<tr>
<td>Number: 837710722</td>
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</table>

<table>
<thead>
<tr>
<th>I. State Agency to be the SAPT Grantee for the Block Grant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency Name: New Mexico Human Services Department</td>
</tr>
<tr>
<td>Organizational Unit: Office of the Secretary</td>
</tr>
<tr>
<td>Mailing Address: PO Box 2348</td>
</tr>
<tr>
<td>City: Santa Fe, NM</td>
</tr>
<tr>
<td>Zip Code: 87504</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II. Contact Person for the SAPT Grantee of the Block Grant</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name: Donna</td>
</tr>
<tr>
<td>Last Name: Sandoval</td>
</tr>
<tr>
<td>Agency Name: New Mexico Human Services Department</td>
</tr>
<tr>
<td>Mailing Address: 729 St. Michael's Drive, San Miguel Plaza</td>
</tr>
<tr>
<td>City: Santa Fe</td>
</tr>
<tr>
<td>Zip Code: 87505</td>
</tr>
<tr>
<td>Telephone: 505-827-7057</td>
</tr>
<tr>
<td>Fax: 505-827-7181</td>
</tr>
<tr>
<td>Email Address: <a href="mailto:Donna.Sandoval@state.nm.us">Donna.Sandoval@state.nm.us</a></td>
</tr>
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I. State Information

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Plan Year
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End Year: 2015

State SAPT DUNS Number
Number: 837710722
Expiration Date

I. State Agency to be the SAPT Grantee for the Block Grant
Agency Name: New Mexico Human Services Department
Organizational Unit: Office of the Secretary
Mailing Address: PO Box 2348
City: Santa Fe, NM
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II. Contact Person for the SAPT Grantee of the Block Grant
First Name: Donna
Last Name: Sandoval
Agency Name: New Mexico Human Services Department
Mailing Address: 729 St. Michael's Drive, San Miguel Plaza
City: Santa Fe
Zip Code: 87505
Telephone: 505-827-7057
Fax: 505-827-7181
Email Address: Donna.Sandoval@state.nm.us

State CMHS DUNS Number
Number: 837710722
Expiration Date

New Mexico
II. Contact Person for the CMHS Grantee of the Block Grant

First Name
Donna

Last Name
Sandoval

Agency Name
New Mexico Human Services Department

Mailing Address
729 St. Michael's Drive, San Miguel Plaza

City
Santa Fe

Zip Code
87505

Telephone
505-827-7057

Fax
505-827-7181

Email Address
Donna.Sandoval@state.nm.us

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name
Leticia

Last Name
Rutledge

Telephone
505-476-9286

Fax
505-476-9272

Email Address
leticia.rutledge@state.nm.us

Footnotes:
August 7, 2013

Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville, Maryland 20857

Dear Ms. Simmons:

As the designee for the State of New Mexico with signatory authority on the Combined Community Mental Health and Substance Abuse Prevention and Treatment Block Grant assurances and certifications, I hereby delegate Diana McWilliams, Chief Executive Officer of the Behavioral Health Purchasing Collaborative and Director of the Behavioral Health Services Division, as the Single State Authority (SSA Director) for New Mexico.

Ms. McWilliams is to be the primary recipient of day to day communications regarding the Block Grant programs, including Synar requirements. All award letters and other communications regarding the Combined Block Grant and Synar are to be sent directly to her. Contact information is:

Diana McWilliams
PO Box 2348
Santa Fe, New Mexico 87504-2438
Tel: 505 476-9295
Fax: 505 476-9272

Please contact my office at 505 827-7750 or Ms. McWilliams directly at 505 476-9295 if additional information is required.

Sincerely,

Sidonie Squier
Cabinet Secretary
Human Services Department
State of New Mexico

Susana Martinez
Governor

November 27, 2012

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland 20857

Dear Ms. Simmons,

I hereby delegate authority to Sidonie Squier, cabinet secretary for the New Mexico Human Services Department, to sign funding agreements and certifications; provide assurances of compliance to the Secretary of the U.S. Department of Health and Human Services; and to perform similar acts relevant to the administration of the Mental Health Block Grant (MHBG) as long as I am governor, unless modified by my office, or until such a time as this delegation of authority is rescinded.

Please contact Secretary Squier at (505) 827-7750 if additional information is required.

Sincerely,

Susana Martinez
Governor
I: State Information

Assurance - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM’s Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.


10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).


14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

__________________________
Name: Sidonie Squier

__________________________
Title: Cabinet Secretary

__________________________
Organization: Human Services Department

__________________________
Date: ________________________

**Footnotes:**
I: State Information

Assurance - Non-Construction Programs

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<td>Human Services Department</td>
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Signature: Sidonie Squier Date: 2/11/13

Footnotes:
I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled “Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions” in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

- Office of Grants and Acquisition Management
- Office of Grants Management
- Office of the Assistant Secretary for Management and Budget

New Mexico  OMB No. 0930-0168  Approved: 05/21/2013  Expires: 05/31/2016
3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-proprietary) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member in Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member in Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, “Disclosure of Lobbying Activities,” in accordance with its instructions. (If needed, Standard Form-LLL, “Disclosure of Lobbying Activities,” its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children’s services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

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b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

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   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will:
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted:
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (d), (f), and (g).

For purposes of paragraph (g) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name: Sidonie Squier
Title: Cabinet Secretary
Organization: Human Services Department

Signature: ___________________________ Date: 2/12/13

Footnotes:
## I: State Information

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Name of Chief Executive Officer (CEO) or Designee: Sidonie Squier
Title: Cabinet Secretary

Signature of CEO or Designee: ____________________________ Date: ______________

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Signature of CEO or Designee: [Signature] Date: [Date]

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Name of Chief Executive Officer (CEO) or Designee: Sidonie Squier
Title: Cabinet Secretary

Signature of CEO or Designee: [Signature] Date: 8/4/13

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Footnotes:
## Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

**Standard Form LLL (click here)**

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Signature: __________________________ Date: __________________

**Footnotes:**
II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities.

Footnotes:
A. Framework for Planning – Mental Health and Substance Abuse Prevention and Treatment

Step One: Planning Steps

For each of the populations and common areas, states should follow the planning steps outlined below:

*Step 1: Assess the strengths and needs of the service system to address the specific populations.* (p 46, Block Grant Application)

**Introduction:**

**Overview of New Mexico’s Behavioral Health System**

New Mexico has a multi-level framework for planning and oversight of behavioral health services to meet the needs of the state. This framework includes an overarching state agency collaborative, MCO to managed services as the Statewide Entity, state administrative staffing in the BH Services Division, 42 local Core Service Agencies, the State BH Planning Council, and 16 active Local Collaboratives to provide local community perspectives.

**New Mexico Behavioral Health Collaborative**

**Organization**

**State-Level Coordination and Planning**

The New Mexico Interagency Behavioral Health Purchasing Collaborative (Collaborative) brings together 17 state agency directors and Cabinet Secretaries to facilitate interagency efforts and oversee the state behavioral health system from various perspectives. The agencies span many areas of government, including: Medicaid, Veterans Affairs, Indian Affairs, Rehabilitation, Education,
Developmental Disabilities and others. See Section V. Support of State Partners for full listing of members.

The Behavioral Health Services Division of the Department of Human Services (BHSD) provides the staff support to the Collaborative and manages grant-funded direct contracts with providers. Diana McWilliams is the State Mental Health Authority and also functions as the Chief Executive Officer of the Collaborative and the Executive Director of the Behavioral Health Systems Bureau. The Collaborative contracts with a Statewide Entity which is a managed care company that manages services through a network of 42 Core Service Agencies and other providers.

The BHSD, as the SSA and SMHA, works closely with the Statewide Entity and the Department of Children, Families and Youth in planning and delivering behavioral health services for children and youth in all New Mexico communities. BHSD and the SE work closely with the Department of Corrections in planning and delivering services to individuals with behavioral health conditions who are returning to the community after prison. BHSD supports the efforts of local drug courts and veteran’s courts. BHSD supports specialized local programs for tribal members including drug courts and detox centers.

The governor-appointed Behavioral Health Planning Council provides state-level planning and provider and consumer perspective in the planning process. The vision of the Behavioral Health Planning Council is “to be a potent voice for children, adults and families and providers that serve them in New Mexico’s consumer-centered, recovery and resiliency-focused, coordinated, and quality behavioral health care system.” To fulfill that vision, the Council works to ensure that it provides a good representation of the state’s multiculturalism, as well as having strong consumer and family member voices. Currently, the Council mirrors the demographic components of the state as a whole.

The Council has strong presence on various State Legislative Task Force Workgroups:

- Senate Memorial 18: To continue the work of the Drug Policy Task Force begun during the last Legislative Session, in order to complete the task force’s comprehensive statewide strategic plan based on the four pillar approach—prevention, treatment, harm reduction, and enforcement.
- House Memorial 77: To provide recommendations for rules and enforcement protocols to address the increasing rate of addiction to and deaths due to accidental overdose of prescription drugs.
- Senate Memorial 56: To develop a comprehensive statewide plan for treatment of adolescent Opioid addiction.

In May 2012, the BH Planning Council was invited by SAMHSA to be part of an effort to build state coalitions and educate mental health and substance use stakeholders on health reform implementation. The Council is the state’s Coalition Coordinating Center (CCC) which means it will work to strengthen New Mexico’s Coalition, participate in educational webinars, work to develop educational materials,
work with their technical coach, participate in an in-person coaching visit and participate in state CCC meetings.

In December 2012, New Mexico began the planning for Centennial Care, a Medicaid 1115 waiver to manage physical health, behavioral health and long term care services in one integrated managed care system. CMS approved the waiver in July 2013 and four MCOs have been selected to implement the integrated system. The BH Collaborative is a co-signer on the contracts with the MCOs. BHSD staff was very involved in the development of the model and the procurement process. BHSD staff is currently working with Medicaid staff on readiness reviews and member outreach. Centennial Care is expected to be fully in place by January 1, 2014.

The Centennial Care vision is to build a service delivery system that delivers the right amount of care at the right time in the right setting. The goal is to educate recipients to become more savvy health care consumers, promote more integrated care, properly case manage the most at-risk members, involve members in their own wellness and pay providers for outcomes, rather than process. New Mexico believes that the up-front investment in “seeding” medical and health homes and investing in health literacy will return a healthier population and a reduction in the spiraling rate of growth.

In Spring 2013, Governor Suzanna Martinez announced that New Mexico would be participating in the Medicaid Expansion. The BH Planning Council and BHSD staff have been active in planning for the Expansion and the enrollment of Newly Eligible individuals.

Accomplishments of the Collaborative and BH Planning Council include:

1. The Collaborative adopted a Strategic Substance Abuse Plan to address the state’s high rate of substance abuse and the unmet needs for substance abuse services. The Strategic Substance Abuse Plan includes goals to expand the number of programs providing local access to Intensive Outpatient Programs for adults and youth with substance abuse disorders.
2. The BH Planning Council through its Adult and Substance Abuse Subcommittee initiated a project to work with the Local Collaboratives (LC’s) to produce a mapping of services, programs and support activities. This “map” will include services funded not only by State Agencies but also recovery programs, consumer operated services, faith-based programs, volunteer support groups, City/County funded programs, etc.
3. The Children and Adolescent Subcommittee of the Council has made extensive outreach and inclusion of youth voice and concerns at its meetings.

**Local-Level Planning and Service Delivery**

New Mexico has designated 42 Core Service Agencies to provide basic mental health and substance abuse services in all areas of the state. Core Service Agencies coordinate care and provide essential services to children, youth and adults who have serious mental illness, severe emotional disturbance, or dependence of alcohol or drugs.
New Mexico has designated 18 CSAs for services to Adults and 18 for services to Children and Youth. Four CSAs serve both populations. Sixteen regional Local Collaboratives bring the local perspective on needs and resources of local communities. Local Collaboratives include consumers, providers, family members and other interested people. The Local Collaborative members are voting members on the BH Planning Council subcommittees and advocate and advise on local needs and resources and provide a conduit for communications between the state-level planning and local efforts.

The Statewide Entity uses six regional offices across the state to provide oversight and technical assistance to ensure that quality behavioral health services are provided at regional, county and/or local levels of care. Technical assistance includes overseeing of payment of claims, training providers, and meeting with local collaboratives, consumers, family members, and other community stakeholders.

Over the past two years, New Mexico has met the needs of adults and children with behavioral health needs in their local communities through: Core Service Agencies (CSAs) and other recovery based treatment centers; consumer wellness centers in three frontier parts of the state; special programs for veterans and their families; increased resources for Native American youth in communities where suicide numbers are high; and outreach for pregnant women with substance use and/or mental disorder and who are caring for dependent children. This application reports how New Mexico is serving the needs of the target populations identified by the Community Mental Health Services (CMHS) and the Substance Abuse Prevention and Treatment (SAPT) block grant requirements.

Addressing the needs of racial, ethnic and sexual gender minorities as well as underserved youth

Cultural Competency
The Collaborative has worked closely with the State Entity, OptumHealth New Mexico (OHNM), to ensure that cultural and linguistic competencies are always incorporated into its joint endeavors. In 2012, OHNM expanded its scope to include serving the NM Systems of Care (SOC) Grant which is administered under the Children, Youth and Families Department – a member of the Collaborative.

A self-assessment tool has been developed intended to measure cultural and linguistic competency among Core Service Agencies (CSAs). The Consortium for Behavioral Health training and Research (CBHTR) implemented and analyzed the survey during the first quarter of 2013. The data will be used to develop training and technical assistance services for the CSA network to develop policies and to implement culturally and linguistically appropriate service delivery best-practices.

Multicultural Advisory Committees

The State Entity has established a number of advisory committees to ensure that planning for behavioral health services addresses the needs of racial, ethnic and sexual gender minorities. The individual advisory committees work with the Multicultural Services Advisory Committee to ensure consistency and communication between the more specialized advisory committees.
The Multicultural Services Advisory Committee (MSAC) identifies training needs, educational materials and consultation services relevant to the needs of diverse populations in New Mexico. Diversity includes, but is not limited to, ethnicity; race; sexual orientation; gender; age; socio/economic status; primary language; English proficiency; spirituality/religion; country of origin; literacy level, employment status; geographic location; disability/physical limitations; immigration status; and criminal involvement. Accomplishments in 2012 included:

1. Established governance of the System of Care (SOC) grant regarding cultural and linguistic matters.
2. Developed and implemented the annual Cultural and Linguistic Appropriate Services self-assessment.
3. Developed and implemented the SOC self-assessment for Core Service Agencies.
4. Revised the Treatment Record Review From to include cultural and linguistic measures.

The Tribal Advisory Committee (TAC) to address the explicit needs of the Native American communities in New Mexico. Specifically, the purpose of the TAC is to assist in supporting the use of resources to and reimbursement strategies for traditional healers, cultural practitioners and traditional health approaches in New Mexico. The TAC assists the MSAC by advancing the goals of cultural competency, sensitivity inclusion, and the relevancy for Native American tribes and pueblos. The committee identifies training needs, educational materials and consultation services relevant to the needs of Native communities. Accomplishments in 2012 included:

1. Provided oversight and technical assistance for nine suicide and substance abuse prevention programs for Native Americans.
2. Expanded treatment services into Native American communities utilizing memorandum fo agreements between Native American Nations and Core Service Agencies.
3. Provided training to Statewide Entity (OHNM) staff on working with tribal governments.
4. Produced a white paper on traditional healing modalities.

The Hispanic Advisory Committee (HAC) assists in supporting the use of resources and access to traditional healers, promotoras, cultural practitioners and traditional health approaches in New Mexico. The HAC works closely with the MSAC to advance the goals of cultural competency, sensitivity, inclusion and relevancy for Hispanic populations. The HAC identifies training needs, educational materials and consultation services relevant to the needs of Hispanic communities in the state. Accomplishments in 2012 included:

1. Provided a 32 hour Spanish/English interactive interpreters’ course
2. Established an in-service training opportunity on the CLAS standards and the Joint Commission on language access.

The Lesbian, Gay, Bi-sexual, Transgender Advisory Committee (LGBTAC) also assists the MSAC to advance the goals of cultural competency, sensitivity, inclusion and relevancy for this diverse New
Mexico population. The committee identifies training needs, educational materials and consultation services relevant to the needs of the LGBT communities within New Mexico. Accomplishments in 2012 included:

1. Advised a research project studied by the Behavioral Research Center of the Southwest. The research project will generate a comprehensive curriculum and training protocol to train lesbian, gay, bisexual and transgender peer specialists on providing peer support, advocacy and referral services for consumers of mental health services.

The Disability Advisory Council (DAC) addresses the needs of people with disabilities. The DAC assists the MSAC to advance the goals of cultural competency, sensitivity, inclusion and relevancy for person with physical disabilities. The committee identifies training needs, educational materials and consultation services relevant to the needs of persons with disabilities/exceptionalities including but not limited to persons form the deaf community; persons with visual impairments; and persons with a dual diagnosis of DD/MI (Developmental Disability/Mental Illness). Accomplishments in 2012 included:

1. Wrote a grant for $10,000 to implement an interpretation program in rural and frontier areas using Telehealth technology to connect deaf consumers in therapy with interpreters via a video process. If funded, a pilot project will be set up in Las Cruces, NM, that will train in sign language as well as Spanish and English interpretation, and will collect satisfaction information from participating providers and clients. Provider data will include promptness of service, quality of interaction, communication access and number of clients served. Interviews with clients will determine if their behavioral health needs were met through Video Relay Interpreting (VRI) services.
II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:
A. Framework for Planning – Mental Health and Substance Abuse Prevention and Treatment

Planning Steps 2 and 3

*Step 2: Identify the unmet service needs and critical gaps within the current system (p 46 of BG Application)* This step should identify the data sources used to identify the needs and gaps of the population relevant to each block grant within the behavioral health care system, especially for those populations described in this document and other populations identified by the state as a priority.

Unmet Needs and Critical Gaps

**The New Mexico State Epidemiological Outcomes Workgroup (SEOW)** is facilitated by the Behavioral Health Services Division. The workgroup is comprised of prevention experts, clinical staff, data quality supervisors, epidemiologists, evaluators, and community providers from: Behavioral Health Services Division, Public Education Department, Children, Youth and Families Department, and Department of Health.

The vision of the NM SEOW is that data and products produced by the SEOW will be utilized to expand data-driven decision making and collaboration that support community level outcomes related to behavioral health. The SEOW provides strategic guidance to the state and communities on using assessment and epidemiological data to support effective data driven decision making and planning for meaningful outcomes. In addition, the workgroup supports a broad, public prioritization processes based on: severity, burden, trends, preventability, changeability, capacity, resources, need, readiness, political will and public concern. The SEOW collects and reports on substance use and mental health indicators and through the Epidemiology and Response Division of the Department of Health which publishes the annual Substance Abuse Epidemiology Profile.

**Consequences of Substance Abuse in New Mexico**

Persons with, or at risk of, having a substance abuse are a focus population for the SAPT Block Grant. New Mexico monitors detailed information on the incidence of substance use and mental illness and their consequences in our State. The state has conducted a number of specific studies that examine unmet needs in special populations over the past year. The state also uses special data reports from SAMHSA including the State Estimates of Substance Use and Mental Disorders from the National Surveys on Drug Use and Health (NSDUH).

The SOEW grant partially funds the annual publication of the New Mexico Substance Abuse Epidemiology Profile. This Profile is a broad compilation of indicators examining substance use and mental illness and their consequences. The Profile has a special focus on data monitoring the special populations that are the priority focus of the SAPT and CMHS Block Grants. The June 2013 publication provides a current picture of the incidence of substance use and mental illness in New Mexico as well as the unmet needs and critical gaps in the current behavioral health service delivery system. It is particularly useful to the NM Behavioral Health Purchasing Collaborative (Collaborative), the BHSD and the Behavioral Health Planning Council in planning to address the
unmet needs in special service populations. As a result of recent data on unmet needs the Collaborative adopted its Strategic Plan for Substance Abuse in 2012. A description of New Mexico’s analysis of unmet needs and gaps in service, and our Planning for the Future is found at the end of this section.

**Alcohol-related Deaths**

Over the past 30 years, New Mexico has consistently had among the highest alcohol-related death rates in the nation. It has had the highest-alcohol related death rate since 1997. The negative consequences of excessive alcohol use are not limited to accidental death, but also include domestic violence, crime, poverty and unemployment. Chronic liver disease, motor vehicle crash and other injuries, mental illness and a variety of medical problems are also associated with chronic alcohol abuse.

New Mexico’s death rate from alcohol-related chronic disease has consistently lead the nation, at 1.5 to 2 times the national rate, according to the most recent New Mexico Substance Abuse Epidemiology Profile (March 2013). While the nation’s alcohol-related death rate decreased 11% from 1990 to 2009, New Mexico’s rate remained high and unchanged.

**Drug-related Deaths**

New Mexico has the highest drug-induced death rate in the nation. Drug-induced death rates are higher for males than females, with Hispanic males having the highest rates. New Mexico’s urban center, Bernalillo County continues to bear the highest burden in number of deaths. Unintentional overdoses account for more than 80% of deaths. Prescription opioids are the most common drug involved in accidental death at 50%. Heroin was involved in about 33% of accidental overdose deaths with other drugs involved in lesser but significant portions of deaths (tranquilizers and muscle relaxants - 27%, cocaine - 25% and antidepressants -16%). The median age of these unintentional overdose deaths was 43.7 years.

To address the high rate of prescription drug overdose deaths in New Mexico, the State has instituted a Prescription Drug Surveillance Program through the combined efforts of the State Board of Pharmacy and the State Licensing Boards for Physicians, Dentists, Nurses and Psychologists. This effort collects and monitors detailed information about prescriptions for opiates and other target drugs and intervenes with prescribers, pharmacists and patients, as appropriate, when problem practices are identified.

**Substance Use Measures**

The NM State Epidemiological Outcome Workgroup (SEOW) monitors outcome measures found in the New Mexico's Indicator-Based Information System for Public Health (NM-IBIS). Outcome measures include the following:
Mental Health Disorders in New Mexico

Suicide remains a problem throughout New Mexico. In 2010, suicide was the second leading cause of death in New Mexico for youth aged 15-44, and the seventh leading cause of death overall. The rate of suicide in New Mexico has been 1.5 to 1.9 times the US rate for the past 30 years. New Mexico has ranked among the top 5 states in the Nation for all but one of those years. Fifteen counties had suicide rates that were twice the national average in 2007-2011. Male suicide rates were three times higher than the rates for females. Native American males have a higher rate of suicide from ages 15-44 while white males have higher rates at older ages. The vast majority of suicides in New Mexico occur before age 65.

While suicide is the second leading cause of death in youth 15-24, the rate tracks the national rates at 8.6%. The number of New Mexico high school students who reported that they “Had seriously considered suicide” has dropped from 20.7% in 2003 to 16.7% in 2011. Girls had a higher rate (20.8%) than boys (12.8%). The rate of suicide attempts by youth varies from 20.2% to 4.5% among New Mexico counties.

The rates for New Mexicans who reported having “Any Mental Illness Past Year” as well as those reporting “Serious Mental Illness in the Past Year” are higher than the national average. In New Mexico, depression is more common among young adults ages 18-24 years (11.4%) (NSDUH). Native American females (16.6%) and Hispanic females (11.1%) report more depression than White females (7.8%). Similarly, higher rates of depression are reported in Native American adults (15.4%) and Hispanic adults (9.9%) than white adults (7.7%). Depression is closely associated among both males and females with higher rates of unhealthy behaviors including physical inactivity, current smoking, binge drinking and driving. (NM Substance Abuse Epidemiology Profile, 2013)
The prevalence of persistent feelings of sadness or hopelessness among New Mexico youth tracks the national rates at 29.1%. Girls were far more likely to report such feelings than boys. The rates of youth reporting sadness or hopelessness varies from 35.9% to 19.9% among New Mexico counties.

Mental Health Measures

The NM State Epidemiological Outcome Workgroup (SEOW) monitors outcome measures found in the New Mexico's Indicator-Based Information System for Public Health (NM-IBIS). Outcome measures for mental health include measures of Youth Resiliency and Risk, Mental Health and Youth measures for mental health.

<table>
<thead>
<tr>
<th>Mental Health Measures</th>
<th>Youth Resiliency &amp; Risk Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult</td>
<td>Current Depression</td>
</tr>
<tr>
<td></td>
<td>Frequent Mental Distress</td>
</tr>
<tr>
<td></td>
<td>Suicide Deaths</td>
</tr>
<tr>
<td>Youth</td>
<td>Persistent Feelings of Sadness and Hopelessness</td>
</tr>
<tr>
<td></td>
<td>Considered and Attempted Suicide</td>
</tr>
<tr>
<td></td>
<td>Academic Preparedness and Effort (gets A’s and B’s, tries hard, comes to class prepared)</td>
</tr>
<tr>
<td></td>
<td>Caring Supportive Relationships (home, school, community, peer)</td>
</tr>
<tr>
<td></td>
<td>Expectations and Behavioral Boundaries (home, school, community, peer)</td>
</tr>
<tr>
<td></td>
<td>Violence (bullying, physical fights, forced to have sex, hit by boy/girlfriend)</td>
</tr>
</tbody>
</table>

Data: Populations in Need and Eligible for Treatment - New Mexico Treatment Needs Assessment

Sub-state Planning Areas

For the purposes of this grant, New Mexico is divided into five regions which are referred to as Sub-state Planning Areas. These areas are consistent with the sub-state regions used by the National Survey on Drug Use and Health (See Map).

Total population data were obtained from the Bureau of Business and Economic Research (BBER), University of New Mexico. BBER has been state-funded to generate the population estimates for New Mexico. BBER estimates for age was around 144,000 persons. Age group-specific NSDUH dependence or abuse prevalence estimates were then multiplied by the number of eligible persons for each region to generate an
estimate of persons in need of and eligible for substance abuse treatment. This synthetic method generated an estimate of roughly 17,600 persons in need of and eligible for services in New Mexico.

Population that would seek treatment: Estimating the numbers of individuals who would seek treatment for substance abuse problem but are not currently being served is a challenge. ERD estimates that 10% of dependent individuals who are not already being served would seek treatment, the same estimate used in past years. Past research in New Mexico has produced a range in prevalence estimates for drug and alcohol dependence from 1.5%, according to a telephone household survey, to 18% (childbearing age women) to 65% (arrestees) who would seek treatment if it were readily available. Also, the national estimated number of persons aged 12 or older needing treatment for an alcohol or drug problem was 23.6 million, while an estimated 2.5 million of these people sought and received treatment at a specialty facility.

Number of Injection Drug Users in Need of Treatment

Estimating the number of Injection Drug Users (IDU) who are 18 years or older living in New Mexico was based upon national data from the NSDUH. Injection drug use prevalence is probably underestimated due to the difficulty in obtaining accurate illicit drug use information via survey techniques and the likelihood of which such sampling methods reach hidden populations. The NSDUH reported that an estimated 1.5% - 1.6% of the 18 and older population in the U.S. had ever injected drugs in their lifetime. Estimates for past year heroin use was 0.2% during the same period. ERD uses this rate (0.2%) to generate the regional estimates of IDU eligible for services.

It is unknown whether IDU are more or less likely than the general substance dependent population to seek treatment. Based upon limited data, ERD estimates that 10% of IDU who are not already receiving services would seek treatment, if available.

Number of Women in Need of Treatment

The number of women needing treatment services was estimated by adjusting the estimation model to account for differential substance dependence and abuse between males and females. According to data from the 2009-2010 national NSDUH, males were almost twice as likely as females to report substance dependence or abuse. The NSDUH reported that, nationwide, 5.8% of females over age 18 reported substance abuse and dependence compared to 12.2% of males. This national ratio of females to males dependent on, or abusing, substances was used to adjust the New Mexico age-group specific rates. For example, for every one male dependent on or abusing substances, 0.457 females were assumed dependent/abusing. This figure was then adjusted to account for the proportion of males to females in each racial and ethnic group for each region.

It is unknown whether substance-dependent women seek treatment at a greater rate than men. Consistent with past years, ERD estimates approximately 10% of women who are dependent on or abusing some substance and not already receiving services, would seek treatment, if it were available.

Prevalence of Substance-Related Criminal Activity
Number of DWI arrests: Regional Driving While Intoxicated (DWI) arrest numbers come from the Traffic Safety Bureau of the New Mexico State Highway and Transportation Department. The data are compiled by UNM/Division of Government Research and made available to the Collaborative, other state agencies, and the general public. While the data collected are complete, variations between counties may represent differential enforcement of DWI laws throughout the State.

Number of drug-related arrests: Currently, the State Police are the only law enforcement agency reporting Uniform Crime Report data in New Mexico. Some counties, however, have submitted no data in recent years. Because the data are largely missing and may be misleading due to reporting error, New Mexico will not report drug-related arrests.

Substance Dependence and Abuse in the Past Year
State and regional estimates of dependence and abuse of specific substances was based on 2010 national NSDUH findings. These estimates are available for the 18-25 age group and the 26 and older age group. Substance dependence estimates were generated using BBER population estimates of these age groups.

<table>
<thead>
<tr>
<th>Type of Substance dependence and abuse</th>
<th>Estimated total number of Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana</td>
<td>2,490</td>
</tr>
<tr>
<td>Cocaine</td>
<td>6,870</td>
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<tr>
<td>Heroin</td>
<td>2,006</td>
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<tr>
<td>Hallucinogens</td>
<td>1,385</td>
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<tr>
<td>Inhalants</td>
<td>231</td>
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<td>Psychotherapeutics</td>
<td>14,274</td>
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<tr>
<td>Pain Relievers</td>
<td>12,037</td>
</tr>
<tr>
<td>Tranquilizers</td>
<td>3,551</td>
</tr>
<tr>
<td>Stimulants</td>
<td>2,237</td>
</tr>
<tr>
<td>Sedatives</td>
<td>1,544</td>
</tr>
<tr>
<td>Alcohol</td>
<td>136,293</td>
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### Substance Dependence and Abuse in Past Year

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<tr>
<th>Sub-state Planning Area</th>
<th>Marijuana</th>
<th>Cocaine</th>
<th>Heroin</th>
<th>Hallucinogens</th>
<th>Inhalants</th>
<th>Psychotherapeutics</th>
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<td>In Need &amp; Eligible</td>
<td>In Need &amp; Eligible</td>
<td>In Need &amp; Eligible</td>
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<td>4,996</td>
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<td>6,870</td>
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<th>Sub-state Planning Area</th>
<th>Pain Relievers</th>
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<th>Stimulants</th>
<th>Sedatives</th>
<th>Alcohol</th>
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<tr>
<td>NW Region</td>
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<td>In Need &amp; Eligible</td>
<td>In Need &amp; Eligible</td>
<td>In Need &amp; Eligible</td>
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<td>State Total</td>
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<td>192</td>
<td>136,293</td>
<td>16,900</td>
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</tbody>
</table>
Mental Health Problem in the Past Year

**Serious Mental Illness:** Serious mental illness ranges from 4.17% to 4.72% of the population, according to Mental Illness 2008-2010 sub-state indicators from NSDUH. Population estimates from BBER were used to estimate the total number of individuals with serious mental illness in sub-state planning regions in New Mexico.

**Any Mental Illness:** NMDUH estimates of any mental illness in the past year range from 18.27% to 19.91% in New Mexico’s sub-state planning regions. These prevalence rates were used to generate the estimated number of individuals who had any mental illness during the period.

**Had Serious Thoughts of Suicide:** NMDUH estimates of those who had serious thoughts of suicide in the past year range from 3.53% to 4.03% in New Mexico’s sub-state planning regions. These prevalence rates were used to generate the estimated number of individuals who had serious thoughts of suicide during the period.

**Had At Least One Major Depressive Episode:** NMDUH estimates of those who had had at least one major depressive episode in the past year range from 5.90% to 6.16% in New Mexico’s sub-state planning regions. These prevalence rates were used to generate the estimated number of individuals who had at least one major depressive episode during the period.

<table>
<thead>
<tr>
<th>Sub-state Planning Area</th>
<th>Serious Mental Illness</th>
<th>Any Mental Illness</th>
<th>Serious Thoughts of Suicide</th>
<th>At Least One Major Depressive Episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>NW Region</td>
<td>In Need</td>
<td>In Need &amp; Eligible</td>
<td>In Need</td>
<td>In Need &amp; Eligible</td>
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<tr>
<td>14,596</td>
<td>1,868</td>
<td>58,515</td>
<td>7,564</td>
<td>12,781</td>
</tr>
<tr>
<td>NE Region</td>
<td>9,573</td>
<td>1,090</td>
<td>43,708</td>
<td>5,037</td>
</tr>
<tr>
<td>Bernalillo County</td>
<td>22,067</td>
<td>1,829</td>
<td>96,741</td>
<td>8,150</td>
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<tr>
<td>SE Region</td>
<td>8,816</td>
<td>1,384</td>
<td>38,059</td>
<td>6,022</td>
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<tr>
<td>SW Region</td>
<td>14,236</td>
<td>2,420</td>
<td>55,166</td>
<td>9,448</td>
</tr>
<tr>
<td>State Total</td>
<td>69,283</td>
<td>8,591</td>
<td>292,107</td>
<td>36,221</td>
</tr>
</tbody>
</table>
Total Population in Need and Eligible for Treatment by Age, Sex, Race, and Ethnicity

The “Population in Need” table below displays estimates of substance abuse treatment need for the state and each region by age, sex, race, and ethnicity. Total population data were obtained from the 2010 BBER population estimates by county, sex, age, race, and ethnicity aggregated by each of five sub-state planning regions. Estimates were not generated for persons less than 18 years old since they are outside of the SAPT target population.

Approximately 17,617 persons in New Mexico are in need and eligible for treatment and this total is allocated to race/ethnicity and age groups using a synthetic estimation method that relies on both U.S. prevalence percents applied to New Mexico and state population distribution of the same age and race groups. Also, substance dependence and abuse estimates were calculated for a separate category of Hispanic ethnicity by age and sex.

The population distribution of sex and racial groups was determined for age group and regional strata. These percentages were applied to the eligible population of dependent/abusing persons, adjusted for the ratio of dependence/abuse for males and females within these strata, and summed to produce statewide estimates for age groups, sex and race categories.

The LGBT Population table shows the number of individuals who are LGBT in need of services and those who are eligible for services based on income.

Population in Need and Eligible for Treatment: Needing Treatment Services, By Race and Ethnicity, 2010

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total</th>
<th>White</th>
<th>Black or African American</th>
<th>Hispanic or Latino/a</th>
<th>Asian</th>
<th>American Indian/Alaska Native</th>
<th>Multi-racial</th>
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<tbody>
<tr>
<td>0-17</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>18-24</td>
<td>3,329</td>
<td>1,682</td>
<td>2,651</td>
<td>1,339</td>
<td>46</td>
<td>1,440</td>
<td>728</td>
</tr>
<tr>
<td>25-44</td>
<td>5,342</td>
<td>2,698</td>
<td>4,373</td>
<td>2,099</td>
<td>106</td>
<td>2,069</td>
<td>1,045</td>
</tr>
<tr>
<td>45-64</td>
<td>2,478</td>
<td>1,252</td>
<td>2,056</td>
<td>1,038</td>
<td>16</td>
<td>636</td>
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<td>468</td>
<td>237</td>
<td>0</td>
<td>17</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>11,705</td>
<td>5,912</td>
<td>9,549</td>
<td>4,823</td>
<td>108</td>
<td>4,163</td>
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<table>
<thead>
<tr>
<th>LGBT Population</th>
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<tbody>
<tr>
<td>In Need</td>
<td>10,811</td>
</tr>
<tr>
<td>In Need and Eligible</td>
<td>1,327</td>
</tr>
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</table>
Step 3.: Prioritize State Planning Activities.

Unmet Needs and Critical Gaps – Planning for the Future

Substance Abuse Prevention Needs

New Mexico has a significant substance abuse problem and prevention is the first defense. The New Mexico Behavioral Health Collaborative has established a number of Priority Areas and Annual Performance Indicators to address this problem. Below, are the prevention priority areas for FY14-15.

Key to acronyms: SAP (substance abuse prevention); SAT (substance abuse treatment); SED (serious emotional disorder);

1. Link Prevention Efforts – Primary Prevention (SAP) this priority area will identify and communicate the existence of all grants and dollars being spent with members of the Prevention Policy consortium to ensure linkages between programs will be established, supported and sustained.

2. Reduce Binge Drinking and Underage Drinking – Primary Prevention and Recovery (SAP) this priority includes steps to reduce binge drinking and underage drinking by 5% by June 2017.

3. Reduce Prescription Drug Misuse and Abuse – Primary Prevention, Trauma, and Integration (SAP) this priority area will include steps to reduce the misuse of prescription drugs by 5% by June 2017.

4. Intensive Outpatient Substance Abuse Treatment for Adults and Youth – Recovery and Trauma (SAT) this priority area will develop a network of IOP substance abuse treatment programs throughout the state.

5. Increase Evidence-based Practices – Integration and Quality (SAT, MHS) this priority area will include steps to increase the number of consumers receiving high fidelity evidence-based services.

6. Screening, Brief Intervention and Referral to Treatment – Recovery, Integration (SAP, SAT, MHP, MHS) this priority area will pursue funding sources for implementing SBIRT in the primary care environment to increase the number of providers using SBIRT for both substance abuse and mental health interventions.

7. Opioid Treatment Programs for Adults – Recovery and Integration (SAT) this priority area will include steps to increase the number of Medicaid approved and accredited Opioid Treatment Programs in the state.

8. Crisis Communities of Care – Recovery, Trauma, Integration (MHP, MHS) this priority area will include steps to develop broad community coalitions in communities throughout the state to enhance and integrate local capacity to prevent and respond to mental health crises.
9. Establish Community-Driven Wraparound System – Recovery (SED and Adolescents) This priority area will include steps to establish a community driven Wraparound System statewide.

10. Medical Detox – Recovery, Integration (SAT) this priority area will study and assess the necessity of increasing the number of medical detoxification facilities in the State.

Statewide Plan for Substance Abuse Services

The NM Behavioral Health Purchasing Collaborative (Collaborative) recognized that unmet needs and critical gaps exist in substance abuse services in the State. The Behavioral Health Services Division, as the State Substance Abuse Agency, developed a Statewide Strategic Plan for Substance Abuse and it was adopted by the Collaborative in October 2012. The Plan identifies a number of unmet needs and critical gaps in substance abuse services. Access is a particular problem across the board due to the rural nature of the State. Quality and consistency of services throughout the State are also of particular concern. Gaps were identified recovery-based services to assist with transitioning from residential services back to community care. Gaps were also identified between prevention efforts and services. Gaps were also identified in the area of public safety with many individuals with substance abuse disorders getting into harm’s way. The Plan identified 10 recommendations to improve access to treatment, enhance recovery options, link prevention efforts and address public safety. Below are some of the key recommendations which align with Block Grant Priorities for FY14-15.

Intensive Out-Patient Substance Abuse Services – Recognizing the pervasive need in New Mexico for effective substance abuse services, agencies within the New Mexico Behavioral Health Purchasing Collaborative placed a priority on expanding the availability of intensive out-patient (IOP) substance abuse treatment services to all New Mexico communities for the next fiscal year. In 2012, less than half of New Mexico counties had an Adult IOP Facility and no Facilities in many of the rural counties in the Eastern and Central Regions of the state. Data shows there is significant need in those areas of the State. The plan is to develop a network of IOP programs for youth and adults that will be connected with a local Core Service Agency (CSA) network. This will ensure that any New Mexican seeking effective treatment for substance abuse will have an IOP program within a reasonable distance from home. Currently there are nineteen providers, in 26 locations, approved to provide IOP for adults; the Collaborative has set a goal of an additional fourteen treatment sites by 2014. The Expansion of IOP programs statewide is a Priority Goal for the MH/SAPT Block Grant for 2014-15.

Screening and Brief Intervention and Treatment (SBIRT) – Recognizing that early identification and treatment of substance use disorders and mental health issues is important to long term outcomes, the NM Behavioral Health Purchasing Collaborative applied and was awarded a grant to establish SBIRT in New Mexico. SBIRT is an evidence-based program that includes screening, brief intervention and - for those needing on-going treatment – referral to care. The grant seeks to provide SBIRT in primary care clinics and Core Service Agencies. The Collaborative seeks to address the gaps in access to early treatment for substance abuse and mental illness by increasing the number of practitioners, in both primary care and specialty BH clinics, who are skilled at SBIRT for both
substance use and mental health issues. SBIRT is included as a Priority Goal for the MH/SAPT Block Grant Funding for 2014-15.

**Mental Health First Aid Training** - Many people with serious mental illness or chronic substance abuse have contact with law enforcement and are subsequently held in detention centers, primarily due to a lack of crisis response services. The New Mexico Behavioral Health Purchasing Collaborative began introducing Mental Health First Aid (MHFA) Training with the TSIG Grant in 2010. To date, 2,700 people have participated in the training.

Currently, 58 instructors provide MHFA training statewide of which 27 offer a Youth Curriculum and 39 offer the Public Safety Curriculum. Ten instructors are from the County Detention facilities, which is a direct outcome from the training recommendation in HJM 17.

The NM Center for Rural and Community Behavioral Health MHFA evaluation team is in the process of completing a survey for all MHFA Instructors in New Mexico to help understand barriers to the further rolling out of MHFA training. In addition to analyzing survey data, they will also be conducting focus groups. This study is being funded by an internal University of NM grant. In addition, they are in the process of submitting another UNM pilot grant that will broaden our understanding of the implementation of MHFA in a cultural and demographic context and that could ultimately lead to more extensive federal grant support.

The ultimate aim is to encourage the provision of Mental Health First Aid Training in rural and ethnically diverse communities in New Mexico. Some additional evaluation possibilities that are currently unfunded include administering pre and post and longitudinal tests to training participants to get a sense of how their mental health literacy and comfort with addressing mental health problems changes after training.

Community Crisis System Planning, which includes Mental Health First Aid Training as a strategy, is a Priority Goal for the MH/SAPT Block Grant.

**Statewide Emergency Hotline** - When a New Mexico resident experiences a mental health crisis, often involving substance abuse, peer support and warm lines might not be available in his/her community; family and community members often do not understand the illness or know how to respond. Law enforcement officers in most areas of the state will take that person to a detention facility because there is no alternative. For people experiencing a behavioral health crisis, having a connection within their community that offers support and understanding, is critical.

To address critical gaps in access to services, BHSD implemented an emergency 24/7 hotline to ensure that individuals have ready access to a behavioral health clinician who can assist with their immediate concerns and link that individual back to their community for on-going services. This initiative began in June 2013.

**Recovery Support Curriculum** - To address gaps in access to quality recovery support services, the BHSD implemented CORE training for all community support workers in Core Service Agencies. The CORE training provides workers with a curriculum of recovery-based activity plans this curriculum
ensures statewide consistency and fidelity to practice in providing Comprehensive Community Support Services – a primary strategy for supporting recovery from substance abuse.

**Regulatory Efforts to Reduce Prescription Drug Abuse** - New Mexico leads the nation in Opioid prescription drug overdose deaths. To address this concern, the New Mexico Regulation and Licensing Board have taken an aggressive approach to monitoring Opioid prescribing practices. The Collaborative has been supportive of this effort.

**Other Services that Address Unmet Needs and Critical Gaps**

**System of Care Grant** – The New Mexico child and adolescent mental health and substance abuse treatment system has undergone many changes over the years. A broad array of treatment services has been developed that currently serves in excess of 41,000 individuals per year.

A goal of the New Mexico behavioral health system has long been the development of a strong System of Care (SOC) for children with serious emotional disturbance (SED). The SOC is based on wraparound principles with a strong youth and family voice. In 2009, the New Mexico Children, Youth and Families Department (CYFD) received a grant from the U.S. Department of Health and Human Services, Center for Mental Health Services, to develop Systems of Care for children and youth with SED. The grant funds three communities, one urban, one rural and one Native American, to teach the child serving agencies and community partners in these communities to utilize wraparound approaches, build youth and family participation and cultural competence. CYFD is working closely with the San Felipe Pueblo and the Mescalero Apache Reservation who have their own SOC grants. This initiative is a Priority Goal for FY1-15.

**Recovery-Oriented Systems** - Recognizing the importance of Recovery Services, Comprehensive Community Support Services (CCSS) was added to the Medicaid State Plan on January 1, 2008, replacing case management services. The intent in establishing this new recovery-based service was to create a service that is more community based, consumer driven, and oriented towards recovery and resiliency. The purpose of CCSS is to coordinate and provide services and resources to individuals/families necessary to promote their recovery and resiliency. CCSS identifies and addresses the strengths as well as the barriers that impede the development of skills necessary for an individual or family in their recovery and resiliency process to function independently in the community. Community support activities address goals specifically in the following areas: independent living, learning, working, socializing and recreation.

CCSS is also important in supporting an individual and family in crisis situations, and providing tailored interventions to develop or enhance an individual’s ability to make informed and independent choices. CCSS gives New Mexico service providers a mechanism to implement the wraparound approach to services with youth who otherwise may be placed in residential treatment. CCSS has also been identified as one of the mandatory services that Core Service Agencies (CSAs) must provide.

Certified Family Specialists (CFS) is being established as a new category of peer support providers for Family Support Services which is a new Medicaid service beginning January 1, 2014. A Certified
Family Specialist is a peer of the parent that is being supported who is parenting or has parented a child experiencing emotional, behavioral or mental health and/or substance use disorders and can articulate the understanding of their experience with another parent or family member. The focus of the service is on empowering parents and caregivers to parent and advocate for their child/youth with emotional, mental or behavioral health and/or substance use related disorders or challenges. The scope of the service involves assisting and supporting family members to navigate through multiple agencies and human service systems (e.g. basic needs, health, behavioral health, education, social services, etc).

The Certified Family Specialists training curriculum will completed by April 2013 and requests for submitting applications will be distributed statewide in May 2013 with the first training class tentatively scheduled for July 2013. This initiative is a Priority Goal for FY1-15.

**Consistent, quality services delivered through evidence-based practices:** serving individuals with Serious Mental Illness, PPWWDC, and Injecting Drug Users. New Mexico’s goal is to Increase the number of sites using evidence-based practices to ensure delivery of quality services. This goal focuses on providing ongoing training for service providers in the following curricula: Matrix Model, CORE, Seeking Safety, and Motivational Interviewing. This initiative is a Priority Goal for FY1-15.

**Women’s Services** - Women who are pregnant and have a substance abuse disorder are a particular concern in New Mexico. Substance abuse in a family is a particular concern as New Mexico has one of the highest rates of substance abuse in the nation. Pregnant women, who have a substance abuse disorder, particularly injecting pregnant women, are a high priority for treatment. In 2013, New Mexico adopted a new law requiring all health care providers to prioritize access to treatment for these women.

BHSD has developed a model of evidence based practices to effectively treat women in residential setting that also take their children. This model includes the use of the following EBP’s: Nurturing Parenting, Seeking Safety and Trauma Focused Evidence Based Practices (EBP’s) including Cognitive Behavioral Therapy. This includes the development and implementation of a Cultural and Linguistic Competency training for all providers including those who serve Pregnant and Parenting women.

BHSD through our State Entity contractor requires every substance abuse provider to prioritize Pregnant and Post-Partum Women and provide interim services. BHSD is working towards integrating a continuum of care utilizing the systems in place so that women have a warm-hand off back into their community. The Statewide Entity reports monthly on any waiting list or delays in access to care for pregnant and postpartum women who are seeking treatment for substance abuse.

Needs identified include a smooth transition from residential to community recovery support services. To address this priority need, BHSD will start to utilize both the Access to Recovery (ATR) programs and the Core Service Agencies to ensure that the women served in residential care have a warm hand off to the next level of care in their perspective home communities to ensure or aid in long term recovery.
**Trauma-Informed Services** - BHSD is committed to meeting the behavioral healthcare needs of our consumers, many of whom come with disclosed or undisclosed trauma histories. To increase EBP’s around trauma informed care BHSD is providing Trauma informed trainings across the state to all BHSD funded providers. The trainings include addressing specific special population including pregnant post-partum and parenting women and veterans.

Over the last year, the Collaborative launched an initiative to develop Recovery Oriented Systems of Care (ROSC), bringing together providers, stakeholders, national leaders, consumers and families. Monthly statewide meetings culminated in a 2 day symposium that hosted 447 of participants and was extremely successful in furthering the discussion and understanding of ROSC and building on partnerships. The symposium featured national experts Dr. Arthur Evans, Dr. Ijeoma Achara, Dr. William White and Michelle Lipinski. Ms. Lipinski agreed to serve as a contract consultant for the New Mexico ROSC initiative, which has continued with the establishment of a small advisory group that meets monthly. The monthly statewide meetings have continued frequently with tele-conferencing at multiple sites around the state. Through the advisory group, five unique but fairly developed recovery communities have been identified around the state (Taos, Santa Fe, Albuquerque, Roswell and Mescalero Apache) and are the cornerstone of our grassroots initiative. Ms. Lipinski created a community assessment tool based on the Blueprint for Change.

Every month BHSD hosts 2-3 presentations by consumer run programs, recovery based programs, training and education programs that are focused on recovery and resiliency. We believe that communities learning from other communities are an integral element in moving New Mexico ROSCs forward. Dr. Bob Phillips of Eastern New Mexico University makes regular educational mini-presentations on the principles and lessons of ROSCs around the country. His presentations are an essential part of the ongoing learning community which continues to grow each month. The response to the meetings and information is genuine excitement. Members are reaching across the aisle, across the state and outside of their comfort zones to build on their own and others resources to support people in recovery.

**Access to Recovery** – Chronic substance abuse is a major problem for New Mexico. The Collaborative supports Access-To-Recovery as a client-centered, community based substance abuse recovery program involving clinical treatment, faith-based counseling and support and many other services supporting individuals during the recovery process. The ATR program is supported by a grant from SAMHSA and is in ending third year of a four year grant.

Recognizing the unmet need for effective substance abuse services for veterans in New Mexico, the NM Behavioral Health Collaborative designated the New Mexico National Guard and other veterans as a priority population within ATR beginning in 2009. The National Guard members and their families are informed of ATR services at multiple points both pre and post deployment. ATR outcome data has shown that the integration of recovery supports (e.g. faith-based counseling, yoga, medication, massage, Native American traditional services among other on traditional recovery supports) with
clinical services based on a single assessment significantly increases the efficacy of treatment abstinence.

The National Guard component has become a center piece of the ATR program in New Mexico and has been implemented as a standard practices at all six ATR sites. In 2012, ATR has become a significant support program for the National Guard, as the New Mexico National Guard has undergone significant budget cuts that have affected National Guard’s internal ability to provide counseling services. In FY14, New Mexico is looking at expanding the ATR provider network ability to serve veterans by developing trauma services, which will provide clinical services for veterans who have a co-occurring trauma related disorder.

**Evidence-Based Practices** - The Behavioral Health Services Division is working with providers to increase the number of sites using evidence-based practices to ensure that services are effective and provided with fidelity to the model. All IOP providers use the evidence-based Matrix Model in their facilities. All Core Service Agencies (CSA) provide Comprehensive Community Support Services which is evidence-based, and their Community Support Workers have been receiving training in the Percensys CORE training; while the CORE training is not presently recognized as an EBP, many activities within the CORE Library of Recovery Skills are reflective of practices from Wellness Management & Recovery, Cognitive Behavioral Therapy, WRAP, Dialectical Behavior Therapy and Motivational Interviewing. Consistent, quality services delivered through evidence-based practices is a Priority Goal for MH/SAPT Block grant.
Table 1 Step 3,4: -Priority Area and Annual Performance Indicators

**Priority #:** 1  
**Priority Area:** Primary Prevention - Link Prevention Efforts  
**Priority Type:** SAP  
**Population(s):** Other  
**Goal of the priority area:**  
Identify and communicate the existence of all grants and dollars being spent with members of the Prevention Policy Consortium (PPC) to insure linkages between programs will be established, supported, and sustained (from BHC Substance Abuse Prevention Strategy, October 2012 for 2013 Implementation, page 25, #7)

**Strategies to attain the goal:**  
Development of a prevention strategy funding table by state/county agency, funding source, amount, and strategy by the Prevention Policy Consortium, a group comprised of state level agencies that meet monthly.

**Annual Performance Indicators to measure goal success**

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator:</strong></td>
<td>NM state agency prevention grants and dollars</td>
</tr>
<tr>
<td><strong>Baseline Measurement:</strong></td>
<td>Identify all available state agency prevention grants and dollars</td>
</tr>
<tr>
<td><strong>First-year target/outcome measurement:</strong></td>
<td>Table contains 50% of known Prevention Policy Consortium (PPC) agency prevention grants and dollars</td>
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<tr>
<td><strong>Second-year target/outcome measurement:</strong></td>
<td>Table contains 100% of PPC agency prevention grants and dollars</td>
</tr>
<tr>
<td><strong>Data Source:</strong></td>
<td>State agencies' prevention budgets</td>
</tr>
<tr>
<td><strong>Description of Data:</strong></td>
<td></td>
</tr>
</tbody>
</table>
Data issues/caveats that affect outcome measures:

Unwillingness or inability of state agencies to share prevention budgets

Priority #: 2
Priority Area: Primary Prevention & Recovery - Reduce Binge Drinking & Underage Drinking
Priority Type: SAP
Population(s): Other (Persons not yet identified with a diagnosis)

Goal of the priority area:
Reduce binge drinking & underage drinking by 5% in NM by June 2017 (From FY13 5-Year Behavioral Health Promotion & Prevention Plan)

Strategies to attain the goal:
For youth, reduce social access through Social Host ordinances, Parent Party Patrols, Parents Who Host Lose the Most campaigns, and media to increase awareness of the problem; reduce retail access through restrictions on alcohol placement, advertising, and sales; strengthen law enforcement of minors in possession laws, sales to minors laws, providing alcohol to minors laws, and age verification, and strengthening enforcement of school ATOD policies. For adults, reduce retail access through restrictions on alcohol placement and hours of sales, outlet density, alcohol license transfers, and the Responsible Beverage Service Model; strengthen law enforcement of sales to intoxicated patrons and DWI laws, increase sobriety checkpoints and saturation patrols; and increased perceived risk of arrest through the publication of law enforcement efforts and consequences for breaking alcohol related laws.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: NM HS Students who Report Drinking Alcohol in past 30 Days
Baseline Measurement: 36.9% among grades 9-12, 2011
First-year target/outcome measurement: (progress to end of SFY 2014) 35.9%
Second-year target/outcome measurement: Final to end of SYF 2014: 34.9%
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<tr>
<th>Indicator #</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator:</strong></td>
<td>NM HS Students who Binge Drank in Past 30 Days</td>
</tr>
<tr>
<td><strong>Baseline Measurement:</strong></td>
<td>Initial data collected prior to and during SYF 2014 - 22.4% among grades 9-12, 2011</td>
</tr>
<tr>
<td><strong>First-year target/ outcome measurement:</strong></td>
<td>Progress to end of SYF 2014: 21.4%</td>
</tr>
<tr>
<td><strong>Second-year target/ outcome measurement:</strong></td>
<td>Final to end of SYF 2014 - 20.4%</td>
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</table>

<table>
<thead>
<tr>
<th>Indicator #</th>
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<tr>
<td><strong>Indicator:</strong></td>
<td>NM Adults who Binge Drank in Past 30 Days</td>
</tr>
<tr>
<td><strong>Baseline Measurement:</strong></td>
<td>17.2% among adults 18+, 2011</td>
</tr>
<tr>
<td><strong>First-year target/ outcome measurement:</strong></td>
<td>Progress to end of SYF 2014 - 16.2%</td>
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</tbody>
</table>
Second-year target/outcome measurement: Final to end of SYF 2014 - 15.2%

Data Source: NM Behavioral Risk Factor Surveillance System (BRFSS)

Description of Data: Phone survey

Data issues/caveats that affect outcome measures: Phone survey, so misses people with no land line or cell phone

Priority #: 3

Priority Area: Primary Prevention, Trauma, Integration - Reduce Prescription Drug Misuse & Abuse

Priority Type: SAP

Population (s): Other (Persons not yet identified with diagnosis)

Goal of the priority area:
Reduce the misuse of prescription drugs by 5% in New Mexico by June 2017 (From FY13 5-Year Behavioral Health Promotion & Prevention Plan)

Strategies to attain the goal:
Coordinate prescription drug misuse/abuse prevention services across state agencies (map resources, identify gaps, identify effective strategies, develop implementation plan; work to improve detection of abuse with treatment providers and law enforcement); improve data collection, analysis, and access to identify key indicators, integrate into reporting requirements and applications; consistently collect identified indicators among representative sample of youth (NM YRRS); and improve cross agency training on PDA to increase workforce competencies & use of EBPs (provide prescription drug abuse prevention training online)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: NM HS students who report using pain killers to get high in past 12 months

Baseline Measurement: 11.3% among grades 9-12, 2011
<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Nonmedical use of pain relievers in past year, 12 years of age +</td>
</tr>
<tr>
<td>Baseline Measurement</td>
<td>5.7% among age 12 and over, 2011</td>
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<tr>
<td>First-year target/outcome measurement</td>
<td>Progress to end of SFY 2014: 5.6%</td>
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<td>Second-year target/outcome measurement</td>
<td>(Final to end of SFY 2014): 5.5%</td>
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<td>Data Source</td>
<td>National Survey on Drug Use &amp; Health (NSDUH) 2011</td>
</tr>
<tr>
<td>Description of Data</td>
<td>Survey data</td>
</tr>
<tr>
<td>Data issues/caveats that affect outcome measures</td>
<td>None</td>
</tr>
</tbody>
</table>
Indicator: Prescription drug overdose death rates per 100,000

Baseline Measurement: 9.8 deaths per 100,000, 2007-2011

First-year target/outcome measurement: 8.8 deaths per 100,000

Second-year target/outcome measurement: 7.8 deaths per 100,000

Data Source: NM Bureau of Vital Record & Health Statistics (BVRHS), 2013

Description of Data: Vital records

Data issues/caveats that affect outcome measures: None

Priority #: 4

Priority Area: Recovery & Trauma - Intensive Outpatient (IOP) Substance Abuse Treatment for Adults and Youth

Priority Type: SAT

Population(s): SED, PWWDC, IVDUs, Other (LGBTQ, Rural, Children/Youth at Risk for BH Disorder, Frontier)

Goal of the priority area: Develop a network of IOP substance abuse treatment programs in NM.

Strategies to attain the goal:
Use Treatment Episode Data (TEDS) and local epidemiology data to identify need and assist providers to become Medicaid certified IOP providers.

Annual Performance Indicators to measure goal success

Indicator #: 1
**Indicator:** Number of approved programs for Adults

**Baseline Measurement:** 19 programs

**First-year target/outcome measurement:** 26 programs

**Second-year target/outcome measurement:** 33 programs

**Data Source:** Internal Medicaid data

**Description of Data:** Count of approved and credentialed programs

**Data issues/caveats that affect outcome measures:** None

---

**Indicator #:** 2

**Indicator:** Number of IOP for Youth

**Baseline Measurement:** 10 programs

**First-year target/outcome measurement:** 18 programs

**Second-year target/outcome measurement:** 22 programs

**Data Source:** Internal Medicaid data

**Description of Data:** Count of approved and credentialed programs

**Data issues/caveats that affect outcome measures:**
Priority #: 5
Priority Area: Integration, Quality - Increased Evidence-Based Practices (EBP)
Priority Type: SAT, MHS
Population: SMI, PWWDC, IVDUs, Other (Adolescents w/SA and/or M H, LGBTQ, Rural, Children/Youth at Risk for BH Disorder, Older adults; Frontier)

Goal of the priority area:
Increase the number of consumers receiving high fidelity EBPs.

Strategies to attain the goal:
Provide ongoing training for service providers in the following curricula such as Multi Sytemic Therapy (MST), Matrix Model, CORE, Seeking Safety, and Motivational Interviewing.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Increased number of consumers receiving high fidelity EBPs
Baseline Measurement: Assess the number of consumers receiving high fidelity EBPs
First-year target/outcome measurement: Increase number of consumers receiving high fidelity EBPs to fidelity by 20% of baseline measurement
Second-year target/outcome measurement: Increase the number of consumers receiving high fidelity EBPs by 10% of baseline measurement

Data Source:
Agency report, as well as fidelity checks through site visits by BHSD staff

Description of Data:
Number of agencies using EPBs to fidelity

Data issues/caveats that affect outcome measures:
None
Priority #: 6

Priority Area: Recovery, Integration - Screening, Brief Intervention & Referral to Treatment (SBIRT) for Adults

Priority Type: SAP, SAT, MHP, MHS

Population(s): PWWDC, IVDUs, Other (LGBTQ, Rural, Underserved Racial and Ethnic Minorities, Older Adults: Frontier)

Goal of the priority area:

Pursue funding sources for implementing SBIRT in the primary care environment in order to increase the number of providers utilizing SBIRT for both substance abuse and mental health interventions.

Strategies to attain the goal:

Use current local-level data that indicate the effectiveness of using SBIRT, for both substance abuse and mental health occurrences, to pursue funding to implement SBIRT in the primary care settings.

---

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

**Indicator:** Funding amount used to support implementation of SBIRT across the state in primary care environments.

**Baseline Measurement:** Analyze former data and costs from 2008-2010 SBIRT pilot program; assess amount used to support SBIRT.

**First-year target/outcome measurement:** Increase the funding available to support SBIRT implementation by 5%.

**Second-year target/outcome measurement:** Increase the funding available to SBIRT implementation by 10%.

**Data Source:** Internal BHSD data
Amount of funding used to support SBIRT

Data issues/caveats that affect outcome measures:
None

Indicator #:
2
Indicator:
Number of primary care settings utilizing SBIRT.
Baseline Measurement:
Number of primary care environments currently utilizing SBIRT.
First-year target/outcome measurement:
Increase the number of primary care environments using SBIRT by 5%
Second-year target/outcome measurement:
Increase the number of primary care environments using SBIRT by 10%
Data Source:
Internal BHSD data
Description of Data:
Number of primary care environments implementing SBIRT

Data issues/caveats that affect outcome measures:
None

Priority #:
7
Priority Area:
Recovery & Integration - Opioid Treatment Programs for Adults
Priority Type:
SAT
Population(s):
PWWDC, IVDUs, Other (Rural, Homeless, Older Adults)
Goal of the priority area:
Increase the number of approved and accredited Opioid Treatment Programs (OTP) in New Mexico
Strategies to attain the goal:

Use Treatment Episode Data (TEDS) and local epidemiology data to identify need and assist providers to become BHSD and DEA approved, as well as JCAHO or CARF accredited OTP providers.

---

### Annual Performance Indicators to measure goal success

**Indicator #:** 1

**Indicator:** Increase the number of BHSD, DEA approved and JCAHO or CARF accredited programs

**Baseline Measurement:** 11

**First-year target/outcome measurement:** 13

**Second-year target/outcome measurement:** 15

**Data Source:**

Internal BHSD data

**Description of Data:**

Count of approved and credentialed programs

**Data issues/caveats that affect outcome measures:**

None

---

**Priority #:** 8

**Priority Area:** Crisis Communities of Care

**Priority Type:** MHP, MHS

**Population(s):** SMI, SED, PWWDC

**Goal of the priority area:**

To develop broad community coalitions in communities throughout the state to enhance and integrate local capacity to prevent and respond to
**Strategies to attain the goal:**

Expand awareness and understanding of mental health disorders through the provision of information, education and training to key stakeholders - including law enforcement, courts, state, city, county and tribal governments, schools, behavioral health providers, state agencies, etc., (HJM 17 Task Force Recommendations, 2011)

---

### Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>Indicator</th>
<th>Baseline Measurement</th>
<th>First-year target/outcome measurement</th>
<th>Second-year target/outcome measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Comprehensive mental health system planning across 3 counties in New Mexico (Guadalupe, Taos, San Juan)</td>
<td>Identify Gaps in community to build a framework for crisis system resources</td>
<td>Community Plan in Place by end of FY2014 in San Juan County</td>
<td>Community Crisis Systems of Care in Taos County for mental health/criminal justice collaboration</td>
</tr>
</tbody>
</table>

**Data Source:**

Community stakeholders such as schools, juvenile justice, law enforcement, first responders, medical and behavioral health agencies, State Entity.

**Description of Data:**

Qualitative and quantitative information on number of encounters with persons and families in mental distress who touched the community system and the outcomes of that encounter (eg., referrals, incarceration, etc.)

**Data issues/caveats that affect outcome measures:**

Different levels of data collection, completeness, and reporting among the different stakeholders.
### First-year target/outcome measurement:
Increase MHFA instructor training/sustainability in local communities at: 3 Tribal Communities and other Collaborative Agencies

### Second-year target/outcome measurement:
Expanded training and outreach to tribes, in addition to continuing work on integration of culturally appropriate teachings of the tribe into the fidelity of the model.

### Data Source:
UNM analysis of MHFA National Database; NM MHFA instructor distribution list;

### Description of Data:
Dates, types of training, number of participants, location, who instructors were, and ratings of instructors. Currently working on longitudinal evaluation on impact and instructors; surveys will be done 3 months after training to see how training is being utilized in communities.

### Data issues/caveats that affect outcome measures:
If instructors don't complete their Web based surveys and reports, data will be incomplete.

---

**Priority #:** 9  
**Priority Area:** Establish Community Driven Wraparound System  
**Priority Type:** Population(s): SED, Other (Adolescents w/SA and/or MH)  
**Goal of the priority area:** Establish a community driven Wraparound system statewide.  
**Strategies to attain the goal:**  
NM Wraparound CARES practice model training plan, contracted Wraparound trainer, Children Youth & Families (CYFD) Professional Development Bureau, and Communities of Care initiative.

### Annual Performance Indicators to measure goal success
**Indicator #:** 1  
**Indicator:** Increase number of people trained in NM Wraparound CARES practice model.
<table>
<thead>
<tr>
<th><strong>Baseline Measurement:</strong></th>
<th>Currently, zero (0) people have been trained.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First-year target/outcome measurement:</strong></td>
<td>100 individuals from communities will be trained.</td>
</tr>
<tr>
<td><strong>Second-year target/outcome measurement:</strong></td>
<td>200 individuals from communities will be trained.</td>
</tr>
<tr>
<td><strong>Data Source:</strong></td>
<td>CYFD Professional Development Bureau</td>
</tr>
<tr>
<td><strong>Description of Data:</strong></td>
<td>none</td>
</tr>
<tr>
<td><strong>Data issues/caveats that affect outcome measures:</strong></td>
<td>None</td>
</tr>
</tbody>
</table>

**Priority #:** 10

**Priority Area:** Substance Abuse, Co-Occurring

**Priority Type:** SAT

**Population(s):**

**Goal of the priority area:**

Study and assess the necessity to increase the number of medical detoxification facilities in the state.

**Strategies to attain the goal:**

**Annual Performance Indicators to measure goal success**

<table>
<thead>
<tr>
<th><strong>Indicator #:</strong></th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator:</strong></td>
<td>Determination of necessity for number of medical detoxification facilities, location of facilities, number of beds per facility, and expectations of substance-type withdrawals.</td>
</tr>
<tr>
<td><strong>Baseline Measurement:</strong></td>
<td>Currently, 1 BHSD funded Medical Detoxification facility in New Mexico.</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td></td>
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<tr>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td></td>
</tr>
</tbody>
</table>

**Data Source:**

NM Substance Abuse Epidemiology Profile, possibly hospital admissions for detox, Turquoise Lodge (sole Medical Detox facility).

**Description of Data:**

Number of persons (county) abusing alcohol, opioids, benzodiazepines; number of persons who are not able to access Turquoise Lodge due to filled capacity.

**Data issues/caveats that affect outcome measures:**

None identified.
### Table 2 State Agency Planned Expenditures [SA]

Planning Period - From 07/01/2013 to 06/30/2015

<table>
<thead>
<tr>
<th>Activity (See instructions for using Row 1.)</th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>C. Medicaid (Federal, State, and Local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), SAMHSA, etc.)</th>
<th>E. State Funds</th>
<th>F. Local Funds (excluding local Medicaid)</th>
<th>G. Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention* and Treatment</td>
<td>$11,237,516</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children’</td>
<td>$1,608,772</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. All Other</td>
<td>$9,628,744</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Substance Abuse Primary Prevention</td>
<td>$5,154,426</td>
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<td>$</td>
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<td></td>
<td></td>
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<tr>
<td>3. Tuberculosis Services</td>
<td></td>
<td></td>
<td></td>
<td>$42,000</td>
<td></td>
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</tr>
<tr>
<td>4. HIV Early Intervention Services</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
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<tr>
<td>5. State Hospital</td>
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<td></td>
<td>$</td>
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<td></td>
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</tr>
<tr>
<td>6. Other 24 Hour Care</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
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<td></td>
</tr>
<tr>
<td>7. Ambulatory/Community Non-24 Hour Care</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
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<tr>
<td>8. Mental Health Primary Prevention</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Administration (Excluding Program and Provider Level)</td>
<td>$485,912</td>
<td></td>
<td></td>
<td>$</td>
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</tr>
<tr>
<td>11. Total</td>
<td>$16,877,854</td>
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<td>$42,000</td>
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</tbody>
</table>

* Prevention other than primary prevention

**Footnotes:**

These are 2 year estimates.

TB - different from previous years as previously the entire TB budget was used. This is an estimate of TB infected individuals also in our SAPT facilities.

NOTE: MEDICAID DATA STILL PENDING AS OF 8/19/13.
Table 2 State Agency Planned Expenditures [MH]

Planning Period - From 07/01/2013 to 06/30/2015

<table>
<thead>
<tr>
<th>Activity (See instructions for using Row 1.)</th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>C. Medicaid (Federal, State, and Local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), SAMHSA, etc.)</th>
<th>E. State Funds</th>
<th>F. Local Funds (excluding local Medicaid)</th>
<th>G. Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. All Other</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Substance Abuse Primary Prevention</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Tuberculosis Services</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4. HIV Early Intervention Services</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>5. State Hospital</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Other 24 Hour Care</td>
<td>$472,092</td>
<td>$</td>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>7. Ambulatory/Community Non-24 Hour Care</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
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<td>$</td>
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<tr>
<td>8. Mental Health Primary Prevention</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>10. Administration (Excluding Program and Provider Level)</td>
<td>$472,092</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>11. Total</td>
<td>$472,092</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

* Prevention other than primary prevention

Footnotes:
The State Hospital is not within HSD so we do not currently have the data.
# Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period - From **07/01/2013** to SFY **06/30/2015**

<table>
<thead>
<tr>
<th>Service</th>
<th>Unduplicated Individuals</th>
<th>Units</th>
<th>SABG Expenditures</th>
<th>MHBG Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Home/Physical Health</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Specialized Outpatient Medical Services</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Acute Primary Care</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>General Health Screens, Tests and Immunizations</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Comprehensive Care Management</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Care coordination and Health Promotion</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Comprehensive Transitional Care</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Individual and Family Support</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Referral to Community Services Dissemination</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Prevention (Including Promotion)</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Screening, Brief Intervention and Referral to Treatment</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Brief Motivational Interviews</td>
<td></td>
<td>$</td>
<td>$</td>
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<tr>
<td>------------------------------</td>
<td>------------------</td>
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<td>---</td>
<td></td>
</tr>
<tr>
<td>Screening and Brief Intervention for Tobacco Cessation</td>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Parent Training</td>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Facilitated Referrals</td>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Relapse Prevention/Wellness Recovery Support</td>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Warm Line</td>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td><strong>Substance Abuse (Primary Prevention)</strong></td>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Classroom and/or small group sessions (Education)</td>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Media campaigns (Information Dissemination)</td>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Systematic Planning/Coalition and Community Team Building (Community Based Process)</td>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Parenting and family management (Education)</td>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Education programs for youth groups (Education)</td>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Community Service Activities (Alternatives)</td>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Student Assistance Programs (Problem Identification and Referral)</td>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Employee Assistance programs (Problem Identification and Referral)</td>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
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<tr>
<td>Community Team Building (Community Based Process)</td>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td></td>
<td></td>
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<tr>
<td>----------------------------------------------</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Engagement Services</strong></td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment</td>
<td>$</td>
<td>$</td>
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<td></td>
</tr>
<tr>
<td>Specialized Evaluations (Psychological and Neurological)</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Planning (including crisis planning)</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consumer/Family Education</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outreach</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidenced-based Therapies</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group Therapy</td>
<td>$</td>
<td>$</td>
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</tr>
<tr>
<td>Family Therapy</td>
<td>$</td>
<td>$</td>
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</tr>
<tr>
<td>Multi-family Therapy</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultation to Caregivers</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medication Services</strong></td>
<td>$</td>
<td>$</td>
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</tr>
<tr>
<td>Medication Management</td>
<td>$</td>
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</tr>
<tr>
<td>Service</td>
<td>Cost</td>
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<tr>
<td>----------------------------------------------</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacotherapy (including MAT)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Laboratory services</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Community Support (Rehabilitative)</strong></td>
<td></td>
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</tr>
<tr>
<td>Parent/Caregiver Support</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Skill Building (social, daily living, cognitive)</td>
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</tr>
<tr>
<td>Case Management</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Behavior Management</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Supported Employment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent Supported Housing</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Recovery Housing</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Therapeutic Mentoring</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traditional Healing Services</td>
<td></td>
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</tr>
<tr>
<td><strong>Recovery Supports</strong></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Peer Support</td>
<td></td>
<td></td>
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<tr>
<td>Recovery Support Coaching</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Cost 1</td>
<td>Cost 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------</td>
<td>--------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recovery Support Center Services</td>
<td>$</td>
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<tr>
<td>Supports for Self-directed Care</td>
<td>$</td>
<td>$</td>
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<tr>
<td><strong>Other Supports (Habilitative)</strong></td>
<td>$</td>
<td>$</td>
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<tr>
<td>Personal Care</td>
<td>$</td>
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<tr>
<td>Homemaker</td>
<td>$</td>
<td>$</td>
<td></td>
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</tr>
<tr>
<td>Respite</td>
<td>$</td>
<td>$</td>
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<tr>
<td>Supported Education</td>
<td>$</td>
<td>$</td>
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</tr>
<tr>
<td>Transportation</td>
<td>$</td>
<td>$</td>
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<td></td>
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<tr>
<td>Assisted Living Services</td>
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<tr>
<td>Recreational Services</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trained Behavioral Health Interpreters</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interactive Communication Technology Devices</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Intensive Support Services</strong></td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse Intensive Outpatient (IOP)</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partial Hospital</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assertive Community Treatment</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Cost 1</td>
<td>Cost 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>--------</td>
<td>--------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive Home-based Services</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multi-systemic Therapy</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive Case Management</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-Home Residential Services</strong></td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children's Mental Health Residential Services</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis Residential/Stabilization</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinically Managed 24 Hour Care (SA)</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinically Managed Medium Intensity Care (SA)</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Mental Health Residential</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth Substance Abuse Residential Services</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapeutic Foster Care</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Acute Intensive Services</strong></td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobile Crisis</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer-based Crisis Services</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Cost1</td>
<td>Cost2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-------</td>
<td>-------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23-hour Observation Bed</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medically Monitored Intensive Inpatient (SA)</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24/7 Crisis Hotline Services</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please list)</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Footnotes:**
New Mexico is unable to provide data for this table at this time.
### III: Use of Block Grant Dollars for Block Grant Activities

#### Table 4 SABG Planned Expenditures

**Planning Period - From 10/01/2013 to 09/30/2015**

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>FY 2014 SA Block Grant Award</th>
<th>FY 2015 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention* and Treatment</td>
<td>$5,618,758</td>
<td></td>
</tr>
<tr>
<td>2. Substance Abuse Primary Prevention</td>
<td>$2,577,213</td>
<td></td>
</tr>
<tr>
<td>3. Tuberculosis Services</td>
<td>$21,000</td>
<td></td>
</tr>
<tr>
<td>4. HIV Early Intervention Services**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Administration (SSA Level Only)</td>
<td>$242,936</td>
<td></td>
</tr>
<tr>
<td><strong>6. Total</strong></td>
<td><strong>$8,459,907</strong></td>
<td></td>
</tr>
</tbody>
</table>

* Prevention other than primary prevention
** HIV Early Intervention Services

**Footnotes:**

New Mexico OMB No. 0930-0168 Approved: 05/21/2013 Expires: 05/31/2016
### III: Use of Block Grant Dollars for Block Grant Activities

#### Table 5a SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

<table>
<thead>
<tr>
<th>Strategy</th>
<th>IOM Target</th>
<th>FY 2014</th>
<th>FY 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>SA Block Grant Award</td>
<td>SA Block Grant Award</td>
</tr>
<tr>
<td><strong>Information Dissemination</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Universal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selective</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unspecified</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>$57,764</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Universal</td>
<td></td>
<td>$189,721</td>
<td></td>
</tr>
<tr>
<td>Selective</td>
<td></td>
<td>$106,360</td>
<td></td>
</tr>
<tr>
<td>Indicated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unspecified</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>$296,081</td>
</tr>
<tr>
<td><strong>Alternatives</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Universal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selective</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unspecified</td>
<td></td>
<td></td>
<td>$28,882</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>$28,882</td>
</tr>
<tr>
<td><strong>Problem Identification and Referral</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Universal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selective</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unspecified</td>
<td></td>
<td></td>
<td>$28,882</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>$28,882</td>
</tr>
<tr>
<td>Category</td>
<td>Universal</td>
<td>Selective</td>
<td>Indicated</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------</td>
<td>-----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Community-Based Process</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 1926 Tobacco</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Prevention Expenditures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total SABG Award</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Planned Primary Prevention Percentage</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Footnotes:
With the exception of Education, the process of inserting the CSAP strategies into the IOM model does not work well because the IOM targets are based on risk classification while the CSAP strategies are not. Consequently, we used the "Unspecified" category for the remaining categories because New Mexico does not collect this data by IOM classification. (The "Other" Category contains administration costs, including salaries.)

The total amount in Table 5a reflects an additional $200,000 of SAPT funds unspent from past years that has been added to the FY14 prevention budget.
### III: Use of Block Grant Dollars for Block Grant Activities

#### Table 5b SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

<table>
<thead>
<tr>
<th>Activity</th>
<th>FY 2014 SA Block Grant Award</th>
<th>FY 2015 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Direct</td>
<td>$189,721</td>
<td></td>
</tr>
<tr>
<td>Universal Indirect</td>
<td>$2,592,114</td>
<td></td>
</tr>
<tr>
<td>Selective</td>
<td>$106,360</td>
<td></td>
</tr>
<tr>
<td>Indicated</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Column Total</td>
<td>$2,888,195</td>
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</tr>
<tr>
<td>Total SABG Award*</td>
<td>$8,459,907</td>
<td></td>
</tr>
<tr>
<td>Planned Primary Prevention Percentage</td>
<td>34.14 %</td>
<td></td>
</tr>
</tbody>
</table>

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

**Footnotes:**

Prevention education amount listed in Table 5a corresponds to the sum of Universal Direct and Selective amounts in Table 5a, based on the type of prevention education offered. Universal indirect includes the amounts captured in the Unspecified categories of the remaining five CSAP categories (Information Dissemination, Alternatives, Community Based Processes, Problem ID and Referral, and Environmental Strategies) as well as the “other” category from Table 5a.
<table>
<thead>
<tr>
<th>Targeted Substances</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>b</td>
</tr>
<tr>
<td>Tobacco</td>
<td>b</td>
</tr>
<tr>
<td>Marijuana</td>
<td>e</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>b</td>
</tr>
<tr>
<td>Cocaine</td>
<td>e</td>
</tr>
<tr>
<td>Heroin</td>
<td>e</td>
</tr>
<tr>
<td>Inhalants</td>
<td>e</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>e</td>
</tr>
<tr>
<td>Synthetic Drugs (i.e. Bath salts, Spice, K2)</td>
<td>e</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Targeted Populations</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Students in College</td>
<td>b</td>
</tr>
<tr>
<td>Military Families</td>
<td>e</td>
</tr>
<tr>
<td>LGBTQ</td>
<td>e</td>
</tr>
<tr>
<td>American Indians/Alaska Natives</td>
<td>b</td>
</tr>
<tr>
<td>African American</td>
<td>e</td>
</tr>
<tr>
<td>Hispanic</td>
<td>b</td>
</tr>
<tr>
<td>Homeless</td>
<td>e</td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islanders</td>
<td>e</td>
</tr>
<tr>
<td>Asian</td>
<td>e</td>
</tr>
<tr>
<td>Rural</td>
<td>b</td>
</tr>
<tr>
<td>Underserved Racial and Ethnic Minorities</td>
<td>b</td>
</tr>
</tbody>
</table>

**Footnotes:**
New Mexico  OMB No. 0930-0168  Approved: 05/21/2013  Expires: 05/31/2016
### III: Use of Block Grant Dollars for Block Grant Activities

#### Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

<table>
<thead>
<tr>
<th>Activity</th>
<th>FY 2014 SA Block Grant Award</th>
<th>FY 2015 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prevention</td>
<td>Treatment</td>
</tr>
<tr>
<td>1. Planning, Coordination and Needs Assessment</td>
<td>$349,635</td>
<td>$15,726</td>
</tr>
<tr>
<td>2. Quality Assurance</td>
<td>$101,987</td>
<td>$15,726</td>
</tr>
<tr>
<td>3. Training (Post-Employment)</td>
<td>$234,873</td>
<td></td>
</tr>
<tr>
<td>4. Education (Pre-Employment)</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>5. Program Development</td>
<td>$136,420</td>
<td>$31,454</td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td>$679,002</td>
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</tr>
<tr>
<td>7. Information Systems</td>
<td>$273,188</td>
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</tr>
<tr>
<td>8. Enrollment and Provider Business Practices (3 percent of BG award)</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>9. Total</td>
<td>$1,775,105</td>
<td>$62,906</td>
</tr>
</tbody>
</table>
Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2014

<table>
<thead>
<tr>
<th>Service</th>
<th>Block Grant</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHA Technical Assistance Activities</td>
<td></td>
</tr>
<tr>
<td>MHA Planning Council Activities</td>
<td>$34,100</td>
</tr>
<tr>
<td>MHA Administration</td>
<td></td>
</tr>
<tr>
<td>MHA Data Collection/Reporting</td>
<td>$34,000</td>
</tr>
<tr>
<td>Enrollment and Provider Business Practices (3 percent of total</td>
<td></td>
</tr>
<tr>
<td>award)</td>
<td></td>
</tr>
<tr>
<td>MHA Activities Other Than Those Above</td>
<td></td>
</tr>
<tr>
<td>Total Non-Direct Services</td>
<td>$68,100</td>
</tr>
</tbody>
</table>

Comments on Data:

Footnotes:
LifeLink contract devoted to the BH Planning Council and a portion of Leticia Rutledge’s salary for T&E.
C. Coverage M/SUD Services

Narrative Question:

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations of MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state’s EHB package?

Footnotes:
C. Coverage for M/SUD Services

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?

On January 8, 2013, Governor Martinez announced the intent to expand Medicaid. The Behavioral Health Services Division, as the SSA and SMHA, has been very involved in the development of the Medicaid Expansion benefit package. While the Alternative Benefit Package has not been finalized, BHSD understands that it will include mental health and substance abuse services at parity with physical health services.

In accordance with the recent release of the final Medicaid eligibility rules on July 5, 2013, NM is developing procedures to qualify recipients with SMI and/or chronic substance abuse for the new eligibility category of Medically Frail. This new category of eligibility will provide these individuals with the option of selecting the full Medicaid benefit package instead of the Alternative Benefit Package. This option will likely provide access to more robust behavioral health benefits.

On October 12, 2013, the NM Superintendent of Insurance selected the Benchmark Plan for the New Mexico Health Insurance Exchange. This plan includes mental health and substance abuse treatment services at parity with physical health.

2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?

On July 12, 2013, New Mexico received approval of an 1115 waiver to integrate Medicaid behavioral health, physical health and long-term care services beginning January 1, 2014. The new 1115 waiver program is called Centennial Care. The BHSD has been very active in the development of the waiver and MCO contracts to implement the waiver. The NM Behavioral Health Collaborative (Collaborative), representing the 17 state agencies with interests in behavioral health, is a co-signer with the Human Services Department, on the contracts. The contracts require specific reporting on behavioral health services. In addition, the contract includes many provisions designed to ensure that the MCOs include behavioral health professional in all areas of operations (eg. call centers, utilization management, member services). MCO contract managers are required to work with the Collaborative and its local collaboratives. Protections are included to ensure that the amount of behavioral health services is not reduced. BHSD staff are participating in Centennial Care readiness reviews of the MCOs to ensure that integration of behavioral health services is a critical focus.

The New Mexico Health Insurance Exchange is still in development. The BHSD intends to work with the Exchange to develop strategies to monitor access to behavioral health services in the Qualified Health Plans.
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.

The New Mexico Health Insurance Exchange is still in development. The BHSD intends to work with the Exchange to develop strategies to monitor access to behavioral health services in the Qualified Health Plans.

4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?

The BHSD, as the SSA and SMHA, will work closely with the Medicaid and Exchange complaints offices to track and review any complaints regarding MHPEA. However, BHSD does not have direct enforcement authority.

5. What specific changes will the state make in consideration of the coverage offered in the state’s EHB package?

Due to the recent release of the final Medicaid eligibility rule in July, BHSD is in the process of revising its assumptions about the impact of Medicaid Expansion. BHSD is using pre-Expansion non-Medicaid service utilization and projected Expansion take-up rates to access the remaining gaps in services for individuals with incomes below 138% FPL. BHSD is still researching reliable assumptions for the take-up rate for those Newly Enrolled who will take the option of the Full Medicaid Benefit vs. the Alternative Benefit Package. While the estimates are preliminary, BHSD has been able to take the estimated impact of Expansion into consideration in the development of the FY14-15 Plan.

Several changes made to Medicaid coverage in FY13 (and included in the planned EHBs) have impacted this FY14-15 Block Grant Plan. Medicaid has expanded coverage to include Opioid Treatment Programs for Methadone as well as Suboxone. Medicaid also expanded coverage to Intensive Outpatient Programs for Substance Abuse. BHSD understand that these services will also be available in Qualified Health Plans through the Exchange.

Under the 1115 waiver which begins January 1, 2014, coverage for three new Medicaid behavioral health services will begin. These recovery-based services include: Recovery Support, Family Support Services, and Respite Care for children and youth with SED. Recovery Support and Family Support Services are peer-support services. BHSD is currently working to build the peer support workforce to implement these services by January, 2014.

With the new approach to integrated care in Centennial care, New Mexico is planning to implement SBIRT for mental health and substance abuse. BHSD had a successful SBIRT program for several years but had to discontinue the effort when the grant expired at a time of tight State budgets. BHSD has included SBIRT as a priority area in the FY14-15 Plan.
The FY14-15 Plan has been developed recognizing that implementing these expansions to Medicaid coverage, as well as the Qualified Health Plans, will take time. Considering New Mexico’s current unmet needs and gaps in services, BHSD is planning conservatively regarding the extent to which Medicaid and QHP coverage will reduce the need for block grant and state funded services through the FY14-15 period.
IV: Narrative Plan

D. Health Insurance Marketplaces

Narrative Question:

Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state’s new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers’ networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?

2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?

3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?

4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?

5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.

6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.

7. For the providers identified in Table 8 - Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state’s Medicaid program. Please provide the assumptions and methodology used to develop the estimate.

8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Footnotes:
D. Health Insurance Marketplaces

SAPT

Background

Excerpt from New Mexico’s Office of Health Care Reform Transition Plan, December 2010

On April 20, 2010, Governor Bill Richardson, by Executive Order 2010-012 established the Health Care Reform Leadership Team in response to passage of the PPACA. The Leadership Team was charged with creating a strategic plan, and coordinating across state agencies that would oversee planning, development and implementation of federal health care reform in New Mexico. On July 1, 2010, the Leadership Team sent to the Governor its report “Implementing Federal Health Care Reform – A Roadmap for New Mexico”. Based on the report, on July 19, 2010, the Governor, by Executive Order 2010-032,

- charged the Leadership Team to continue in its mission to oversee the planning, development and implementation of health care reform in New Mexico;
- Expanded the membership of the Health Care Reform Leadership Team to include representation from the New Mexico Higher Education Department; Public Education Department; Department of Finance and Administration; General Services Department, Risk Management Division; Office of the Governor’s Council on Women’s Health; and the Workers’ Compensation Administration;
- Created a New Mexico Office of Health Care Reform – administratively attached to the Human Services Department- authorized with decision-making authority and dedicated existing staff, including personnel from state agencies represented on the Leadership Team, to plan, coordinate, and administer implementation of federal health care reform while reporting to the Health Care Reform Leadership Team;
- Conducted tribal consultation regarding health care reform initiatives and policies that will impact American Indians in order to ensure the adherence to New Mexico’s Tribal Collaboration Act SB196 and federal requirements mandated and regulated by the U.S. Health and Human Services Department (HHS);
- Maintained involvement of, and coordination with, New Mexico’s Congressional delegation; providers; insurers; health plans; consumers; advocacy groups; tribes, tribal organizations, and urban Indians; and other members of the public.

In 2013, the Governor appointed the New Mexico Healthcare Exchange, responsible for outreach and education to the general public about health insurance enrollment and to train providers and employers on the implications and requirements for assisting in the enrollment process. Appointees Required by State Statutes include Superintendent of Insurance and NM Human Services Department, Cabinet Secretary. Other appointees include Governor and Legislative appointees.
1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?

New Mexico is currently working on this process.

2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?

New Mexico is currently working on this process.

3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing third party Medicaid, the CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?

New Mexico is currently working on this process.

4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?

New Mexico is currently working on this process.

5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.

BHSD does not currently have this information.

6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY2015. Please provide the assumptions and methodology used to develop the estimate.

BHSD does not currently have this information.

7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2012 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.

BHSD does not currently have this information.
8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

BHSD does not currently have this information.
IV: Narrative Plan

E. Program Integrity

Narrative Question:

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
   a. Budget review;
   b. Claims/payment adjudication;
   c. Expenditure report analysis;
   d. Compliance reviews;
   e. Encounter/utilization/performance analysis; and
   f. Audits.
4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

Footnotes:
New Mexico is unable to respond to this section at this time.

1. Does the state have a program integrity plan regarding the SABG and MHBG?

2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?

3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
   a. Budget review;
   b. Claims/payment adjudication;
   c. Expenditure report analysis;
   d. Compliance reviews;
   e. Encounter/utilization/performance analysis; and
   f. Audits.

4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?

5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?
IV: Narrative Plan

F. Use of Evidence in Purchasing Decisions

Narrative Question:

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services. SAMHSA is requesting that states respond to the following questions:

1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?

2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?
   a) What information did you use?
   b) What information was most useful?

3) How have you used information regarding evidence-based practices?
   a) Educating State Medicaid agencies and other purchasers regarding this information?
   b) Making decisions about what you buy with funds that are under your control?

Footnotes:
F. Use of Evidence in Purchasing Decisions

New Mexico is currently unable to provide information for this section.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services. SAMHSA is requesting that states respond to the following questions:

Through the oversight of the Collaborative,
1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?

2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?

   a) What information did you use?

   b) What information was most useful?

3) How have you used information regarding evidence-based practices?

   a) Educating State Medicaid agencies and other purchasers regarding this information?

   b) Making decisions about what you buy with funds that are under your control?
IV: Narrative Plan

G. Quality

Narrative Question:

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

<table>
<thead>
<tr>
<th>Health</th>
<th>Prevention</th>
<th>Substance Abuse Treatment</th>
<th>Mental Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Youth and Adult Heavy Alcohol Use - Past 30 Day</td>
<td>Reduction/No Change in substance use past 30 days</td>
<td>Level of Functioning</td>
</tr>
<tr>
<td>Home</td>
<td>Parental Disapproval Of Drug Use</td>
<td>Stability in Housing</td>
<td>Stability in Housing</td>
</tr>
<tr>
<td>Community</td>
<td>Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval</td>
<td>Involvement in Self-Help</td>
<td>Improvement/increase in quality/number of supportive relationships among SMI population</td>
</tr>
<tr>
<td>Purpose</td>
<td>Pro-Social Connections Community Connections</td>
<td>Percent in TX employed, in school, etc - TEDS</td>
<td>Clients w/ SMI or SED who are employed, or in school</td>
</tr>
</tbody>
</table>

1) What additional measures will your state focus on in developing your State BG Plan (up to three)?

2) Please provide information on any additional measures identified outside of the core measures and state barometer.

3) What are your states specific priority areas to address the issues identified by the data?

4) What are the milestones and plans for addressing each of your priority areas?

Footnotes:
IV. Narrative Plan

G. Quality and

R. Quality Improvement Reporting

Note: The Quality Task Force in BHSD addresses “Quality” and “Quality Improvement Reporting”. Because the work of quality improvement and enhancement overlaps and integrates together, this same narrative will fit both G. Quality and R. Quality Improvement Reporting sections.

The New Mexico Behavioral Health Services Division (BHSD) is responsible for reporting to SAMHSA as the recipient of various federal block grants. Client data is obtained from numerous state departments and the State Entity (SE) for population of the required reports. BHSD has submitted the Client Level Detail File as required by the Data Infrastructure Grant (DIG). Specific to federal block grants, provider, consumer and service utilization data are obtained through the SE’s service registration, claims and invoice systems.

Additionally, BHSD has worked with the Human Services Department’s (HSD) Information Technology Division (ITD) to build the Behavioral Health Data Warehouse (BHDW). The BHDW provides the Quality Improvement (QI) Committee a rich data source. The QI Committee is developing an indicator matrix drawing from a variety of data sources that will provide an inventory of measures by which to track critical outcomes and performance measures. These metrics will provide the data for dashboards/barometers to monitor New Mexico’s mental health, addictions systems and programmatic improvements. BHSD in collaboration with the SE has also developed and implemented the State Outcomes Tracking system (STOT). Beginning January 1, 2013 all substance abuse providers are required to enter consumer data into the web-based system in order to capture the GPRA/NOMS and the Patient Health Questionnaire – 9 (PHQ-9).

The QI Committee was formed by the New Mexico Behavioral Health Purchasing Collaborative at the introduction of the SE to the state’s behavioral health system. The QI Committee is a cross agency group made up of representatives from: Behavioral Health Services Division, Children Youth & Families Department, Medical Assistance Division, Aging and Long Term Services Department, Department of Health’s Division of Health Improvement, and the Quality Division Director from the SE.

The QI Committee provides oversight on quality related activities of the SE. The QI Committee reviews the SE’s Annual Quality Program Plan, Evaluation Report and subsequent Quality Work Plan. As part of their process, the QI Committee reviews specific reports, including outcomes and performance measurements, tracking and trending of such data, and report-outs to the New Mexico Behavioral Health Purchasing Collaborative. Critical incidents are monitored through
the monthly Critical Incidents Report from the SE. Complaints and grievances are monitored through the quarterly Complaints and Grievances Report from the SE. Processes are detailed at the end of this document.

In addition, the QI Committee has developed an Annual Strategic Quality Priorities Plan (i.e., a Continuous Quality Improvement Plan). The QI Committee works with the SE to assure that they: provide data to inform the status on the priorities; implement interventions to improve performance; and provide subsequent data to examine achievement of benchmarks.

### Strategic Quality Priorities Plan for FY 2013

<table>
<thead>
<tr>
<th>FY 2013 Priorities</th>
<th>Indicators</th>
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<tbody>
<tr>
<td>Program Quality</td>
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</table>
| 1. Appropriate Psychotropic prescribing practices for children. | Prescribing practices identified for FY 2011 were:  
  1. Two or more antipsychotic prescribed;  
  2. Any Behavioral Health medication prescribed for children aged 0-5;  
  3. Greater than three Behavioral Health medications prescribed.  
  
At the onset of this initiative, The SE’s Clinical Pharmacist identified outlier prescribers meeting one of the above three criteria through pharmacy claims data. The number of uniquely identified prescribers was large (over 70 out of 660+ prescribers in the network). The workgroup determined that another level of criteria would be useful; a prescriber appears on one report with 10 or more different consumers in any one given month or prescriber appears on one report with four consecutive months of one or more consumers. This added criteria served to decrease the number to 24 prescribers.  

During FY 2011 the parameters were developed and the pharmacy data monitoring protocol and report process were refined. The expectation at the start of this initiative was that as the data and patterns of prescribing are monitored, the numbers of consumers affected by prescribing practices falling within the above criteria would decrease over time. This premise did not prove correct for the Two or More Antipsychotics and the Greater Than Three Behavioral Health Medications criteria. For the Any Behavioral Health Medication in Children Ages 0-5 category, a slight decrease was evidenced in the last two quarters of FY 2012.  

In November of 2011, these targeted prescribers received an introductory letter informing them that their prescribing practices had been identified as outliers and the SE requested an explanation of the prescribing rationale. Of the 24 letters sent, 3 were returned for incorrect addressing (prescribers moved). Of the 21 remaining prescribers, 11 responded with rationale, several reported via telephone that they had no intention of responding. After much discussion on how to effectively address this priority, the Prescribers Workgroup is re-evaluating interventions for FY 2013. The SE’s pharmacy is implementing new data analytic technology to better assist ongoing monitoring and review of prescribing practices within the SE’s provider network. The current program has had limited results due to inefficiencies in the process to include data being delayed, including only prescribers who hit a given threshold, it is time and labor intensive and the passive methods of disseminating
<table>
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<th>FY 2013 Priorities</th>
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<tr>
<td>Paper mailings to a few targeted health care professionals does not address the concerns of the broader population of youth receiving medications. The new program will be built upon improved data processing efficiencies.</td>
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2. Successfully implement evidenced based and practice based treatment alternatives for youth.  
Track Outcomes for clients receiving the EBP of Intensive Outpatient. Targeted outcomes are being identified from the literature (e.g., retention in treatment, timely follow-up - client improvement).  
Trend outcomes.  
- Increased adolescent IOP programs approved.  
- Increased number of adolescents served.  
- CYFD developed a plan for tracking outcomes of youth receiving IOP that includes 12 measures.  

<table>
<thead>
<tr>
<th>FY 2013 Client Outcomes</th>
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| 3. Increase in # and % of high severity clients who categorically improve on the STOT drug & alcohol domains. | Trend change over time in the alcohol and drug domains, quarterly as measured by the State Outcomes Tracking system (STOT).  
- Baselines are being established in FY 2013.  
- BHSD is currently implementing the STOT system that will be required for all substance abuse providers. The STOT is a web-based application that includes the GPRA/NOMs and the Patient Health Questionnaire (PHQ-9). The outcome data related to drug and alcohol used will be used for this priority. The STOT provides the state with a rich source of data for use in QI activities. |

<table>
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<tr>
<th>Service System Improvements</th>
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| 4. Increase Provider competence in building recovery & resiliency - oriented treatment systems at the provider level. | Improve recovery-based practice with clinical staff in agencies.  
- Recovery oriented (ROSI) questions integrated into the Treatment Record Review (TRR) tool.  
- Revised TRR tool implemented.  
- Report quarterly on the findings and progress with targeted interventions beginning FY 2013-Quarter 2. |
| 5. Development of a comprehensive continuum of care for adults, youth & children | Adults: Length of time to next appropriate level of care, specifically:  
- What is the readmission rate to inpatient and residential care?  
- Percent of clients who receive 7 and 30 day follow-up from:  
  - Residential Substance Abuse to IOP  
  - Inpatient to Comprehensive Community Support Services (CCSS)  
Children: Length of time to next appropriate level of care, specifically:  
- What is the readmission rate to inpatient and residential care?  
- Percent of clients who receive 7 and 30 day follow-up from: | Adults: Length of time to next appropriate level of care, specifically:  
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<tbody>
<tr>
<td>• Residential to IOP&lt;br&gt;• Inpatient to CCSS</td>
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A new report (QI-135) has been developed that tracks a consumer’s next treatment episode after inpatient, RTC, TFC and IOP (broken down by children and adults). The QI Committee is analyzing trends in order to establish a baseline and recommend targets.

6. Improved access and availability of services to rural and frontier consumers through use of telehealth technology

<table>
<thead>
<tr>
<th>Within the current sites, establish baseline data on:</th>
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<tbody>
<tr>
<td>• Number of clients served by telehealth in rural &amp; frontier counties.</td>
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<tr>
<td>• Number of units by type of service.</td>
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<tr>
<td>• Track expansion of sites and services.</td>
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<tr>
<td>• Qualitative measure for Client satisfaction.</td>
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<tr>
<td>• Track Vidyo Initiative.</td>
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</table>

7. Increased provider use of QM/QI practices within their agencies

<table>
<thead>
<tr>
<th>QM/QI plans required from all high volume providers (approximately 40) and have been submitted to OHNM.</th>
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<tbody>
<tr>
<td>• OHNM will update grading/review tool and will review and grade plans by end of October and report findings and planned interventions to the QI Subcommittee by the end of November.</td>
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</table>

Quality Service Review (QSR)

A major initiative in QI has been introduced by the Collaborative to systematically develop Clinical Practice Improvement. New Mexico Behavioral Health Providers (specifically, the Core Service Agencies) are using a New Mexico Quality Service Review (QSR) process to assess their practice and client progress. QSR is a systemic approach to assess an agency’s clinical practice—its strengths and challenges. The QSR protocol systematically looks at a client, their progress and the agency clinical practice functions. The tools are designed to review human service systems to determine what is working at the point of practice delivery for specific consumers and why it is working. It is based on an in-depth case review method involving multiple stakeholders, and uses a performance appraisal process to assess individuals, benefit from services and how well the service systems address their needs. The Collaborative has brought together providers and members of local communities through the Local Collaboratives to review the service systems for each of the Local Collaboratives across the state. This allows the providers and members of the local communities to self assess the breadth and efficacy of the local behavioral health service system. By the end of FY12, all CSAs have been trained in the use of QSR. A significant proportion will have been reviewed and gotten their performance baselines. A third of the CSAs have received consultation on how to integrate QSR into their clinical supervision.

By FY 2014, all Core Service Agencies (CSAs) will have instituted a Clinical Practice
Improvement Program that includes process improvement approaches, relevant data collection, fidelity measures and data outcome monitoring.

The state has made significant gains in establishing QSR as a systematic approach to clinical practice improvement among the CSAs. During FY 2012 our QSR experts trained 173 staff in 23 CSAs; and, provided individualized staff consultation on clinical supervision to eight CSAs. In addition, seven comprehensive case reviews have been conducted in five children’s CSAs and two adult CSAs. During FY 2013, two additional CSAs have received their comprehensive reviews and the SE’s Vice President of Quality, Care Coordination and Utilization Management along with the regional staff were trained in QSR.

Effective FY 2013, the CSA audit tool will include specific QSR review components to help monitor and support further Clinical Practice Improvements. In January 2013, five CSAs were trained in the use of the QSR data application so they can run the QSR reports within their own agencies. Additional agencies will be offered the tool in the Summer.

In the Spring of 2013, two 2-day Basic trainings (one on the adult protocol and another on the youth protocol) will be offered, along with additional trainings in Clinical Supervision and Case Formulation.

**Process for Responding to Emergencies**

In the event of a disaster, the SE is to be notified by the state. The SE will contact service providers in the affected area(s). The contract Scope of Work as written by the SE details providers’ responsibilities in response to disasters.

In the event of a psychiatric emergency, the SE maintains an 800 line that is staffed 24/7 by licensed clinicians. The clinician will triage the call and instruct the individual to either go to the ED or will facilitate an appointment within eight hours at the nearest behavioral health clinic. Providers are required under the Scope of Work in their contracts to adhere to the following standards for appointment access:

- Routine appointments within 14 days;
- Urgent appointments within 24 hours; and
- Crisis appointments within 2 hours (face to face).

The SE also generates the Access Standards Report semi-annually that provides information regarding the results of “secret shopper calls” to providers, conducted by the SE staff, in order to determine consumer access to urgent, emergent and routine care. The purpose of this report is to allow the Collaborative and the SE to monitor providers on client access to services, specifically related to treatment time by situational status (Emergency, Urgent, and Routine).
Process for Responding to Critical Incidents

The SE adheres to the Sentinel Events and Peer Review Committee Procedure, Policy QM008. The purpose of the policy is to outline a quality improvement and peer review process for reported sentinel events. The peer reviews of sentinel events are intended to accomplish the following goals:

- To ensure that sentinel events are appropriately reported, reviewed and monitored as part of an overall patient safety program;
- To identify facility and clinician performance improvement areas;
- To improve the overall quality of care provided to consumers; and
- To focus clinician or facility attention on the assessment of the sentinel event and to identify changes in the clinician or facility systems and/or processes to reduce the probability of a sentinel event in the future.

The SE’s Chief Medical Officer or designee reviews all sentinel events and reports to the Peer Review Committee recommendations for improving consumer care and safety, including recommendations that Network Services or Quality Improvement conduct a site audit or record review of the facility/clinician. The Peer Review Committee may also provide facilities and clinicians with written feedback related to observations made as a result of the review. The results of any review may be used by the Chief Medical Officer, in collaboration with the SE’s Vice President of Quality and Compliance, to make recommendations to suspend, terminate, or alter the participation status of programs, facilities or clinicians, or to conduct a site audit.

In addition, the SE provides the Collaborative with monthly and annual Critical Incident reports. The purpose of these reports is to provide an overview of Critical Incidents reported to the SE and involuntary hospitalizations. These reports are received from providers across all regions of New Mexico, at different levels of care, and among different consumer populations. The reports and analyses present the number of critical incidents and involuntary hospitalizations, types of critical incidents, and the distribution of incidents among special populations served by the SE. The reports describe quality improvement activities implemented by the SE during this reporting period.

Process for Responding to Complaints and Grievances

Monitoring complaints and grievances is a standard Quality Assurance practice that allows for consumer and provider feedback regarding satisfaction with system processes and practices which then allows the SE the opportunity to address issues at the provider level, systemically, internally and with Collaborative practices.
The SE defines grievances based on the New Mexico Administrative Code definitions and processes. In order to ensure comprehensive identification of problems within the service system, the SE has also implemented a process to capture quality of care issues from Care Coordination in addition to provider and consumer grievances.

The SE is required to provide the Collaborative with quarterly complaints and grievances reports and analyses. These reports and analyses breakdown the number and percentage of consumer and provider complaints and grievances by region and category. Categories included are: access, quality of care/service, consumer services, utilization review/care coordination, claims/reimbursement, pharmacy formulary/prior authorization and other.

Quality of care grievances are categorized as such when they are first received by the SE. They are then referred to the Quality Improvement Department for investigation. Following investigation, these may or may not be actual quality of care issues. If it is determined that there may be potential for a quality of care issue, the case is referred to the peer review committee for review, investigation and corrective action if necessary. In these instances, the complainant is informed that the case has been referred, but we may not be able to share the results of the investigation due to confidentiality rules related to peer-review. Finally, the case is closed.

Any grievance received which indicates a potential health or safety concern is immediately referred to the SE’s Quality Improvement Specialists in one of the five regions for investigation and follow-up action as required.
IV: Narrative Plan

H. Trauma

Narrative Question:

In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA’s trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Footnotes:
H. Trauma

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
Yes, New Mexico providers use an enhanced assessment in which trauma is screened for. Our specialized service providers such as Veterans and Sexual Assault victims are highly trained to assess for and treat trauma in their clients.

2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
NM is working to expand trauma informed care across the state and has selected a trainer whose main focus is to give state providers, private providers, and other interested parties training in trauma-focused EBP’s. The goal is for all state providers to be able to recognize, treat, and provide a trauma safe environment for their clients. Our providers work to meet the clients’ needs at their level, and if the client is ready to engage in treatment for their traumatic experience or providers will use EBP’s such as seeking safety, EMDR, or Prolonged Exposure therapy in treatment. Client’s needing specialized trauma services such as veterans PTSD and sexual trauma are referred to providers that specialize in these specific areas of trauma.

3. Does your state have any policies that promote the provision of trauma-informed care?
New Mexico is currently working on a state wide initiative to roll out Trauma Informed Care (TIC) statewide. The State has a state level TIC workgroup designed for community providers to be involved with the development and process of rolling out TIC across the state. A TIC workgroup has been organized to work on which model of TIC, the state will utilize in its statewide roll out of TIC training. TIC training has already begun, and will continue for the next several years. Through the State SE Optum Health providers can access online trainings related to trauma and PTSD as well.

4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
New Mexico utilizes Seeking Safety, EMDR, and Prolonged exposure. New Mexico has chosen Seeking Safety as its primary EBP for trauma, as it gives providers a safe and effective baseline treatment to help individuals with traumatic experiences. The state has funded a full time training position with Presbyterian Medical Services, who actively trains organization and individual providers in TIC, Military Culture, and Seeking Safety. This position also serves a state mentor for those that he has trained.

5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?
New Mexico’s current focus on training through the PMS trainer mentioned above is TIC, Seeking Safety, and Veteran Culture. Every year BHSD supports 3 Veteran conferences in which providers can receive training in areas of trauma practices and veterans can receive information on programs and methods utilize to help treat various traumatic experiences they have experienced.

Behavioral Health Services Division (BHSD) is committed to meeting the behavioral health needs of our consumers, many of whom come with disclosed or undisclosed trauma histories. To increase EBP’s around trauma informed care BHSD is providing Trauma informed trainings across all BHSD providers. The trainings address specific special populations including pregnant post-partum and parenting women and veterans.

Below are four tables which describe trainings conducted and those which are available.

<table>
<thead>
<tr>
<th>Training Name</th>
<th>Date</th>
<th>Host Organization</th>
<th>Location</th>
<th>Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seeking Safety Overview†</td>
<td>Aug 2012</td>
<td>NM Addiction Education Network Conference</td>
<td>Silver City</td>
<td>University staff, students, and addiction providers</td>
</tr>
<tr>
<td>Combat Environ/Seeking Safety Overview‡</td>
<td>Aug 2012</td>
<td>BHSD Conference</td>
<td>Albuquerque</td>
<td>Conference attendees</td>
</tr>
<tr>
<td>Veteran Awareness‡</td>
<td>Aug 2012</td>
<td>Luna Community College</td>
<td>Las Vegas, NM</td>
<td>Reps of various departments including nursing departments and student services.</td>
</tr>
<tr>
<td>Combat Environ/Seeking Safety</td>
<td>Sep 2012</td>
<td>San Juan Alternative Sentencing</td>
<td>Farmington</td>
<td>Alt Sentencing staff, PMS staff</td>
</tr>
<tr>
<td>Combat Environ/Seeking Safety Overview</td>
<td>Oct 2012</td>
<td>Healthcare for the Homeless</td>
<td>Albuquerque</td>
<td>HCH staff</td>
</tr>
<tr>
<td>Intro to Trauma-informed Care</td>
<td>Oct 2012</td>
<td>St. Luke’s Clinic</td>
<td>Las Cruces</td>
<td>Nursing staff and local Social Work students</td>
</tr>
<tr>
<td>Intro to Trauma-informed Care and Intro to Seeking Safety†</td>
<td>Nov 2012</td>
<td>Human Resource Development</td>
<td>Taos</td>
<td>BH and Juvenile Justice Providers/staff</td>
</tr>
<tr>
<td>Intro to Trauma and Seeking Safety</td>
<td>Nov 2012</td>
<td>YDI</td>
<td>Albuquerque</td>
<td>YDI clinical and admin staff</td>
</tr>
<tr>
<td>Motivational Interviewing§</td>
<td>Nov 2012</td>
<td>ENMU</td>
<td>Roswell</td>
<td>BH providers</td>
</tr>
<tr>
<td>Intro to Trauma and Seeking Safety</td>
<td>Jan 2013</td>
<td>YDI – Amistad</td>
<td>Albuquerque</td>
<td>Frontline milieu staff</td>
</tr>
<tr>
<td>Seeking Safety</td>
<td>Feb 2013</td>
<td>PiW</td>
<td>Los Lunas</td>
<td>BH providers and admin staff</td>
</tr>
<tr>
<td>Self-care for Peer</td>
<td>Apr 2013</td>
<td>PiW</td>
<td>Los Lunas</td>
<td>Peer support staff</td>
</tr>
</tbody>
</table>
The next three tables describe “canned” presentations that are available or will be available this FY. Training options are not limited to those described here, as we can modify/develop training as required.

The table below describes a full-day training intended to expose providers to developmental trauma, PTSD, and considerations for treating military and veterans. This is essentially what we presented in Taos, November 2012. Many of these individual topics can be expanded and offered in stand-alone presentations of an hour or two.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Time Required</th>
<th>Target Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Trauma (Neurosequential Development, and Adverse Childhood Experiences)</td>
<td>2 hours</td>
<td>Providers (behavioral, medical, community support, PSR, etc.)</td>
</tr>
<tr>
<td>Adult and Military Trauma (Combat environment, and Violent Crime in New Mexico)</td>
<td>1.5 hours</td>
<td></td>
</tr>
<tr>
<td>Post Traumatic Stress Disorder and Traumatic Brain Injury</td>
<td>1 hour</td>
<td></td>
</tr>
<tr>
<td>Evidence-based Treatments for PTSD (overview discussion of Seeking Safety, Cognitive Processing Therapy, and Prolonged Exposure)</td>
<td>1 hour</td>
<td></td>
</tr>
<tr>
<td>Military Sexual Trauma</td>
<td>.25 hour</td>
<td></td>
</tr>
<tr>
<td>Grief, Guilt, and Suicide</td>
<td>.50 hour</td>
<td></td>
</tr>
<tr>
<td>Spirituality</td>
<td>.25 hour</td>
<td></td>
</tr>
<tr>
<td>Sleep</td>
<td>.25 hour</td>
<td></td>
</tr>
<tr>
<td>Resilience and Wellness</td>
<td>.50 hour</td>
<td></td>
</tr>
<tr>
<td>Resources for Veterans</td>
<td>.25 hour</td>
<td></td>
</tr>
<tr>
<td>Training Duration</td>
<td>7.5 hours</td>
<td></td>
</tr>
</tbody>
</table>

The table below describes an Introduction to Trauma-informed Care. All of these topics can be offered in a stand-alone format of an hour or two each.
### Trauma-informed Care

<table>
<thead>
<tr>
<th>Topic</th>
<th>Time Required</th>
<th>Target Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Trauma (Neurosequential Development, and Adverse Childhood Experiences)</td>
<td>2 hours</td>
<td>Providers (behavioral, medical, community support, PSR, etc.)</td>
</tr>
<tr>
<td>Adult and Military Trauma (Combat environment, and Violent Crime in New Mexico)</td>
<td>1.5 hours</td>
<td>Administrative staff, Front office staff</td>
</tr>
<tr>
<td>Post Traumatic Stress Disorder and Traumatic Brain Injury</td>
<td>1 hour</td>
<td></td>
</tr>
<tr>
<td>Treatment Options for PTSD (overview discussion of Seeking Safety, Cognitive Processing Therapy, and Prolonged Exposure)</td>
<td>.50 hour</td>
<td></td>
</tr>
<tr>
<td>Becoming a Trauma-informed Organization (systemic considerations, self-care, and network development)</td>
<td>1 hour</td>
<td></td>
</tr>
<tr>
<td>Becoming a Learning Community</td>
<td>.50 hour</td>
<td></td>
</tr>
<tr>
<td><strong>Training Duration</strong></td>
<td><strong>6.5 hours</strong></td>
<td></td>
</tr>
</tbody>
</table>

The table below lists some stand alone trainings that are available as required.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Time Required</th>
<th>Target Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Trauma</td>
<td>2 hours</td>
<td>BH providers</td>
</tr>
<tr>
<td>Combat Environment</td>
<td>2 hours</td>
<td></td>
</tr>
<tr>
<td>Evidence-based Treatments for PTSD Options for PTSD (overview discussion of Seeking Safety, Cognitive Processing Therapy, and Prolonged Exposure)</td>
<td>1 hour</td>
<td></td>
</tr>
<tr>
<td>Self-care for Providers</td>
<td>1.5 hours</td>
<td></td>
</tr>
<tr>
<td>Spirituality/Soul Wound in Trauma Survivors</td>
<td>1 hour</td>
<td></td>
</tr>
<tr>
<td>Seeking Safety*</td>
<td>4 hours</td>
<td></td>
</tr>
<tr>
<td>Motivational Interviewing</td>
<td>2 Days</td>
<td></td>
</tr>
<tr>
<td>Cognitive Processing Therapy*</td>
<td>2 Days</td>
<td></td>
</tr>
<tr>
<td>Prolonged Exposure*</td>
<td>2 Days</td>
<td></td>
</tr>
<tr>
<td>Crisis Intervention (CPI)</td>
<td>**</td>
<td></td>
</tr>
</tbody>
</table>
IV: Narrative Plan

I. Justice

Narrative Question:

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas. Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

Please answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?
2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?
4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?
5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

I. Justice

The House Memorial 45 Task Force, December 2012, addressed “Problem Solving Courts” as one of its nine recommendations. The Memorial asked that the task force consider issues related to civil commitment and treatment guardianship; amending a section of the mental health and developmental disabilities code – making changes to the provisions related to treatment guardians; and changing the role of district attorney in civil commitment procedures.

As related to “Problem Solving Courts”, the report states:

Problem: Some of the concerns combined into House Memorial 45 were concerns about people involved in the criminal justice system. Pre-trial specialty courts have had proven success in New Mexico. In some jurisdictions, access to a treatment court gives access to services that would otherwise not be accessed by the person who is charged with a crime. Additional mechanisms for supervising and treating persons whose competency to stand trial is in question would assist in preventing the revolving door of people appearing, mostly for misdemeanors and being found to lack competency.

Recommendation: Establish problem solving courts such as treatment, mental health and drug courts throughout New Mexico, particularly increasing the number and availability of mental health courts.

Discussion: There are five mental health courts, sometimes called treatment courts, and forty-three drug courts (adult, juvenile, family dependency, and DWI). Treatment courts/mental health courts have arisen in five jurisdictions in differing ways. For example, in one jurisdiction people were failing in drug court because their needs for treatment were primarily mental health needs that they were self-medicating with illegal drugs. In another jurisdiction the treatment court program began as a pilot and now records only an 18% recidivism rate. At least one District Attorney has initiated her own kind of voluntary pre-trial diversion and treatment program for people revolving through her office for minor misdemeanors.

The Task Force noted the importance again of relationship and especially the interest, commitment and compassion of the problem-solving court judge. Mental health or treatment courts as well as drug courts appear to succeed by including a service array with three elements: court supervision, case management and treatment provision (both individual and group). A treatment court may include the involvement of a psychiatrist and opportunities to receive assistance with medications in addition to judicial supervision. The stability of specialty court funding is a significant factor in program variations. Further, these pre-trial specialty services are often coordinated and made available to those charged with a crime in ways that are not available to people who are not involved in the criminal justice system.
Responses to Block Grant Application Questions:

1. **Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?**

   The Children Youth & Families Department (CYFD) already does this and has done so for years. It is not a new thing based on the Affordable Care Act but what NM has been doing since SCHIP began as part of access to care for JJ clients.

   For adults, yes, however, there is not a mechanism to enroll adult consumers while they are still incarcerated. The Corrections Department will make efforts to promote enrollment upon release to probation and parole.

2. **What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?**

   Youth entering the Juvenile Justice system are screened for mental health and substance abuse needs and referred for services as indicated. The screenings are done through our Community Behavioral Health Coordinators (licensed social workers) who are located in the Juvenile Probation offices. When screenings indicate the need for MH and/or SA services, youth are referred to the network of community mental health providers for treatment.

   For adults, screening for mental health and substance abuse disorders, pre-adjudication, is generally accomplished by the Pre-Trial Services Division, a branch of the Administrative Office of the Courts.

3. **Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?**

   New Mexico is unique in that the Children, Youth and Families Department is the SMHA and SSA for children and youth and also houses the Juvenile Justice and Child Welfare systems. Extensive efforts at diversion are coordinated by CYFD as described in number 2 above. Recommendations and services provided become part of the record and are taken into consideration at adjudication. Youth Correctional facilities are also operated by CYFD and, therefore, mental health services are provided in the facilities in a manner that is as consistent with community services as possible and transition is emphasized.

   CYFD has a Transitional Supports Unit for youth being discharged; we have an Entitlement Bureau that ensures that whenever possible youth are covered by Medicaid the day they are discharged so MH / SA services can begin immediately.
The Behavioral Health Purchasing Collaborative (SMHA/SSA) does work with adult corrections around diversion of individuals with mental health and substance abuse disorders, but many interventions are the direct result of action taken by the New Mexico Corrections Department on its own reentry initiatives.

4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?

CYFD is researching this question.

For adults, the criminal justice populations present a challenge to managed care. They have typically been overlooked or marginalized, and the Corrections Department's membership on the Collaborative aims, in part, to keep the spotlight on the behavioral health needs of these individuals.

5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

A variety of training and collaboration efforts are carried out by the Behavioral Health Purchasing Collaborative, the single state entity (Optum Health), and individual agencies within the Collaborative. On the Juvenile side, the major effort is the Judicial Conclave held every January. This event brings together the Judiciary, Mental Health, Juvenile Justice and Child Welfare personnel to train and disseminate information from the four systems.

The New Mexico Corrections Department has provided cross-trainings to managed care organizations on working with adult criminal justice populations, and will continue to do so throughout the implementation of Centennial Care.
**IV: Narrative Plan**

**J. Parity Education**

**Narrative Question:**

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?

2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.)?

3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

**Footnotes:**
**J. Parity Education**

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?

The New Mexico Behavioral Health Planning Council was one of a few states to receive an invitation from SAMHSA to develop a communication strategy to improve consumer knowledge about Medicaid Expansion and parity. The committee had working sessions for about a year. SAMHSA provided expertise for several sessions at the beginning. The effort continues through the Behavioral Health Planning Council.

2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.)?

New Mexico BHSD is participating in about 60 town hall meetings to educate the public, consumers and providers, about Medicaid Expansion, the Health Insurance Exchange and New Mexico’s new 1115 integrated care waiver, Centennial Care.

3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

The BHPC can use its subcommittees and local collaboratives throughout the State to strategically outreach to those who are directly impacted by parity.
IV: Narrative Plan

K. Primary and Behavioral Health Care Integration Activities

Narrative Question:

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?
2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?
3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?
4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.
5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.
6. Describe how your behavioral health providers are screening and referring for:
   a. heart disease,
   b. hypertension,
   c. high cholesterol, and/or
   d. diabetes.

Footnotes:
K. Primary and Behavioral Health Care Integration Activities

Background
Answers to the application questions are directly from the *NM Centennial Care Plan*.

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?

The State will, over the next several years, move intensive care coordination to the “point of service” by incentivizing the proliferation of patient centered medical homes and health homes. As individuals choose or are enrolled in either the medical home primary care model and/or the health home for the management of chronic conditions, those entities will assume responsibility for intensive care coordination. The Managed Care Organizations (MCOs) will be expected to continue to provide overarching care coordination, technical assistance, and to assure the care coordinators in these “point of service” models full access to all of the MCO resources and utilization and encounter data that would be required for a care coordinator to understand the entire spectrum of a beneficiaries needs.

The State’s intent is to initially develop health homes in pilot site Core Service Agencies (CSAs) in Albuquerque and expand to other geographic areas of the State as best practices develop. This model for behavioral health homes is being designed in conjunction with the physical health MCOs and the model will be used for other populations as the health home concept is expanded. Over time, the State intends to establish health homes for other chronic conditions.

The next step in the integration of care is the establishment of health homes. New Mexico is currently working with a Section 2703 planning grant to design its first State Plan Amendment (SPA) to establish health homes throughout the state. The initial concentration for the health home model is for individuals receiving services to treat a behavioral health condition. The State’s intent is to initially develop health homes in pilot site Core Service Agencies (CSAs) in Albuquerque and expand to other geographic areas of the State as best practices develop. This model for behavioral health homes is being designed in conjunction with the physical health MCOs and the model will be used for other populations as the health home concept is expanded. Over time, the State intends to establish health homes for other chronic conditions.

The health homes, once established, will assume responsibility for the six services required by federal law:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support, which includes authorized representatives;

• Referral to community and social support services, if relevant; and
• The use of health information technology to link services, as feasible and appropriate.

The State will work with CMS and its actuaries to assure that services provided by the health homes are not duplicated by the MCOs. The intent is to push comprehensive case management to the point of service with oversight and back-up resources provided by the MCOs’ care coordination systems.

2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?
See answer in #1.

3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?

New Mexico has some success stories helping beneficiaries understand their health needs and how to access the health care system. The Federally Qualified Health Centers (FQHCs) in particular rely on community health workers called promotoras. However, the promotoras are not statewide and not all providers are allied with them. The State will require plans to do much more aggressive outreach to their patients and offer information both about how to navigate and most efficiently use the health care system as well as how to manage their health conditions. Much of this work can be most effectively done through the use of a trained, “lay” workforce to work with beneficiaries to engage in their own health. Whether the plans “make or buy” this service, it will be a contractual requirement that community health workers be available as a resource to both the Care Coordination staff and to beneficiaries who seek to educate themselves about their health. In addition, plans will be expected to develop culturally sensitive, relevant and accessible materials on using the health care system and addressing chronic health care issues.

New Mexico has contractually encouraged its Salud MCOs to work towards the development of patient-centered medical homes. Progress has been made but there is more work to be done to “grow” both urban and rural medical homes where primary care is provided and the patient is surrounded by both care coordination and access to other community supports. The new requirement in the Affordable Care Act (ACA) to pay primary care physicians at 100% of the Medicare rate will be helpful in furthering the establishment of primary care medical homes. For the years 2014-2016, the federal government will make up the difference between current payment rates and the new requirement. If the medical homes can demonstrate better health outcomes for their patients, the State may consider continuing a higher payment rate to those providers that demonstrate quality metrics.
4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.

TUPAC, at the Department of Health (DOH), does not have the authority to mandate behavioral health facilities to go tobacco-free or to address nicotine dependence as part of their services. They are a prevention and education – based program on tobacco control for the state. DOH has received calls from two facilities, Santa Fe Recovery Center and The Na’Nizhoozhi Center Inc. in Gallup to explore these possibilities. DOH does not know of any other facilities who are considering this systemic change, they are trying to develop relationships with BH facilities to explore these systemic changes. DOH states, “Our experience with this is that the facilities are hesitant to go tobacco-free and address nicotine dependence because it will meet with resistance from the patients and staff.”

5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.

See answer in #4.

6. Describe how your behavioral health providers are screening and referring for:
   a. heart disease,
   b. hypertension,
   c. high cholesterol, and/or
   d. diabetes.

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.
IV: Narrative Plan

L. Health Disparities

Narrative Question:

In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?

2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?

3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?

4. How will you use Block Grant funds to measure, track and respond to these disparities?

Footnotes:
L. Health Disparities

Background
The State Entity has worked closely with the Collaborative for several years to ensure that behavioral health providers, state agencies, peer specialists, and other organizations and agencies are aware of cultural differences and understand how to be culturally sensitive.

As mentioned in Step 2 of the Application, a self-assessment tool has been developed intended to measure cultural and linguistic competency among Core Service Agencies (CSAs). The Consortium for Behavioral Health training and Research (CBHTR) will implement and analyze the survey during the first quarter of 2013. The data will be used to develop training and technical assistance services for the CSA network to develop policies and to implement culturally and linguistically appropriate service delivery best-practices.

A Multicultural Services Advisory Committee (MSAC) identifies training needs, educational materials and consultation services relevant to the needs of diverse populations in New Mexico. Diversity includes, but is not limited to, ethnicity; race; sexual orientation; gender; age; socio/economic status; primary language; English proficiency; spirituality/religion; country of origin; literacy level, employment status; geographic location; disability/physical limitations; immigration status; and criminal involvement. Accomplishments in 2012 included:

1. Governance of the SOC grant regarding cultural and linguistic matters.
2. The development and implementation of the annual Cultural and Linguistic Appropriate Services (CLAC) OHNM self-assessment.
3. The design and development of the SOC self-assessment for CSAs.
4. Revisions of the OHNM Treatment Record Review Form to include cultural and linguistic measures.

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?
The BHSD Quality Team receives client level data that includes race, ethnicity, gender and age. Language services and LGBTQ information is not currently being collected.

2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?
BHSD will need to work with its Managed Care Organizations (MCOs) to create an intake/assessment tool that addresses language needs and other “disparity-vulnerable” subpopulations. The interview and the tool must be sensitive to cultural differences.

3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity vulnerable subpopulations?
The State Entity has worked diligently during the past three years to educate, train and implement cultural competency standards across professional fields. The State will need to modify its data collection system or create a new audit tool to identify disparities in access, services, outcomes, etc.

The NM Data Dashboard collects and tracks access and quality data that includes demographics and access, but not by “language” or LGBTQ disparities.

The Consumer and Youth/Family Member Satisfaction Survey collects demographic data, but does not match satisfaction questions according to gender or race/ethnicity.

The NM Substance Abuse Epidemiology Profile collects and reports detailed demographic information on physical and mental health; substance abuse; and death rates – but not by LGBTQ or language.

However, the Department of Health Epidemiology Bureau does collect data on “Individuals in need and In Need and Eligible for Services” that does identify LGBTQ and race.

The system is in place. It needs to be further refined.

4. How will you use Block Grant funds to measure, track and respond to these disparities?
Scopes of Work and Contracts can include a requirement that agencies receiving block grant funding must collect and document demographic client encounters and treatment that would also ask questions about LGBTQ and language. Again, the tool, or assessment questionnaire must be culturally sensitive and appropriate.
IV: Narrative Plan

M. Recovery

Narrative Question:

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).

5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?

7. Does the state have an accreditation program, certification program, or standards for peer-run services?

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?

2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

New Mexico
M. Recovery

Behavioral Health care, support and recovery is important to the New Mexico Human Services Department (HSD). Its Strategic Plan states in Goal 4, Task 4.2: Align New Mexico’s behavioral health system within the changing healthcare environment by -

Activities:

1. Establish a Medicaid-funded pilot program for “health homes” for chronic conditions which integrate community behavioral health and primary care services and emphasize health promotion.
   a. In 2014, pilot at least two “health homes” addressing the integration of care for people with serious mental illness and substance abuse problems.

2. Develop “Health Homes” in Core Services Agencies (CSA’s) to assure an essential presence of behavioral health in the integrated health care environment.

3. Strengthen the development of community-based behavioral health services for adults and children.
   a. Develop a crisis system to prevent recipients with mental health and substance abuse problems from being inappropriately detained in jails or by law enforcement by leveraging existing funds and resources.
   b. Build services in local communities to keep children and youth in homes (or homelike services) in school and in communities.
   c. Develop a New Mexico Clearinghouse for Native American Suicide Prevention to provide culturally appropriate suicide prevention, intervention and post-event assistance.

4. Expand and improve the capacity of the behavioral health workforce in New Mexico
   a. Increase the employment of paraprofessionals (e.g., peers and families specialists) to deliver recovery support services.
   b. Establish the use of telehealth services throughout the CSA’s to increase access to psychiatric services.

5. Develop Wellness Centers that will offer support, education, information and opportunities to assist consumers recover a life that is rewarding and meaningful.

Responses to BG Application Questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

At the heart of the Collaborative's vision is the expectation that the lives of individuals with mental illness and substance use disorders ("Consumers") will improve, that consumers of
Mental Health Services and family members will have an equal voice in the decisions that affect them and their loved ones, and that those most affected by mental illness and substance abuse can recover to lead full, meaningful lives within their communities. To achieve this will require a paradigm shift not only within the service delivery culture but also within the existing consumer of Mental Health Services/family member networks.

The vision of the Office of Consumer Affairs (OCA) – housed in the Behavioral Health Services Division (BHSD) – “is to assure that the voice of New Mexican consumers and family member is heard and included in all major decisions pertaining to mental health and substance abuse issues. The mission is accomplished through progress on the following strategies: training, program development and advocacy, funding and participation/information dissemination.” (Found at http://www.bhc.state.nm.us/BHConsumers/OCA.html)

Our partner, OptumHealth NM, promotes the message that “…Recovery is a journey of healing and transformation enabling a person with a behavioral health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. (found at https://www.optumhealthnewmexico.com/consumer/en/index.jsp)

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

Through the HSD’s veterans’ court program, we have hired a veteran peer mentor coordinator, who is responsible for providing leadership, training, and coordination of volunteer Veteran peer mentors for individuals are involved in the program. Our VFSS program out of Rio Rancho, delivered by Presbyterian Medical Services (PMS) also has hired veteran clinicians, trainers, and coordinators to provide services and leadership in different areas of the program, each at a different level of their own recovery from PTSD, Substance abuse, etc.

The CSAs have increased the number of CPSW’s hired in the last year. Counseling Associates, Inc through the PPW program also employs peer support specialist to help with the women’s inpatient treatment program.

At the state level, at least one BHSD Program Director is in a position of leadership for programming and still works on his PTSD as a combat veteran. Potentially, others here as well fit a similar bill. BHSD also in the past when available have contracted with consumers to provide insight and leadership to initiatives and program development.

Office of Consumer Affairs

The Leadership Academy is a 3 to 4 day class that teaches individuals how to advocate for self and others. Individuals also learn to be active members of organizations and productive voting members of boards by learning and using Roberts Rules of Order. The last day of the class is
dedicated to Role-playing everything that was learn with hopes that they will then start their own consumer run Advocacy group or Organization.

The Mutual Support and Self-Help is a one day training to teach individuals the importance of mutual support and self-help in one’s own recovery and how to start and maintain/sustain the group we also look at different kind of groups and formats that others have used.

Continuing Education Units (CEUs) are offered for Suicide Prevention Training (from NREPP, but modified for state); QPR (Question, Persuade, Refer) and ASIST (Applied Suicide Intervention Skills Training); and Basic Housing Training.

Many consumers have taken on leadership roles including those who are chairs or co chairs of their local collaboratives, Behavioral Health Planning Council subcommittees, and the Behavioral Health Planning Council. At least five peers have become recognized statewide for their leadership, experience and expertise and work closely with BHSD through the OCA. They are:

Donald Hume – Lead Trainer for OCA and owner of Recovery Based Solutions
Ann Jennings – Communications Coordinator for OCA
Marcia Hawthorne – Peer Training Coordinator
Pat Loyd – Director of Peer Bridgers at UNM
Dahlia Christen – Peer Supervisor at Healthy Homes at The Life Link

Systems of Care

Progress toward achieving the third goal to “expand community capacity to serve children and adolescents with SEDs and their families” includes efforts by Local Management Teams and the SOC Governance Team composed of cross-agency managers and community representatives who direct the planning and implementation of SOC. Participants in the Local Management Teams include CSAs in the Highland Cluster and Grant County anchor sites, and Tribal government in the Santa Clara Pueblo anchor site, as “host agencies” for local SOCs. In turn, CSAs and the Tribal provider serve as sites for the provision of care coordination conducted in wraparound fashion. The mapping and description of capacity and community resources done by the evaluation team for the services and cost study, as well as focus groups, will also support identification of current gaps and areas of possible expansion. A significant CLC issue critical to serving children, adolescents and their families is ensuring language access to all points of service into SOC. The enrollment of Hispanic children into SOC has resulted in a high number of monolingual and Limited English Proficient (LEP) families seeking services. In Grant County and Highland Cluster, all of the Welcome Packet materials have been translated into Spanish. Highland Cluster and Grant County CSAs employ bi-lingual Community Support Workers
(CSW) providing Comprehensive Community Support Services (CCSS) to the SED-enrolled populations. The Grant County CSA employs a CSW who, in addition to being bi-lingual Spanish speaking, is also fluent in American Sign Language. Additional language access steps to enroll children and families with Spanish speaking linkages have been instituted to ensure timely enrollment and engagement into SOC. Santa Clara Pueblo in currently engaged in the hiring process for its behavioral health and local youth and family coordinators, with an emphasis on hiring individuals who speak the native Tewa language.

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

Several of BHSD’s programs or initiatives provide person center planning or self-direction. For example, Access to Recovery (ATR) is all about self direction, and client choice is at the forefront of this program. No one can tell a client which provider to choose. Our veterans program VFSS also follows this model in that they work on the issues that they see important, (not forced into working on PTSD\Trauma) and are met at their level of need. CSSS is also self directed in the way that the CSSS providers help the client identify their needs and then help them learn how to achieve those needs (Teach not Do for them concept).

Peers do recovery plans, and Advanced Directives for Mental Health, and WRAP plans which are participant-centered.

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible?

Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).

Our Core Service Agency (CSA) network employs CPSW for peer support and the CSSS array of services also meets this need. The Special program Bureau or Unit is working to interconnect programs so that clients can receive Recovery Support Services (RSS) simultaneously, or as an aftercare step down approach as well. For example we are working to connect PPW client’s that come out of Carlsbad for follow up services in their home community with ATR or CSA’s or both in some circumstances as ATR is the only program that can pay for certain RSS services.

We have several contracts for warm lines for peer to peer and crisis. One of which is in San Miguel County which is a warm line for peer to peer contact and the other is the veteran crisis line paid for by PMS through VFSS funds.
The state also supports Oxford housing (recovery housing) in which the State pays for 1.5 FTE’s for Oxford House to continually increase the number of Oxford Houses available. Oxford House is also a self-directed and peer supported model for recovery as well.

BHSD is working on plans to provide CRAFT - both in ATR and VFSS (thru PMS) - to provide consumer/family education to help individuals seek and engage in treatment. The Vet peer coordinator and volunteers also provide peer-based crisis services supported by clinical staff of the VA, PIW, and PMS at this time.

Two major activities currently underway by BHSD are Recovery Oriented System of Care and Trauma Informed initiatives which both work to align a continuum of care model for the state and should have a step up and step down approach to treatment.

Peer support is provided through CCSS at 12 of the CSAs around the state (if you need a list of those please let me know). There are a variety of non CSAs that provide peer support as more than half our certified peers work outside a CSA. All the Wellness Centers provide or are supposed to be providing WARM lines (Catron County Grassroots, Restoring Health to the Pathways of Life, Hozho Center for Personal Enhancement, Mental Health Association of New Mexico to be in place and operational by January 2013). Peer support has been in Las Cruces through Southwest Counseling for 15 years.

**Systems of Care**

Progress toward achieving the third goal to “expand community capacity to serve children and adolescents with SEDs and their families” includes efforts by Local Management Teams and the SOC Governance Team composed of cross-agency managers and community representatives who direct the planning and implementation of SOC. Participants in the Local Management Teams include CSAs in the Highland Cluster and Grant County anchor sites, and Tribal government in the Santa Clara Pueblo anchor site, as “host agencies” for local SOCs. In turn, CSAs and the Tribal provider serve as sites for the provision of care coordination conducted in wraparound fashion. The mapping and description of capacity and community resources done by the evaluation team for the services and cost study, as well as focus groups, will also support identification of current gaps and areas of possible expansion. A significant CLC issue critical to serving children, adolescents and their families is ensuring language access to all points of service into SOC. The enrollment of Hispanic children into SOC has resulted in a high number of monolingual and Limited English Proficient (LEP) families seeking services. In Grant County and Highland Cluster, all of the Welcome Packet materials have been translated into Spanish. Highland Cluster and Grant County CSAs employ bi-lingual Community Support Workers (CSW) providing Comprehensive Community Support Services (CCSS) to the SED-enrolled populations. The Grant County CSA employs a CSW who, in addition to being bi-lingual Spanish speaking, is also fluent in American Sign Language. Additional language access steps to enroll children and families with Spanish speaking linkages have been instituted to ensure
timely enrollment and engagement into SOC. Santa Clara Pueblo is currently engaged in the hiring process for its behavioral health and local youth and family coordinators, with an emphasis on hiring individuals who speak the native Tewa language.

The Behavioral Health Planning Council has encouraged the concept of Communities of Care to be implemented statewide, which would be inclusive of the entire life span including adults and older adults.

5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

Through the work of the State Entity’s Cultural Competency Division, extensive training has been conducted for better understanding of behavioral health as related to the LGBT community, Native Americans, Hispanic populations, and persons who are deaf and hard of hearing or blind.

BHSD sponsors the Peer Mentor Program for the courts system for Veterans. Also BHSD provides funding for the CPSW program for the Veterans through PIW. Also up until September OCA paid for CPSW trainings that were Native American sensitive through Restoring Health to the Pathways of Life – with an emphasis on Navajo traditions.

6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?

The Office of Consumer Affairs (OCA) provides a few CEU trainings for the CPSWs that pertain to work such as 2 Basic Housing and this year we are providing a six CEU training on Suicide Prevention.

7. Does the state have an accreditation program, certification program, or standards for peer-run services?

The certification program for Peers started in May of 2009. Four peer run Wellness Centers were funded through BHSD in 2010-201. Recovery Based Solutions also receives funding through BHSD but is not a Wellness Center. The job description for a peer is as follows:

- Coaching, role modeling and mentoring
- Services to facilitate peer client self-discovery
- Skill-building and recovery activities to assist in achievement of recovery and resiliency goals
- Assisting in the development of recovery plans - Identifying needs; Assessing supports; Partnering with others to assist individuals in overcoming barriers to service
Community Support Services provided by the CPSW shall be performed with a special emphasis on recovery and resiliency principles and processes, including but not limited to:

- Empowering the individual to embrace hope and participate in his or her own recovery;
- Supporting the individual in identifying strengths and needs related to become independent;
- Supporting the individual in identifying and achieving personal recovery goals (which should include attainment of meaningful employment if desired by the individual);
- Promoting an individual’s responsibility related to illness self-management.

Recovery Based Solutions and Mutual Self Help and Recovery provide Leadership Academy. The Wellness Centers provide self-help groups such as AA, NA, CA, and Double Trouble in Recovery (DTR) for co-occurring.

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

BHSD
As mentioned earlier, two major activities currently underway by BHSD are Recovery Oriented System of Care and Trauma Informed initiatives which both work to align a continuum of care model for the state and should have a step up and step down approach to treatment. Monthly teleconference and/or video conference meetings provide opportunity for provider agencies, state partners, consumers and family members to learn about innovate, evidence based practices taking place across communities – offering both clinical and experienced based presentations and discussion.

Consumer, Family and Youth Satisfaction Survey

Done jointly with the BHSD Quality Team, Children, Youth and Families Department (CYFD), and the State Entity (OptumHealthNM), the 2012 Survey Report reflects satisfaction levels on services received for behavioral health. Respondents included 1,374 adults, 1,015 family members, and 149 youth respondents. Individuals and families in recovery depend on at least 5 domains of service: Access; Appropriateness; Satisfaction; Effectiveness; Empowerment. Three year comparisons were identified. (See Attachment CFY Survey)

In general, the statewide responses were as follows:

<table>
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<tr>
<th></th>
<th>Access</th>
<th>Appropriateness</th>
<th>Satisfaction</th>
<th>Effectiveness</th>
<th>Empowerment</th>
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New Mexico OMB No. 0930-0168 Approved: 05/21/2013 Expires: 05/31/2016
Effectiveness is defined as “the extent to which services provided to individuals with behavioral health needs have a positive or negative effect on their well being, life circumstances, and capacity for self-management and recovery.”

While the percent of positive responses for this domain seems low, the neutral or negative responses were 36% for Adults and 43% for Youth/Family.

System of Care

Progress toward achieving the fifth goal to “integrate a CQI framework” includes weekly evaluation meetings of core evaluation staff to ensure consistent data collection across sites and evaluation staff working with each of the local sites to ensure consistent enrollment into the descriptive study and the longitudinal outcome study. Data is also provided back to the Governance Team and Local Management Teams and their respective subcommittees, including DPRs and data gleaned from EDIFS and NOMs data collection. An SOC evaluation subcommittee has been established to gain youth, family, and provider voice in the evaluation process and decisions are made based on this feedback. A plan for collecting data for the services and cost study is in progress. The evaluation team is in the process of developing the annual process evaluation survey and has been gaining youth and family voice to ensure that the items on the survey are relevant and important to the CQI process. The goal of the survey is to determine what movement has been made toward reaching goals, what barriers have been identified, and how these barriers have been handled. The evaluation team has also reviewed data collected through the longitudinal outcome study and the descriptive study. This data was presented for discussion to the Governance Team and the local management teams. Meeting minutes have also been reviewed, with recommendations presented to the Governance Team to continue the CQI process.

The SOC Statewide Youth Coordinator has been an active participant in the Behavioral Health Collaborative Consumer Satisfaction Project, responsible for oversight and implementation of the Consumer, Youth and Family Satisfaction Surveys. The SOC Statewide Family Coordinator will be joining these efforts in FFY’13. The Statewide Youth Coordinator oversaw the successful implementation of the Youth Satisfaction Survey, with youth serving on the research team, collecting data and discussing the results in order to understand the findings. This survey was conducted in Spanish and English, with approximately 150 youth participants from throughout the state. The adult survey was translated into Spanish and future discussions will involve adding more CLC questions to provide more opportunities for consumers to identify how cultural considerations are being addressed at the provider level. The CLC Manager has also initiated discussions with the Statewide Youth Coordinator on reviewing the youth survey for CLC content and subsequent translation.
Local clinical practice will be reviewed and measured through the Quality Service Review (QSR), a nationally-used practice improvement tool. It provides quantitative data and qualitative feedback on the improvements in individual case outcomes, agency clinical practice and local systems of care. The Highland Cluster and Grant County anchor sites have been trained, had comprehensive reviews, reviewed in other agencies, had clinical supervision and other consultation in QSR. Statewide, significant efforts have been made to incorporate QSR into the provider network. Efforts include the following:

2009-2010:

- Conducted 2 Reviewer trainings on the children’s QSR protocol and 2 trainings on the adult QSR protocol;
- Trained 31 local agency staff and 19 state staff;
- Provided “on-the-job” review opportunities to 50 trained persons who were “shadow reviewers” in local QSR onsite reviews;
- Conducted onsite reviews in 9 communities across 18 agencies (9 children and 9 adult agencies);
- Reviewed specific practices with 35 children and families
- Reviewed specific practices with 23 adult consumers
- Interviewed more than 600 persons involved with behavioral health services in the 9 communities

In 2011 - Significant gains have been made in establishing QSR as a systematic approach to clinical practice improvement among the CSA. Since June, 2011, QSR experts have:

- Trained 173 staff trained in 23 core services agencies;
- Provided individualized staff consultation on clinical supervision to 8 core service agencies
- Provided “on-the-job” opportunities to 24 trained persons who were “shadow reviewers” in local QSR onsite review; and,
- Conducted 7 comprehensive case reviews in 5 children’s CSA and 2 adult CSA’s

Responses to Involvement of Individuals and Families

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?

Behavioral Health Planning Council

As mentioned in Section W. State Behavioral Health Advisory Council:
The Statutory Subcommittees conduct the work of the Council - Adult, Substance Abuse, Medicaid, Native American, and Children/Adolescents. It is in those Subcommittees where the broadest base of input is provided from consumers and family members with the least amount of
expense. To further their productivity, the Council continues to offer direction on the functions of the subcommittees and their relationships to the Council and the Local Collaboratives.

The voice of consumers and family members is heard through many different forums including:

The members of the Adult/Substance Abuse/Medicaid Subcommittee are continuing to work with the Local Collaboratives (LC’s) to produce a mapping of services, programs and support activities. This “map” will include services funded not only by State Agencies/OptumHealth but also recovery programs, consumer operated services, faith-based programs, volunteer support groups, City/County funded programs, etc. Focus has been: LC 6 (Grant, Hidalgo and Luna counties), LC 7 (Torrance, Catron and Socorro counties), LC 11 (San Juan County) and LC 15 (the Navajo Nation). The NM Aging and Long Term Services Department has compiled data and placed it on their online NM Social Services Resource Directory. The Children / Adolescent Subcommittee is working on a similar mapping project with an emphasis on “community supports”. When completed, this website could become an integral part of a comprehensive behavioral health resource system.

The Council and the Collaborative have long recognized that behavioral health is essential to overall health. Subcommittee members have taken the work of SAMHSA’s *Eight Dimensions of Wellness* (social, environmental, physical, emotional, spiritual, occupational, intellectual and financial) back to their home communities – to local Senior Jubilees, to local consumer groups, to psychosocial rehabilitation groups, and to individuals. All agreed that 1) Behavioral Health is essential to health, 2) Prevention works, 3) Treatment is effective and 4) People recover.

The members of the Adult/Substance Abuse/Medicaid Subcommittee (ASAMSC) have worked on one Dimension each month, translating the ideas into advice about how it is possible to really live that dimension of wellness. Drawing upon their personal experiences, all members of the subcommittees have suggested practical ways in which health can be maintained and ensured. Each month, the work of the subcommittee was complied into a brochure. A full set of these New Mexico Eight Dimensions of Wellness brochures will be available. These brochures are printed not only in English but also in Spanish and have been distributed to the Local Collaboratives. The intent is to expand distribution to providers, Health Councils, libraries, etc. This project is a wonderful example of providing “advice” through lived experience. The ASAMSC is now working on making one document that promotes and contains each of these brochures.

The Council has strong presence on various State Legislative Task Force Workgroups:

- SM 18: To continue the work of the Drug Policy Task Force begun during the last Legislative Session, in order to complete the task force’s comprehensive statewide strategic
plan based on the four pillar approach—prevention, treatment, harm reduction, and enforcement.

- HM 77: To provide recommendations for rules and enforcement protocols to address the increasing rate of addiction to and deaths due to accidental overdose of prescription drugs.
- SM 56: To develop a comprehensive statewide plan for treatment of adolescent Opioid addiction.

The 4th Annual BHPC/LC Summit in 2012 was very successful in that approximately 160 Local Collaborative members gathered to share successes and offer resources to build and support local partnerships and initiatives around substance abuse prevention, recovery and mental health treatment and recovery. The theme for the summit was SAMHSA’s National Campaign of the 8 Dimensions of Wellness. The day started off with special two special guest speakers: Mike Duffy from SAMHSA and Pamela Drake addressing The Interdisciplinary Science of Prevention.

Presentations were given throughout the day highlighting successful programs throughout the state such as The Opportunities and Challenges of Establishing Sustainable Relationships between the Tribal, County and State Government of Sandoval County, The Warm Line in Las Vegas, NM, and The Consumer-Run Wellness Center/Inside Out in Espanola, NM to name a few.

The Native American Subcommittee (NASC) has been very active reaching out to local community and provider agencies in order to make the necessary connections for learning, mentoring and supporting one another on our journeys to improve the behavioral health services in NM. One of the more recent presentations given to the NASC was from the San Juan County Partnership/Dine Ba Hozho Coalition. They presented the outcomes from their “MOST of US/Nizhoni Youth survey.” This survey looked at two different schools in Shiprock, with a combined total of 200 students. The surveyor’s goals were to see if community beliefs and perceptions about the youth in their community “matched” what students self-reported in anonymous surveys. They looked at tobacco, alcohol and drug use. The study found that there was a significant difference between the community’s perception of their youth and what the youth self-reported as their “reality.” By collecting this data they developed a media campaign, using a Positive Community Norms model, which provides a framework that keeps “human services professionals grounded in real time, centered on science based interventions, focused on the need of individual communities and regions, and stays informed by listening to wide segments of the community.”* They also utilize the Navajo Wellness Model for their work. The San Juan County Partnership has partnered up with the NASC to reach out to the Children’s and Adolescents Subcommittee and the Council to strategize how we can share this information with other Native American populations, as well as youth organizations across the state.
System of Care
Progress toward achieving the second goal to “foster cross-agency collaboration through the Project Steering Committee and Local Collaborative SOC Subcommittees,” includes the development of parallel governance and management structures at the state and local levels. Through a strategic planning session held on December 1, 2011 with representation from the three anchor sites and key stakeholders, the decision was made to disband the Project Steering Committee and instead transform the Statewide Management Team into the SOC Governance Team. Membership changes to the SOC Governance Team include increased youth and family representation from each of the three anchor sites, juvenile justice and protective services senior management, local behavioral health provider agencies in the anchor sites, as well as increased participation by OHNM. The SOC Governance Team provides the venue for local management teams, youth, family members, local provider agencies including CSAs, and SOC key staff to identify and make recommendations for policy issues impacting the behavioral health service system. At the Highland Cluster anchor site Local Management Team meetings, following the departure of the Anchor Site Manager in August 2012, other key partners have increased their involvement and assumed leadership roles that will support long-term sustainability of that meeting. The CYFD Juvenile Justice Probation Supervisor for the Highland Cluster area now chairs the Local Management Team and has also joined the statewide Governance Team. In Grant County, there has been an increase in multi-agency discussions and partnering with local education staff. Other activities under this goal include an ongoing social marketing campaign aimed at local communities and Local Collaboratives to educate stakeholders and communities on SOC.

2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
The Collaborative has sponsored statewide town hall meetings, including tribal consultations, to hear questions and concerns regarding any major changes the state plans to implement. Extensive outreach and communications regarding Core Service Agencies (CSAs) took place during 2010-2011; including advisory workgroups that included consumers and family members to provide input on what services are important to them.

When Medicaid Reform became a pending issue, similar outreach and communications were provided to local collaboratives, the Behavioral Health Planning Council and its subcommittees, town hall meetings, and tribal consultations. Centennial Care is rolling out in 2013, which – again – will include various levels of communications (media, face to face meetings, publications, etc) and many opportunities for the general public to comment, ask questions, and provide feedback.
The Behavioral Health Planning Council is a continuous resource for information on the most current and pertinent issues. With its video conference and teleconference meeting format, stakeholders may listen to leaders in behavioral health government, the State Entity, and local communities provide the latest initiatives and hear feedback from participants.

The Collaborative also allows the same opportunities through its quarterly meetings, which are also videoconferenced statewide.

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

Forty-four Core Service Agencies (CSAs) have been designated by the State to coordinate care and provide essential services to children, youth and adults who have a serious mental illness, severe emotional disturbance, or dependence on alcohol or drugs. For those eligible to receive services, the CSAs provide or coordinate psychiatric services, medication management, everyday crisis services, and comprehensive community support services (CCSS) that support an individual’s self-identified recovery goals, and other clinical services.

CSAs and other behavioral health providers use a number of treatment methods designed to engage consumers in their treatment and desired outcomes. Therapies include: Cognitive Behavior Therapy; Trauma Informed Care; Access to Recovery; WRAP; Intensive Outpatient Program.

4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Through the Office of Consumer Affairs, extensive outreach is conducted to recruit, train and retain peers in the behavioral health field.

The Leadership Academy is a 3 to 4 day class that teaches individuals how to advocate for self and others. Individuals also learn to be active members of organizations and productive voting members of boards by learning and using Roberts Rules of Order. The last day of the class is dedicated to Role-playing everything that was learn with hopes that they will then start their own consumer run Advocacy group or Organization.

The Mutual Support and Self-Help is a one day training to teach individuals the importance of mutual support and self-help in one’s own recovery and how to start and maintain/sustain the group we also look at different kind of groups and formats that others have used
Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?

Since development of the New Mexico Long Term Supportive Housing Plan in 2007, the New Mexico Behavioral Health Purchasing Collaborative (the Collaborative) has provided guidance in developing effective supportive housing public policy; coordinating funding streams at the Federal, State and local level; and facilitating working partnerships among local communities, housing organizations and service agencies. This Plan was developed to benefit consumers and their families by reducing roadblocks to services, improving access and providing evidence-based best practice permanent supportive housing to support community recovery and resiliency services. New Mexico’s ten year supportive housing unit goal is to create 5,000 units across New Mexico before 2017.

The Collaborative partnered with the New Mexico Mortgage Finance Authority in 2008 and instituted a program of bonus points to incentivize Low Income Housing Tax Credit project developers to reserve up to 20% of affordable housing units in new or rehabilitated housing developments for persons with a range of disabilities and special needs. This has resulted in leveraging an additional 273 supportive housing units for ‘special needs’ households benefitting 696 persons in 11 New Mexico counties from 2009 - 2013.

While much of the initial work targeted supportive housing for people with behavioral health disorders, the housing plan always addressed strategies to promote and provide supportive housing for people with a broader range of disabilities. In 2010 the Collaborative member agencies broadened their efforts to include persons in the ‘Special Needs’ population who are in need of supportive services to live independently. The special needs population now includes households in which an individual or household member has a substantial, long term disability in one of these categories: Serious mental illness; addictive disorder; developmental disability; physical, sensory, or cognitive disability occurring after the age of 22; disability caused by chronic illness; age-related disability (i.e., frail elderly, or, young adults with special needs); or, households/individuals who are homeless. The Collaborative designates and funds Local Lead Agencies in 11 NM counties to perform special needs tenant screening and referral; and, develop partnerships with the services providers that act as referral agents and direct services providers as needed by these consumers.

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?

Persons in recovery, whether from the challenges of mental illness or substance abuse, require a range of housing options to address their housing needs at various stages in the recovery process including short term move in assistance and eviction prevention funds, interim crisis housing after de-institutionalization, transitional housing, and various types of permanent supportive housing (PSH) programs. The State of New Mexico allocates approximately $1 million in
annually recurring State funds that supports the following programs that benefit adults and youth with severe mental illness:

**Move In Assistance and Eviction Prevention Fund:** The program is used by qualified households for rent, damage deposit, utility deposits, utilities or other approved costs in their own housing unit/ apartment directly related to preventing homelessness, or accessing and maintain housing. The applicant (or dependent) must have a diagnosed/documented severe, persistent mental illness or co-occurring substance use disorder; maximum lifetime grant amount of $500.00.

**Crisis Housing Program:** The program, serving both Bernalillo and San Miguel Counties, provides temporary housing for persons being discharged from psychiatric centers, hospitals, jails or other institutional settings who have no housing and are diagnosed with SMI. It offers up to 120-day stays to find employment, have income entitlements reinstated, teach life skills for independent living and transition to their own permanent housing in the community.

**Linkages Program:** This nationally recognized permanent supportive housing program provides 39 rental vouchers and necessary support services to homeless, very low income persons who have been diagnosed with severe mental illness and co-occurring substance abuse issues. This program has been operating since 2007 in three sites -- Santa Fe, Albuquerque and the Silver City/Deming area. The Linkages Program was identified as a national promising practice by the Office of Planning and Evaluation of the U.S. Department of Health and Human Services. Linkages was cited in the November 2011 ASPE Research Brief of HHS’ that identified programs that link human services with housing supports to prevent and end family homelessness.

**Transitions Program:** A permanent supportive housing program for youth ages 18 to 21, funded by the Children, Youth, and Families Department since November 2007. Transitions provides rental subsidies and supportive services to youth in transition, who are either aging out of foster care, or are being released from juvenile justice facilities on parole in Bernalillo County.

**Healthy Homes: Peer Experts Supportive Housing Program:** This is a 5 year SAMHSA-funded program to serve homeless adults with severe mental illness in Santa Fe County. The goals of Healthy Homes are to: 1) improve access to (Permanent Supportive Housing) PSH for adults with SMI; 2) develop an innovative role for Certified Peer Specialists with supportive housing expertise; 3) expand the newly established coordination between housing agencies (LLAs) and behavioral health agencies (CSAs) at the state and local levels; 4) ensure outreach to traditionally underserved communities such as Native Americans, rural New Mexicans and veterans; and 5) support the development of a sustainable PSH approach in the State.
IV: Narrative Plan

N.1. Evidence Based Prevention and Treatment Approaches for the SABG

Narrative Question:

As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including: (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals, families, and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco, and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state’s prevention system?

5. How is the state’s budget supportive of implementing the Strategic Prevention Framework?

6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)


Footnotes:
N.1. Evidence Based Prevention and Treatment Approaches for the SABG

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

The State Epidemiological Outcomes Workgroup (SEOW) regularly reviews data from a variety of sources, including the Youth Risk and Resiliency Survey, the BRFFS, crash data, and community surveys to identify and prioritize substance abuse issues, intervening variables contributing to these problems, and prevention services to address them. This analysis consistently identifies driving while intoxicated, binge and heavy drinking, and underage drinking as the most prevalent and costly problem behaviors, closely followed by prescription drug and opioid abuse. Intervening variables identified from data as contributing to these problems include lack of perceived negative consequences related to lack of enforcement of ATOD laws: social access to alcohol by minors; retail access to alcohol, social access to prescription drugs, and individual level factors associated with underage drinking. (These selected intervening variables have also been vetted to ensure that they are likely to be changeable.) This analysis has led to the selection of evidence-based strategies that were proven effective in New Mexico during the SPF-SIG grant period that address the intervening variables and problem behaviors.

2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

All strategies funded by SAPT dollars in New Mexico are vetted by the SEOW to ensure that they are evidence based, cost effective, and appropriate to the populations served and the substance abuse-related behaviors and intervening variables that are targeted. The current list of strategies, listed under the appropriate intervening variables are:

1. **Low Enforcement of ATOD Laws**
   a. Advocacy & coordination for stronger enforcement of all existing youth and adult alcohol & drug related laws (minors in possession, sales to minors, providing alcohol to a minor, Social Host Ordinances; DWI, sales to intoxicated, server liability)
   b. Advocacy & coordination to increase enforcement efforts: sobriety checkpoints, saturation patrols, shoulder taps, party patrols, SID activity (compliance checks), DWI efforts
   c. Advocacy & coordination for stricter enforcement of youth graduated licenses
   d. Develop and strengthen enforcement of ATOD policies at schools
   e. Strengthening MIP laws to include consumption/intoxication as a criminal offense
2. Low Perceived Risk of Arrest/ Legal Consequence
   a. Publicizing law enforcement efforts (sobriety checkpoints, saturation patrols, etc.)
   b. Publicizing consequences for breaking ATOD laws

3. Retail Access
   a. Responsible Beverage Service Model (a package including alcohol merchant education, store manager policies, age verification, server training)
   b. Restrictions on alcohol placement in stores
   c. Restrictions on alcohol advertising by schools, day care centers, etc.
   d. Restrictions on alcohol sales (days, hours)
   e. Restrictions on alcohol outlet density
   f. Prevention of alcohol license transfers or new licenses

4. Social Access (for youth only)
   a. Advocacy for and passing of a Social Host Ordinance
   b. Developing and coordinating a Parent Party Patrol
   c. Parents Who Host Lose the Most
   d. Media to increase awareness of 4th degree felony and social host laws

5. Individual Level Risk and Resiliency Factors
   a. Dare to Be You
   b. Botvin’s Life Skills Training
   c. Power to Change (Modification of Project Venture)
   d. Project Venture
   e. Strengthening Families
   f. Too Good for Drugs

Through the Prevention Policy Consortium, a collaboration of 16 state agencies that fund prevention, the Office of Substance Abuse Prevention (OSAP) is aware of where most prevention funds are deployed in the state. Community providers, through local level assessments, are knowledgeable of other prevention resources at the local level, and report on these resources. Noting where these resources are available enables OSAP to avoid funding a duplication of services. In addition, the state entity’s billing system clearly identifies scopes of work by funding source to further reduce the possibility of double billing for the same services.

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

BHSD uses the Prevention Policy Consortium, a collaboration of 16 state agencies that fund prevention, as a primary means of developing and improving the prevention infrastructure in New Mexico. The PPC meets monthly and has four goal action teams dedicated to specific issues, such as tobacco and alcohol prevention. These teams are mapping resources and gaps in the prevention network, and developing the capacity to leverage resources to areas and populations most in need.

BHSD’s contracts for the operation of the New Mexico ATODA Prevention Workforce System. The system offers 26 days of training each year. These trainings are designed to provide prevention professionals with the knowledge to effectively implement evidence-based prevention
in the field and to prepare for certification as Certified Prevention Specialist. Each provider is required to ensure that employees funded through the SAPT block grant obtain training at a rate of 30 training hours per full time equivalent position.

4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state’s prevention system?

OSAP tracks four key indicators at the state level to evaluate the effectiveness of its prevention system.

1. Underage DWIs
2. Adult DWIs
3. Underage Binge Drinking
4. Adult Binge Drinking

We collect data on these indicators from providers and monitor the effectiveness of strategies in moving the key indicators over time.

At the community provider level, each funded provider must develop an evaluation plan that is outcomes based. These goals are related to the state indicators listed above. In addition, the local providers track outcomes for objectives with specific strategies and related intervening variables identified in their statements of work. Sample indicators include the number of citations issued for minors in possession, which is an indicator for success in advocating for stronger enforcement as a strategy for addressing low perceived risk of consequences for underage drinking.

5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

The Strategic Prevention Framework (SPF) is infused throughout New Mexico’s prevention operations. The state staff uses the SPF to guide its own planning and funding decisions. Every year, we use the EPI Profile as part of the evaluation of the past year’s efforts and as the start of the assessment process through the State Epidemiological Outcomes Workgroup (SEOW) and through the PPC. This data then drives the planning process, and guides funding decisions.

OSAP prevention service providers are required to use the Strategic Prevention Framework (SPF) as their operating model. Each year the providers are required to provide documentation of their strategic plan, as well as a management plan, logic models, and an evaluation plan. Providers are reimbursed for services based on units of service of assessment, capacity building, planning, implementation, and evaluation. The state supports providers in using the SPF with contracts for technical assistance in the SPF and a prevention workforce training system that delivers training in the context of the SPF process.

6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)
$1,955,300 of $2,888,195 of the prevention set-aside is provided to community organizations. This is 67% of the prevention budget.


Approximately 83% of the funds given to community programs are used for evidence-based practices and environmental strategies. The specific strategies are listed in 2 above. This amounts in total to $1,622,899 allocated among 16 providers throughout New Mexico.
IV: Narrative Plan

N.2. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

Narrative Question:
States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.

Footnotes:
N.2. Evidence Based Prevention and Treatment Approaches for the SABG

States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.

The State of New Mexico requested and received permission to hire an FTE for a mental illness prevention /behavioral health promotion position funded out of the CMHS portion of the Block Grant. Once hired, the Mental Illness Prevention Coordinator will begin to research and develop a state and community level system using the Strategic Prevention Framework process (develop a state needs assessment, a capacity building plan, a strategic plan, an implementation plan, and evaluation plan) and evidence-based strategies, seek additional funding opportunities to increase state capacity and implement strategies, and represent the state’s expertise in this area for policy development in the State Epidemiological Outcomes Workgroup and the Prevention Policy Consortium. Any subawards must comply with New Mexico procurement code which requires a competitive request-for-applications (RFA) process for awards over $49,000.
IV: Narrative Plan

O. Children and Adolescents Behavioral Health Services

Narrative Question:

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

Footnotes:
O. Children and Adolescents Behavioral Health Services

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?
The State of New Mexico currently has an SOC grant from SAMSHA which runs through 2015. This grant is the platform for implementation of systems change in the State of New Mexico for SOC principles and practices utilizing a “wraparound” model. Currently, SOC practice is being piloted in three communities. Beginning this year, FY 13, CYFD will be developing a Quality Service Review model to train and monitor provider organizations in the wraparound model. In this process, state staff will utilize an in-depth case review and practice appraisal process to find out how well children and their families are benefiting from services received and how well locally coordinated services are working for these children and families. QSR results provide a rich array of teaching stories, performance patterns, and lessons for affirming good practice already in place and for identifying next step actions for practice development and capacity-building efforts.

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?
The state is developing an individualized care planning process for children and youth with SED utilizing the “wraparound” model described above. It includes guiding values and principles, standards of care (clinical practice), systems supports and measurement and evaluation.

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
CYFD core legislatively mandated functions include Child Welfare, Juvenile Justice and Mental Health. Both the structure of CYFD and its’ processes include collaboration as a basic operating principle. One potential problem is the Centennial Care program, New Mexico’s response to the Affordable Care Act. Centennial care is changing the system to a “carve in” model with four or five managed care organizations (MCO’s). It will be an immense challenge to collaborate and coordinate with four or five for profit organizations that are not versed in SOC principles. Planning for this change is now in the earliest stages.

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
Currently the state provides financial and training support for MST and IOP Matrix model services. CYFD will continue to identify additional EBP’s and promising practices for dissemination

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
The State of New Mexico has developed a “data warehouse” where MCO’s, and in some cases providers, will be required to deposit all required data as identified in the MCO contracts for use by state staff. State staff are currently working on establishing performance measures and identification of data elements to bring the warehouse on line.
IV: Narrative Plan

P. Consultation with Tribes

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

For the context of the Block Grants awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for tribal members on tribal lands. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Footnotes:
P. Consultation with Tribes

Behavioral Health Services Division, Human Services Department

Within the Human Services Department (HSD), the Behavioral Health Services Division (BHSD) regularly interacts with Tribal and Native American provider agencies across New Mexico. Six Tribal and Native American provider agencies are currently allocated just over 16% of Substance Abuse Prevention and Treatment (SAPT) funds. Census data indicates that American Indians represent almost 11% of New Mexico residents. The Tribal and Native American agencies include:

- Eight Northern Indian Pueblos Council
- First Nations Community Healthsource
- Five Sandoval Indian Pueblo Incorporated
- Navajo Nation Department of Behavioral Health Services
- Na’Nihzhoozhi Center Incorporated
- Pueblo of Laguna Service Center

No Tribal or Native American provider agency currently receives Community Mental Health Services (CMHS) funding.

Four of these agencies are represented by 14 different Pueblos and one Tribe. Each of these agencies offers a range of substance abuse prevention and/or treatment with SAPT funding – including a range of community-based activities, outpatient counseling, or residential services. Given the diversity among each of the six agencies, each agency was invited to provide its unique feedback for the 2012-2013 unified Block Grant Application. Formal letters were sent requesting input into the new State Application through the BHSD Executive Director to tribal leadership at four tribally-governed agencies and to executive directors at two Native American agencies.

No appreciable issues or concerns were received from any of the six agencies with regard to the Block Grant application. BHSD expects to continue funding the same agencies for the same activities, at the same levels, for its next fiscal year. As such, the six tribal provider agencies were not asked for their input to the FY14-15 Block Grant Application.

As stated in our past Application, New Mexico government regularly collaborates with 22 federally recognized Tribes, Nations and Pueblos located within its boundaries. The five Departments of Health and Human Services, including Human Services Department (HSD), are guided in their government-to-government interactions by two documents. The New Mexico Health and Human Services Department Tribal Consultation Protocol (2007) guides formal consultation between Cabinet Secretaries and Tribal Leadership in New Mexico. The more recent State-Tribal Collaboration Policy (2009) guides a wider array of formal government-to-
government engagement. This later document came out of the State-Tribal Collaboration Act (STCA) of 2009. The STCA is a statutory commitment of New Mexico State government to work with Tribes, Nations and Pueblos on a government-to-government basis to better collaborate and communicate on issues of mutual concern.

Each State Agency has a Tribal Liaison. These liaisons interact closely with tribal and Native American communities, ensuring appropriate communications take place, facilitating tribal consultations or collaborations, and being a direct resource to tribal leadership for any concerns that may arise.

The New Mexico Interagency Purchasing Collaborative is comprised of 17 cabinet level representatives which includes the Secretary of the Indian Affairs Department (IAD). The Secretary of IAD is also a member of the Behavioral Health Planning Council and is Chair of the Council’s Native American Subcommittee. While all local collaboratives are invited to participate on the Native American subcommittee, membership is primarily made up of the five Native Local Collaboratives who are consumers, family members, providers and advocates. This subcommittee provides strong local voices to the Legislative body through the BHPC and the Collaborative to guide behavioral health planning and services for tribal and Native American communities.

**Medical Assistance Division (MAD), Human Services Department**

MAD manages the New Mexico Medicaid program. MAD recognizes that the Native American population has unique health care needs and that a large portion of health care is provided by the Federally-funded Indian Health Service (IHS) and Tribal 638 programs. MAD maintains an ongoing dialogue with Tribal leaders, IHS/Tribal 638 health care delivery systems, and Native American Medicaid recipients through multiple methods, including but not limited to: technical assistance and clarification to IHS/ Tribal 638 programs on Medicaid provider policies; the Medicaid application process; provider reimbursement rates; provider participation agreements; consumer advocacy; and collaboration with other programs whether they are State, Tribal or Federal. In addition, Medicaid is exploring ways in which technology can reach rural and frontier Tribal areas of New Mexico though activities such as telehealth and Project Echo out of the University of New Mexico.

MAD continues to provide Presumptive Eligibility/Medicaid On-Site Application Assistance (PE/MOSSA) throughout the State. Most recently, MAD received a Children’s Health Insurance Program Reauthorization Act (CHIPRA) Cycle II grant, which runs from August, 2011 to August, 2013. Its focus is on using technology to facilitate enrollment and renewal for PE/MOSAA applications. The grant was awarded to New Mexico in the amount of over $2 million dollars. HSD will utilize iREACH software to allow the electronic submission of MOSAA generated Medicaid applications by participating PE determiners statewide. Currently
over 60 individuals within IHS and Tribal 638 facilities throughout the State have signed up to be a part of this electronic MOSAA application project.

In the summer and fall of 2011, the HSD/MAD traveled throughout the State to gather input from urban Indian programs, Tribes, Pueblos, and the Navajo Nation in the redesign of Medicaid. Input was also sought from IHS and Tribal 638 health programs. In February, 2012 the HSD presented the Centennial Care Plan to Tribal leadership and a formal State-Tribal Consultation was held on March 20, 2012 to present details of the Plan and obtain feedback and comments from Tribal leaders, providers, consumers, and the general public. We continue to seek input from the public and Tribes for the 1115 Research and Demonstration Waiver/Centennial Care.

Looking ahead, MAD is committed to continue to work with Native American Medicaid recipients, IHS, Tribal 638 programs and other stakeholders to meet the growing demands of providing quality health care to the Medicaid eligible Native Americans in New Mexico. There are seven Medicaid programs through which eligible New Mexico Tribal members may receive services:

1. **Coordination of Long-Term Services (CoLTS)**
   - Total Enrollment in FY 2012: 40,028
   - American Indian/Alaska Native (AI/AN) Enrollment: 7,022 (or 18%)

2. **State Coverage Insurance (SCI)**
   - Total Enrollment: 39,489
   - AI/AN Enrollment: 2,616 (or 7%)

3. **Salud! Managed Care - Physical Health**
   - (Blue Cross/Blue Shield, Lovelace, Molina, and Presbyterian Salud)
   - Total Enrollment: 513,144
   - AI/AN Enrollment: 10,818 (or 2%)

4. **Medicaid School Health**
   - Total Enrollment: 20,813 Medical School-Based Services (MSBS)
     - 84 School-Based Health Centers (SBHCs)
   - AI/AN Enrollment: MSBS data not available (info isn’t recorded)
     - 32 SBHCs (or 38%) are in tribal communities

5. **Medicaid Behavioral Health Services**
   - Total Enrollment in Managed Behavioral Health: 374,843
   - AI/AN Enrollment in Managed Behavioral Health: 17,748 or 5%
6. Medicaid Fee-for-Service (FFS) Program
   Total Enrollment: 141,021
   AI/AN Enrollment: 70,822 (or 50%)

7. Medicaid Home and Community-Based Services (HCBS) Waivers, including:
   - Developmental Disabilities (DD) Waivers;
   - Medically Fragile (MF) Waivers;
   - AIDS Waivers;
   - CoLTS “c” Waivers; and
   - Mi Via Waivers
   - Brain Injury

   DD Waiver Total Enrollment: 3,814
   DD Waiver AI/AN Enrollment: 481 (or 13%)
   MF Waiver Total Enrollment: 214
   MF Waiver AI/AN Enrollment: 25 (or 12%)
   AIDS Waiver Total Enrollment: 20
   AIDS Waiver AI/AN Enrollment: 1 (or 5%)
   CoLTS “c” Waiver Total Enrollment: 40,028
   CoLTS “c” Waiver AI/AN Enrollment: 7,022 (or 18%)
   Mi Via Waiver Total Enrollment: 962
   Mi Via Waiver AI/AN Enrollment: 97 (or 9%)
   Brain Injury Total Enrollment: 313
   Brain Injury AI/AN Enrollment: 38 (or 12%)

MAD will continue to work with tribal members, representatives, providers and other stakeholders with all the HCBS Waiver programs.
IV: Narrative Plan

Q. Data and Information Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Footnotes:
Q. Data and Information Technology

The New Mexico Health Information Collaborative (NMHIC) chose Orion Health’s HIE platform for the statewide health information exchange in January 2013. The Orion Health platform will power the statewide exchange and expand the capabilities offered to healthcare providers across the State of New Mexico. This will be a phased process with the expectation of development for a long-term community record for each patient. Participants of the NMHIC will have on-line access to data analytics, dashboards, health tools, and various other features to help manage patient care to the fullest capacity. ([https://www.nmhic.org](https://www.nmhic.org))

New Mexico successfully submitted the client level detail file (CLDF), required under the provision of the Data Infrastructure Grant (DIG), to SAMHSA in December of 2012. A second file, State Hospital Readmission (SHR), is due on March 1, 2013 and is in the preparation process for submittal. Optum Health New Mexico (OHNM) and the New Mexico Behavioral Health Institute provide the mental health data contained in the CLDF and SHR files.

In the 2012 application, it was stated, “New Mexico receives funding under the Data Infrastructure Grant and has reached the stage of a data model for a behavioral health system-wide data warehouse.” The DIG project manager is allocating year three funds from the grant to research the possibility of incorporating data from the NMBHI into the data warehouse.

The DIG grant did not fund the data warehouse. Funds from DASIS, designed to support data infrastructure projects, were used to design and build the data warehouse. OHNM started submitting weekly files of all behavioral health records (substance abuse and mental health) in 2012. A workgroup comprised of the Information Technology Division (ITD), the Behavioral Health Services Division (BHSD), the Children, Youth and Families Department (CYFD) and the New Mexico Corrections Department (NMCD) collaborated in determining the fields and data required for maximizing usage of reporting data from the warehouse.

The 2012 application stated, “Until the state data warehouse project is completed, BHSD must rely on OHNM to provide reports and files needed for reporting on TEDS and the NOMS.” Using the data warehouse for TEDS is not a viable option at this time for New Mexico. Various factors occurring over the last year have changed this priority.

A. Original structure of data warehouse was modified by restrictions of the proprietary data format OHNM would allow for the transferred file.

B. In 2014, New Mexico is implementing Centennial Care for Medicaid Managed Care. This will require BHSD to work with the four new managed care organizations and the Medical Assistance Division (MAD) to obtain consistent data for the data warehouse.
C. Upon completion of collecting the data needed and redesigning the database, a major programming project will be required to produce TEDS files. The code used by OHNM is proprietary and not available to the State of New Mexico.
IV: Narrative Plan

R. Quality Improvement Plan

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue to reflect this evidence of effectiveness. The state’s CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

Footnotes:
IV. Narrative Plan

G. Quality and

R. Quality Improvement Reporting

Note: The Quality Task Force in BHSD addresses “Quality” and “Quality Improvement Reporting”. Because the work of quality improvement and enhancement overlaps and integrates together, this same narrative will fit both G. Quality and R. Quality Improvement Reporting sections.

The New Mexico Behavioral Health Services Division (BHSD) is responsible for reporting to SAMHSA as the recipient of various federal block grants. Client data is obtained from numerous state departments and the State Entity (SE) for population of the required reports. BHSD has submitted the Client Level Detail File as required by the Data Infrastructure Grant (DIG). Specific to federal block grants, provider, consumer and service utilization data are obtained through the SE’s service registration, claims and invoice systems.

Additionally, BHSD has worked with the Human Services Department’s (HSD) Information Technology Division (ITD) to build the Behavioral Health Data Warehouse (BHDW). The BHDW provides the Quality Improvement (QI) Committee a rich data source. The QI Committee is developing an indicator matrix drawing from a variety of data sources that will provide an inventory of measures by which to track critical outcomes and performance measures. These metrics will provide the data for dashboards/barometers to monitor New Mexico’s mental health, addictions systems and programmatic improvements. BHSD in collaboration with the SE has also developed and implemented the State Outcomes Tracking system (STOT). Beginning January 1, 2013 all substance abuse providers are required to enter consumer data into the web-based system in order to capture the GPRA/NOMS and the Patient Health Questionnaire – 9 (PHQ-9).

The QI Committee was formed by the New Mexico Behavioral Health Purchasing Collaborative at the introduction of the SE to the state’s behavioral health system. The QI Committee is a cross agency group made up of representatives from: Behavioral Health Services Division, Children Youth & Families Department, Medical Assistance Division, Aging and Long Term Services Department, Department of Health’s Division of Health Improvement, and the Quality Division Director from the SE.

The QI Committee provides oversight on quality related activities of the SE. The QI Committee reviews the SE’s Annual Quality Program Plan, Evaluation Report and subsequent Quality Work Plan. As part of their process, the QI Committee reviews specific reports, including outcomes and performance measurements, tracking and trending of such data, and report-outs to the New Mexico Behavioral Health Purchasing Collaborative. Critical incidents are monitored through
the monthly Critical Incidents Report from the SE. Complaints and grievances are monitored through the quarterly Complaints and Grievances Report from the SE. Processes are detailed at the end of this document.

In addition, the QI Committee has developed an Annual Strategic Quality Priorities Plan (i.e., a Continuous Quality Improvement Plan). The QI Committee works with the SE to assure that they: provide data to inform the status on the priorities; implement interventions to improve performance; and provide subsequent data to examine achievement of benchmarks.

### Strategic Quality Priorities Plan for FY 2013

<table>
<thead>
<tr>
<th>FY 2013 Priorities</th>
<th>Indicators</th>
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</thead>
<tbody>
<tr>
<td><strong>Program Quality</strong></td>
<td><strong>Prescribing practices identified for FY 2011 were:</strong></td>
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At the onset of this initiative, The SE’s Clinical Pharmacist identified outlier prescribers meeting one of the above three criteria through pharmacy claims data. The number of uniquely identified prescribers was large (over 70 out of 660+ prescribers in the network). The workgroup determined that another level of criteria would be useful; a prescriber appears on one report with 10 or more different consumers in any one given month or prescriber appears on one report with four consecutive months of one or more consumers. This added criteria served to decrease the number to 24 prescribers.

During FY 2011 the parameters were developed and the pharmacy data monitoring protocol and report process were refined. The expectation at the start of this initiative was that as the data and patterns of prescribing are monitored, the numbers of consumers affected by prescribing practices falling within the above criteria would decrease over time. This premise did not prove correct for the Two or More Antipsychotics and the Greater Than Three Behavioral Health Medications criteria. For the Any Behavioral Health Medication in Children Ages 0-5 category, a slight decrease was evidenced in the last two quarters of FY 2012.

In November of 2011, these targeted prescribers received an introductory letter informing them that their prescribing practices had been identified as outliers and the SE requested an explanation of the prescribing rationale. Of the 24 letters sent, 3 were returned for incorrect addressing (prescribers moved). Of the 21 remaining prescribers, 11 responded with rationale, several reported via telephone that they had no intention of responding. After much discussion on how to effectively address this priority, the Prescribers Workgroup is re-evaluating interventions for FY 2013. The SE’s pharmacy is implementing new data analytic technology to better assist ongoing monitoring and review of prescribing practices within the SE’s provider network. The current program has had limited results due to inefficiencies in the process to include data being delayed, including only prescribers who hit a given threshold, it is time and labor intensive and the passive methods of disseminating...
<table>
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<tr>
<th>FY 2013 Priorities</th>
<th>Indicators</th>
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<tbody>
<tr>
<td>paper mailings to a few targeted health care professionals does not address the concerns of the broader population of youth receiving medications. The new program will be built upon improved data processing efficiencies.</td>
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<tr>
<td>2. Successfully implement evidenced based and practice based treatment alternatives for youth.</td>
<td>Track Outcomes for clients receiving the EBP of Intensive Outpatient. Targeted outcomes are being identified from the literature (e.g., retention in treatment, timely follow-up- client improvement). Trend outcomes.</td>
</tr>
<tr>
<td></td>
<td>• Increased adolescent IOP programs approved.</td>
</tr>
<tr>
<td></td>
<td>• Increased number of adolescents served.</td>
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<tr>
<td></td>
<td>• CYFD developed a plan for tracking outcomes of youth receiving IOP that includes 12 measures.</td>
</tr>
</tbody>
</table>

**FY 2013 Client Outcomes**

| 3. Increase in # and % of high severity clients who categorically improve on the STOT drug & alcohol domains. | Trend change over time in the alcohol and drug domains, quarterly as measured by the State Outcomes Tracking system (STOT).  |
| | • Baselines are being established in FY 2013.  |
| | • BHSD is currently implementing the STOT system that will be required for all substance abuse providers. The STOT is a web-based application that includes the GPRA/NOMs and the Patient Health Questionnaire (PHQ-9). The outcome data related to drug and alcohol used will be used for this priority. The STOT provides the state with a rich source of data for use in QI activities. |

**Service System Improvements**

| 4. Increase Provider competence in building recovery & resiliency – oriented treatment systems at the provider level. | Improve recovery-based practice with clinical staff in agencies.  |
| | • Recovery oriented (ROSI) questions integrated into the Treatment Record Review (TRR) tool.  |
| | • Revised TRR tool implemented.  |
| | • Report quarterly on the findings and progress with targeted interventions beginning FY 2013-Quarter 2. |

| 5. Development of a comprehensive continuum of care for adults, youth & children | Adults: Length of time to next appropriate level of care, specifically:  |
| | • What is the readmission rate to inpatient and residential care?  |
| | • Percent of clients who receive 7 and 30 day follow-up from:  |
| | • Residential Substance Abuse to IOP  |
| | • Inpatient to Comprehensive Community Support Services (CCSS)  |
| | Children: Length of time to next appropriate level of care, specifically:  |
| | • What is the readmission rate to inpatient and residential care?  |
| | • Percent of clients who receive 7 and 30 day follow-up from: |
Quality Service Review (QSR)

A major initiative in QI has been introduced by the Collaborative to systematically develop Clinical Practice Improvement. New Mexico Behavioral Health Providers (specifically, the Core Service Agencies) are using a New Mexico Quality Service Review (QSR) process to assess their practice and client progress. QSR is a systemic approach to assess an agency’s clinical practice—its strengths and challenges. The QSR protocol systematically looks at a client, their progress and the agency clinical practice functions. The tools are designed to review human service systems to determine what is working at the point of practice delivery for specific consumers and why it is working. It is based on an in-depth case review method involving multiple stakeholders, and uses a performance appraisal process to assess individuals, benefit from services and how well the service systems address their needs. The Collaborative has brought together providers and members of local communities through the Local Collaboratives to review the service systems for each of the Local Collaboratives across the state. This allows the providers and members of the local communities to self assess the breadth and efficacy of the local behavioral health service system. By the end of FY12, all CSAs have been trained in the use of QSR. A significant proportion will have been reviewed and gotten their performance baselines. A third of the CSAs have received consultation on how to integrate QSR into their clinical supervision.

By FY 2014, all Core Service Agencies (CSAs) will have instituted a Clinical Practice
Improvement Program that includes process improvement approaches, relevant data collection, fidelity measures and data outcome monitoring.

The state has made significant gains in establishing QSR as a systematic approach to clinical practice improvement among the CSAs. During FY 2012 our QSR experts trained 173 staff in 23 CSAs; and, provided individualized staff consultation on clinical supervision to eight CSAs. In addition, seven comprehensive case reviews have been conducted in five children’s CSAs and two adult CSAs. During FY 2013, two additional CSAs have received their comprehensive reviews and the SE’s Vice President of Quality, Care Coordination and Utilization Management along with the regional staff were trained in QSR.

Effective FY 2013, the CSA audit tool will include specific QSR review components to help monitor and support further Clinical Practice Improvements. In January 2013, five CSAs were trained in the use of the QSR data application so they can run the QSR reports within their own agencies. Additional agencies will be offered the tool in the Summer.

In the Spring of 2013, two 2-day Basic trainings (one on the adult protocol and another on the youth protocol) will be offered, along with additional trainings in Clinical Supervision and Case Formulation.

**Process for Responding to Emergencies**

In the event of a disaster, the SE is to be notified by the state. The SE will contact service providers in the affected area(s). The contract Scope of Work as written by the SE details providers’ responsibilities in response to disasters.

In the event of a psychiatric emergency, the SE maintains an 800 line that is staffed 24/7 by licensed clinicians. The clinician will triage the call and instruct the individual to either go to the ED or will facilitate an appointment within eight hours at the nearest behavioral health clinic. Providers are required under the Scope of Work in their contracts to adhere to the following standards for appointment access:

- Routine appointments within 14 days;
- Urgent appointments within 24 hours; and
- Crisis appointments within 2 hours (face to face).

The SE also generates the Access Standards Report semi-annually that provides information regarding the results of “secret shopper calls” to providers, conducted by the SE staff, in order to determine consumer access to urgent, emergent and routine care. The purpose of this report is to allow the Collaborative and the SE to monitor providers on client access to services, specifically related to treatment time by situational status (Emergency, Urgent, and Routine).
Process for Responding to Critical Incidents

The SE adheres to the Sentinel Events and Peer Review Committee Procedure, Policy QM008. The purpose of the policy is to outline a quality improvement and peer review process for reported sentinel events. The peer reviews of sentinel events are intended to accomplish the following goals:

- To ensure that sentinel events are appropriately reported, reviewed and monitored as part of an overall patient safety program;
- To identify facility and clinician performance improvement areas;
- To improve the overall quality of care provided to consumers; and
- To focus clinician or facility attention on the assessment of the sentinel event and to identify changes in the clinician or facility systems and/or processes to reduce the probability of a sentinel event in the future.

The SE’s Chief Medical Officer or designee reviews all sentinel events and reports to the Peer Review Committee recommendations for improving consumer care and safety, including recommendations that Network Services or Quality Improvement conduct a site audit or record review of the facility/clinician. The Peer Review Committee may also provide facilities and clinicians with written feedback related to observations made as a result of the review. The results of any review may be used by the Chief Medical Officer, in collaboration with the SE’s Vice President of Quality and Compliance, to make recommendations to suspend, terminate, or alter the participation status of programs, facilities or clinicians, or to conduct a site audit.

In addition, the SE provides the Collaborative with monthly and annual Critical Incident reports. The purpose of these reports is to provide an overview of Critical Incidents reported to the SE and involuntary hospitalizations. These reports are received from providers across all regions of New Mexico, at different levels of care, and among different consumer populations. The reports and analyses present the number of critical incidents and involuntary hospitalizations, types of critical incidents, and the distribution of incidents among special populations served by the SE. The reports describe quality improvement activities implemented by the SE during this reporting period.

Process for Responding to Complaints and Grievances

Monitoring complaints and grievances is a standard Quality Assurance practice that allows for consumer and provider feedback regarding satisfaction with system processes and practices which then allows the SE the opportunity to address issues at the provider level, systemically, internally and with Collaborative practices.
The SE defines grievances based on the New Mexico Administrative Code definitions and processes. In order to ensure comprehensive identification of problems within the service system, the SE has also implemented a process to capture quality of care issues from Care Coordination in addition to provider and consumer grievances.

The SE is required to provide the Collaborative with quarterly complaints and grievances reports and analyses. These reports and analyses breakdown the number and percentage of consumer and provider complaints and grievances by region and category. Categories included are: access, quality of care/service, consumer services, utilization review/care coordination, claims/reimbursement, pharmacy formulary/prior authorization and other.

Quality of care grievances are categorized as such when they are first received by the SE. They are then referred to the Quality Improvement Department for investigation. Following investigation, these may or may not be actual quality of care issues. If it is determined that there may be potential for a quality of care issue, the case is referred to the peer review committee for review, investigation and corrective action if necessary. In these instances, the complainant is informed that the case has been referred, but we may not be able to share the results of the investigation due to confidentiality rules related to peer-review. Finally, the case is closed.

Any grievance received which indicates a potential health or safety concern is immediately referred to the SE’s Quality Improvement Specialists in one of the five regions for investigation and follow-up action as required.
IV: Narrative Plan

S. Suicide Prevention

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

• Provide the most recent copy of your state's suicide prevention plan; or
• Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans available on the SAMHSA website at here.

Footnotes:
S. Suicide Prevention

Provide the most recent copy of your state's suicide prevention plan: See Attachment NM Suicide Prevention Plan.

Describe when your state will create or update your plan: The NM Suicide Prevention Plan team - composed of multiple state agencies, prevention advocates, survivors of suicide, and local collaboratives - met for over a year to begin the discussion about suicide prevention efforts currently underway and to collaborate on how to promote uniform information to New Mexicans. Members attended SPRCC Webinars and conducted research. Goals were identified. Strategies were developed. Data were collected. But the work group had a difficult time embracing strategies and assigning responsibilities to state agencies already working under stringent budgetary constraints meeting agency specific priorities.

In the end of the work process, the work team agreed to recommend that Block Grant monies be used to support education, information and training on suicide prevention and screening for health care providers, public schools, Chapter Houses, and Senior Citizen Programs. State agencies are unable to provide such funding at this time from their budgets, and this recommendation would support their desire to assist in the outreach.

Overview of process: The team chose to first identify activities already in place and expand or refine those activities for cross agency/community utilization. New Mexico and national data were reviewed and presentations were heard. The team reviewed plans from other states for pertinence to our own New Mexico populace. The result of this collaboration resulted in defining New Mexico’s Goals for Suicide Prevention and the groups of New Mexicans at highest risk for suicide. The plan is relevant to all age groups, across race and ethnicity, and urban, frontier or rural landscape. The team agreed that the goals and strategies could be used to benefit the following populations:

- Youth
- LGBTQ
- Older adults
- Veterans and their families
- Native Americans
- Persons living in rural and frontier New Mexico

Five goals were identified on which to build strategies over the next three years.

1. New Mexicans raise awareness about suicide and practical steps that can be taken to prevent it
2. Expand New Mexico suicide prevention training for providers and communities
3. New Mexico improves the continuum of prevention, early recognition and referral to treatment
4. Improve the quality and use of suicide surveillance systems
5. New Mexicans accept the responsibility to reduce access to common methods of lethal means

Within each goal is the assumption that the objectives and strategies to fulfill the goals are community driven and culturally sensitive.

Technical Assistance:
The “final” plan was titled as a “work in progress”. The work team recognized that the plan is not finished. It may be helpful to request and receive technical assistance from SAMHSA to help us truly finalize a plan that is a workable and reasonable product that can be used across state agencies and community entities. The Plan is mostly complete.
Recommendations for a State Plan for Preventing Suicide in New Mexico

2014-2015

FINAL AS OF JUNE 30, 2013

THIS IS A WORK IN PROGRESS AND IS STILL OPEN TO MODIFICATION.
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Task Force Members

Steve Adelsheim, University of New Mexico, CRCBH
Claire Arth, Veterans Administration
Jesse Chavez, Local Collaborative Cross Agency Team, NM Children Youth and Families Department
William Clapp, New Mexico Children, Youth and Family Department
Cindy Collyer, Behavioral Health Planning Council, Behavioral Health Consumer
Nancy Kirkpatrick, New Mexico Department of Health, Office of School and Adolescent Health
Anthony Louderbough, New Mexico Department of Aging and Long Term Services
Heidi Macdonald, New Mexico Indian Affairs Department
Brenda Mayne, New Mexico Veterans Administration
Karen Meador, New Mexico Human Services Department, Behavioral Health Division
Tierney Murphy, New Mexico Department of Health, Injury and Behavioral Health Epidemiology Bureau
Leticia Rutledge, New Mexico Human Services, Behavioral Health Division
Sherrie Lesansee, University of New Mexico
Patricia Serna, North Central Community Based Services, Inc., Suicide Prevention Advocate
Tami Spellbring, Local Collaborative Cross Agency Team, NM Children Youth and Families Department
**Goals**

1. **New Mexicans raise awareness** about suicide and practical steps that can be taken to prevent it.

2. **Expand New Mexico suicide prevention training** for providers and communities.

3. **New Mexico improves the continuum of prevention and referral to treatment.**

4. **Improve the quality and use of suicide surveillance systems.**

5. **New Mexicans accept responsibility to reduce access to common methods of lethal means.**

**Introduction**

New Mexico prides itself in being a tri-cultural community, embracing our different traditions and honoring our history. The Task Force members who worked on this Plan were representative of our state demographics, and believed strongly that the plan should have “community” at its core.

Community and hope go hand in hand. Central to all communities, from the beginning of time, is the importance of interdependence with fellow human beings. Community celebrates life in its rituals and is essential in raising children and taking care of our elders. Simply, community means we are there for each other.

New Mexico suicide rates are startling. The Task Force recognized that not only families need to understand and be aware of the potential for loved ones taking their own lives, but health care providers also need to be made aware of the patients they treat.

After admitting that State agencies and private agencies might not have supplementary revenue to take on additional training, outreach and education on suicide prevention initiatives, the Task Force recommended that the Uniform Mental Health and Substance Abuse Prevention and Treatment Block Grant be partially utilized to assist providers, families and communities in suicide prevention awareness and training. Using Block Grant funds, New Mexico can pilot certain activities to improve data collection, distribute learning tools, and expand awareness.

**Recommendation to help achieve these goals by the Task Force:**

Utilize Mental Health and Substance Abuse Prevention and Treatment Block Grant funding for training and credentialing of behavioral health providers in suicide screening and awareness: to raise awareness of available local resources; and to educate communities on how to best respond to and assist friends, families and neighbors who may be in need of assistance during an emotional crisis.
Why Bother?

New Mexicans from various backgrounds and age groups are experiencing feelings of sadness, alienation, anxiety and other stressful emotions. Some are also struggling with substance abuse.

According to the New Mexico Substance Abuse Epidemiology Profile, March 2013:

For the past three decades (1981-2011), the New Mexico’s suicide rate has been 1.5 - 1.9 higher than the U.S. rate. When national rates declined, New Mexico rates remained high. Because men tend to use more lethal means such as firearms, suicides in males are three times higher than for female rates; overall, suicide rates are highest (51.7) for White males 65 years old and older.

Between years 2007-2011, five counties consistently had the highest suicide rates: Grant, Rio Arriba, Otero, McKinley and Taos.

While we cannot directly correlate the data to mental health and the suicide rates, the highest rates for alcohol related chronic disease deaths occurred in Rio Arriba, McKinley, Socorro, Quay, Hidalgo and Cibola. Drug induced death occurred highest in Rio Arriba, Mora, Sierra, Hidalgo, Grant counties.

Adult Mental Health

Based on 2006 NM Behavioral Risk Factor Surveillance Survey (BRFSS) results, Frequent Mental Distress (FMD) was more prevalent among respondents who also reported having an anxiety disorder, current depression, past suicidal ideations, and alcohol dependence or abuse. The number of adults reporting FMD in the past 30 days was highest in Cibola, Valencia, Torrance, Curry, Socorro and Luna counties – all of which are rural parts of the state.

Current depression in the past two weeks was recorded as highest in San Miguel, Valencia, Lea, McKinley, and Otero counties – again, rural communities.

Youth Mental Health

“Persistent feelings of sadness or hopelessness” among NM high school students was reported higher for girls (37.3%) than boys (21.2%). The counties with the highest prevalence of feelings of sadness or hopelessness were Sierra, Luna and Lea.

Among high school students, in 2009, the counties with the highest prevalence of youth seriously considering suicide were in Luna, Sierra and McKinley.

Girls (12.3%) had a higher rate of suicide attempts than boys (5.0%). White students had a lower rate of suicide attempts (6.4%) than American Indian students (10.5%). The highest rates for suicide attempts occurred in McKinley, San Juan and Luna.
While not directly correlated to youth mental health, risky behaviors were highest in the following counties:

<table>
<thead>
<tr>
<th>Risky Behavior</th>
<th>Counties</th>
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<tbody>
<tr>
<td>Drinking and Driving</td>
<td>Union, Sierra, Eddy counties</td>
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<tr>
<td>Current Marijuana Use</td>
<td>Mora, Taos, Sierra counties</td>
</tr>
<tr>
<td>Cocaine Use</td>
<td>Los Alamos, Hidalgo, Rio Arriba counties</td>
</tr>
<tr>
<td>Painkillers to get High</td>
<td>Grant, Rio Arriba, Otero counties</td>
</tr>
<tr>
<td>Heroin Use</td>
<td>Hidalgo, Rio Arriba, Mora counties</td>
</tr>
<tr>
<td>Methamphetamine Use</td>
<td>Rio Arriba, Luna, Grant counties</td>
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<tr>
<td>Frequent Smoking</td>
<td>Otero, Torrance, Catron counties</td>
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Suicide Rates by Gender and Age Groups in New Mexico, 2007-2011; *NM Substance Abuse Epidemiology Profile, March 2013*

<table>
<thead>
<tr>
<th>Gender</th>
<th>Ages 0-24</th>
<th>Ages 25-64</th>
<th>Ages 65+</th>
<th>All Ages</th>
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<tr>
<td>MALE</td>
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<tr>
<td>White</td>
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<tr>
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<tr>
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<td>14.2</td>
<td>21.8</td>
<td>16.6</td>
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<tr>
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<td>15.2</td>
<td>39.2</td>
<td>40.2</td>
<td>31.1</td>
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</table>

Suicide Rates by Gender and Age Groups in New Mexico, 2007-2011; *NM Substance Abuse Epidemiology Profile, March 2013*

<table>
<thead>
<tr>
<th>Gender</th>
<th>Ages 0-24</th>
<th>Ages 25-64</th>
<th>Ages 65+</th>
<th>All Ages</th>
</tr>
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<tbody>
<tr>
<td>FEMALE</td>
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<td>White</td>
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<td>3.5</td>
<td>13.3</td>
<td>6.7</td>
<td>9.0</td>
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Background: Suicide Prevention Efforts in New Mexico

Suicide rates in New Mexico have remained high for the past 10 years.

In recent years, New Mexico has invested millions of dollars in providing outreach, support and training to Native American communities experiencing an epidemic of youth suicides; to rural high schools where copy cat suicides occurred; and community health care centers that found a rise in depression and attempted suicide among veterans and their families.

There are many recommendations to reduce suicide and to assist individuals and families through a perceived crisis. Government and advocacy agencies have studied suicide issues over the 15-20 years - and yet New Mexico’s suicide rates continue to remain high. In more recent years, several work groups have studied the problem and offer doable recommendations – many of which are being implemented statewide or community by community (see Historical Considerations below).

- From the House Joint Memorial 45 task force, Mental Health First Aid activities across the state have trained the trainers, community stakeholders, corrections department personnel, and tribal communities to better understand mental illness and help reduce stigma.

- From House Joint Memorial 17 - A statewide behavioral health crisis phone system, New Mexico Crisis and Access and Line, manned by ProtaCall, immediately counsels callers as needed and/or refers them to appropriate resources; 3 rural communities are designing a crisis plan that addresses immediate behavioral health needs, diverts from hospital admits or incarceration through partnerships with hospitals, rescue/paramedic services, counseling centers, faith communities, peers and others.

- From the 2011 NM Youth Suicide Prevention and Early Intervention, State Suicide Prevention Project, NM Department of Health Office of School and Adolescent Health - outreach to rural and urban public schools provides information, education and training to students, teachers, and other school personnel.

- From the Annual Report 2010 NM Child Fatality Review culturally appropriate crisis response teams have responded to several Native American communities where a rash of youth suicides occurred, and several tribes have developed social support resources for their communities.

The NM Suicide Prevention team met for over a year to share information about activities taking place through their organizations and the work that still needs to be done to promote understanding, provide resources and reduce stigma. Data were reviewed and presentations were heard. The team reviewed plans from other states for pertinence to our own New Mexico populace. This collaboration resulted in defining New Mexico’s Goals for Suicide Prevention and the groups of New Mexicans at highest risk for suicide. The plan is relevant to all age groups, across race and ethnicity; urban, frontier or rural landscape; and physical and behavioral health services.

This plan has multiple purposes.
1. To provide a systems approach to support grassroots efforts
2. To identify where traction in suicide prevention efforts already exists
3. To measure our efforts and outcomes and blaze a path for best practices
4. To identify gaps in suicide prevention programs to build capacity and resources
5. To serve as a benchmark of our behavioral health work, and serve as a tool to remind all state agencies of our promise to New Mexicans
6. Identify funding for suicide prevention

New Mexico identified 5 goals on which to build strategies over the next three years.

1. New Mexicans raise awareness about suicide and practical steps that can be taken to prevent it
2. Expand New Mexico suicide prevention training for providers and communities
3. New Mexico improves the continuum of prevention, early recognition and referral to treatment
4. Improve the quality and use of suicide surveillance systems
5. New Mexicans accept the responsibility to reduce access to common methods of lethal means

Within each goal is the assumption that the objectives and strategies to fulfill the goals are community driven and culturally sensitive. Within each goal, individuals from varying demographics will benefit which would include:

- Youth
- Lesbian, bisexual, gay, transgender and questioning youth
- Older adults
- Veterans and their families
- Native Americans
- Persons living in rural and frontier New Mexico

This Plan incorporates the seven goals indentified in SAMHSA’s 2012 National Strategy for Suicide Prevention (NSSP) plan:

- Foster positive dialogue, counter shame, prejudice, and silence; and build public support for suicide prevention
- Address the needs of vulnerable groups, be tailored to the cultural and situational contexts in which they are offered, and seek to eliminate disparities;
- Be coordinated and integrated with existing efforts addressing health and behavioral health and ensure continuity of care;
- Promote changes in systems, policies, and environments that will support and facilitate the prevention of suicide and related problems;
- Bring together public health and behavioral health;
• Promote efforts to reduce access to lethal means among individuals with identified suicide risks and;
• Apply the most up-to-date knowledge base for suicide prevention

**Historical Considerations**

Rather than start with a blank page, the task force reviewed recommendations derived from other workgroups for consideration into this plan. Taken from numerous work group reports and recommendations, the Plan incorporates recommendations into part of its action plan. Below is a very small sample of recommendations that are supported in this Plan:

From *House Memorial 45 Task Force Recommendations, 2012* - Education and Training – widely disseminate guidance on early signs of mental illness, Psychiatric Advance Directives, access to treatment guardians, Mental Health First Aid; establish and fund Mental Health First Aid programs and other proven mental health education and skills training for first responders, health care responders, healthcare professionals, law enforcement, detention and corrections officials, and the general public

From the *Five Year Behavioral Health Promotion & Prevention Plan, NM Human Services Department Office of Substance Abuse Prevention, and the Prevention Policy Consortium, 2012* - Reduce prevalence of poor mental health and its consequences; Coordination of services across multiple agencies to address mental illness and mental health promotion; Expand education on mental health screening

From the *House Joint Memorial 17 Task Force Recommendations, NM Human Services Department November 2011* - Establish peer training programs and training for family members, natural supports, teachers, students, and first responders; Develop broad community coalitions in all communities or counties of the state to enhance and integrate local capacity to respond to mental health crises;

From the *2011 NM Youth Suicide Prevention and Early Intervention, State Suicide Prevention Project, NM Department of Health Office of School and Adolescent Health (OSAH)* - Increase evidence based suicide prevention programs in schools and communities through Gatekeeper training and school climate programs; Means restriction; promotion of trigger locks through means restriction training in gatekeeper training, awareness campaign, gun lock distribution; Increase programs that address the reduction of social stigma through evidence based school climate efforts including; bullying prevention, GSA, and other positive youth development approaches; cultural competence in school health trainings

*From the Annual Report 2010 NM Child Fatality Review* - Implement suicide prevention training for school teachers, all staff, coaches and parents of students in Bureau of Indian Education Schools, require that all BIE schools have a crisis intervention plan and post-intervention plan and provide
related training to all school, staff, parents and the community on the QPR (Question/Persuade/Refer) model; Promote gun safety to prevent accidental child deaths involving firearms; Establish school based programs for the lesbian, gay, bisexual and transgender population.

From the Aging and Long Term Services Department presentation to the Suicide Prevention Planning Team: behavioral health treatment should be integrated with primary medical care; Community workers need training to recognize, respond and effectively refer; Outreach services to home bound seniors and senior centers.

From Adolescent Suicide Prevention Program: A Public Health Model for Native American Communities - Assist community members in identifying issues that need to be addressed: Offer a consistent array of behavioral health services with identifiable staff; work closely with local school through a Natural Helpers Program; evaluate the entire program and its components on a regular basis to determine program efficacy.

**Snapshot of New Mexico Data**

**Suicide in New Mexico**

Suicide is a significant public health problem in New Mexico. During 1999-2011, there was an average of 365 suicides per year, one life per day prematurely ended due to self-inflicted harm over 13 years (total deaths: N=4,753).

Over the past couple of decades, suicide rates in NM have remained high, and have consistently been one and a half to two times higher than U.S. rates (Figure 1). Recently, suicide rates have been increasing, both in NM and the U.S. From 1999-2011, the NM suicide rate increased 13.4%, from 17.9 per 100,000 to 20.3 per 100,000, mirroring a similar increase (15%) in suicides at the national level. New Mexico currently ranks fourth highest in the nation for suicide age-adjusted mortality among all states and the District of Columbia (WISQARS, 2010).

In 2011, suicide was the eighth leading overall cause of death in the NM population. However, it was the second leading cause of death among NM youth and adolescents and adults in age groups from 10-44 years; and the fifth leading cause of death among adults 45-54 years.

Annually, there have been more suicide deaths than motor vehicle traffic crash deaths in NM since 2007. Suicide in NM has ranked second among all causes of injury mortality since 2008. Nationally, suicide ranked first as the leading cause of all injury mortality in 2009, surpassing fatalities from motor vehicle traffic crashes for the first time.
Suicide and Gender

Male suicide rates in New Mexico are three to four times higher than female suicide rates. Males generally have a higher rate of completed suicide because they tend to use more lethal means, plan the suicide attempt more carefully, and avoid detection.

From 2007-2011, the age-adjusted male suicide rate was 31.1 per 100,000 compared to the female rate of 9.0 per 100,000. Male suicide rates were higher than female suicide rates across the life span, with rates generally increasing with age and peaking in elderly males 85 years and older (Figure 2). Female suicide rates also increased with age, but peaked among middle-aged women 45-54 years, and then gradually decreased with advancing age.
Suicide and Race/ethnicity

Among racial/ethnic groups, Whites (24.0 per 100,000) and American Indians (20.8 per 100,000) had higher age-adjusted suicide rates compared to Hispanics (14.9 per 100,000). However, there was variation in suicide rates among the three major racial/ethnic groups by age (Figure 3).

Suicide rates were significantly higher among American Indian (AI) adolescents and young adults 15-24 years and adults 25-34 years compared to Whites and Hispanics of the same ages. However, suicide rates among White adults increased with age, and surpassed rates among AIs and Hispanics in the age group 45-54 years, and remained significantly higher throughout the remainder of the lifespan.
Suicide Mechanism of Injury

In 2011, the majority of suicides (52.5%) were due to self-inflicted firearm injuries. Among males, the leading mechanisms of injury were firearm (59.5%), followed by hanging or strangulation (23.6%), and poisoning (9.9%). In contrast, the majority of suicides among females were due to poisoning (41.9%), followed by firearm (30.5%) and hanging (22.9%).

Figure 4. Suicide mechanism of injury by sex, 2011: Source: NMDOH, BVRHS.
**County Suicide Rates**

In 2007-2011, thirteen NM counties had age-adjusted suicide rates above the NM suicide rate of 19.8 per 100,000 (Figure 5). All but one county in NM that had more than ten deaths during this time period had suicide rates higher than the 2009 U.S. rate of 11.8 per 100,000. Suicide rates in Grant County (33.9 per 100,000) and Otero County (27.2 per 100,000) were significantly higher compared to the NM suicide rate. Eight NM counties had rates that were more than twice the U.S. rate.

**Figure 5. Age-adjusted suicide deaths and rates by county of residence, NM, 2007-2011 and U.S., 2009**

### Suicide Circumstances

Circumstances associated with suicide deaths highlight important differences in risk factors reported for male vs. female suicide victims (Figure 6). In 2010, male victims were more likely than...
females to disclose suicidal feelings or intent to another person and to have an alcohol problem. Female victims were more likely to have a mental health problem; to have received treatment for a mental health problem in the past 2 months or at any time in the past; to have made previous suicide attempts; and to have a physical health problem that contributed to their deaths.

Figure 6. Prevalence of reported circumstances‡ for all suicide victims by sex

More than a third (37.2%) of suicide victims who were tested for blood alcohol tested positive; and almost one quarter (23.2%) of suicides were alcohol related, or had a blood alcohol concentration (BAC) greater than or equal to 100 mg/dl or 0.10%. Alcohol related suicide deaths were more common among males (24.7%) compared to females (19.2%) (Figure 6). These data may be used to inform the development and implementation of suicide prevention strategies, focusing on the differences in circumstances reported for male and female suicide victims.
Goal One: New Mexicans raise awareness about suicide and practical steps that can be taken to prevent it.

Strategy 1.1: Continue to provide access to information through schools, community programs, and other sources.

Indicator 1.1a: The Office of School and Adolescent Health will implement suicide prevention training in at least one high school in every school district by 2015

Indicator 1.1b: The Department of Aging and Long Term Services will engage in dialogue with community senior programs on how to recognize risk, respond and refer effectively to behavioral health providers. Indicator 1.1c:

Indicator 1.1c: The Department of Indian Affairs will work with the Department of Aging and Long Term Services to engage in dialogue with community senior programs on suicide risk factors and protective factors.

Strategy 1.2: Education and Training –

Indicator 1.2a: State Departments of Health, Human Services Department, Aging and Long Term Services, Indian Affairs, Children Youth and Families, Public Education and others will widely disseminate guidance on early signs of mental illness, Psychiatric Advance Directives, access to treatment guardians, and Mental Health First Aid.
Goal Two: Expand New Mexico suicide prevention training for providers and communities

Strategy 2.1: Increase community awareness of suicide

Indicator 2.1a: Departments of Health, Children Youth and Families, Human Services and Aging and Long Term Services and Indian Affairs will share/adapt training model for use by other communities

Indicator 2.1b: The Department of Health will release widely the “More than Sad” video and presentation materials to 9th graders and higher, in at least one high school in every school district.

Strategy 2.2: Increase evidence based suicide prevention programs in schools and communities through gatekeeper training and school climate programs

Indicator 2.2a: Public Education Department will work with school administration to develop suicide prevention schedules to both building faculty and 9th grade freshmen Health Classes.

Indicator 2.2b: Department of Health Office of School and Adolescent Health will train 1000 teachers statewide in recognizing signs of mental/behavioral health distress and proper referral

Strategy 2.3: Train the trainers

Indicator 2.3a: CYFD will expand QPR Training for CYFD staff
Goal Three: New Mexico improves the continuum of prevention and referral to treatment

**Strategy 3.1: Train/Educate Primary Care providers on behavioral health screening tools**
Indicator 3.1a: HSD and DOH will offer a training primer to all providers on early identification and prevention awareness

Indicator 3.2b: ALTSD will provide in-service to ALTSD employees and volunteers to enable them to recognize, respond and refer effectively. Indicator 3.3c: Providers will develop a safety plan with individuals and their families.

**Strategy 3.2: Prevention, De-Escalation and Referral (link)**
Indicator 3.2a: Crisis Lines will have immediate linkages with Core Service Agencies and other resources in the state such as gatekeepers and First Responders.

**Strategy 3.3: Treatment – (intervention)**
Indicator 3.3a: Clients will be triaged appropriately to a therapist, emergency room, or other provider. HSD will provide monitoring to ensure compliance.

Indicator 3.3b: Providers will use Best Practice Therapy.

**Strategy 3.4: Evaluation**
Indicator 3.4a: HSD will use data, create a Surveillance System, recommend Best Practices, and Check Results
Goal Four: Improve the quality and use of suicide surveillance systems

Strategy 4.1: Build state and NM community capacity to evaluate suicide prevention programs

Indicator 4.1a: Partner with NM programs who request assistance with program’s evaluation in FY13-Fy14

Indicator 4.1b: Long term evaluation of program gathered from YRRS bi-yearly reports

Strategy 4.2: Identify new funding sources for community & state evaluation activities

Indicator 4.2a: Evaluate innovations – EBPs

Strategy 4.3: Require evaluation of state funded suicide prevention programs

Indicator 4.3a: Build understanding on the value of evaluation
Goal Five: New Mexicans accept responsibility to reduce access to common methods of lethal means

**Strategy 5.1: Promote gun safety to prevent accidental deaths involving firearms** *(From the Annual Report 2010 NM Child Fatality Review)*

Indicator 5.1a: Department of Health will promote means restriction; promotion of trigger locks through means restriction training in gatekeeper training, awareness campaign, gun lock distribution

Indicator 5.1b: Department of Health, Human Services Department, Aging and Long Term Services Department, Department of Veteran Affairs will raise awareness and promote safe firearm storage practices

Indicator 5.1d: Aging and Long Term Services Department will distribute educational material to consumers living in home care

**Strategy 5.2: Raise awareness and promote safe prescription medication storage and disposal**
IV: Narrative Plan

T. Use of Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

• What strategies the state has deployed to support recovery in ways that leverage ICT;
• What specific application of ICTs the State BG Plans to promote over the next two years;
• What incentives the state is planning to put in place to encourage their use;
• What support system the State BG Plans to provide to encourage their use;
• Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
• How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;
• How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
• What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Footnotes:
T. Use of Technology

*What Strategies the state has deployed to support recovery in ways that leverage ICT: What specific application of ICTs the state BG plans to promote over the next 2 years:*

New Mexico continues to expand telehealth access across the state with the partnership of state agencies, the State Entity, community providers, and the University of New Mexico. Technology is widely used to conduct meetings, training or consultation via videoconference, teleconference or webinars. The use of this technology has reduced the burden of long travel times in the vast geographic areas of the state and allowed more people to access services, training and information.

**State Entity**

In Q2FY13, **1,037 unique consumers** residing in **27 New Mexico counties** received Behavioral Health services via Telehealth resulting in claims paid by the State Entity (SE), OptumHealth New Mexico.

The SE’s participation in the needs assessment of the organizational, developmental, and programmatic requirements of Telehealth programs is as follows:

- Telehealth Overview Training and Telehealth Medicaid Rules Training are presented each May and November via WebEx.
- SE will continue to work with CRCBH/CBHTR in development of:
Telehealth Consumer Satisfaction Survey data. CRCBH/CBHTR delivers aggregated data quarterly, for inclusion on the OHNM website, posted at: https://www.optumhealthnewmexico.com/provider/telehealthsurvey.html

- New Mexico Telehealth Alliance - Attend board meetings to share information and coordinate development efforts. Current issues: NMTHA is conducting market research to align its goals with those of the Telehealth market. Also challenging the NM Medicaid requirement for originating-site practitioners.

- UNM Project ECHO - Promoting support of mid-level provider training program.

- The SE’s participation in the expansion of Telehealth sites.

- **Vidyo in Production** - OptumHealth New Mexico invested $17,000.00 to purchase access to Vidyo, a “cloud-based” Telehealth service recently implemented by OptumHealth Behavioral Solutions. This application became fully operational in mid-April of FY12.

Seven or more simultaneous Telehealth connections can be accommodated at one time. Since the application runs on PCs or laptops, this investment will enable Telehealth at new sites and at very little expense to providers.

OHNM continues to seek additional opportunities to implement Vidyo.

**New and Prospective Originating Sites**

The following are areas targeted for Telehealth expansion utilizing Vidyo:

**Core Service Agencies** - Continuing work to expand service access to rural and frontier areas by establishing new **Vidyo** (web-based) telehealth service.

1. **Implementing: Border Area Mental Health** (BAMH) is a Core Service Agency with four locations in four counties, two classified as frontier and two classified as rural. All four counties provide little or no current Telehealth service.

   Follow-up with BAMH is needed to ensure the needed firewall changes occurred, so that testing and user training can be scheduled.

2. **Implementing: Valencia Counseling Services** (VCS) is a Core Service Agency with five locations in four counties, two classified as frontier and two classified as rural. The addition of Vidyo service will enable VCS to provide telehealth services to/from all five locations.

   Final testing on the Vidyo system was completed on Nov. 13, 2012. User training was delayed due to the holidays and needs to be scheduled.
3. **Implementing: The Counseling Center (CC)** is a Core Service Agency with two locations in two counties, one classified as frontier and another classified as rural. The addition of Vidyo will expand telehealth services currently available in the two counties.

Telehealth service is operational at The Counseling Center and the user training was completed on Nov. 14, 2012.

*Indian Health Services (IHS) and 638 sites.* Presented Vidyo to Native American Subcommittee in July.

- **Pursuing:**
  1. **638 sites generally** – Follow up needed on interest expressed by Tesuque Pueblo and Santo Domingo Pueblo Health Center.
  2. **Albuquerque Area IHS** – Per the Chief Medical Officer, there is interest in provision of Telehealth services to a number of IHS and 638 sites. Pursuing with Dr. Carolyn Morris.
  3. **Fort Defiance IHS Hospital** – Follow-up needed on development and completion of a project plan review with Clinical Planner, and subsequent presentation to board. Will partner with Dr. Carolyn Morris on this provider.
  4. **On hold: Navajo Nation Department of Behavioral Health Services** – Identified challenges below continue to hinder possibility of implementation:
     - Internet connectivity was recently lost at two of seven sites
     - Request For Proposal process is required
     - Recent management change may have altered priorities

*Attainment of SE’s contractual Telehealth goals.*

- Covered under other headings **except** Telehealth training goals. Providing training on Telehealth practices and procedures and claims to providers. Consulting with internal and Regional OHNM personnel

*Number of Telehealth specialty services available through the Telehealth network.*

Telehealth clinical services during this quarter included the following:

- 744 claims for 90862GT/ Pharmacologic Management
- 160 claims for 90801GT/ Diagnostic services
- 1 claim for 90806GT/ Individual psychotherapy, face-to-face, 45-50 minutes
- 1 claim for 90804GT/ Individual psychotherapy, face-to-face, 20-30 minutes
How behavioral health Telehealth services are being integrated into the New Mexico service system, including training and TA to school-based behavioral health providers.

- School-Based Health Centers - Region IX Education Cooperative continues to provide services under a grant. Other School-Based Health Centers have closed, primarily due to the challenges of paying for the expensive connectivity initially established under the state program. In addition, some school-based clinic managers do not perceive a need for behavioral health services provided via Telehealth.

Ways the SE is looking at increasing consumer access to specialty providers through Telehealth technology.

Our strategy includes:

- Expansion of participating originating and distant sites.
- Coordination and cooperation with other state Telehealth organizations.

Barriers encountered to sustaining Telehealth in the state.

- Connectivity - Availability is improving, but testing is required to assure the quality of lower-cost connectivity.
- Availability of potential physical health originating sites - Working with regions to identify potential sites in rural and frontier locations.
- Budget support for cost of Telehealth equipment or online Telehealth connectivity.

How the State will use ICTs for collecting data for program evaluation at both client and provider levels

Discussion of strategies used to measure and improve consumer satisfaction in provision of culturally competent care.

- Consumer Satisfaction Survey data is available for review on the OptumHealth New Mexico provider and consumer portals, in English and Spanish, and is updated quarterly.
- Telehealth Provider Best Practice Review – Administered initial Provider Best Practices Review (see sample) with Hogares in Albuquerque. Respondent was an Administrative Assistant most closely involved with day-to-day scheduling and administration of consumer telehealth encounters. The Review document targets compliance with best practices and New Mexico Medicaid Telehealth-specific requirements. Initial purpose is educational. Under consideration for inclusion of
results in formal provider Quality data, to allow future follow up on

**OptumHealth NM Customer Utilization (Non-Cumulative)**

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<tr>
<td>CIBOLA</td>
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<td>COLFAX</td>
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<td>DE BACA</td>
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<td>GUADALUPE</td>
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<td>LINCOLN</td>
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<td>QUAY</td>
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<td>SAN MIGUEL</td>
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<td>SOCORRO</td>
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<td>TORRANCE</td>
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<td>CHAVES</td>
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<td>CURRY</td>
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<td>LEA</td>
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<td>MCKINLEY</td>
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<td>OTERO</td>
<td>33</td>
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<tr>
<td>RIO ARRIBA</td>
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<tr>
<td>ROOSEVELT</td>
<td>39</td>
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</table>

recommended changes. Now scheduling additional surveys with Quality Auditors.
Red highlight indicates potentially significant reduction in number of consumers served, compared to same quarter in previous year.

Green highlight indicates potentially significant increase in number of consumers served, compared to same quarter in previous year.

**University of New Mexico Activities**

Through the Center for Rural & Community Behavioral Health (CRCBH) of the UNM-HSC Department of Psychiatry, great advances have been made in the use of telemedicine to help address the gaps in specialized behavioral health services, training and workforce development.

CRCBH partners with Hidalgo Medical Services and Sangre de Cristo Community Health Partnership and utilizes telehealth to promote integration of behavioral health and primary care by providing psychiatric consultation to their primary care staff.

CRCBH also partners with the Albuquerque Area Indian Health Service to provide direct service, consultations, and trainings to their network of providers in tribal communities through the Indian Health Service Tele-Behavioral Health Center of Excellence. Psychiatry residents and fellows in training regularly participate in these activities in order to develop their familiarity and expertise in using telehealth.

The UNM Department of Psychiatry is now routinely using telehealth to conduct emergency psychiatric assessments of patients who present in crisis to Sandoval Regional Medical Center. Since the beginning of this program in November 2012, approximately 1-2 patients with acute psychiatric emergencies are assessed via telehealth each day which reduces transport costs, and time spent in the emergency department awaiting referrals and assessment. The UNM Center for Telehealth and Cybermedicine played a key role in developing this new use of telehealth.

Other training and educational project in which CRCBH is involved with includes the Child & Adolescent Behavioral Health Training Series sponsored by the Office of School Health, as well
as rural training opportunities for Department of Psychiatry residents, fellows, and psychology interns.

Since July 2012 CRCBH has provided:

- 26 Primary Care Case Consultation Sessions with Sangre de Cristo and Hidalgo Medical Services
- 1016 hours of clinical care via telehealth through the I.H.S. Telebehavioral Health Center of Excellence
- 66 Training Sessions delivered via telehealth (Please see topics listed below). The attendance at these trainings continues to grow. Since July 2012, CRCBH has issued 717 Continuing Education Credits for participation in telehealth trainings on behavioral health topics.

Summary of Training Topics:

<table>
<thead>
<tr>
<th>PAIN &amp; CO-OCCURRING ADDICTIONS SERIES</th>
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<tbody>
<tr>
<td><strong>Dr. Snehal Bhatt and Dr. Joanna Katzman</strong></td>
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<tr>
<td>Introduction to Addiction: epidemiology, basic neurology, course/prognosis w/ a special focus on chronic diseases</td>
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<tr>
<td>Opiate Dependence (with a focus on prescription opiate dependence)</td>
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<tr>
<td>Introduction to Medication Assisted Treatments for Opiate Dependence</td>
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<tr>
<td>Medication Assisted Treatment of Opiate Dependence</td>
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<tr>
<td>Epidemiology of chronic pain</td>
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<td>Clinical interview of patient with pain</td>
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<tr>
<td>Migraines</td>
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<td>Co-occurring chronic pain and depression</td>
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<td>Co-occurring Pain and Anxiety</td>
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<tr>
<td>Pain and Neurology</td>
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<tr>
<td>Screening for Addiction and Monitoring for Aberrant Behavior in Patients with Chronic Pain</td>
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<tr>
<td>Chronic Pain, Anxiety, and Common Neurological Conditions</td>
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<tr>
<td>Motivational Interviewing with Kamilla Venner</td>
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<tr>
<td>Brief Interventions</td>
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<tr>
<td>Pain and Psychiatry</td>
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<tr>
<td>Taking a Neurological Exam</td>
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<tr>
<td>The Musculoskeletal Exam in the Chronic Pain Patient</td>
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<tr>
<th>TBI, DEVELOPMENTAL DELAY AND INTELLECTUAL DISABILITY</th>
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<tbody>
<tr>
<td><strong>Dr. Alya Reeve</strong></td>
</tr>
<tr>
<td>Diagnosing mental illness</td>
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<tr>
<td>Dyscontrol, affect dysregulation, memory problems</td>
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<tr>
<td>Clinical Assessment: techniques, strategies, adaptations</td>
</tr>
<tr>
<td>Developmental disability systems of care</td>
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<tr>
<td>Pharmacology: general pharmacologic approach for ID/DD and TBI</td>
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</tbody>
</table>
Complementary and Alternative Medicine
Psychopharmacology: Mitigating Dyscontrol in ID, DD, and TBI (Part 1)
Psychopharmacology: Mitigating Dyscontrol in ID, DD, and TBI (Part 2)
Behavioral support; psychotherapy; group therapy
Psychopharmacology Part 3: Treating Mood Disorders
Comparison of diagnostic systems: ICD-9, -10, -11; DSM-IV TR, DSM-5
Psychopharmacology Part 4: Reducing Anxiety Symptoms in TBI, ID/DD
Fetal Alcohol Syndrome and Effects
Psychopharmacology Part 5: Mixed Features
Psychopharmacology Part 6: Uses, Does, Monitoring, Efficacy
Detecting TBI/ID/DD
Autism Spectrum Disorders
Non verbal Mental Status Examination

CHILD AND ADOLESCENT PSYCHIATRY SEMINAR AND CLINIC
Dr. Avron Kreichman and guest speakers

Serious Mental Illness in Youth: Working with Families
Identifying Early Psychosis
Attention Deficit Hyperactivity Disorder: A Focus on Inattention
Anxiety Disorders in Children and Adolescents
Prevention and Early Intervention for Severe Mental Disorders in Youth
Self Injury and Suicidality in Youth Case Consultations
Psychosis in Children and Adolescents
Attenuated Psychosis
Sleep Disorders in Children and Adolescents
Self Injury and Suicidality in Youth Case Consultations
Understanding Mental Illness in the Hispanic Community: Stigma, Idioms of Distress, and Implications for Treatment

THURSDAY SEMI-MONTHLY SPECIAL TOPICS
Dr. Caroline Bonham and guest speakers

Prescribing with the Geriatric Population
Traditional and Western Approaches to Counseling Theory: Stages of Change and Motivational Interviewing
Suicide and Suicidality in Native American Youth
Traditional and Biomedical Approaches to Screening and Assessment of Co-occurring Disorders

Traditional and Biomedical Approaches to Diagnosis of Co-occurring Disorders
Traditional & Biomedical Approaches to Treatment of Co-Occurring Disorders
Historical Trauma and Unresolved Grief
Infant Mental Health
Early Identification of Psychosis in Children
Dementia with Behavioral Disturbances/Treatment Modalities
Working with Multiethnic Youth and Families
Alcohol Abuse and Dependence in Native Americans

HISTORICAL TRAUMA SERIES
Dr. Maria Yellow Horse Braveheart

An Introduction and Review on Historical Trauma Intervention
Historical Trauma and Parenting
New Mexico Communities Impacted by Training Sessions since July 2012
IV: Narrative Plan

U. Technical Assistance Needs

Narrative Question:

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Footnotes:
IV: Narrative Plan
U. Technical Assistance Needs

Narrative Questions:

1. **What areas of technical assistance is the state currently receiving?**
   BHSD staff is working with the Behavioral Health Planning Council and a SAMHSA contractor to identify topics and strategies to help the current Council members understand how they can use data to target working priorities; identify policy issues on which they can advocate; and learn from other states on the issues and strategies they have undertaken.

2. **What are the sources of technical assistance?**
   Current SAMHSA contractor.

3. **What technical assistance is most needed by state staff?**
   A. Completing the State Suicide Plan
   B. Tying in state priorities with the Block Grant expenditure finance tables (NM cannot easily match our expenditures with the standard tables that are provided in the Block Grant due to differing categories, interpretations, etc.)
   C. Training assistance in understanding how to complete our MOEs.

4. **What technical assistance is most needed by behavioral health providers?**
   As NM modifies its contracts and scopes of work to mirror it priorities, providers may need assistance in understanding the what is meant by performance outcomes and expectations.
IV: Narrative Plan

V. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.

- The state justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.

- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.

- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.

- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

45 SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

Footnotes:
V. State Partners

New Mexico created the Purchasing Collaborative in 2004, a collective of 18 state agencies to address behavioral health issues and needs in the state. Included among the state agencies are the NM Corrections Department, the Public Education Department, Children Youth and Families Department, Indian Affairs Department, Housing Mortgage Authority, Department of Health, and the Human Services Department. See the Statute in the Attachments which outlines roles and responsibilities as Collaborative state agencies and expectations for the state’s behavioral health system.

As mentioned in our previous Block Grant Application, the vision of the Collaborative is to be a single statewide behavioral health delivery system in which funds are managed effectively and efficiently and to create an environment in which the support of recovery and development of resiliency is expected, mental health is promoted, the adverse affects of substance abuse and mental illness are prevented or reduced, and behavioral health consumers are assisted in participating fully in the lives of their communities.

The Collaborative is charged with a number of responsibilities including:

- Inventoring all expenditures for mental health and substance abuse services;
- Creating a single behavioral health care and services delivery system that promotes mental health, emphasizes prevention, early intervention, resiliency, recovery and rehabilitation and funds are managed efficiently, and ensures availability of services throughout the State;
- Paying special attention to regional, cultural, rural, frontier, urban and border issues, and seeking and considering suggestions of Native Americans.
- Contracting with a single, Statewide services purchasing entity (SE); Monitoring service capacities and utilization in order to achieve desired performance measures and outcomes;
- Making decisions regarding funds, interdepartmental staff, grant writing and grants management;
- Comprehensive planning and meeting State and federal requirements;
- Overseeing systems of care, data management, performance and outcome indicators, rate setting, services definitions, considering consumer, family and citizen input, monitoring training, assuring that evidence-based practices receive priority, and providing oversight for fraud and abuse and licensing and certification.

The Collaborative meets quarterly and receives regular reports and updates on current major behavioral health issues that are impacting communities and determine how to address those
issues. For instance, as a small example, the Collaborative has addressed and made policy recommendations regarding suicides in tribal communities; opiate overdoses among urban high school youth; over prescription of pain meds by physicians; over use of residential beds to treat substance abuse disorders; as well as data reporting from the State Entity on services being provided broken out demographically.

The Behavioral Health Purchasing Collaborative's Steering Team, chaired by the Collaborative CEO, meets weekly to coordinate priorities at the Collaborative level, monitor Collaborative progress in all areas, and develop policy recommendations for consideration by the Collaborative. The Steering Team is comprised of a group of leaders from various member agencies including the Human Services Department's Behavioral Health Services Division, Children, Youth and Families, Department of Corrections, and the Public Education Department.

As an aside but important circumstance, the chair of the Collaborative is the Human Services Department Cabinet Secretary who also sits on the Advisory Board of the New Mexico Health Insurance Exchange/Marketplace. This connection is vital for keeping the Collaborative informed and for ensuring that critical behavioral health and physical health needs of New Mexicans are addressed.
Section 9-7-6.4 NMSA 1978

RELEVANT TO BEHAVIORAL HEALTH; ESTABLISHING AN INTERAGENCY BEHAVIORAL HEALTH PURCHASING COLLABORATIVE AND A BEHAVIORAL HEALTH PLANNING COUNCIL; PRESCRIBING POWERS, DUTIES AND MEMBERSHIP; RECONCILING MULTIPLE AMENDMENTS TO THE SAME SECTION OF LAW IN LAWS 2003.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

Section 1. PURPOSE.--The purpose of creating a single interagency behavioral health purchasing collaborative is to develop a statewide system of behavioral health care that promotes the behavioral health and well-being of children, individuals and families; encourages a seamless system of care that is accessible and continuously available; and emphasizes prevention and early intervention, resiliency, recovery and rehabilitation.

Section 2. A new section of the Public Health Act is enacted to read: "BEHAVIORAL HEALTH PLANNING COUNCIL CREATED--POWERS AND DUTIES--MEMBERSHIP.--There is created the "behavioral health planning council".

A. The council shall consist of the following members, all of whom shall be appointed by and serve at the pleasure of the governor:
   (1) consumers of behavioral health services and consumers of substance abuse services, as follows:
      (a) adults with serious mental illness;
      (b) seniors;
      (c) family members of adults with serious mental illness and of children with serious emotional or neurobiological disorders;
      (d) persons with co-occurring disorders; and
      (e) Native American representatives from a pueblo, an Apache tribe, the Navajo Nation and an urban Native American population;
   (2) providers;
   (3) state agency representation from agencies responsible for:
      (a) adult mental health and substance abuse;
      (b) children's mental health and substance abuse;
      (c) education;
      (d) vocational rehabilitation;
      (e) criminal justice;
      (f) juvenile justice;
      (g) housing;
      (h) medicaid and social services;
      (i) health policy planning;
      (j) developmental disabilities planning; and
      (k) disabilities issues and advocacy;
   (4) such other members as the governor may appoint to ensure appropriate cultural and geographic representation; and
   (5) advocates.

B. Providers and state agency representatives together may not constitute more than forty-nine percent of the council membership.

C. The council shall:
   (1) advocate for adults, children and adolescents with serious mental illness or severe emotional, neurobiological and behavioral disorders, as well as those with mental illness or emotional problems, including substance abuse and co-occurring disorders;
(2) report annually to the governor and the legislature on the adequacy and allocation of mental health services throughout the state;
(3) encourage and support the development of a comprehensive, integrated, community-based behavioral health system of care, including mental health and substance abuse services, and services for persons with co-occurring disorders;
(4) advise state agencies responsible for behavioral health services for children and adults, as those agencies are charged in Section 9-7-6.4 NMSA 1978;
(5) meet regularly and at the call of the chair, who shall be selected by the council membership from among its members;
(6) establish subcommittees, to meet at least quarterly, as follows:
   (a) a medicaid subcommittee, chaired by the secretary of human services or a designee, which may also serve as a subcommittee of the medicaid advisory committee;
   (b) a child and adolescent subcommittee, chaired by the secretary of children, youth and families or a designee;
   (c) an adult subcommittee, chaired by the secretary of health or a designee;
   (d) a substance abuse subcommittee, chaired by the secretary of health or a designee, which shall include DWI issues and shall include representation from local DWI councils; and
   (e) other subcommittees as may be established by the chair of the council to address specific issues. All subcommittees may include nonvoting members appointed by the chair for purposes of providing expertise necessary to the charge of the respective subcommittee;
(7) review and make recommendations for the comprehensive mental health state block grant and the substance abuse block grant applications, the state plan for medicaid services and any other plan or application for federal or foundation funding for behavioral health services; and
(8) replace the governor's mental health planning council and act in accordance with Public Law 102-321 of the federal Public Health Service Act."

Section 3. Section 9-2A-8 NMSA 1978 (being Laws 1992, Chapter 57, Section 8, as amended) is amended to read:
"9-2A-8. DEPARTMENT--ADDITIONAL DUTIES.--In addition to other duties provided by law or assigned to the department by the governor, the department shall:
   A. develop priorities for department services and resources based on state policy and national best-practice standards and local considerations and priorities;
   B. strengthen collaboration and coordination in state and local services for children, youth and families by integrating critical functions as appropriate, including service delivery and contracting for services across divisions and related agencies;
   C. develop and maintain a statewide database, including client tracking of services for children, youth and families
   D. develop standards of service within the department that focus on prevention, monitoring and outcomes;
   E. analyze policies of other departments that affect children, youth and families to encourage common contracting procedures, common service definitions and a uniform system of access;
   F. enact regulations to control disposition and placement of children under the Children's Code, including regulations to limit or prohibit the out-of-state placement of children, including those who have developmental disabilities or emotional, neurobiological or behavioral disorders, when in-state alternatives are available;
G. develop reimbursement criteria for licensed child care centers and licensed home providers establishing that accreditation by a department-approved national accrediting body is sufficient qualification for the child care center or home provider to receive the highest reimbursement rate paid by the department;

H. assume and implement responsibility for children’s mental health and substance abuse services in the state, coordinating with the human services department and the department of health;

I. assume and implement the lead responsibility among all departments for domestic violence services;

J. implement prevention and early intervention as a departmental focus;

K. conduct biennial assessments of service gaps and needs and establish outcome measurements to address those service gaps and needs, including recommendations from the governor’s children’s cabinet and the children, youth and families advisory committee; and

L. ensure that behavioral health services provided, including mental health and substance abuse services for children, adolescents and their families, shall be in compliance with requirements of Section 9-7-6.4 NMSA 1978."

Section 4. Section 9-3-5 NMSA 1978 (being Laws 1977, Chapter 257, Section 6, as amended) is amended to read:

“9-3-5. SECRETARY--DUTIES AND GENERAL POWERS.--
A. The secretary of corrections is responsible to the governor for the operation of the corrections department. It is his duty to manage all operations of the department and to administer and enforce the laws with which he or the department is charged.

B. To perform his duties, the secretary has every power expressly enumerated in the laws, whether granted to the secretary of the department or any division of the department, except where authority conferred upon any division is explicitly exempted from the secretary’s authority by statute. In accordance with these provisions, the secretary shall:

(1) except as otherwise provided in the Corrections Department Act, exercise general supervisory and appointing authority over all department employees, subject to any applicable personnel laws and regulations;

(2) delegate authority to subordinates as he deems necessary and appropriate, clearly delineating such delegated authority and the limitations thereto;

(3) organize the department into those organizational units he deems will enable it to function most efficiently, subject to any provisions of law requiring or establishing specific organizational units;

(4) within the limitations of available appropriations and applicable laws, employ and fix the compensation of those persons necessary to discharge his duties;

(5) take administrative action by issuing orders and instructions, not inconsistent with the law, to assure implementation of and compliance with the provisions of law for whose administration or execution he is responsible and to enforce those orders and instructions by appropriate administrative action or actions in the courts;

(6) conduct research and studies that will improve the operations of the department and the provision of services to the citizens of the state;

(7) provide courses of instruction and practical training for employees of the department and other persons involved in the administration of programs with the objective of improving the operations and efficiency of administration;

(8) prepare an annual budget of the department;

(9) provide cooperation, at the request of heads of administratively attached agencies, in order to:
(a) minimize or eliminate duplication of services and jurisdictional conflicts;
(b) coordinate activities and resolve problems of mutual concern; and
(c) resolve by agreement the manner and extent to which the department shall provide budgeting, record-keeping and related clerical assistance to administratively attached agencies;

(10) appoint, with the governor's consent, a "director" for each division. These appointed positions are exempt from the provisions of the Personnel Act. Persons appointed to these positions shall serve at the pleasure of the secretary;

(11) give bond as provided in the Surety Bond Act. The department shall pay the costs of the bonds; and

(12) require performance bonds of such department employees and officers as he deems necessary, as provided in the Surety Bond Act. The department shall pay the costs of the bonds.

C. The secretary may apply for and receive, with the governor's approval, in the name of the department any public or private funds, including United States government funds, available to the department to carry out its programs, duties or services.

D. Where functions of departments overlap or a function assigned to one department could better be performed by another department, a secretary may recommend appropriate legislation to the next session of the legislature for its approval.

E. The secretary may make and adopt such reasonable and procedural rules and regulations as may be necessary to carry out the duties of department and its divisions. No rule or regulation promulgated by the director of any division in carrying out the functions and duties of the division shall be effective until approved by the secretary. Unless otherwise provided by statute, no regulation affecting any person or agency outside the department shall be adopted, amended or repealed without a public hearing on the proposed action before the secretary or a hearing officer designated by him. The public hearing shall be held in Santa Fe unless otherwise permitted by statute. Notice of the subject matter of the regulation, the action proposed to be taken, the time and place of the hearing, the manner in which interested persons may present their views and the method by which copies of the proposed regulation, proposed amendment or repeal of an existing regulation may be obtained shall be published once at least thirty days prior to the hearing date in a newspaper of general circulation and mailed at least thirty days prior to the hearing date to all persons who have made a written request for advance notice of hearing. All rules and regulations shall be filed in accordance with the State Rules Act.

F. Behavioral health services, including mental health and substance abuse services, provided by the department for persons under the department's supervision shall be in compliance with the requirements of Section 9-7-6.4 NMSA 1978.
Section 6. Section 9-7-6.1 NMSA 1978 (being Laws 1999, Chapter 270, Section 1) is amended to read:

"9-7-6.1. BEHAVIORAL HEALTH SERVICES--POWERS AND DUTIES OF THE DEPARTMENT OF HEALTH.--Subject to appropriation, the department shall:

A. contract for behavioral health treatment and support services, including mental health, alcoholism and other substance abuse services;
B. establish standards for the delivery of behavioral health services, including quality management and improvement, performance measures, accessibility and availability of services, utilization management, credentialing and recredentialing, rights and responsibilities of providers, preventive behavioral health services, clinical treatment and evaluation and the documentation and confidentiality of client records;
C. ensure that all behavioral health services, including mental health and substance abuse services, provided, contracted for or approved are in compliance with the requirements of Section 9-7-6.4 NMSA 1978;
D. assume responsibility for and implement adult mental health and substance abuse services in the state coordinating with the human services department and the children, youth and families department;
E. establish criteria for determining individual eligibility for behavioral health services; and
F. maintain a management information system in accordance with standards for reporting clinical and fiscal information."

Section 7. Section 9-7-6.2 NMSA 1978 (being Laws 1999, Chapter 270, Section 2) is amended to read:

"9-7-6.2. CONTRACT ELIGIBILITY.--Subject to the provisions of Section 9-7-6.4 NMSA 1978, the department may enter into contracts for behavioral health services with municipalities, counties, state institutions of higher education, tribal or pueblo governments or organizations, regional provider service networks or private nonprofit or for-profit corporations authorized to do business in New Mexico."

Section 8. A new section of the Department of Health Act, Section 9-7-6.4 NMSA 1978, is enacted to read:

"9-7-6.4. INTERAGENCY BEHAVIORAL HEALTH PURCHASING COLLABORATIVE.--
A. There is created the "interagency behavioral health purchasing collaborative", consisting of the secretaries of human services, health, corrections, children, youth and families, finance and administration, labor, public education and transportation; the directors of the state agency on aging, the administrative office of the courts, the New Mexico office of Indian affairs, the New Mexico mortgage finance authority, the governor's committee on concerns of the handicapped, the developmental disabilities planning council, the vocational rehabilitation division the public education department and the New Mexico health policy commission; and the governor's health policy coordinator, or their designees. The collaborative shall be chaired by the secretary of human services with the respective secretaries of health and children, youth and families alternating annually as co-chairs.
B. The collaborative shall meet regularly and at the call of either co-chair and shall:
   (1) identify behavioral health needs statewide, with an emphasis on that hiatus between needs and services set forth in the department of health's gap analysis and in on-going needs assessments, and develop a master plan for statewide delivery of services;
   (2) give special attention to regional differences, including cultural, rural, frontier, urban and border issues;
inventory all expenditures for behavioral health, including mental health and substance abuse;

plan, design and direct a statewide behavioral health system, ensuring both availability of services and efficient use of all behavioral health funding, taking into consideration funding appropriated to specific affected departments; and

contract for operation of one or more behavioral health entities to ensure availability of services throughout the state.

C. The plan for delivery of behavioral health services shall include specific service plans to address the needs of infants, children, adolescents, adults and seniors as well as to address workforce development and retention and quality improvement issues. The plan shall be revised every two years and shall be adopted by the department of health as part of the statewide health plan.

D. The plan shall take the following principles into consideration, to the extent practicable and within available resources:

1. services should be individually centered and family focused based on principles of individual capacity for recovery and resiliency;
2. services should be delivered in a culturally responsive manner in a home or community-based setting, where possible;
3. services should be delivered in the least restrictive and most appropriate manner;
4. individualized service planning and case management should take into consideration individual and family circumstances, abilities and strengths and be accomplished in consultation with appropriate family, caregivers and other persons critical to the individual's life and well-being;
5. services should be coordinated, accessible, accountable and of high quality;
6. services should be directed by the individual or family served to the extent possible;
7. services may be consumer or family provided, as defined by the collaborative;
8. services should include behavioral health promotion, prevention, early intervention, treatment and community support; and
9. services should consider regional differences, including cultural, rural, frontier, urban and border issues.

E. The collaborative shall seek and consider suggestions of Native American representatives from Indian nations, tribes, pueblos and the urban Indian population, located wholly or partially within New Mexico, in the development of the plan for delivery of behavioral health services.

Section 9. Section 9-7-11.2 NMSA 1978 (being Laws 1991, Chapter 139, Section 2, as amended) is amended to read:

"9-7-11.2. NEW MEXICO HEALTH POLICY COMMISSION CREATED--COMPOSITION--DUTIES.--

A. There is created the "New Mexico health policy commission", which is administratively attached to the department of finance and administration.
B. The New Mexico health policy commission shall consist of eight members appointed by the governor with the advice and consent of the senate to reflect the ethnic, economic, geographic and professional diversity of the state. No member of the commission shall have a pecuniary or fiduciary interest in the health services industry for three years preceding his appointment to the commission. Two members shall be appointed for one-year
terms, three members shall be appointed for two-year terms, three members shall be appointed for three-year terms and all subsequent appointments shall be made for three-year terms.

C. The New Mexico health policy commission shall meet at the call of the chairman and shall meet not less than quarterly. The chairman shall be elected from among the members of the commission. Members of the New Mexico health policy commission shall not be paid but shall receive per diem and mileage expenses as provided in the Per Diem and Mileage Act.

D. The New Mexico health policy commission shall establish task forces as needed to make recommendations to the commission on various health issues. Task force members may include individuals who have expertise or a pecuniary or fiduciary interest in the health services industry. Voting members of a task force may receive mileage expenses if they:

1. are members who represent consumer interests;
2. are individuals who were not appointed to represent the views of the organization or agency for which they work; or
3. represent an organization that has a policy of not reimbursing travel expenses of employees or representatives for travel to meetings.

E. The New Mexico health policy commission shall:

1. develop a plan for and monitor the implementation of the state’s health policy;
2. obtain and evaluate information from a broad spectrum of New Mexico’s society to develop and monitor the implementation of the state’s health policy;
3. obtain and evaluate information relating to factors that affect the availability and accessibility of health services and health care personnel in the public and private sectors;
4. perform needs assessments on health personnel, health education and recruitment and retention and make recommendations regarding the training, recruitment, placement and retention of health professionals in underserved areas of the state;
5. prepare and publish an annual report describing the progress in addressing the state’s health policy and planning issues. The report shall include a work plan of goals and objectives for addressing the state’s health policy and planning issues in the upcoming year;
6. distribute the annual report to the governor, appropriate state agencies and interim legislative committees and interested parties;
7. establish a process to prioritize recommendations on program development, resource allocation and proposed legislation;
8. provide information and analysis on health issues;
9. serve as a catalyst and synthesizer of health policy in the public and private sectors;
10. respond to requests by the executive and legislative branches of government; and
11. ensure that any behavioral health projects, including those relating to mental health and substance abuse, are conducted in compliance with the requirements of Section 9-7-6.4 NMSA 1978."

Section 10. Section 9-8-6 NMSA 1978 (being Laws 1977, Chapter 252, Section 7, as amended) is amended to read:

"9-8-6. SECRETARY--DUTIES AND GENERAL POWERS.--
A. The secretary is responsible to the governor for the operation of the department. It is his duty to manage all operations of the department and to administer and enforce the laws with which he or the department is charged.
B. To perform his duties, the secretary has every power expressly enumerated in the laws, whether granted to the secretary or the department or any division of the department, except where authority conferred upon any division is explicitly exempted from the secretary's authority by statute. In accordance with these provisions, the secretary shall:

1. except as otherwise provided in the Human Services Department Act, exercise general supervisory and appointing authority over all department employees, subject to any applicable personnel laws and regulations;
2. delegate authority to subordinates as he deems necessary and appropriate, clearly delineating such delegated authority and the limitations thereto;
3. organize the department into those organizational units he deems will enable it to function most efficiently, subject to any provisions of law requiring or establishing specific organizational units;
4. within the limitations of available appropriations and applicable laws, employ and fix the compensation of those persons necessary to discharge his duties;
5. take administrative action by issuing orders and instructions, not inconsistent with the law, to assure implementation of and compliance with the provisions of law for whose administration or execution he is responsible and to enforce those orders and instructions by appropriate administrative action in the courts;
6. conduct research and studies that will improve the operations of the department and the provision of services to the citizens of the state;
7. provide courses of instruction and practical training for employees of the department and other persons involved in the administration of programs with the objective of improving the operations and efficiency of administration;
8. prepare an annual budget of the department;
9. provide cooperation, at the request of heads of administratively attached agencies, in order to:
   a. minimize or eliminate duplication of services and jurisdictional conflicts;
   b. coordinate activities and resolve problems of mutual concern;
   c. resolve by agreement the manner and extent to which the department shall provide budgeting, record-keeping and related clerical assistance to administratively attached agencies;
10. appoint, with the governor's consent, a "director" for each division. These appointed positions are exempt from the provisions of the Personnel Act. Persons appointed to these positions shall serve at the pleasure of the secretary, except as provided in Section 9-8-9 NMSA 1978;
11. give bond in the penal sum of twenty-five thousand dollars ($25,000) and require directors to each give bond in the penal sum of ten thousand dollars ($10,000) conditioned upon the faithful performance of duties as provided in the Surety Bond Act. The department shall pay the costs of these bonds; and
12. require performance bonds of such department employees and officers as he deems necessary as provided in the Surety Bond Act. The department shall pay the costs of these bonds.

C. The secretary may apply for and receive, with the governor's approval, in the name of the department, any public or private funds, including United States government funds, available to the department to carry out its programs, duties or services.

D. Where functions of departments overlap or a function assigned to one department could better be performed by another department, the secretary may recommend appropriate legislation to the next session of the legislature for its approval.
E. The secretary may make and adopt such reasonable and procedural rules and regulations as may be necessary to carry out the duties of the department and its divisions. No rule or regulation promulgated by the director of any division in carrying out the functions and duties of the division shall be effective until approved by the secretary unless otherwise provided by statute. Unless otherwise provided by statute, no regulation affecting any person or agency outside the department shall be adopted, amended or repealed without a public hearing on the proposed action before the secretary or a hearing officer designated by him. The public hearing shall be held in Santa Fe unless otherwise permitted by statute. Notice of the subject matter of the regulation, the action proposed to be taken, the time and place of the hearing, the manner in which interested persons may present their views and the method by which copies of the proposed regulation, proposed amendment or repeal of an existing regulation may be obtained shall be published once at least thirty days prior to the hearing date in a newspaper of general circulation and mailed at least thirty days prior to the hearing date to all persons who have made a written request for advance notice of hearing.

F. In the event the secretary anticipates that adoption, amendment or repeal of a rule or regulation will be required by a cancellation, reduction or suspension of federal funds or order by a court of competent jurisdiction:

   (1) if the secretary is notified by appropriate federal authorities at least sixty days prior to the effective date of such cancellation, reduction or termination of federal funds, the department is required to promulgate regulations through the public hearing process to be effective on the date mandated by the appropriate federal authority; or

   (2) if the secretary is notified by appropriate federal authorities or court less than sixty days prior to the effective date of such cancellation, reduction or suspension of federal funds or court order, the department is authorized without a public hearing to promulgate interim rules or regulations effective for a period not to exceed ninety days. Interim regulations shall not be promulgated without first providing a written notice twenty days in advance to providers of medical or behavioral health services and beneficiaries of department programs. At the time of the promulgation of the interim rules or regulations, the department shall give notice of the public hearing on the final rules or regulations in accordance with Subsection E of this section.

G. If the secretary certifies to the secretary of finance and administration and gives contemporaneous notice of such certification through the human services register that the department has insufficient state funds to operate any of the programs it administers and that reductions in services or benefit levels are necessary, the secretary may engage in interim rulemaking. Notwithstanding any provision to the contrary in the State Rules Act, interim rulemaking shall be conducted pursuant to Subsection E of this section, except:

   (1) the period of notice of public hearing shall be fifteen days;

   (2) the department shall also send individual notices of the interim rulemaking and of the public hearing to affected providers and beneficiaries;

   (3) rules and regulations promulgated pursuant to the provisions of this subsection shall be in effect not less than five days after the public hearing;

   (4) rules and regulations promulgated pursuant to the provisions of this subsection shall not be in effect for more than ninety days; and

   (5) if final rules and regulations are necessary to replace the interim rules and regulations, the department shall give notice of intent to promulgate final rules and regulations at the time of notice herein. The final rules and regulations shall be promulgated not more than forty-five days after the public hearing and filed in accordance with the State Rules Act.

H. At the time of the promulgation of the interim rules or regulations, the department shall give notice of the public hearing on the final rules or regulations in accordance with Subsection E of this section.
I. The secretary shall ensure that any behavioral health services, including mental health and substance abuse services, provided, contracted for or approved are in compliance with the requirements of Section 9-7-6.4 NMSA 1978.

J. All rules and regulations shall be filed in accordance with the State Rules Act.”

Section 11. Section 22-14-8 NMSA 1978 (being Laws 1967, Chapter 16, Section 197, as amended by Laws 1993, Chapter 226, Section 31 and also by Laws 1993, Chapter 229, Section 2) is amended to read:

“22-14-8. VOCATIONAL REHABILITATION DIVISION--POWERS--DUTIES. --The vocational rehabilitation division of the public education department shall:
A. provide vocational rehabilitation to qualified individuals;
B. administer any state plan or federal aid funds relating to vocational rehabilitation;
C. cooperate and make agreements with public or private agencies to establish or to maintain a vocational rehabilitation program;
D. enter into reciprocal agreements with other states to provide vocational rehabilitation;
E. accept gifts or grants to be used for vocational rehabilitation;
F. enforce regulations for the administration of laws relating to vocational rehabilitation;
G. conduct research and compile statistics relating to vocational rehabilitation; and
H. ensure that behavioral health services, including mental health and substance abuse services, provided, contracted for or approved are in compliance with the requirements of Section 9-7-6.4 NMSA 1978.”

Section 12. Section 34-9-3 NMSA 1978 (being Laws 1959, Chapter 162, Section 3, as amended) is amended to read:

“34-9-3. DIRECTOR--DUTIES.--The director of the administrative office of the courts shall, under the supervision and direction of the supreme court:
A. supervise all matters relating to administration of the courts;
B. examine fiscal matters and the state of the dockets of the courts, secure information as to the courts' need of assistance and prepare and transmit to the supreme court statistical data and reports as to the business of the courts;
C. submit to the supreme court and to the legislature by January 30 of each year a report of the activities of the administrative office of the courts and of the state of business of the courts, including the statistical data submitted to the supreme court pursuant to Subsection B of this section, and the director's recommendations. This report is a public document;
D. deal with the problems of finance of those courts supported by legislative appropriation and be concerned with adequate but economical financing of each of these courts and the equitable distribution of available funds among them. For this purpose, the director shall receive, adjust and approve proposed budgets submitted by these courts prior to submission of the budgets to the state budget division of the department of finance and administration for inclusion in the executive budget. The district courts of all counties within a judicial district shall be included within a single budget. Budget proposals shall be submitted by the courts at the time and in the form prescribed by the director;
E. perform other duties in aid of the administration of justice and the administration and dispatch of the business of the courts as directed by the supreme court. The courts shall comply with all requests of the director for information; and
F. encourage that any behavioral health services, including mental health and substance abuse services, funded, provided, contracted for or approved by the office be in compliance with the requirements of Section 9-7-6.4 NMSA 1978."

Section 13. A new section of the Mortgage Finance Authority Act is enacted to read:

"DUTIES--BEHAVIORAL HEALTH.--The authority shall:

A. appoint a representative to both the behavioral health planning council and the interagency behavioral health purchasing collaborative; and

B. ensure that any behavioral health services, including mental health and substance abuse services, and any housing provided for consumers of those services, that are provided, contracted for or approved by the authority are in compliance with requirements of Section 9-7-6.4 NMSA 1978."

Section 14. Section 67-3-8 NMSA 1978 (being Laws 1967, Chapter 226, Section 7, as amended) is amended to read:

"67-3-8. POWERS AND DUTIES OF SECRETARY.--The secretary shall:

A. serve as the chief staff officer of the state transportation commission and shall be responsible to the commission for the operations and management of the work of the department;

B. organize the department in such a manner as to properly conduct the work of the department;

C. establish six highway construction districts with the approval of the state transportation commission. The secretary shall designate a district engineer in each construction district to supervise and manage the operations of the district. The district engineer shall be a professional engineer. The authority and responsibility for the actual construction for all construction projects within the district shall be delegated to the district engineer. District engineers shall attend state transportation commission meetings;

D. in accordance with the provisions of the Personnel Act, employ such assistants and employees as may be required for the efficient operation of the department, each of whom shall possess all the qualifications that may be prescribed for such position; provided that, notwithstanding the provisions of the Personnel Act, no more than five division directors shall be covered by and subject to the Personnel Act;

E. observe, administer and enforce the provisions of law now existing or hereafter enacted that pertain to the state highways, the state transportation commission or the department; and

F. ensure that any behavioral health services, including mental health and substance abuse services, provided, contracted for or approved are in compliance with the requirements of Section 9-7-6.4 NMSA 1978."

Section 15. STATE AGENCY ON AGING--SUCCESSOR AGENCY--DUTY.--The state agency on aging, or a successor agency, shall appoint the secretary or the secretary's designee to serve as a member of the interagency behavioral health purchasing collaborative and shall ensure that any behavioral health services, including mental health and substance abuse services funded, provided, contracted for or approved, are in compliance with the requirements of Section 9-7-6.4 NMSA 1978.

Section 16. NEW MEXICO OFFICE OF INDIAN AFFAIRS--SUCCESSOR AGENCY--DUTY.--The New Mexico office of Indian affairs, or a successor agency, shall appoint the secretary or the secretary's designee to serve as a member of the interagency behavioral health purchasing collaborative and shall ensure that all behavioral health services, including mental
Section 17. PUBLIC EDUCATION DEPARTMENT.--The public education department shall appoint the secretary of public education or the secretary's designee to serve as a member of the interagency behavioral health purchasing collaborative and shall ensure that any behavioral health services, including mental health and substance abuse services funded, provided, contracted for or approved, are in compliance with the requirements of Section 9-7-6.4 NMSA 1978.

Section 18. REPEAL.--Section 24-1-26 NMSA 1978 (being Section 1) is repealed. Laws 2003, Chapter 59 HB 271
Section 1. Section 24-1-28 NMSA 1978 (being Laws 2004, Chapter 46, Section 2) is amended to read:

"24-1-28. BEHAVIORAL HEALTH PLANNING COUNCIL CREATED--POWERS AND DUTIES--MEMBERSHIP. -- There is created the "behavioral health planning council".

A. The council shall consist of the following members, all of whom shall be appointed by and serve at the pleasure of the governor:

(1) consumers of behavioral health services and consumers of substance abuse services, as follows:
   (a) adults with serious mental illness;
   (b) seniors;
   (c) family members of adults with serious mental illness and of children with serious emotional or neurobiological disorders; and
   (d) persons with co-occurring disorders;

(2) Native American representatives from a pueblo, an Apache tribe, the Navajo Nation and an urban Native American population;

(3) providers;

(4) state agency representation from agencies responsible for:
   (a) adult mental health and substance abuse;
   (b) children’s mental health and substance abuse;
   (c) education;
   (d) vocational rehabilitation;
   (e) criminal justice;
   (f) juvenile justice;
   (g) housing;
   (h) medicaid and social services;
   (i) health policy planning;
   (j) developmental disabilities planning; and
   (k) disabilities issues and advocacy;

(5) such other members as the governor may appoint to ensure appropriate cultural and geographic representation; and

(6) advocates.

B. Providers and state agency representatives together may not constitute more than forty-nine percent of the council membership.

C. The council shall:

(1) advocate for adults, children and adolescents with serious mental illness or severe emotional, neurobiological and behavioral disorders, as well as those with mental illness or emotional problems, including substance abuse and co-occurring disorders;

(2) report annually to the governor and the legislature on the adequacy and allocation of mental health services throughout the state;

(3) encourage and support the development of a comprehensive, integrated, community-based behavioral health system of care, including mental health and substance abuse services, and services for persons with co-occurring disorders;

(4) advise state agencies responsible for behavioral health services for children and adults, as those agencies are charged in Section 9-7-6.4 NMSA 1978;

(5) meet regularly and at the call of the chair, who shall be selected by the council membership from among its members;

(6) establish subcommittees, to meet at least quarterly, as follows:
   (a) a medicaid subcommittee, chaired by the secretary of human services or a designee, which may also serve as a subcommittee of the medicaid advisory committee;
(b) a child and adolescent subcommittee, chaired by the secretary of children, youth and families or a designee;

(c) an adult subcommittee, chaired by the secretary of health or a designee;

(d) a substance abuse subcommittee, chaired by the secretary of health or a designee, which shall include DWI issues and shall include representation from local DWI councils;

(e) a Native American subcommittee, chaired by the secretary of Indian affairs or a designee; and

(f) other subcommittees as may be established by the chair of the council to address specific issues. All subcommittees may include nonvoting members appointed by the chair for purposes of providing expertise necessary to the charge of the respective subcommittee;

(7) review and make recommendations for the comprehensive mental health state block grant and the substance abuse block grant applications, the state plan for medicaid services and any other plan or application for federal or foundation funding for behavioral health services; and

(8) replace the governor's mental health planning council and act in accordance with Public Law 102-321 of the federal Public Health Service Act." HB 259
IV: Narrative Plan

W. State Behavioral Health Advisory Council

Narrative Question:

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

Footnotes:
What planning mechanism does the state use to plan and implement substance abuse services?

The New Mexico Behavioral Health Planning Council continues to serve as the advisory body to the Governor and the Interagency Behavioral Health Purchasing Collaborative on issues relating to mental health, substance abuse, and developmental disabilities. The Council is comprised of volunteers from across the state and across the spectrum of behavioral health stakeholders who met quarterly during the year.

The Statutory Subcommittees conduct the work of the Council - Adult, Substance Abuse, Medicaid, Native American, and Children/Adolescents. It is in those Subcommittees where the broadest base of input is provided from consumers and family members with the least amount of expense. To further their productivity, the Council continues to offer direction on the functions of the subcommittees and their relationships to the Council and the Local Collaboratives.

The voice of consumers and family members is heard through many different forums including:

The members of the Adult/Substance Abuse/Medicaid Subcommittee are continuing to work with the Local Collaboratives (LC’s) to produce a mapping of services, programs and support activities. This “map” will include services funded not only by State Agencies/OptumHealth but also recovery programs, consumer operated services, faith-based programs, volunteer support groups, City/County funded programs, etc. Focus has been: LC 6 (Grant, Hidalgo and Luna counties), LC 7 (Torrance, Catron and Socorro counties), LC 11 (San Juan County) and LC 15 (the Navajo Nation). The NM Aging and Long Term Services Department has compiled data and placed it on their online NM Social Services Resource Directory. The Children / Adolescent Subcommittee is working on a similar mapping project with an emphasis on “community supports”. When completed, this website could become an integral part of a comprehensive behavioral health resource system.

The Council and the Collaborative have long recognized that behavioral health is essential to overall health. Subcommittee members have taken the work of SAMHSA’s Eight Dimensions of Wellness (social, environmental, physical, emotional, spiritual, occupational, intellectual and financial) back to their home communities – to local Senior Jubilees, to local consumer groups, to psychosocial rehabilitation groups, and to individuals. All agreed that 1) Behavioral Health is essential to health, 2) Prevention works, 3) Treatment is effective and 4) People recover.

The members of the Adult/Substance Abuse/Medicaid Subcommittee (ASAMSC) have worked on one Dimension each month, translating the ideas into advice about how it is possible to really live that dimension of wellness. Drawing upon their personal experiences, all members of the subcommittees have suggested practical ways in which health can be maintained and ensured. Each month, the work of the subcommittee was compiled into a brochure. A full set of these New Mexico Eight Dimensions of Wellness brochures will be available. These brochures are printed not only in English but also in Spanish and have been distributed to the Local Collaboratives. The intent is to expand distribution to providers, Health Councils, libraries, etc. This project is a wonderful example of providing “advice” through lived experience. The ASAMSC is now working on making one document that promotes and contains each of these brochures.
The Council has strong presence on various State Legislative Task Force Workgroups:

SM 18: To continue the work of the Drug Policy Task Force begun during the last Legislative Session, in order to complete the task force’s comprehensive statewide strategic plan based on the four pillar approach—prevention, treatment, harm reduction, and enforcement.

HM 77: To provide recommendations for rules and enforcement protocols to address the increasing rate of addiction to and deaths due to accidental overdose of prescription drugs.

SM 56: To develop a comprehensive statewide plan for treatment of adolescent Opioid addiction.

2. How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?

In May 2012, SAMHSA invited New Mexico as one of seven states to be part of an effort to build state coalitions and educate mental health and substance use stakeholders on health reform implementation. These coalitions include state mental health and substance use consumer and peer organizations, recovery community organizations, family member organizations, provider organizations, and other behavioral health stakeholder organizations to participate in their Health Reform Learning Collaborative.

In addition, the Council is the state’s Coalition Coordinating Center (CCC) which means we are asked to: work to strengthen New Mexico’s Coalition, participate in educational webinars, work to develop educational materials, work with our technical coach, participate in an in-person coaching visit and participate in state CCC meetings.

To date, the Council Chair and other Council members have attended webinars on: understanding basic insurance and coverage concepts, what we should know about Essential Health Benefits for our state, and what is the Coalition for Whole Health report and how does it apply to our State. The council plans to attend one more webinar regarding how the Mental Health Parity and Addiction Equity Act correspond with the process for establishing Essential Health Benefits in our state.

Through its Parity workgroup, information has disseminated issue statements from the Legal Action Center, who is contracted with SAMHSA to build these Coalitions, on Essential Health Benefits, Health Homes and Medicaid coverage and financing changes in the Affordable Care Act.

At this point, the following organizations have joined the Coalition: Sangre de Cristo Community Health, Albuquerque Center for Hope and Recovery, New Mexico Family Network, Brian Injury Alliance, Raincloud, Coalition for Healthy and Resilient Youth, National Alliance on Mental Illness, New Mexico Alliance of Youth Providers, Recovery Based Solutions and Mental Health Association of New Mexico.

Information learned through these means, as well as observation of and participation on the Health Insurance Exchange Workgroup is helping us collect information about many of the changes that will affect the Behavioral Health community in the near future. We have been trying to address the questions that our community has regarding their coverage and care as theses answers become known. Many of the questions people are asking about are being asked by this application.
3 Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.

An important part of the Council’s activities is to have some of its members be a part of the Block Grant Review Committee. They are to ensure that the content of the Block Grant application includes improvements to systems, programs, and policies. Reviewers are also encouraged to make recommendations to the written plan. This process provides the Council opportunities to learn about what the state is planning for services and programs; they can see what is missing or what the plan is lacking and add to it; and their recommendations go to SAMHSA, the Governor, the Purchasing Collaborative and the Planning Council.

In past years, the Chair of the Council and/or other Council representatives participated at the Community Mental Health Services/Substance Abuse Prevention and Treatment Block Grantee Conference. This assisted in a better understanding of the role of the Council and the priorities at the federal level.

4 Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?

Since 2006, the Council has integrated wholly mental health issues with substance use issues. Members include: individuals who have personal experience living with a mental health, substance disorder, and/or co-occurring illness and their knowledge of the behavioral health system; providers of behavioral health services; prevention advocates.

The 4th Annual BHPC/LC Summit in 2012 was very successful in that approximately 160 Local Collaborative members gathered to share successes and offer resources to build and support local partnerships and initiatives around substance abuse prevention, recovery and mental health treatment and recovery. The theme for the summit was SAMHSA’s National Campaign of the 8 Dimensions of Wellness. The day started off with special two special guest speakers: Mike Duffy from SAMHSA and Pamela Drake addressing The Interdisciplinary Science of Prevention.

Presentations were given throughout the day highlighting successful programs throughout the state such as The Opportunities and Challenges of Establishing Sustainable Relationships between the Tribal, County and State Government of Sandoval County, The Warm Line in Las Vegas, NM, and The Consumer-Run Wellness Center/Inside Out in Espanola, NM to name a few.

Recently, Behavioral Health Day was celebrated in the State’s Capitol for the sixth year in a row. The intention of Behavioral Health Day is to celebrate and recognize real people from communities all around the state, via Local Collaboratives, called STARs. Behavioral Health Day honors these individuals (STARs) because they have overcome their challenges and are now advocates in their own communities to educate and inform others about Mental Health and Substance Abuse Recovery. The Council utilizes the opportunity of Behavioral Health Day to also introduce legislators to those living and working in the behavioral health world.

Sixteen STARs were recognized in 2013 for their outstanding contributions to their communities and for their commitments to recovery and wellness. State Senator Howie Morales, Department Secretary of Human Services Sidonie Squire, and Acting CEO of the Behavioral Health Collaborative/Acting Director
of the Behavioral Health Services Division Diana McWilliams joined the celebrations by giving speeches at the Awards Dinner and at the State Capitol. They recognized the STARs for their bravery in sharing their stories and congratulated them for conquering their struggles amongst the challenges of daily life.

The Awards Dinner not only recognizes Local Collaborative STARs, but the Council also celebrates the Lifetime Achievement Award and the John Henry Award, an award that goes to outstanding Service Animals. This year was very special in that the Council not only had the Lifetime Achievement Award, but it also distributed a Posthumous Lifetime Achievement Award.

The Native American Subcommittee (NASC) has been very active reaching out to local community and provider agencies in order to make the necessary connections for learning, mentoring and supporting one another on our journeys to improve the behavioral health services in NM. One of the more recent presentations given to the NASC was from the San Juan County Partnership/Dine Ba Hozho Coalition. They presented the outcomes from their “MOST of Us/Nizhoni Youth survey.” This survey looked at two different schools in Shiprock, with a combined total of 200 students. The surveyor’s goals were to see if community beliefs and perceptions about the youth in their community “matched” what students self-reported in anonymous surveys. They looked at tobacco, alcohol and drug use. The study found that there was a significant difference between the community’s perception of their youth and what the youth self-reported as their “reality.” By collecting this data they developed a media campaign, using a Positive Community Norms model, which provides a framework that keeps “human services professionals grounded in real time, centered on science based interventions, focused on the need of individual communities and regions, and stays informed by listening to wide segments of the community.”* They also utilize the Navajo Wellness Model for their work. The San Juan County Partnership has partnered up with the NASC to reach out to the Children’s and Adolescents Subcommittee and the Council to strategize how we can share this information with other Native American populations, as well as youth organizations across the state.

The Children’s and Adolescents Subcommittee is reinstituting focus on Infant Mental Health and strengthening and expanding its outreach to youth through numerous activities. The subcommittee is a leader in preparations for Children’s Mental Health Week in May.

The Council and its subcommittees are updated monthly on ongoing or current behavioral health activities taking place across the state and members provide insight on community concerns, offer their lived experience advice, and learn about initiatives that are taking place in nearby communities. Updates are provided by the Collaborative CEO and the CEO of the State Entity.

5 **Is the membership representative of the service population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?**

The vision of the Behavioral Health Planning Council is “to be a potent voice for children, adults and families and providers that serve them in New Mexico’s consumer-centered, recovery and resiliency-focused, coordinated, and quality behavioral health care system.”

To fulfill that vision, the Council has worked tirelessly to ensure that it is a good representation of the state’s multiculturalism, as well as having strong consumer and family member voices. Currently, the Council mirrors the demographic components of the state as a whole.
At least two of our members are now entering into their sixth year of service on the Council. When they were first appointed, they were parents of young children with SED. Their children are now older which changes their appointment category (family of individuals with SED, SMI, co-occurring, etc.). The Council is currently trying to find appointment that would meet the “families of young children” category.

Recently, the NM Governor reappointed and made new appointments to the Council. Of the 22 members; 11 identify as Consumers and/or Family Members and 11 are identified as state government employees and providers. We are currently working with the Governor’s Office to appoint a few more members to the Council that identify as consumers and/or family members so that we are back in compliance with the state statute of 51%. Our goal is to have our future appointees identify as parents of young children with SED.

Keeping diverse membership engaged

Through the use of video, telephonic, and internet conferencing, the Council is beginning to see a reduction in travel costs and an increase in participation in meetings. The Collaborative website, and specifically the section designated for the Council, is becoming a reliable source of information for members of the Council and others who are interested in behavioral health issues. The website allows all minutes and meeting information to be posted online allowing easy access to the documents for anyone with computer access.

Through the example of the Council, the Purchasing Collaborative has adopted video conferencing as well for their meetings allowing our consumers and family members to participate.

The Council focuses more and more on the Collaborative website http://www.bhc.state.nm.us/html to provide agendas, minutes, announcements, initiatives, etc, for Local Collaboratives, the Council and the Subcommittees. Annual Reports and State of the Council reports are available on that website (bhc@state.nm.us). The Human Services Department has received feedback from various communities that the (host site) website is not user-friendly. They have heard this concern and the re-design of the website is a priority for 2013 and have asked the Council to have a representative for that workgroup.

The Council updated its Orientation workbook, and added a CD and work book for new members of the Council and its Subcommittees. The orientation materials will help new members, as well as returning members, to get a global perspective of the Council’s operations and how the various committees are an integral part of the state’s process. In 2012, orientation was offered statewide through the use of videoconference, giving participants an opportunity to ask questions and be part of small group discussion without having to travel extensive miles. (See Attachment BH Planning Council Orientation)

Expanded partnerships

Local Collaboratives are represented on the Council and/or its statutory subcommittees. But, LCs want to maintain their autonomy as the local voice to the Collaborative and the Governor beyond the Council’s umbrella. LCs desired to create a network of LC peers from which they could learn, share experiences, and continue the work of grassroots activities. With the ending of state funding support, the LCs sought sustainability efforts through the creation of an LC Alliance – run by LC leadership with minimal technical assistance support by state agency staff.
Their first meeting in July 2012 resulted in identifying priorities for the upcoming year and the creation of several ad hoc committees including a committee to study legislation opportunities for future funding. The Alliance -

- decided to meet quarterly
- elected a Ad Hoc/Leadership group
- utilize conference calling
- will review the original Letters of Readiness of the Local Collaboratives to revisit their original intent and discuss if they need to be redesigned based on the current realities of funding and levels of volunteerism

6 Please describe the duties and responsibilities of the Council.

The New Mexico Behavioral Health Planning Council continues to serve as the advisory body to the Governor and the Interagency Behavioral Health Purchasing Collaborative on issues relating to mental health, substance abuse, and developmental disabilities. The Council is comprised of volunteers from across the state and across the spectrum of behavioral health stakeholders who met quarterly during the year.

Formerly known as the Governors’ Mental Health Council, the Council was established in 2004 as part of House Bill 271. The Council is required to:

- advocate for adults, children and adolescent with serious mental illness or severe emotional, neurobiological and behavioral disorders, as well as those with mental illness or emotional problems, including substance abuse and co-occurring disorders;
- Report to the Governor and Legislature on the adequacy and allocation of mental health services throughout the state;
- Encourage and support the development of a comprehensive, integrated, community-based behavioral health system of care, including mental health and substance abuse services, and services for persons with co-occurring disorders;
- Advise state agencies responsible for behavioral healthy services for children and adults;
- Review and make recommendations on various plans and applications for the comprehensive mental health state block grant and the substance abuse block grant applications, the state plan for Medicaid services, and any other plan or application for federal or foundation funding for behavioral health services.

The Council has advised the Governor and the Purchasing Collaborative on a variety of topics and projects, including strategic priorities, grant utilization, Medicaid cost containment, service implementation and delivery issues, systems of care, and letters of support.

The Council has represented the Collaborative and the State in many areas, including: Legislative Memorials, Core Service Agency development, Supportive Housing, Children, Youth and Family involvement, Cultural Competency, SAMSHA Grantee Conferences and National Association of Mental Health Planning Councils.

As mentioned earlier, the Council also consists of five statutory subcommittees: Adult, Substance Abuse, Children/Adolescents, Native American and Medicaid. Subcommittee membership is comprised of local collaboratives members and at-large members from throughout the state. Meetings are held around the state by video, internet, or telephone to allow the largest number of interested people to participate.
The Chair of the Council has begun to remind council members that “Advice is a Product”. Advice can take many forms such as on some initiative from the State, the Local Collaboratives or the Federal government; it can be a practical piece of work such as the Mapping Project or the 8 Dimensions of Wellness it can be simply reminding other participants of a Task Force what “lived experience” really looks like.

In July, 2012, per the By-laws, the Council elected a new Chair (family member) and Vice-Chair (consumer).

The Council has worked to better define its role, to fulfill its commitments to the State and the people of New Mexico, and to plan for the future of the Council going forward. Over time, the role of the Council has evolved to become a strong advisory board for state agencies responsible for behavioral health services for children and adults. Although the Council has no formal role in creating policy, direct interaction between State staff and the Council and its subcommittees help shape policy as the State develops it. State staff has come to look to the Council when they need to know what the people of New Mexico think.
## IV: Narrative Plan

### Behavioral Health Advisory Council Members

Start Year: 2014  
End Year: 2015  

<table>
<thead>
<tr>
<th>Name</th>
<th>Type of Membership</th>
<th>Agency or Organization Represented</th>
<th>Address, Phone, and Fax</th>
<th>Email (if available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthony Bustos</td>
<td>Providers</td>
<td>1383 Oakwood Cir Portales, NM 88130</td>
<td>PH: 575-799-7599</td>
<td><a href="mailto:tony.bustos@teambuilders.org">tony.bustos@teambuilders.org</a></td>
</tr>
<tr>
<td>Carol Luna Anderson</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>PO Box 4939 Santa Fe, NM 87502</td>
<td>PH: 505-438-0010</td>
<td><a href="mailto:carol@thelifelink.org">carol@thelifelink.org</a></td>
</tr>
<tr>
<td>Cheril Carrington</td>
<td>State Employees</td>
<td>NM Higher Education Department, 2048 Galisteo St Santa Fe, NM 87505</td>
<td>PH: 505-476-8429</td>
<td><a href="mailto:cheril.carrington@state.nm.us">cheril.carrington@state.nm.us</a></td>
</tr>
<tr>
<td>Christine Wendel</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>1000 Cordova Pl #707 Santa Fe, NM 87505</td>
<td>PH: 505-466-6010</td>
<td><a href="mailto:chrisw7185@earthlink.net">chrisw7185@earthlink.net</a></td>
</tr>
<tr>
<td>Cindy Collyer</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>PO Box 446 El Prado, NM 87529</td>
<td>PH: 575-758-9523</td>
<td><a href="mailto:chickenlady1963@hotmail.com">chickenlady1963@hotmail.com</a></td>
</tr>
<tr>
<td>Claire Leonard</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>PO Box 727 Reserve, NM 87830</td>
<td>PH: 575-533-6836</td>
<td><a href="mailto:coleonard@me.com">coleonard@me.com</a></td>
</tr>
<tr>
<td>Erica Padilla</td>
<td>State Employees</td>
<td>Children Youth and Families, PO Drawer 5160 Santa Fe, NM 87502</td>
<td>PH: 505-827-3991</td>
<td><a href="mailto:erica.padilla@state.nm.us">erica.padilla@state.nm.us</a></td>
</tr>
<tr>
<td>Gail Falconer</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>10 Falcon Nest Moriarty, NM 87305</td>
<td>PH: 505-954-1934</td>
<td><a href="mailto:gaifalconer@gmail.com">gaifalconer@gmail.com</a></td>
</tr>
<tr>
<td>Jane Jackson-Bear</td>
<td>Providers</td>
<td>6528 Quail Run Rd NE Rio Rancho, NM 87144</td>
<td>PH: 505-994-3661</td>
<td><a href="mailto:jjshush2003@gmail.com">jjshush2003@gmail.com</a></td>
</tr>
<tr>
<td>Lisa Trujillo</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>946 NM 76 Chimayo, NM 87522</td>
<td>PH: 505-351-2180</td>
<td><a href="mailto:lisa.trujillo@gmail.com">lisa.trujillo@gmail.com</a></td>
</tr>
<tr>
<td>Michael Estrada</td>
<td>State Employees</td>
<td>NM Corrections Department, PO Box 27116 Santa Fe, NM 87502</td>
<td>PH: 505-827-8830</td>
<td><a href="mailto:michael.estrada@state.nm.us">michael.estrada@state.nm.us</a></td>
</tr>
<tr>
<td>Pamela Drake</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>2608 E. Blanco Rd Bloomfield, NM 87413</td>
<td>PH: 505-566-5867</td>
<td><a href="mailto:drakep@sjcpartnership.org">drakep@sjcpartnership.org</a></td>
</tr>
<tr>
<td>Pauline Martinez</td>
<td>Others (Not State employees or providers)</td>
<td>211 53rd St Albuquerque, NM 87105</td>
<td>PH: 505-204-3883</td>
<td><a href="mailto:paulinemartinez4623@yahoo.com">paulinemartinez4623@yahoo.com</a></td>
</tr>
<tr>
<td>Robinson Tom</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>PO Box 1618 Crownpoint, NM 87313</td>
<td>PH: 505-240-7326</td>
<td><a href="mailto:robinsonjtom@rocketmai.com">robinsonjtom@rocketmai.com</a></td>
</tr>
<tr>
<td>Susie Kimble</td>
<td>Providers</td>
<td>4096 Demos Ave Las Cruces, NM 88011</td>
<td>PH: 575-382-3813</td>
<td><a href="mailto:Susie.Kimble@uhsinc.com">Susie.Kimble@uhsinc.com</a></td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Organization</td>
<td>Address</td>
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</tr>
<tr>
<td>Woods Houghton</td>
<td>Family Members of</td>
<td>Family Members of Individuals in Recovery (to</td>
<td>4306 Old Cavern Hwy, Carlsbad, NM 88220</td>
<td><a href="mailto:whoughto@nmsu.edu">whoughto@nmsu.edu</a></td>
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<tr>
<td></td>
<td>Individuals in Recovery</td>
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<td>PH: 575-885-6595</td>
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<tr>
<td>Denise McGhee-Weaver</td>
<td>State Employees</td>
<td>NN DD Planning Council, 2473 Tyler Loop NE</td>
<td>PH: 505-206-3534</td>
<td><a href="mailto:ddmcghee@live.com">ddmcghee@live.com</a></td>
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<tr>
<td></td>
<td></td>
<td>Rio Rancho, NM 87144</td>
<td></td>
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<tr>
<td>Karen Meador</td>
<td>State Employees</td>
<td>Human Services Department, PO Box 2348</td>
<td>PH: 505-476-9252</td>
<td><a href="mailto:karen.meador@state.nm.us">karen.meador@state.nm.us</a></td>
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<tr>
<td></td>
<td></td>
<td>Santa Fe, NM 87504</td>
<td></td>
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<tr>
<td>Arthur Allison</td>
<td>State Employees</td>
<td>Department of Indian Affairs, 1220 St. Francis Dr</td>
<td>PH: 505-476-1600</td>
<td><a href="mailto:arthur.allison@state.nm.us">arthur.allison@state.nm.us</a></td>
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<tr>
<td>Debbie Hambel</td>
<td>State Employees</td>
<td>Division of Vocational Rehabilitation, 5301</td>
<td>PH: 505-841-6451</td>
<td><a href="mailto:debbie.hambel@state.nm.us">debbie.hambel@state.nm.us</a></td>
</tr>
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<td>Central Ave NE, Ste 1600</td>
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<td>Albuquerque, NM 87108</td>
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<tr>
<td>Michele Franowsky</td>
<td>State Employees</td>
<td>Public Defender's Office, 505 Marquette Av NW</td>
<td>PH: 505-841-5185</td>
<td><a href="mailto:michele.franowsky@state.nm.us">michele.franowsky@state.nm.us</a></td>
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<tr>
<td></td>
<td></td>
<td>Albuquerque, NM 87102</td>
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<tr>
<td>Judy Bonnell</td>
<td>Family Members of</td>
<td>PO Box 278, High Rolls, NM 88325</td>
<td><a href="mailto:bonnell@tularosa.net">bonnell@tularosa.net</a></td>
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<td>Individuals in Recovery</td>
<td>(to include family members of adults with SMI)</td>
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**Footnotes:**
## IV: Narrative Plan

### Behavioral Health Council Composition by Member Type

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<tr>
<th>Type of Membership</th>
<th>Number</th>
<th>Percentage</th>
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<tr>
<td><strong>Total Membership</strong></td>
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<tr>
<td>Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)</td>
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<tr>
<td>Family Members of Individuals in Recovery* (to include family members of adults with SMI)</td>
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<tr>
<td>Parents of children with SED*</td>
<td>0</td>
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<tr>
<td>Vacancies (Individuals and Family Members)</td>
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<tr>
<td>Others (Not State employees or providers)</td>
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<tr>
<td><strong>Total Individuals in Recovery, Family Members &amp; Others</strong></td>
<td>11</td>
<td>50%</td>
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<tr>
<td>State Employees</td>
<td>8</td>
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<tr>
<td>Providers</td>
<td>3</td>
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<td>Federally Recognized Tribe Representatives</td>
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<tr>
<td>Vacancies</td>
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<tr>
<td><strong>Total State Employees &amp; Providers</strong></td>
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<td>50%</td>
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<td>Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations</td>
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<td>Providers from Diverse Racial, Ethnic, and LGBTQ Populations</td>
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<td><strong>Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations</strong></td>
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<tr>
<td>Persons in recovery from or providing treatment for or advocating for substance abuse services</td>
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* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Five Council members volunteered to be reviewers of the FY14-15 Block Grant. As in past years, reviewers read the draft plan and comment on the adequacy of services and issues that are addressed. Reviewers for this grant represent consumers and family members, and several live in rural and frontier areas. Their input is integrated into the grant. Biggest concerns include the provision of statewide communications regarding Medicaid changes; addressing lack of services and providers in frontier areas; and the importance of resources for families and children - particularly in rural parts of the state.

**Footnotes:**
4 indiv/family members and 2 providers have diverse racial, ethnic and/or LGBTQ backgrounds; and 4 persons/providers are in recovery. Did not include above because it changes the total number of Council members.
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<table>
<thead>
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<td><strong>X. Enrollment and Provider Business Practices, Including Billing Systems</strong></td>
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<tr>
<td><strong>Narrative Question:</strong></td>
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<td>Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:</td>
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<td></td>
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<tr>
<td>• Outreach and enrollment support for individuals in need of behavioral health services.</td>
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<tr>
<td>• Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.</td>
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<tr>
<td>• Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.</td>
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<tr>
<td>• Third-party contract negotiation.</td>
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<tr>
<td>• Coordination of benefits among multiple funding sources.</td>
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<tr>
<td>• Adoption of health information technology that meets meaningful use standards.</td>
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<td><strong>Footnotes:</strong></td>
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</table>
IV: Narrative Plan

X. Enrollment and Provider Business Practices, Including Billing Systems

New Mexico is unable to respond to this section at this time.

Narrative Question:
Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

• Outreach and enrollment support for individuals in need of behavioral health services.
• Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
• Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
• Third-party contract negotiation.
• Coordination of benefits among multiple funding sources.
• Adoption of health information technology that meets meaningful use standards
IV: Narrative Plan

Y. Comment on the State BG Plan

Narrative Question:

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.
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<td>Identified Needs</td>
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<tr>
<td>Summary of the 2013 IPRC Accomplishments</td>
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<td>Appendix A: Individual Peer Review Results</td>
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</table>
Introduction

The Substance Abuse Prevention and Treatment Block Grant (SAPT) Independent Peer Review Committee (IPRC) is pleased to present its 2013 New Mexico Independent Peer Review Annual Report prepared for the New Mexico Human Services Department/Behavioral Health Services Department (BHSD) and the State Entity, OptumHealth New Mexico. The report consists of an overview, a summary of the site visit findings, and lists current issues and recommendations compiled and documented by Independent Peer Review Committee members during their individual site visits to SAPT-funded substance abuse treatment facilities.

Objectives of the SAPT Independent Peer Review Committee

- To provide a summary of the findings highlighted in the report and to assist in the development of a plan of action to improve the overall quality of substance abuse services provided in the State of New Mexico.

- To review the strengths and any weaknesses in the substance abuse treatment delivery system in the State of New Mexico.

- To bring forward findings and concerns raised by treatment providers as described in this report.

- To provide recommendations to BHSD and the State Entity for future planning initiatives.

- To assist in collaborative efforts with treatment providers in accordance with the Independent Peer Review Committee’s mission statement.

2013 Independent Peer Review Committee Membership

Members:
- Martin Garcia, LPCC Private Consultant, Chairperson
- JoAnne LoPorto, UNM ASAP
- Maurice Payne, LPCC, First Nations Community Health Source (Bernalillo)
- Lupe Bryan, LADAC, Private Consultant (Bernalillo)
- Patrick Collins, LPCC, CHC Private Consultant (Roswell)
- Crystal Heredia-Sanchez, LISW Southern New Mexico Human Development (Anthony)
- Silvia Madrid, LPCC, LADAC, Border Area Mental Health Services (Silver City)
- Lawrence Medina, MBA, Rio Grande Treatment Center (Las Vegas)
- Kathleen Semerad, Tri-County Community Services (Taos)
- Jolene Schneider, LADAC, Four Winds Recovery Center (Farmington)
- Melissa Palmer, LPCC, Border Area Mental Health Services (Silver City)
- Troy Hill, LMFT, Border Area Mental Health Services (Deming)

Partners:
- Brenda Martinez, SCPS, Senior Director of BHSD & Block Grant Services-OptumHealth New Mexico
- Leticia Rutledge, MA, Block Grant Coordinator-BHSD
A Brief Note from the Independent Peer Review Committee

We are grateful to the New Mexico Behavioral Health Services Division of the Human Services Department and State Entity of New Mexico, the individual treatment facilities and the members of the Independent Peer Review Committee for their continuing commitment to the SAPT Independent Peer Review process.

Our hope is that this report will assist BHSD, The State Entity (OptumHealth NM), treatment providers, and consumers, in the effort to improve the quality, efficacy and appropriateness of substance abuse treatment services in the State of New Mexico.

Feedback to this committee is welcomed as vital and essential to our efforts to improve the quality of substance abuse treatment services and the SAPT Independent Peer Review process in the state of New Mexico.

Members’ Responsibilities

In addition to performing individual site visits (four-member teams) at substance abuse treatment facilities, Independent Peer Review Committee members participate in a wide variety of training and reporting activities. These include:

- Review visit findings with agency. Dialogue with key staff regarding SAPT implementation;
- Enhance collaborations with partner agencies;
- Prepare the final report to present to BHSD and the State Entity;
- Conduct site visits and report back to the larger peer review committee;
- Participate in monthly IPRC meetings;
- Recruitment and training of new team members; and
- Annual evaluation and update of the Independent Peer Review process and tools;

Current Membership Profile

The committee membership includes representation from/experience in the following treatment modalities:

- residential treatment
- outpatient treatment
- intensive outpatient treatment programs (IOP)
- social detoxification program
- opiate replacement therapy
• integration of treatment for individuals with co-occurring disorders

IPRC members submitted an application, applicants were then invited, selected and appointed because of their experience, education, training and commitment to recovery and resiliency efforts in New Mexico. Examples of their individual professional and personal backgrounds included:

• Documented experience in providing supervision of staff within a substance abuse treatment facility; and

• Documented experience in the administration of a substance abuse treatment facility.

• Completion of the required clinical supervision hours by the New Mexico Counseling and Therapy Practice Board and/or other administrative/supervision training;

• All IPRC members perform a combination of clinical and administrative supervision activities as well as providing some direct clinical services as part of their responsibilities at their respective treatment facilities.

**Peer Review Definition**

This report will serve to summarize the activities of the New Mexico Independent Peer Review Committee for State Fiscal Year (SFY) 2013. Below you will find a brief explanation of the Independent Peer Review process taken from the Federal Register 96.136 as mandated by provisions in the Substance Abuse Prevention and Treatment Block Grant.

A. The State shall for the fiscal year for which the grant is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved, and ensure that at least 5 percent of the entities providing services in the State under such program are reviewed. The programs reviewed shall be representative of the total population of such entities.

B. The purpose of independent peer review is to review the quality and appropriateness of treatment services. The review will focus on treatment programs and the substance abuse service system rather than on the individual practitioners. The intent of the independent peer review process is to continuously improve the treatment services to alcohol and drug abusers within the State system. “Quality” for purposes of this section, is the provision of treatment services which, within the constraints of technology, resources, and patient/client circumstances, will meet accepted standards and practices which will improve patient/client health and safety status in the context of recovery. “Appropriateness” for the purposes of this section, means the provision of treatment services consistent with the individual’s identified clinical needs and level of functioning.

C. The independent peer reviewers shall be individuals with expertise in the field of alcohol and drug abuse treatment. Because treatment services may be provided by multiple disciplines, States will make every effort to ensure that independent peer reviewers are representatives of the various disciplines utilized by the program under review. Individual peer reviewers must be knowledgeable about the modality being reviewed and its underlying theoretical approach to addictions treatment, and must be sensitive to the cultural and environmental issues that may influence the quality of the services provided.
D. As part of the independent peer review, the reviewers shall review a representative sample of patient/client records to determine quality and appropriateness of treatment services while adhering to all Federal and State confidentiality requirements, including 42 C.F.R. Part 2. The reviewers shall examine the following:

E. Admission criteria/intake process;
   a. assessments;
   b. treatment planning, including appropriate referral, e.g., prenatal care and tuberculosis and HIV services;
   c. documentation of implementation of treatment services;
   d. discharge and continuing care planning; and
   e. indications of treatment outcomes.

F. The State shall ensure that the independent peer review will not involve practitioners/providers reviewing their own programs, or programs in which they have administrative oversight, and that there be a separation of peer review personnel from funding decision makers. In addition, the State shall ensure that independent peer review is not conducted as part of the licensing/certification process.

The SAPT Peer Review Committee Process

This year the IPRC reviewed the tools used in previous years and those used by other states which resulted in a tool and process that facilitated the achievement of the Committee’s goals. The following process and tools were used for the SFY 2013 peer review process:

- “Walk Through Process” from [www.NIATX.net](http://www.NIATX.net)
- A chart review tool
- Continuous Quality Improvement Questions
- Environmental Survey

As noted, new members joined current committee members, some of whom participated since inception of this peer review process, adding to consistency of the discussion. BHSD and the State Entity, OptumHealth New Mexico provided orientation and training to Committee members which included overview of the SAPT Block Grant requirements; the purpose and goals of the Committee and in-depth cultural competency training.

The 2013 Independent Peer Review continued to be a method to present data obtained from Provider site visits to the State Entity and BHSD for consideration in the review/development of:

- Improvements in substance abuse treatment care standards;
- Quality and appropriateness of individual treatment services;
- Identification and response to the needs of substance abuse programs, staff and clients;
- Development and implementation strategies to address issues of concern identified through site visits; and
• Recommendations and suggestions on desired technical assistance for the improvement of substance abuse treatment programming in New Mexico.

This process also benefits this IPRC specifically by:

• Allowing members who want to contribute to the development and improvement of substance abuse treatment programming the opportunity to make a local and statewide positive impact in the substance abuse delivery system in New Mexico;
• Encouraging the utilization of peer resources by substance abuse treatment professionals;
• Maintaining a system to monitor and improve the Peer Review process;
• Offering an opportunity to visit other sites in which the Peer Reviewers can garner information, network, share knowledge and expertise, and learning about new referral sources;
• Focusing on cultural competence as an initiative by providing Review Members the opportunity to meet Providers who offer services to diverse populations; and
• Offer an additional venue for New Mexicans to be heard regarding desired services and gaps.

In order to achieve these goals, committee members evaluated, discussed and compiled the feedback provided by agency staff, during the provider site visits.

The New Mexico IPRC meets monthly. Phone conferencing is available for those members who are unable to drive to Albuquerque. The IPRC Secretary recorded the minutes of each meeting which was then reviewed and approved at the next meeting. Meeting activities included research assignments and continued discussion, specifically for new members, on how to conduct a site visit that would result in a positive experience for all involved.

Site Visit Selection and Implementation Process

Providers not previously reviewed were visited this fiscal year. Sites were selected by region to allow for statewide representation and to visit programs previously not visited.

1. The previous year’s tool was reviewed and amended for ease of use and clarity of intent.
2. Review teams were selected.
3. Peer Review Committee Members were able to review Providers in their own region.
4. Letters of formal notification to the Peer Site visit process were sent to the selected Provider sites, by State Entity, indicating a visit would be scheduled with them.
5. Contact was made by one of the review team members confirming the date and time of the site visit. An introductory letter indicating the purpose of the review and an orientation to the process was sent.
6. The review teams generally consisted of two to four Peer Review Committee Members for each site visit.
7. A schedule for the peer review site visits was determined by the peer review team to include, but was not limited to: an orientation to the Peer Review Process including the roles of team
8. Review of findings by the Peer Review Team and an exit/wrap up meeting with Provider staff indicating strengths, challenges and suggestions.

The programs that were selected for a site review represented various levels of care:

• Outpatient Substance Abuse Treatment
Prior to each site visit, the Executive Director of each selected Provider was given the following information:

a. Formal notification by the State Entity that their agency had been selected for an Independent Peer Review site visit, including a request that the selected agency assign a representative to coordinate the visit with the Independent Peer Review Site Visit Team.

b. All agency personnel were invited to participate in an informational meeting with the Independent Peer Review team at the beginning of the site visit. The meeting served to:
   - Introduce agency personnel and Independent Peer Review Team Members.
   - Review the goals, objectives and mission of the Independent Peer Review process.
   - Explain the Independent Peer Review process and the necessary elements of the site visit.
   - Participate in a tour of the treatment facility.

The Peer Review teams completed a review of 3 to 5 clinical records per IPRC review. Chart Record review results were documented on the New Mexico Independent Peer Review site visit Review Tool Summary. The purpose of the record review was to evaluate the strengths and weaknesses of the treatment services being provided; document protocols, policies and procedures; identify gaps in services; and to assess the need for technical assistance and training.

The NIATx walk-through tool was used to experience the treatment process through the eyes of a consumer. A walk through from the first contact through transfer of care was conducted at each agency selected. Agency personnel were then invited to participate in an exit interview with the Independent Peer Review Team. The exit interview served to:

a. Provide a forum to discuss the observed strengths of the program.

b. Provide feedback regarding the review of the clinical records.

c. Provide feedback from agency personnel regarding the Independent Peer Review process; state behavioral health program funding; contracting processes; and gaps in treatment programming in the state.

Site Visit Reports

The focus of the Independent Peer Review Committee continued to shift to a more thorough review of program activities rather than exclusively focusing on the review of clinical records. This brief summary will serve to highlight some of the findings from the site visit process. Six sites were selected to be reviewed during this fiscal year. Individual peer review reports can be found in Appendix A.
Recommendations and Comments of the Independent Peer Review Committee

- Acknowledge that the review, while statutorily mandated, may require additional staffing to meet the goals, and has not been adequately funded.

- Explore ways to increase diverse representation on the Independent Peer Review Committee.

- Reach out and educate all SAPT funded providers to increase Independent Peer Review Committee membership.

- Develop systems that will assure prompt response to issues identified through the Independent Peer Review process.

- Develop and implement technical assistance and training options as identified by the site visit Providers’ suggestions and recommendations.

Identified Needs

After careful evaluation of this year’s IPRC site visits and provider input, the following areas of need have been identified:

- Treatment partners report that funding continues to be an issue. Some services are funded and then shortly thereafter are not funded, for example CCSS. Obtaining prior authorizations are difficult and administratively burdensome. There are many essential services that are not funded such as Urine Drug Screens and transportation. Traditional practices are often not recognized as EBP and therefore often are not a recognized service.

- Treatment partners request more relevant clinical skills training be provided to them to meet the needs of diverse patient populations. Additional training identified included substance abuse and prevention training.

- The IPRC and treatment partners request feedback from Center for Substance Abuse Treatment (CSAT) as to how we are doing as a peer review committee and what they are doing with the information we provide them.

- The IPRC recommended that all providers who receive SAPT Block Grant funding be provided a copy of this document.

- The IPRC recommends that the Site Visit tools be updated to address the current issues of program implementation, specifically addressing the feedback that was solicited from the providers visited.

- Treatment Planning and Documentation Training:
  - Co-occurring disorders require distinct/multiple targeting in Problems, Goals, Objectives and Intervention strategies;
  - Objectives need to be stated in behavioral, measurable, observable and specific terms;
  - Progress notation needs considerable improvement in utilization of D-A-P format
General Comments

New Mexico is a culturally diverse state and largely rural and frontier. Providers coordinate and work together and with the State Entity (OptumHealth New Mexico) to get clients placed with the appropriate provider based on client input and client choice so they can get the help that they are seeking. There has been cutting edge, national quality training over the last few years in New Mexico on the use of evidence-based and evolving practices and strategies to meet the needs of the our clients in our state. Providers have used this information to incorporate evidence-based practices into treatment. These trainings and conferences include Gender-Responsive Treatment, MATRIX Model Intensive Outpatient Treatment, Motivational Interviewing, Community Reinforcement Approach (CRA), Community Reinforcement Approach Family Training (CRAFT), Recovery-Oriented Systems of Care, Network for the Improvement of Addiction Treatment (NIATx), Nurturing Parent Program, and many others.

Providers are committed to improving accessibility and provision of substance abuse services in the state by working alongside the State Entity (OptumHealth New Mexico), BHSD and local stakeholders. Providers serve on many local and state committees and work closely with the Behavioral Health Purchasing Collaborative. The Local Collaboratives are located in each judicial district in the state and are comprised of consumers, providers and others. Provider agencies take pride in hiring credentialed staff with experience in treating the clientele. Federal funding streams such as Temporary Assistance for Needy Families (TANF); Access to Recovery (ATR); Screening, Brief Intervention, Referral and Treatment (SBIRT); previously, the Community Mental Health Block Grant and the SAPT block grant are extremely important to maintaining an effective, accessible and efficient behavioral health care system in New Mexico and providers work to synchronize and maximize the resources available.

Concerns

The members of the IPRC are recognizing a pattern of certain continuous concerns that have been noted in this report:

- The pool of licensed professional applicants to substance abuse treatment agencies continues to shrink. This may result in "possible deficiencies during auditing and accreditation visits." The committee is unsure of the cause. However, low salary, lack of third party payee/resources and lack of license reciprocity, non-competitive salaries for potential candidates, may contribute to these declining numbers. There may be a disincentive to enter the substance abuse field due to low pay as compared to those offered in the mental health field. The cost of training and licensure in the field of substance abuse may be another disincentive.

- Recruiting and maintaining qualified trained minority, culturally competent and trauma informed staff continues to be an ongoing problem. It appears that this may result in a barrier to accessing culturally appropriate, trauma informed treatment.

- Funding streams for particular modalities (e.g., gender specific treatment, intensive outpatient, psychiatric service support medications and transportation for clients to services/programming/treatment) are not apparent. Adequate resources are not available to
fund grant writing positions. When a grant is obtained there is no funding to sustain it once the
grant is over.

- When agencies are a part of the audit process they would appreciate feedback.

- As the year progressed, committee member involvement waned. Committee members must
be recruited earlier. Incentives for continued involved throughout the process need to be
considered.

- Communication between the committee members and the selected Provider site proved, at
times, to be difficult.

- Staff development training continues to come up as a need

- Treatment planning education is needed

### Summary of 2013 IPRC Accomplishments

- Committee work included further refinement and revision of the tool and the process, the
development of a more engaging and inclusive process for agency staff to provide more input
and suggestions to improve the substance abuse delivery system statewide as well as
highlighting its remarkable strength and resiliency despite limited funding to serve substance
dependent clients in our culturally diverse, largely rural and frontier state.

- Reviewed and Refined the audit tool for the next fiscal year, which and included a better tool
for chart audit.

- New members recruited and trained became committed to the process.

- Timeline was set at the beginning.

- Call- in option was available for all IPRC monthly meetings.

- Tool was carefully reviewed and revised and enhanced to be more useful. This revision was
completed to reflect the focus of individual programs sites, clinical records, program goals,
philosophies and activities. The continued use of “Walk Through” process utilizing NIATX has
made the review more qualitative and less like an audit Notations were made referencing
where to find the requirements in the Federal Register. The tool was sent out ahead of time to
agencies up for review.

- Facilitated a streamlined site visit process that reduced impact and stress on visited agencies
and reduced time onsite.

- Completed agency review selection.

- Selected and reviewed five sites at SAPT Block Grant substance abuse treatment facilities,
one of which was a Native American agency.

- Solicited input from sites reviewed, in an effort to actively recruit new committee members.

- Site reviews were completed earlier.
• Participation at the sites by providers was welcoming.

• This year’s site visits were extremely useful for the committee members and providers visited and was a positive experience.

• Accomplished a collegial spirit.

• Discussed the possibility of having the meetings in various locations throughout the state for next year.

• Discussed the feasibility of using video conferencing was discussed for next year.

• The agencies in this year’s audit schedule completed the list of all SAPT-funded agencies visited within the last four years. Next year’s schedule will begin the second round of visits since OHNM assumed responsibility for the IPRC.

• Completed the IPRC Annual Report.
Appendix A

Independent Peer Review Results

Site Visit Description:

Agency 1 (Northern/Urban)

1. The IPRC Team for this visit:
   a. Lawrence Medina, Rio Grande Treatment Center
   b. Patrick Collins, Private Consultant
   c. JoAnn LoPorto, UNM ASAP
   d. Maurice Payne, First Nations Community HealthSource

2. The staff members whom we interviewed in depth for the site Visit were as follows:
   a. Administrator
   b. Clinical Services Administrator
   c. Intake Coordinator
   d. Therapist
   e. Agency consumer

3. Consumer Experience – AGENCY 1 Consumer met with the visitors and openly discussed her treatment experience
   a. Initially, primary care; referred to behavioral health services
      i. Really appreciate engagement and acceptance of who I am, and tolerance for imperfection
      ii. Suboxone Group
      iii. Hepatitis C Treatment Program
      iv. Multiple groups, especially coincident with Hepatitis C Treatment
   b. Current treatment
      i. Individual Therapy - weekly
         1. EMDR really beneficial
      ii. Psychiatry and Medical Physician
         1. Suboxone – long-term
      iii. Volunteer work

4. We visited the following physical sites
   a. All services are based at the AGENCY 1 Facility

5. Administrative staff provided an agency overview, the community served and staffing issues
   a. AGENCY 1 is part of a parent company
b. The behavioral health services are co-located with parent company FQHC

c. AGENCY 1 and the FQHC have JACHO Accreditation

d. AGENCY 1 is designated as a Core Service Agency (CSA)

e. AGENCY 1 has 106 staff overall
   i. 2 Medical doctors
   ii. 3 psychiatric prescribers
   iii. 2 intake coordinators (independently licensed)
   iv. Adult - 10 clinicians
      1. 1 licensed psychologist
      2. 7 independent
      3. 2 non-independent
      4. 12 CSW’s (CCSS)
   v. Children
      1. 1 Intake clinician
      2. 7 Independently-licensed clinicians
      3. 4 School-based clinicians
      4. 20 MST Therapists
   vi. Assertive Community Treatment team (ACT)
      1. 2 Therapists
      2. 2 CSW’s
      3. 2 Peer-support
      4. 1 Nurse
   f. AGENCY 1 uses Electronic Health Record software
      i. NextGen Software
      ii. Just initiated in past three months; first year is transitional

Site Visit Questions, Answers and Observations – NAITx Walk through

1. First contact.
   A. When your agency is called, does the client get a busy signal, voice mail, an automated
greeting, or does a live person answer the call?
      1) Live person answers calls – 8:00 AM – 7:00 PM MTWThF
      2) Bilingual capacity both live and after-hours
   B. Does your agency offer a client an appointment on the first call?
      1) Yes – appoint with intake coordinator
      2) Crisis walk-in available during business hours
   C. How long would a typical client have to wait for an initial appointment?
1) Two-three weeks at present
2) There is no data tracking of “routine” requests for access
3) Priority – Pregnant women, IV Drug Users

D. Would a typical client have to miss work to make the appointment?
   1) No, open 8:00 – 7:00 (Both therapy and medical)

E. Would a typical client have difficulty reaching the site?
   1) Bus lines within one block of building
   2) Located on edge of city

F. Is transportation available?
   1) Variety of public actions
      a) City bus
      b) Safe-ride
      c) Premier Transportation (Medicaid)
      d) Park-and-ride

G. Are Walk-in hours available?
   1) Scheduled @ 8:00 AM and 1:00 PM
      2) Crisis response available immediately – on-call availability

2. First appointment. On the day of the appointment, what is your experience/impression assuming you had never been to the site before.

A. Is transportation an issue? (No, see above)
   1) Are parking, directions, and signals adequate? Yes (92 Parking spaces)

B. Does the site feel friendly and welcoming, or cold and harsh? Yes.

3. The intake process. What are your impressions as a client, or family member new to substance abuse treatment?

A. Does the family member typically accompany the client through the entire intake process?
   1) Yes, this is available at the discretion of the client

B. How long does a typical client spend in the waiting room?
   1) Ten minutes, maximum

C. Is a urine test required?
   1) No, not at intake
   2) UA’s are routinely included in
      a) Suboxone services

D. Will a client have to wait between the initial assessment, and your first treatment session, and if so, how long?
   1) Presumption of Co-occurring (Behavioral health/Substance) until disproved
   2) Multiple group modalities available – access readily available
   3) Individual therapy access is limited – acute within a week
4) Psychiatric access within a week
5) CCSS within 14 days

4. Transfer between levels of care. Describe the process of transferring between levels of care; for instance, going from detox to residential, or outpatient to IOP. (Outpatient, ACT)
   A. How much paperwork has to be filled out?
      1) Exclusively handled by external referral
      2) As CSA, track clients through external placement
   B. Are the same questions asked that were required in the intake process? NA
   C. Please describe the transition process from different levels of care? Is it a smooth process? NA
   D. Describe how family members have been involved in the transition process? NA
   E. What two things would you most want to change? NA

Quality Questions:
1. Is there a Quality Improvement process/plan in place at your agency? Please provide documentation.
   A. Quality Improvement
      1) Internal medical records auditing - 21 performance indicators
      2) Semi-annual Consumer Satisfaction Surveys
      3) QIC through Parent Company Central Office
2. Please describe how you identify what processes and/or areas you would like to study.
   A. Parent Company Compliance Department selects priorities
3. Please describe how you use the data you collected to change the processes.
   A. Data feedback from Central office
   B. Performance that falls below expectation requires corrective action planning; central office monitors follow-through
4. Once you implement the changes please describe how you monitor that the changes are successful and if not what do you do. (How do you close the loop)?
   A. Parent Company Central Office monitors follow-through
5. Please describe what indicators you are currently tracking.
   A. 21 performance indicators – medical records documentation audits
   B. Customer satisfaction thresholds
   C. Medical indicators
      1) Obesity
      2) Diabetes
      3) Hypertension
      4) Smoking Cessation
Additional Questions:

1. What makes this agency distinct from others?
   A. Size
   B. True, integrated “Medical Home”
   C. Higher proportion of Behavioral Health to Medical health (95% BH: 5% Medical)
   D. Integration of treatment for persons with co-occurring disorders
   E. Trauma-informed system of care
   F. Weekly Interdisciplinary Treatment Team – weekly meetings

2. What clinical services are most advantageous to your clinic?
   A. MST Program – very positive outcomes (measured nationally)
   B. ACT Model – significant outcomes accomplishment; community recognition
   C. Psychiatric Services Access; integration with medical docs
   D. Extensive Group modalities
      1) DBT
      2) Women’s trauma recovery group
      3) Depression/Bipolar Group (13 years history)

3. What assistance or training would you like to receive from Optum Health and/or BHSD?
   A. Proactive training before holding accountable to new and/or evolving standards
   B. More access to free trainings, especially for compliance with state requirements

4. What changes would you recommend to improve the total quality of services offered?
   A. Currently expected to provide unfunded elements of service
   B. Medicaid and BHSD pay for same array of services
   C. Coding that correlates with service standards (especially intake process)

5. Do you think the Independent Peer Review Process was beneficial to your agency?
   A. Good for morale; appreciate the openness that happens with peers

6. Would you or anyone in your agency/consumer/family member like to participate in this Peer Review Process?
   A. A Therapist will explore the possibility

7. If your agency is required to provide outreach services to IUD or pregnant women, how would your agency do this, what difficulties (barriers) do you see in achieving this, what technical (help) would you need from OHNM and/or BHSD.
   A. Funding would be necessary

8. What other things would you like us to know?
   A. Covered everything

9. What is your experience with CCSS as compared to regular Case Management?
   A. Prefer Case management – harder to deliver services under the CCSS model
B. The role-out by BHSD was very inadequate; and caps were necessary to manage to overbilling by a few providers; it took years to learn the standards

10. What is your opinion of the concept CSA?
   A. It requires cultivation of a co-dependency between provider and client.
   B. Limited resources, excessive demands

11. How have you navigated the interface between serving your target population and the requirements of the federal government, state and the managed care organization? What solutions would you propose?
   A. Over-management.

**Chart Audit:**

1. Review - 3 charts were reviewed
   A. File # 57329
   B. File # 943881
   C. File # 690387

2. Electronic Record & Paper Chart combined – AGENCY 1 moved to EHR in November 2013

3. Findings included the following:
   A. Excellent system as Parent Company is transitioning to EHR/EMR
   B. Each file evidenced service delivery consistent with SAPT standards
   C. Strengths noted
      1) Clinical Assessments noted to be very complete; risk factors defined; Integrated medical history
      2) Identification of co-occurring disorders well-detailed
      3) Detailed Psychosocial History
      4) Evident that best practice standards were implemented
      5) One Discharge Plan was well-defined with specific targets
      6) Progress notes were well done
   D. Deficiencies noted:
      1) One file did not address objective in the quarterly treatment plan review
      2) One file had inadequate explanation of client involvement in treatment plan development
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<tr>
<td>ITEM</td>
<td>FINDING (Circle applicable finding)</td>
<td>COMMENTS</td>
</tr>
<tr>
<td>---------------------</td>
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<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>SOUND</td>
<td>Quiet</td>
<td>Music or TV</td>
</tr>
<tr>
<td></td>
<td>Noisy</td>
<td>Educational Materials</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Education Media</td>
</tr>
<tr>
<td>FURNISHINGS/ARTWORK</td>
<td>Reflect Target Populations</td>
<td>General</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inviting &amp; comfortable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Uninviting or uncomfortable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lots of beautiful artwork, most done by consumers</td>
</tr>
<tr>
<td>BATHROOMS</td>
<td>Accessible</td>
<td>Clean &amp; Sanitary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Messy or Unsanitary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Industrial</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Homey</td>
</tr>
<tr>
<td>LIGHTING</td>
<td>Industrial</td>
<td>Soft</td>
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<tr>
<td></td>
<td></td>
<td>Natural Lighting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adequate</td>
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<tr>
<td></td>
<td></td>
<td>Inadequate</td>
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<tr>
<td>CLINICIAN WORKSPACE</td>
<td>Functional</td>
<td>Facilitative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exceptional (Explain)</td>
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<tr>
<td></td>
<td></td>
<td>Staff-centered</td>
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<tr>
<td></td>
<td></td>
<td>Client-centered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Each staff member had different design/feel. Very comforting and welcoming</td>
</tr>
<tr>
<td>GROUP ROOMS</td>
<td>Functional</td>
<td>Facilitative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exceptional (Explain)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lots of windows and natural (sun) lighting. Nice views</td>
</tr>
<tr>
<td>EMPLOYEE RELATED</td>
<td>Fire Extinguisher, Escape Map</td>
<td>WC/Labor Laws/Incentives posted</td>
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<tr>
<td></td>
<td></td>
<td>Supervisory Support/Training/Supervision</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Training opportunities posted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quality performance reports posted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Staff lounges with an outdoor patio on both floors. Clean</td>
</tr>
<tr>
<td>MISCELLANEOUS</td>
<td>HIPAA compliant sign in process.</td>
<td></td>
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<tr>
<td>(Please note any</td>
<td></td>
<td></td>
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<tr>
<td>additional</td>
<td></td>
<td></td>
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<tr>
<td>observations)</td>
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</tbody>
</table>
Site Visit Description:
Agency 2 (Northern/Rural-Native)

1. The IPRC Team:
   A. JoAnne LoPorto – UNM/ASAP-Milagro
   B. Lupe Bryan-Five Sandoval Indian Pueblos
   C. Jolene Schneider-Four Winds Recovery Center
   D. Kathleen Semerad – Tri-County Community Services

2. The staff members interviewed during the site visit:
   A. Program Manager, Residential Facility
   B. Clinical Director, Outpatient

3. We visited the physical site on the Pueblo

4. Program Overview:

5. Levels of Care –
   A. Long-term residential (90 day)
      1) Population Served - Adult Males
      2) There are a total of 14 beds
      3) Services
         a) Substance abuse treatment services
            • Admission Criteria
               ⇒ Males ages 18 and up
               ⇒ Medically and psychologically stable
               ⇒ Priority based on Pueblo membership and needs
      4) Staffing
         a) (1) Clinical director serving both the Agency 2 residential program and the outpatient services in town.
         b) (1) Program manager on site
c) (1) Licensed therapist

d) (4) Behavioral Health Technicians

5) Methodology
a) Individual and Group counseling
b) Re-engagement with traditional lifestyle and beliefs
c) Participation in agriculture and harvesting of animals
d) Participation in both onsite and outside 12-step meetings
e) Involvement with community through service activities

6) Referral Sources
a) Other agencies,
b) probation/parole,
c) federal probation/parole

7) Referral Process
a) Contact is made by the referral source
b) Referral packet that includes ASI, relevant mental health screening, relevant legal documentation, and medical clearance is provided to the program
c) Treatment team reviews referral packets at weekly meeting

Site Visit Questions, Answers and Observations– NAITx Walk through

1. First contact.
   A. When your agency is called, does the client get a busy signal, voice mail, an automated greeting, or does a live person answer the call?
      1) Program is staffed 24 hours per day. Voicemail is available.
   B. Does your agency offer a client an appointment on the first call?
      1) No but clients can be referred their outpatient program to begin the process.
   C. How long would a typical client have to wait for an initial appointment?
1) Average wait time for intake into residential program is 30 days.

D. Would a typical client have to miss work to make the appointment?
   1) Yes this is a residential program

E. Would a typical client have difficulty reaching the site?
   1) No the location is familiar to most community members and referral sources

F. Is transportation available?
   1) There is currently some public transportation that will bring clients nearby.
   2) Most intakes are driven by the referral source or family

G. Are there walk–in hours available?
   1) No by appointment only

2. First appointment. On the day of the appointment, what is your experience/impression assuming you had never been to the site before.

A. Is transportation an issue?
   1) See above

B. Are parking, directions, and signals adequate?
   1) The parking is more than adequate for program needs. There is signage on the nearby highway and a map included in admission packet

C. Does the site feel friendly and welcoming, or cold and harsh?
   1) The site feels warm and welcoming. It gives the impression of a homey, farm-like atmosphere with many trees and a calming environment.

3. The intake process. What are your impressions as a client, or family member new to substance abuse treatment?

A. Does the family member typically accompany the client through the entire intake process?
   1) The family is welcome to be present for part of the intake process and is informed of contact and visit policies and rules.

B. How long does a typical client spend in the waiting room?
   1) Intakes are done individually so there is no waiting

C. Is a urine test required?
   1) Yes. Clients are given both a urine test and a breathalyzer at intake.
D. Will a client have to wait between the initial assessment, and your first treatment session, and if so, how long?
   1) Clients begin treatment as soon as intake is complete

4. Transfer between levels of care. Describe the process of transferring between levels of care; for instance, going from detox to residential, or outpatient to IOP.
   A. How much paperwork has to be filled out?
      1) Paperwork is minimal
   B. Are the same questions asked that were required in the intake process?
      1) No
   C. Please describe the transition process from different levels of care? Is it a smooth process?
      1) The transition is smooth and seamless. The client works with an outpatient counselor that has already facilitated groups with them in residential.
   D. Describe how family members have been involved in the transition process?
      1) Family involved in therapeutic process while client is in treatment. Family participates in aftercare process.

5. What two things would you most want to change?
   A. Additional staff resources
      1) more Behavioral Health Technicians and
      2) one more full-time therapist,
   B. renovation or upgrades to kitchen, grounds, housing

Quality Questions:
1. Is there a Quality Improvement process/plan in place at your agency? Please provide documentation.
   A. Patient satisfaction survey, broken into five sections, scale of 1-5, facility, therapy, food, groups, overall.
   B. Grads voluntarily agree to receive surveys at three month intervals to follow up
   C. Q.I. activities such as chart review occur at regular intervals
2. Please describe how you identify what processes and/or areas you would like to study.
   A. Evaluate intake process, physical environment, food, therapeutic processes
3. Please describe how you use the data you collected to change the processes.
A. Analyze information to identify trends and patterns and address issues as needed.

4. Once you implement the changes please describe how you monitor that the changes are successful and if not what do you do. (How do you close the loop)?
   A. Continue the process through satisfaction surveys and other Q.I. activities.

5. Please describe what indicators you are currently tracking.
   A. See #2 above

Additional Questions:

1. What makes this agency distinct from others?
   A. Length of stay,
   B. attention to cultural needs,
   C. ability to focus on specific population

2. What clinical services are most advantageous to your clinic?
   A. Traditional activities and
   B. the therapeutic approach in individual sessions

3. What assistance or training would you like to receive from Optum Health and/or BHSD?
   A. Consolidate audits and
   B. provide more training on audit expectations

4. What changes would you recommend to improve the total quality of services offered?
   A. Increase funding,
   B. stop expecting more without more funds

5. Do you think the Independent Peer Review Process was beneficial to your agency?
   A. It is helpful, expands knowledge of issues and other practices
   B. It is helpful to give providers a voice, putting faces to programs, and networking are beneficial

6. Would you or anyone in your agency/consumer/family member like to participate in this Peer Review Process?
   A. There was participation at last meeting and may be continued future involvement
7. If your agency is required to provide outreach services to IUD or pregnant women, how would your agency do this, what difficulties (barriers) do you see in achieving this, what technical (help) would you need from OH and/or BHSD.
   A. N/A

8. What other things would you like us to know?
   A. N/A

9. What is your experience with CCSS as compared to regular Case Management?
   A. None

10. What is your opinion of the concept CSA?
    A. N/A

11. How have you navigated the interface between serving your target population and the requirements of the federal government, state and the managed care organization? What solutions would you propose?
    A. A team approach with qualified staff.

**Chart Audit:**

1) **Chart #1 – Open File** - Yes: 13 No: 4
   a) No indication in chart that consumer was involved in the treatment planning process.
   b) Objectives were not measurable.
   c) -No indication on treatment plan of the frequency of individual counseling, group counseling, etc. and the counselor or staff that would be providing these services.
   d) Progress notes did not indicate that an orientation and aftercare planning took place (however this was an open file so aftercare planning may have been started, just not documented yet.)

2) **Chart #2 – Open File** - Yes: 18 No: 1
   a) Plan demonstrated client’s priorities and goals
   b) Culturally relevant interventions
   c) All services documented matched treatment plan objectives
   d) No indication of new problems created or status change other than “expected treatment progression.”
   e) Lack of documentation re: discharge planning.

3) **Chart #3 – Closed File** - Yes: 20 No: 0
a) Nice integrated assessment with mental health, medical, and substance abuse evaluations all documented.
b) Goals were changed/amended as client progressed through the programming.
c) Very specific discharge plan.
d) Chart very organized.
e) Treatment plan very clearly linked to assessments.
f) “Great clinical supervision and teamwork.”

4) **Chart #4 – Closed File** - Yes: 20 No: 0
   a) Records from other agencies regarding client’s care over the 12 months prior to admission.
   b) Very specific and measurable methods and objectives.
   c) Mental health evaluation nicely worked into co-occurring treatment plan.
   d) Legal issues tightly linked into treatment planning.
   e) Very thorough discharge plan that addresses employment, housing, transportation.
   f) Large emphasis on identifying client strengths during assessments, and then worked into treatment planning. Direct quotes provided re: client strengths.
   g) Treatment plan and interventions drew upon client’s strong motivation for getting sober – stage of change appropriate.
## Environmental Survey:

**AGENCY:** AGENCY 2  
**DATE:** 9/28/2013  
**RATER:** Jolene Schneider

<table>
<thead>
<tr>
<th>ITEM</th>
<th>FINDING (Circle applicable finding)</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NEIGHBORHOOD</strong></td>
<td>[Residential]</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Commercial</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rural</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The neighborhood has a calm, quiet, rural feel.</td>
<td></td>
</tr>
<tr>
<td><strong>VISIBILITY</strong></td>
<td>Clear, Visible Signage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Obscure Signage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Entrance Easy to Locate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Entrance not Obvious</td>
<td></td>
</tr>
<tr>
<td></td>
<td>There was signage identifying the program nearby.</td>
<td></td>
</tr>
<tr>
<td><strong>BUILDING</strong></td>
<td>Free-Standing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Attached to Clinic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Multi-purpose</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td></td>
<td>There are three separate buildings. One serves as the client living area, a second building serves as the program and counseling office, and third serves as a workout area and laundry room.</td>
<td></td>
</tr>
<tr>
<td><strong>PARKING</strong></td>
<td>Difficult</td>
<td>Easy</td>
</tr>
<tr>
<td></td>
<td>Adequate</td>
<td>Inadequate</td>
</tr>
<tr>
<td></td>
<td>Handicap Access</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Parking is adequate.</td>
<td></td>
</tr>
<tr>
<td><strong>PUBLIC TRANSPORTATION</strong></td>
<td>Available</td>
<td>Not available</td>
</tr>
<tr>
<td><strong>SECURITY</strong></td>
<td>Security Guard Present</td>
<td>No Security Guard</td>
</tr>
<tr>
<td><strong>LOBBY AREA</strong></td>
<td>Small</td>
<td>Medium</td>
</tr>
<tr>
<td></td>
<td>Large</td>
<td>Exclusive</td>
</tr>
<tr>
<td></td>
<td>Shared</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lobby area is appropriate for its needs and is welcoming.</td>
<td></td>
</tr>
<tr>
<td><strong>LOBBY SEATING</strong></td>
<td>Chairs</td>
<td>Couches</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>Adequate</td>
</tr>
<tr>
<td></td>
<td>Inadequate</td>
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<tr>
<td></td>
<td>The seating is comfortable and adequate for program needs.</td>
<td></td>
</tr>
<tr>
<td>ITEM</td>
<td>FINDING (Circle applicable finding)</td>
<td>COMMENTS</td>
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<tr>
<td>------------------------------</td>
<td>------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>FRONT DESK ACCESS</td>
<td>Open</td>
<td>Located in an office.</td>
</tr>
<tr>
<td>SOUND</td>
<td>Noisy</td>
<td>The environment was quiet and conducive to recovery.</td>
</tr>
<tr>
<td>FURNISHINGS/ARTWORK</td>
<td>Reflected</td>
<td>All furnishings and artwork are reflective of the cultural orientation of clients served.</td>
</tr>
<tr>
<td>BATHROOMS</td>
<td>Accessible</td>
<td>Accessible and clean.</td>
</tr>
<tr>
<td>LIGHTING</td>
<td>Industrial</td>
<td>Lighting was conducive to a therapeutic environment.</td>
</tr>
<tr>
<td>CLINICIAN WORKSPACE</td>
<td>Functional</td>
<td>Workspace is demonstrative of a comfortable and facilitative of recovery work.</td>
</tr>
<tr>
<td>GROUP ROOMS</td>
<td>Functional</td>
<td>Group rooms were comfortable, providing ample space for clients.</td>
</tr>
<tr>
<td>EMPLOYEE RELATED</td>
<td>Fire</td>
<td>Training opportunities posted</td>
</tr>
<tr>
<td>MISCELLANEOUS (Please note any additional observations)</td>
<td>Overall impression is that the program is located in a private, serene location that is welcoming and conducive to the recovery process.</td>
<td></td>
</tr>
</tbody>
</table>
Site Visit Description:

Agency 3 (Eastern-Rural)

1. The IPRC Team:
   A. Martin Garcia
   B. Lupe Bryan-Five Sandoval Indian Pueblos
   C. Kathleen Semerad – Tri-County Community Services

2. The staff members interviewed during the site visit:
   A. Program Manager, Residential Facility
   B. Clinical Director, Outpatient

3. We visited the physical site on the Pueblo

4. Program Overview:
   A. Agency 3 sits on Historic Route 66 and is a cross-roads community.
      1) There is a lot of drug trafficking happening because of the location and there are many
         transients here. There is just also a large truck stop just off the interstate.
      2) Many families will stay in Community to visit family members incarcerated at the nearby
         prison.
      3) They are seeing an increase in Meth problems.
      4) Doctors from UNM are assisting Community in addressing drug issues; some of these
         doctors were those born and raised in Community.
      5) Community needs are housing and transportation.
      6) There is a strong sense of pride in local business establishments i.e. family owned
         restaurant, motels. Community is a close-knit community.
   B. This office is part of a larger medical-based system.
      1) This clinic services about 100 clients in various services.
      2) They see 10 to 20 clients weekly for substance abuse
   C. Services
      1) Psychiatric Coverage (Telehealth)
         a) Psychiatry
         b) Nurse Practitioners
      2) Outpatient Therapy,
      3) Substance Abuse Treatment,
      4) Comprehensive Community Support Services (CCCSS), and
      5) Crisis Management
      6) They don’t do groups as clients are reluctant to attend due to close-knittedness of
         community/privacy concerns
   D. Staffing
      a) Licensed master’s level Social Worker
      b) LADAC
**Site Visit Questions, Answers and Observations—NAITx Walk through**

1. **First contact.**

   A. When your agency is called, does the client get a busy signal, voice mail, an automated greeting, or does a live person answer the call?
      
      1) A live person answers, an answering machine is back-up if on phone with somebody, for immediate callback.
      
      2) Substance abusers have priority;
      
      3) No waiting list for substance abuse clients.

   B. Does your agency offer a client an appointment on the first call?
      
      1) Actual appointment; depending on the needs of the client; ]

   C. How long would a typical client have to wait for an initial appointment?
      
      1) Following week from initial assessment.

   D. Would a typical client have to miss work to make the appointment?
      
      1) They work with client’s schedule if they are working.
      
      2) Many people working in hospitality industry, shorter hours.

   E. Would a typical client have difficulty reaching the site?
      
      1) Agency is well known in community.
      
      2) Most community people walk to and from places.
      
      3) There is no problem for clients getting here.
      
      4) One issue for the community is that the pharmacy moved from downtown area, and it is now in the County Hospital., which is some distance away.
      
      5) The Agency offers mail delivery option; prescriptions arrive there and are distributed to clients.

   F. Is transportation available?
      
      1) No, but walkable from center of town.

   G. Are Walk-in hours available?
      
      1) For initial screening

2. **First appointment. On the day of the appointment, what is your experience/impression assuming you had never been to the site before.**

   A. Is transportation an issue?
      
      1) No public transportation is available but is walkable from center and most areas of town.

   B. Are parking, directions, and signals adequate?
      
      1) Yes

   C. Does the site feel friendly and welcoming, or cold and harsh?
      
      1) Very Welcoming.
3. **The intake process. What are your impressions as a client, or family member new to substance abuse treatment?**

   A. Does the family member typically accompany the client through the entire intake process?
      1) Not usually but depends on client.
      2) Sometime are involved in driving client to another service or level of care.

   B. How long does a typical client spend in the waiting room?
      1) Minimal wait, seen at scheduled time.

   C. Is a urine test required?
      1) No.
      2) UA’s done as part of probation visits in neighboring community, which is about an hour’s drive.

   D. Will a client have to wait between the initial assessment, and your first treatment session, and if so, how long?
      1) Usually following week unless acuity dictates otherwise.

4. **Transfer between levels of care. Describe the process of transferring between levels of care; for instance, going from detox to residential, or outpatient to IOP.**

   A. Only one level of care. The Parent medical Center will refer for higher level of care if necessary.

   B. Provider noted barriers to inpatient treatment; i.e. waiting lists, (4 to 6 weeks waiting period, distance dire need for detox services)

   C. How much paperwork has to be filled out?
      1) NA

   D. Are the same questions asked that were required in the intake process?
      1) NA

   E. Please describe the transition process from different levels of care? Is it a smooth process?
      1) NA

   F. Describe how family members have been involved in the transition process?
      1) Sometimes they may assist in transporting, as higher levels of care are not available in Community.

5. What two things would you most want to change?

   A. Want a detox center;
   B. More funding to provide adequate services.

**Quality Questions:**

1. Is there a Quality Improvement process/plan in place at your agency? Please provide documentation.
   A. Yes. Binder not available on site.

2. Please describe how you identify what processes and/or areas you would like to study.
A. Target areas are identified per patient surveys, chart reviews, feedback from multiple reviewers throughout the year, Optum-Health, BHSD, Joint Commission.

3. Please describe how you use the data you collected to change the processes.
   A. As a “Needs Assessment” to be followed by a plan of action.

4. Once you implement the changes please describe how you monitor that the changes are successful and if not what do you do. (How do you close the loop)?
   A. Chart reviews on a quarterly basis and on-going.
   B. Staff training to insure understanding and compliance.
   C. Supervisors review in order to document progress on indicators/targets.
   D. Once a year agency reviews their crisis protocols and performance.
   E. Individual Performance Evaluations.
   F. Quality Assurance meetings.

5. Please describe what indicators you
   A. Presence in chart of clinical items on “Face-sheet” and “Summary list” Interviews
   B. How well they are meeting client needs relative to CCSS.

**Additional Questions:**

1. What makes this agency distinct from others?
   A. Agency has indigent funds for clients that don’t have insurance.
   B. Contract with Optum for indigent funds.
   C. Being a State agency.
   D. Recognized as Molina health provider.
   E. Accredited by Joint Commission.

2. What clinical services are most advantageous to your clinic?
   A. All Services.

3. What assistance or training would you like to receive from Optum Health and/or BHSD?
   A. Motivational Interviewing,
   B. Learning how to bill,
   C. more CEUs available for licensure,
   D. Matrix Model,
   E. Whatever assessment replaces the ASI.

4. Do you think the Independent Peer Review Process was beneficial to your agency?
   A. To be determined.

5. Would you or anyone in your /consumer/family member like to participate in this Peer Review Process?
   A. Staff is interested; phone in to meetings, possibly more later on.
6. If your agency is required to provide outreach services to IUD or pregnant women, how would your agency do this, what difficulties (barriers) do you see in achieving this, what technical (help) would you need from OH and/or BHSD.
   A. Agency would provide services if necessary but have only had 1 pregnant woman in recent years.
   B. More local resources are needed - referrals are made to out of town services presently.

7. What is your opinion of the concept CCSS/CSA?
   A. Limits client’s choice.
   B. Division by Age,
      1) The Agency handles adults.
      2) TeamBuilders sees teens,

8. How have you navigated the interface between serving your target population and the requirements of the federal government, state and the managed care organization? What solutions would you propose?
   A. Agency strives to provide high quality care in line while meeting requirements.

Chart Review:

1. File # 730400713 (open) –
   A. 19/19 Standards met.
   B. Additional comments:
      1) Client signature present), but no indication in notes about client involvement (TP Standard #4).
      2) Objectives not measurable (TP Standard 10) and
      3) no indication of method used (TP Standard #11).
   C. Specific Recommendations
      1) “Great objectives on this chart.
      2) How will you measure the outcome?”

2. File # 853 (Closed) –
   A. 18/19 Standards met.
   B. Additional Comments:
      1) good treatment overview.
      2) This client had multiple no shows, and no intervention re: no shows documented.
      3) Also there was an increase in the ASI scores and no documentation of why this would be (thoroughness #2).
   C. Specific Recommendations: interventions re: addressing no shows.

3. File # xxx xx 7415(open)
   A. 15/19 Standards met.
   B. Additional Comments:
1) Client indicated she has been in abusive relationship in past, however healthy relationships r/o PTSD not documented.

2) No safety plan documented (thoroughness #2).

3) No documentation that ASI discussed with client.

4) Really liked the spiritual assessment that was completed with client (completeness #3).

5) How do you measure “working towards staying sober?” (Treatment plan #10).

6) Only intervention documented is Psychoeducation, no mention of CBT, relapse prevention. (Treatment plan #11).

C. Specific recommendations:

1) Need more measurable objectives and no documentation of stages specific treatment or stages of change (Treatment planning #16).

2) Provide client with more choices in treatment modality, and maybe benefit measurable, stage specific treatment planning.

4. File # 21195 (closed)

A. 16/19 Standards Met.

B. Additional Comments

1) The Agency substance abuse screening tool is very thorough.

2) No indication that ASI results discussed with client (Assessment #2).

3) No mention of stages of change,

4) no reference to self-help, support groups as relapse prevention tool, and

5) there are objectives, but no methods

6) there is indication of a battery charge however this doesn’t seem to have been addressed re: treatment planning, interventions. (Treatment planning #10, 11, 12).

C. Specific recommendations:

1) Provide proof that ASI results discussed with client,

2) no attention to stages of change, and

3) no addressing of a battery charge history.
**Environmental Survey:**

**AGENCY: AGENCY 3**  
**DATE: 10-19-12**  
**RATER: Martin Garcia**

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<tr>
<th>ITEM</th>
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<th>COMMENTS</th>
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<td>NEIGHBORHOOD</td>
<td>Residential</td>
<td>Nestled in Residential Neighborhood, walkable from municipal area</td>
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<td>Free-Standing</td>
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<td>PARKING</td>
<td>Difficult</td>
<td>On street. New patients will park on side streets and “walk up”</td>
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<td>Staff-centered</td>
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<td>Client-centered</td>
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<td></td>
<td>Mix of staff and client</td>
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<td></td>
<td>centered-give sense of clinician as</td>
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<td>real people without being too</td>
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<td>Exceptional (Explain)</td>
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<td></td>
<td>Nice touch with coffee mugs</td>
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<td></td>
<td>but don’t do groups due to client</td>
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<td>resistance-small town etc.</td>
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<td>Fire Extinguishers, Escape Map</td>
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<td>WC/Labor Laws/Incentives posted</td>
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<td>Supervisory Support/Training/Supervision</td>
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<td>Training opportunities posted</td>
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<td>Quality performance reports posted</td>
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<td></td>
<td>All present</td>
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<tr>
<td>MISCELLANEOUS (Please note any additional observations)</td>
<td>Staff helpful and knowledgeable about resources, history of area, Main clinician local</td>
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</table>
Site Visit Description:
Agency 4 (Northern-Urban)

1. The IPRC Team for this visit:
2. JoAnn LoPorto, UNM ASAP
3. Patrick Collins, Private Consultant
4. Martin Garcia, Private Consultant
5. The staff members whom we interviewed in depth for the site Visit were as follows:
6. Executive Director
7. Director for Behavioral Health Services
8. We visited the following physical sites
9. Building 1 – Intake, Medical, CCSS and residential (2nd & 3rd floors)
10. Building 2 – Outpatient therapy
11. Executive Director provided an agency overview, the community served and staffing issues
12. AGENCY 4 is a free standing agency – 501c.3
13. Services – Core Service Agency (CSA) and a licensed Community Mental Health Center (CMHC); CARF Accredited
   A. Mental Health & SA Treatment - outpatient therapy
   B. Intensive Outpatient Programs (IOP) – gender-specific
   C. Comprehensive Community Support Services (CCSS)
   D. Psychosocial Rehabilitation Program (PSR)
   E. Permanent supportive housing
   F. Medical Clinic
      1) Psychiatry
      2) Suboxone clinic
      3) Primary care (limited)
   G. Human Trafficking aftercare services
   H. Women’s & Families outreach & advocacy program (Sojourners)
   I. IV drug user and Homeless mentally III community outreach
   J. Supported Employment
   K. Community & Clinical Education program
   L. Research component – clinical research trials
14. AGENCY 4 has 50+ staff overall
   A. 12 Peer Support Specialists
   B. 9 Therapists
   C. 7 Community Support Workers
   D. 3 PSR Staff
   E. 3 physicians (PT)
   F. 4 Housing Specialists
   G. Support Staff

15. AGENCY 4 uses Electronic Health Record software
   A. ClaimTrac - January 2013
   B. Still using paper documents during transition to fully electronic record

Site Visit Questions, Answers and Observations– NAITx Walk through

1. First contact.
   A. When your agency is called, does the client get a busy signal, voice mail, an automated greeting, or does a live person answer the call?
      1) Live receptionist (automated if three lines occupied)
   B. Does your agency offer a client an appointment on the first call?
      1) Yes; same day access - Screening – Paperwork at front desk; reviewed by Intake Therapist (LPCC) - ~50% of new clients
      2) Outreach clients - Same day Clinical Intake - ~50% of new clients
   C. How long would a typical client have to wait for an initial appointment?
      1) Within ten days for full clinical intake at Agency 4
      2) Same day at Outreach Clinic
   D. Would a typical client have to miss work to make the appointment?
      1) Open 8:00 – 5:00
         a) Some services available outside those hours
         b) Evening groups
   E. Would a typical client have difficulty reaching the site?
      1) Central location on main bus route
   F. Is transportation available?
      1) Public transportation
      2) Agency transportation
   G. Are Walk–in hours available?
1) Yes (see above)

2. **First appointment.** On the day of the appointment, what is your experience/impression assuming you had never been to the site before.
   
   A. Is transportation an issue? No
   B. Are parking, directions, and signals adequate? Yes
   C. Does the site feel friendly and welcoming, or cold and harsh? Friendly and welcoming

3. **The intake process.** What are your impressions as a client, or family member new to substance abuse treatment?
   
   A. Does the family member typically accompany the client through the entire intake process?
      1) Available option, but rarely used by clients
      2) Reconciliation is a priority value during the course of treatment
   B. How long does a typical client spend in the waiting room?
      1) Short waits are most common
   C. Is a urine test required?
      1) No, not at intake
      2) Integrated into particular services (e.g., Suboxone Clinic)
   D. Will a client have to wait between the initial assessment, and your first treatment session, and if so, how long?
      1) Heavy utilization of group modalities – same week access; most are gender specific
      2) Individual therapy – less than two weeks

4. **Transfer between levels of care.** Describe the process of transferring between levels of care; for instance, going from detox to residential, or outpatient to IOP.
   
   A. How much paperwork has to be filled out?
      1) Internal referral form for change to higher level-of-care; minimal new paperwork
   B. Are the same questions asked that were required in the intake process? NA
   C. Please describe the transition process from different levels of care? Is it a smooth process? Smooth
   D. Describe how family members have been involved in the transition process?
      1) Not much involvement, due to client disconnection; based upon client preference
   E. What two things would you most want to change?
      1) More gradation in available levels-of-care funded in NM
**Quality Questions:**

1. Is there a Quality Improvement process/plan in place at your agency? Please provide documentation.
   
   A. Excellent QI Description and Workplan – Multiple Committees implement various components
      
      1) Executive/Management Committee (Monthly)
      2) Quality Improvement Committee (Monthly)
      3) Health and Safety Committee (Quarterly)
      4) Clinical Review Committee (Quarterly)
      5) Consumer relations Committee (Quarterly)
      6) Grievance Committee (Ad hoc – meets in response to formal incidents)
   
   B. Annual Review and Planning Process: Administrative and Program Plans (Title and responsible persons)
      
      1) Accessibility – Executive Director and QI Coordinator
      2) Community Relations – Executive Director
      3) Quality Improvement – QI Coordinator
      4) Cultural Competency – QI Coordinator
      5) Training – Director of Training
      6) Health and Safety – Director of Operations
      7) Operations and Information Technology – Director of Operations
      8) Risk Management – Executive Director
      9) Strategic Plan – Executive Director, Board of Directors
      10) Corporate Compliance – Executive Director
      11) Comprehensive Community Support Services – CCSS Program Manager
      12) Intensive Outpatient Treatment – Director of Behavioral Health Services
      13) Outpatient Treatment – Director of Behavioral Health Services
      14) Psychosocial Rehabilitation Program & Clubhouse – PSR Coordinator
      15) Successful Living Initiative – SLI Program Manager
   
   C. Reports ongoing to Management and annual report to DHI Licensing
   
   D. Praised by CARF Site Visitors

2. Please describe how you identify what processes and/or areas you would like to study.
   
   A. Buying into (Quality Service Review (QSR) process through CSA affiliation

3. Please describe how you use the data you collected to change the processes.
   
   A. Multiple reports provided to Administration, Clinical Supervision and Board
4. Once you implement the changes please describe how you monitor that the changes are successful and if not what do you do. (How do you close the loop)?
   A. Ongoing analysis and review by the committees
   B. Agency is committed to Plan-Do-Check-Act (PDCA) Model

5. Please describe what indicators you are currently tracking.
   A. See Workplan
   B. Multiple Indicators under agency five areas:
      1) **Access** to services
      2) **Availability** of services and programs
      3) **Effectiveness** (Outcomes) of services and programs
      4) **Consumer Satisfaction** with services and programs
      5) Maximum **Efficiency** in resource utilization/timeliness of services

**Additional Questions:**

1. What makes this agency distinct from others?
   A. High quality policies and procedures
   B. CARF Accreditation
   C. Does “everything under one roof”
   D. Human Trafficking Aftercare Program

2. What clinical services are most advantageous to your clinic?
   A. Trauma-informed Care integration into agency

3. What assistance or training would you like to receive from OptumHealth and/or BHSD?
   A. Money/funding

4. What changes would you recommend to improve the total quality of services offered?
   A. Workforce issues: e.g., More flexibility in qualifications standards for who can deliver services
   B. More advocacy at state level – e.g., pay for supervision

5. Do you think the Independent Peer Review Process was beneficial to your agency?
   A. Yes, we’re too busy, but appreciate the exchange of ideas

6. Would you or anyone in your agency/consumer/family member like to participate in this Peer Review Process?
   A. Difficult to allocate time; we’ll look at it

7. If your agency is required to provide outreach services to IUD or pregnant women, how would your agency do this, what difficulties (barriers) do you see in achieving this, what technical (help) would you need from OHNM and/or BHSD.
   A. Yes – we use SAPT grant-funding specifically to support this
B. No help needed

8. What other things would you like us to know?
   A. Nothing more

9. What is your experience with CCSS as compared to regular Case Management?
   A. Feedback from CCSS staff feel they are being asked to function above their level – CORE evaluation process, specifically
   B. Not paying for transportation has had a negative impact.

10. What is your opinion of the concept CSA?
    A. I’m not really aware of the concept of CSA – confusion and lack of consistent interpretation of standards from OptumHealth and BHSD

11. How have you navigated the interface between serving your target population and the requirements of the federal government, state and the managed care organization? What solutions would you propose?
    A. Too many different audits – distracting from service delivery

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**Chart Audit:**

1. Review 4 charts were reviewed
   A. File # DUJ
   B. File # ROL
   C. File # ARC
   D. File # BAA

2. Findings included the following:
   A. Excellent documentation overall; all relevant documentation/treatment meet standards.
   B. Strengths noted
      1) Clinical Assessments noted to be very complete; risk factors defined.
      2) Identification of co-occurring disorders well-detailed
   C. Deficiencies noted:
      1) One file could have had more clear indications of required documents; more fully completed documents (signatures, etc.)
      2) One treatment plan did not specify Interventions frequency
      3) One client appeared to have lost contact, but no disposition documented
## Environmental Survey:

**AGENCY:** AGENCY 4  
**DATE:** 04/26/2013  
**RATER:** Martin Garcia

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<th>COMMENTS</th>
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<td>NEIGHBORHOOD</td>
<td>Residential Commercial</td>
<td>Commercial zone off main SF Street</td>
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<td>VISIBLEITY</td>
<td>Clear, Visible Signage Obscure Signage</td>
<td>Entrance Easy to Locate Entrance not Obvious</td>
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<td>Free-Standing Attached to Clinic Hospital Multi-purpose</td>
<td>2 multistoried buildings, main Building includes housing program on upper floors</td>
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<td>Difficult Easy Adequate Inadequate</td>
<td>Handicap Access Graveling in front might be difficult for wheelchairs but other entrance available</td>
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<tr>
<td>PUBLIC TRANSPORTATION</td>
<td>Available Not available Special needs available Special needs not available Agency-provided</td>
<td>On bus line, central location</td>
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<td>SECURITY</td>
<td>Security Guard Present No Security Guard Consumers have access to secure areas Consumers do not have access to secure areas Front Desk Routing-Coverage</td>
<td>Multiple entrances, waiting areas for each service</td>
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<td>LOBBY AREA</td>
<td>Small Medium Large Exclusive Shared</td>
<td>Many lobby areas-small nicely furnished SF style artwork, comfortable</td>
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<td>LOBBY SEATING</td>
<td>Chairs Couches Other Adequate Inadequate</td>
<td>Rustic style-padded, no long waits</td>
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<td>Impressive artwork, question of whether columned area with donors noted might be off putting to homeless population but may not be out of step with Santa Fe</td>
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<td>Clean &amp; Sanitary</td>
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<td>Soft, Natural Lighting</td>
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<td>Nice lighting in many areas</td>
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<td>Staff-centered, Client-centered</td>
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<td>Clean uncluttered, both training and other conferences, blinds available but not in use in one group room overlooking parking lot, presumed bystanders were consumers</td>
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<td>GROUP ROOMS</td>
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<td>Facilitative, Exceptional (Explain)</td>
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<td>ITEM</td>
<td>FINDING (Circle applicable finding)</td>
<td>COMMENTS</td>
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<td>Fire Extinguishers, Escape Map</td>
<td>WC/Labor Laws / Incentives posted Supervisory Support/ Training Supervision Training opportunities posted Quality performance reports posted</td>
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<td>MISCELLANEOUS (Please note any additional observations)</td>
<td>Agency houses, housing on 2nd and 3rd floors; Treatment, medical, recreation, CCSS, psychiatry</td>
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Site Visit Description:
Agency 5 (Native American-Rural)

1. The IPRC Team for this visit:
   A. Jolene Schneider, BA, LADAC Executive Director, Four Winds Recovery Center
   B. Melissa Palmer, LPCC, Clinical Director BAMHS
   C. Troy C Hill, MS, LMFT Division Manager BAMHS

2. The staff members whom we interviewed in depth for the Site Visit were as follows:
   A. Clinical Director
   B. Delegated clinical supervisor

3. This clinic has 13 staff: Six are clinical. Seven are administrative/support

4. We visited the following physical sites:
   A. Administrative Offices
   B. Hogan Meeting Room
   C. Sweat Lodge
   D. 2 buildings for clinical staff/group rooms

Site Visit Questions, Answers and Observations—NAITx Walk through

1. First contact.
   A. When your agency is called, does the client get a busy signal, voice mail, an automated greeting, or does a live person answer the call?
      1) 8am – 5pm Answer phones
      2) Crisis response Team after hours
   B. Does your agency offer a client an appointment on the first call?
      o No appointments walk-in. Four staff for screening intakes. Intake today and start orientation on Tuesday. Start groups immediate.
   C. How long would a typical client have to wait for an initial appointment?
      1) No wait.
   D. Is transportation available?
      1) We make it available with medical first priority
      2) Transportation is provided if needed. The distance traveled for services averages 30-35 miles.
   E. Are Walk-in hours available?
      1) Always
2. First appointment. On the day of the appointment, what is your experience/impression assuming you had never been to the site before.
   A. No appointment necessary. You can walk in and start the intake process in 90 minutes or so.

3. The intake process. What are your impressions as a client, or family member new to substance abuse treatment?
   A. How long does a typical client spend in the waiting room?
      1) A few minutes
   B. Is a urine test required?
      1) No, we use for treatment only
   C. Will a client have to wait between the initial assessment, and your first treatment session, and if so, how long?
      1) Can walk-in for intake/assessment, show-up on Tuesday for orientation and start with the next available group in most cases. "We are group intensive."
   D. Does the site feel friendly and welcoming or cold and harsh?
      1) Very friendly

4. Transfer between levels of care. Describe the process of transferring between levels of care; for instance, going from detox to residential, or outpatient to IOP. (Outpatient, ACT)
   A. Basically provide Outpatient services that can vary from 2 -9 hours per week. They expect clients to be in services for 90 days minimum.
   B. Provide 8 sessions for school referral
   C. Will modify treatment program if working or going to school.
   D. Once a client is discharged they can return if necessary. “the door is always open.”
   E. Do you need to change anything in your intake/assessment/orientation process?
      o “No, it's good now.”

**Quality Questions:**

1. Is there a Quality Improvement process/plan in place at your agency?
   A. “Clinical Director takes care of all of that.”
   B. Interview with Clinical Director reveals that an online audit is completed with AccuCare program

2. Please describe how you identify what processes and/or areas you would like to study.
   A. We do collect client feedback which is made available to our Clinical Director who looks for improvement needs.

3. Once you implement the changes please describe how you monitor that the changes are successful and if not what do you do. (How do you close the loop)? Online audit. Specific indicators include assessment/treatment plan/progress notes.
4. Please describe what indicators you are currently tracking.
   A. No shows/drop-outs

Additional Questions:
1. What makes this agency distinct from others?
   A. Our location
   B. Our willingness to respond to community needs
   C. Including traditional/faith based interventions
2. What clinical services are most advantageous to your clinic?
   A. Each counselor brings their own unique experience and knowledge
   B. Utilizes the Gorsky Model for treatment
   C. “The ability to change what we are doing to make it interesting”
   D. Incorporating both traditional and western interventions at this agency
3. What assistance or training would you like to receive from OptumHealth and/or BHSD?
   A. Training in Co-occurring, PTSD/trauma based services, counselor wellness and DSM V.
   B. More reimbursement for traditional services
   C. “What we need most right now is more training.”
4. What changes would you recommend to improve the total quality of services offered?
   A. More education for all staff
   B. Equine Therapy (one staff is training to provide this)
5. Do you think the Independent Peer Review Process was beneficial to your agency?
   A. “I think it will be helpful, we have not done this before.”
6. Would you or anyone in your agency/consumer/family member like to participate in this Peer Review Process?
   A. The Clinical Director has already expressed interest in participating
7. If your agency is required to provide outreach services to IUD or pregnant women, how would your agency do this, what difficulties (barriers) do you see in achieving this, what technical (help) would you need from OHNM and/or BHSD.
   A. Pregnant women are our first priority
   B. Barriers: “no, it needs to be done.”
   C. Technical Assistance: Need more cell phone towers. It can be dangerous in the areas where there is no service. “we also need rural addresses.”
8. What other things would you like us to know?
   A. The importance of faith (traditional/western) in treatment
9. What is your experience with CCSS as compared to regular Case Management?
A. This agency is not using CCSS yet. “I have looked at it and it makes more sense than traditional case management. It is more focused.” Staff needs more training.

10. What is your opinion of the concept CSA? Not CSA
   A. HIS is not really able to offer much psychiatric services with one CNP.
   B. CSAs have not typically followed-up post referral

11. How have you navigated the interface between serving your target population and the requirements of the federal government, state and the managed care organization? What solutions would you propose?
   A. Keeping the case loads small (average caseload is 15)
   B. “We have a great Office Specialist who takes care of all the billing/forms.”

Chart Audit:

1. Review 4 charts were reviewed
2. Findings included the following:
   A. Strengths noted include:
      1) Good coordination of care through all levels of care
      2) Appropriate delivery of services
      3) Assessments were complete
      4) Documentation in progress notes was detailed and gave a clear picture of client treatment
      5) One treatment plan reflected client status and progress in regard to updates in goals and objectives
   B. Deficiencies noted include:
      1) One file was lacking any treatment plan outlining service delivery
      2) One file did not note progress in treatment goals on updated treatment plan
      3) Lack of assessment for possible co-occurring mental disorders
      4) Lack of documentation explaining client’s absence from treatment for two months. No discharge summary or progress notes reflecting what happened to the client.
      5) One treatment plan was not signed by the client or clinician and did not reflect client status and progress despite client attending one or more sessions per week
### Environmental Survey:

**AGENCY:** AGENCY 5  
**DATE:** June 14, 2013  
**RATER:** Melissa Palmer

<table>
<thead>
<tr>
<th>ITEM</th>
<th>FINDING (Circle applicable finding)</th>
<th>COMMENTS</th>
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</table>
| NEIGHBORHOOD          | Residential                         | Commercia l  
|                       |                                     | Rural  
|                       |                                     | Other |
| VISIBILITY            | Clear, Visible Signage              | Obscure Signage  
|                       |                                     | Entrance Easy to Locate  
|                       |                                     | Entrance not Obvious |
| BUILDING              | Free-Standing                       | Attached to Clinic  
|                       |                                     | Hospital  
|                       |                                     | Multi-purpose  
|                       |                                     | Other |
| PARKING               | Difficult                           | Easy  
|                       |                                     | Adequate  
|                       |                                     | Inadequate  
|                       |                                     | Handicap Access |
| PUBLIC TRANSPORTATION | Available                           | Not available  
|                       |                                     | Special needs available  
|                       |                                     | Special needs not available  
|                       |                                     | Agency-provided |
| SECURITY              | Security Guard Present              | No Security Guard  
|                       |                                     | Consumers have access to secure areas  
|                       |                                     | Consumers do not have access to secure areas  
|                       |                                     | Front Desk Routing-Coverage |
| LOBBY AREA            | Small                               | Medium  
|                       |                                     | Large  
|                       |                                     | Exclusive  
|                       |                                     | Shared |
| LOBBY SEATING         | Chairs                              | Couches  
|                       |                                     | Other  
|                       |                                     | Adequate  
|                       |                                     | Inadequate |
| FRONT DESK ACCESS     | Open                                | Sliding Window  
|                       |                                     | Other  
|                       |                                     | Near  
<p>|                       |                                     | Distant |</p>
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<td>Educational Materials</td>
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<td>Staff-centered</td>
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<td>Fire Extinguishers &amp; Escape Map</td>
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<td>MISCELLANEOUS (Please note any additional observations)</td>
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Goal 1: Improving access to Prevention and Treatment Services
The Human Services Department/Behavioral Health Services Division (BHSD) contracted with the State Entity (SE) for its behavioral health programs and services. The SE subcontracted with community mental health centers, substances abuse treatment programs, and other community providers to deliver services to adults (18 and over). BHSD’s target population was adults with income 150% of poverty, under the federal guidelines, and uninsured.

BHSD, through the SE, provided a comprehensive continuum of care for the treatment of substance abuse and co-occurring disorders (mental health and substance abuse disorders). The continuum of care included social detoxification (social detox) services, residential substance abuse treatment, and outpatient treatment services. The SE maintained a regionally-based service system for which access was centralized through a 1-800 number. Although social detox and residential services were not available in each of the regions, individuals had access to these services through the SE’s 1-800 number. The following services were available through the BHSD-funded providers although each individual provider does not provide all the services listed below:

1. Treatment Services
Behavioral health individual, group, and/or family counseling and therapy: These are health care services provided to prevent or reduce the adverse effects of substance abuse and/or mental illness.
Assessment/evaluation and screening services: The behavioral health assessment (HCPCS H0031) is performed prior to receipt of services and completed within 30 days of intake. The target population is individuals who have clinically significant behavioral, psychological symptoms or patterns and/or environmental risk factors, i.e., mental health, substance abuse, and/or co-occurring conditions. The behavioral health screen (HCPCS H0002) is given to individuals entering the behavioral health service system and is intended to indicate whether there is a probability that a mental health problem and/or drug/alcohol abuse or dependence problem is present.

Medication and medication management: These are oral, injectable, intravenous, or topical medications that are administered and their effects monitored. This includes methadone, buprenorphine and other medications used to treat substance abuse or addiction. Management includes ongoing review of symptoms, side effects, effectiveness, compliance, and lab reports/results. Medication education involves the instruction of the recipient, family, significant others and caregivers in the expected effects of prescribed medication. Medication management services must be provided face-to-face or by telehealth where available.
Opioid Treatment Programs (OTP): In the last year, New Mexico opened its eleventh Opiate Treatment Program (OTP) and Medicaid approved payment for Methadone as an entitlement benefit. Nine of the eleven OTP’s are Medicaid approved and two are pending. With the announcement that Medicaid would cover Methadone treatment for addiction, providers and the state immediately started receiving calls from folks struggling with opiate dependence asking about the start date of Medicaid coverage and expressing relief and plans to seek treatment.
2. Support Services
Case management: Based on the needs of the client, case management services may include but are not limited to arranging, managing, and advocating for the services to meet the specific client’s complex needs and linking the client with systems that provide him or her with needed services and resources.

Self Help/Peer Services: Peer Supports are a unique relationship between peers of lived experience who assist each other in their endeavor to achieve recovery and resiliency. Certified Peer Support Worker (CPSWs) work as a Community Support Worker within a Core Service Agency which provides Comprehensive Community Support Services. Self-help groups are groups in which individuals who have behavioral health issues get together and work on their individual issues. Peers also contract with the BHSD to provide services such as: WRAP (Wellness Recovery Action Plan), Senior Jubilees, as well as develop and maintain local community behavioral health agencies that provide a place of support for those in recovery.

3. Crisis Intervention Services
Telephonic crisis intervention: Telephone services are provided on a 24 hour/7 day per week basis to consumers, families, and the consumers’ support systems who are in crisis, and to callers who represent or seek assistance for persons in a mental health crisis. All calls must be answered by a person trained in crisis response. Individual crisis workers covering the crisis telephone must have a Bachelor’s degree, 20 hours of crisis intervention training, 1 year of work experience with individuals with mental illness and/or substance-related disorders and receive 10 hours of crisis related continuing education annually. Supervision is done by a licensed independent mental health professional, a clinical nurse specialist or a psychiatrist. Face-to-face intervention services must be available immediately or within one hour of the initial crisis call. The telephone crisis worker remains on the line until a face-to-face response occurs, as applicable.

The BHSD and OptumHealth contracted this past fiscal year with ProtoCall, an agency that provides 24/7 telephonic support to callers from New Mexico. All persons who answer this 1-800 number are licensed clinicians; they provide an initial assessment to help screen the caller to the correct services. Once they have made an assessment, the telephone operators then contact the nearest behavioral health service provider to the caller to inform them of the caller’s circumstances. The ProtoCall operators also provide the behavioral health services information to that caller.

Face to Face crisis intervention: A crisis assessment is conducted immediately at the facility or in vivo for the purposes of developing a system of triage to determine urgent or emergent needs of the person in crisis. The focus is to resolve the crisis situation and stabilize the individual so that longer-term supports can be constructed. Actions may include the observation of the individual, evaluation of medication needs, environmental change, identification of his/her support system, and contact with case manager or treatment team. A follow-up within 24 hours of initial crisis may be by telephone call or face-to-face contact with the individual.

4. Residential Services
Subacute Detoxification (Residential program, inpatient, sometimes referred to as “social detox”): Residential detoxification services include 24-hour supervision, observation, and support for individuals
who are intoxicated or experiencing withdrawal. This service is delivered by appropriately trained staff, is characterized by its emphasis on peer and social support, and provides care to individuals whose intoxication/withdrawal signs and symptoms are sufficiently severe to require 24-hour structure and support, but do not require medical detoxification. This is a time-limited (maximum of 7 days) service delivered under a defined set of physician-approved policies and procedures or clinical protocols.

- Subacute Detoxification (Residential program, inpatient, sub-intensive medical monitored): This service, equivalent to the American Society of Addiction Medicine (ASAM) Level III.7D, medical monitored inpatient detoxification, is an organized service, delivered by medical and nursing professionals, that provides 24-hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds. The target population is individuals whose intoxication/withdrawal symptoms are sufficiently severe to require 24-hour structure and support, and require medical monitoring or administration of prescription medications.

- Behavioral Health Short-Term Residential, without room & board: A short-term residential treatment program offers 24-hour intensive residential treatment, habilitative, and rehabilitative services for up to 30 days in a highly structured, community-oriented environment. The focus of services is to stabilize the individual and provide a safe and supportive living environment during detox and/or recovery from addictions. BHSD funding covers services but not room and board which is supported by the treatment agency through other sources of revenues, i.e., food stamps. The target population are individuals, 18 years of age or older, with substance abuse or co-occurring disorders; capable of independent functioning, and require a continuous structure program of substance abuse services.

- Behavioral Health Long-Term Residential, without room & board: A long-term residential program offers the same service as short-term, but the stay is typically longer than 30 days, normally 3-4 months. BHSD funding covers services but not room and board which is supported through other sources of revenues, i.e., food stamps. The target population are individuals, 18 years of age or older, with substance abuse or co-occurring disorders; capable of independent functioning, and require a continuous structure program of substance abuse services.

Turquoise Lodge Hospital is licensed as a 34-bed special hospital that provides in-patient hospital-based chemical dependency treatment for all New Mexicans. Its service array included American Society of Addiction Medicine (ASAM) Level IV D, III.7 D Detoxification Services, including 24 hour medical and nursing care, and ASAM Level III.7 and III.5 Rehabilitation Services. The rehabilitation program (Rehab Unit) offered individual and group counseling, family therapy, a family program, psycho-educational groups and leisure education. Patients began services in the Detoxification (Detox) Unit. The patient’s desire for continued inpatient services and the treatment team’s assessment determined if the patient continued inpatient services in the Rehab Unit. Length of stay for the Detox Unit was 5 – 7 days. Length of stay for the Rehab Unit was determined by patient need, but ranged from 2 to 4 weeks.

The population served by Turquoise Lodge Hospital included adult patients, age 18 and above. Patients had to meet American Society of Addiction Medicine placement criteria of III.7 or IV services, meaning that patients had significant withdrawal potential and had additional medical and/or psychiatric complications. Typically, the patients treated were withdrawing from opioids, alcohol, benzodiazepines, and/or pain medications. All drugs of abuse were seen in the patients served. Patients served may also have included those who were also coping with co-occurring disorders, such as psychotic disorders, major
depression, Bi-Polar Disorder, or anxiety disorders. Turquoise Lodge Hospital served all New Mexicans, regardless of ability to pay, in its capacity as a safety net (charity care) service provider.

Goal 2: Providing Primary Prevention Services

The Office of Substance Abuse Prevention (OSAP), housed in BHSD, shall meet the requirement to expend not less than 20 percent of the SAPT Block Grant on the array of primary prevention strategies listed below that is directed at individuals not identified to be in need of treatment during FY 2014–FY 2015.

OSAP contracted with the State Entity (SE) to subcontract and monitor primary prevention activities during FY 2012.

OSAP accomplished this agreement through the realization of New Mexico’s third 5-year alcohol, tobacco and other drug abuse (ATODA) Prevention Plan. With the guiding principles of SAMHSA’s Strategic Prevention Framework (SPF) as the foundation of prevention services, New Mexico accomplished the following five-step process: 1) utilized statewide and local level needs assessment, 2) mobilized and/or built capacity, 3) expanded the State’s comprehensive strategic plan, 4) implemented evidence based prevention programs and infrastructure, and developed activities, and 5) monitored process, and evaluated effectiveness. The SPF approach to prevention remained an integral part of the State’s infrastructure.

The OSAP and SE will support a minimum of sixteen (16) community-based programs with SAPT Block Grant funds to provide evidence based prevention services throughout the state based on a reapplication process.

(a) Each program under consideration must submit a community needs assessment, a capacity plan, an implementation/strategic plan, and an outcome evaluation plan including measurable goals, objectives, and activities to be accomplished.

(b) All are required to utilize a variety of prevention strategies, including the Strategic Prevention Framework and the CSAP 6 Strategies.

Information Dissemination:

(a) Information dissemination on substance abuse prevention will be distributed throughout the year for OSAP sub recipients and preventionists through various outlets, including two OSAP recipient meetings, a State Prevention Planning Meeting, the OSAP website (www.nmprevention.org), the “Safer New Mexico Now” website (www.safernm.org), and as needed by OSAP staff.

(b) Southern New Mexico Human Development, a provider agency along the Mexican border, will continue to serve as a resource center for community members and service agencies for evidence based substance abuse prevention information in both English and Spanish.

(c) In conjunction with OSAP, the State Epidemiological Workgroup (SEW) will distribute 100 issues of the September 2010 New Mexico Substance Abuse Epidemiology Profile by fall of 2010 to OSAP sub recipients, state agencies (Behavioral Health Services Division, Traffic Safety Bureau, Children, Youth, & Families, Behavioral Health Collaborative, DWI Czar & Affiliates)
and state prevention groups (State Prevention Planning Group, Prevention Advocates, ) to use in prioritizing consequences, indicators, usage patterns, and strategic planning. (prevention 5 year plan)

Education:
(a) OSAP sub recipients shall choose culturally appropriate evidence based ATODA prevention curriculum for individuals and youth and families using the Institute of Medicine (IOM) classification for levels of prevention and the Strategic Prevention Framework. (prevention 5 year plan)
(b) OSAP sub recipients will include fidelity processes into logic models and strategic plans, and use trained objective observers to conduct fidelity checks. (prevention 5 year plan)
(c) Education strategies for youth, parents, and families will include skill building, problem-solving, effective communication, childhood development, increased self-confidence, stress management, family management, positive youth development, mentoring, peer-led groups, and interactive teaching and booster sessions. Although primarily focused on the academic school year, many strategies are implemented year round. Given the reduction in funding for FY2011, target numbers of 10,000 from FY2010 have been reduced.
(d) Counseling Associates, Inc. will implement the Life Skills curricula to 400 12-14 year old youth in the Roswell, NM area.
(e) Forty Native American youth and parents from Isleta Pueblo will participate the Dare To Be You curricula delivered by Youth Development, Inc.
(f) North Central Community Based Services will serve 135 5th & 6th graders in rural Northern New Mexico through the Too Good for Drugs curriculum.

Alternatives:
(a) OSAP sub recipients will be encouraged to collaborate with other community agencies and the Local Collaboratives to provide alternative alcohol/drug free activities for youth.

Problem Identification and Referral:
(b) OSAP will request the SE to provide training to all sub recipients on the SE’s referral process which will include use of the customer service toll-free number.
(c) OSAP will strengthen the information and referral process for treatment requirement in FY12 sub recipient contracts.
(d) OSAP will coordinate with prevention and treatment leaders in articulating an evidence based model for the integration of prevention and treatment services to include early intervention services designed to address risk factors related to substance abuse and potentially co-occurring disorders that arise before addiction is established. (prevention 5 year plan)

Community based Processes:
(a) The statewide prevention training system, through a contract for $120,000 with Kamama Consulting in FY2011, expects to offer 30 training workshops over three quarters on a regional basis to approximately 200 prevention professionals. In addition, eight online prevention courses will be available through the Southwest Prevention Center at the University of Oklahoma to OSAP sub recipients and statewide preventionists.
In conjunction with OSAP, the SEW will work with 11 Local Epidemiological Workgroups to provide technical assistance, guidance, and support in the collection of local data (i.e., city, neighborhood, rural, etc.), identifying trends, monitoring data, and using the data for strategic planning. (prevention 5 year plan)

(c) The SEW will serve as an advisory board to the OSAP Cross-Site Evaluation Team to assist in the development of tools and recommendations regarding appropriate methods for measuring change at the community level. (prevention 5 year plan)

(d) The SEW shall create assessment strategies which address intervening variables and causal factors applicable to New Mexico so that preliminary data, its analysis, and applicable reports are readily accessible. (prevention 5 year plan)

(e) The Workforce Development Committee (WDC) comprised of a broad representation of behavioral health prevention staff will guide strategic planning for increasing statewide capacity for behavioral health prevention services. (prevention 5 year plan)

(f) In collaboration with BHSD and the NM Credentialing Board for Behavioral Health Professionals (NMCBBH), the WDC will support a Prevention Generalist Training & Certification track by FY12 to focus on the following topics: suicide, substance abuse, DWI, injury, and domestic violence.

(g) The WDC will work to increase the number of Certified Prevention Specialists by submitting recommendations for required courses for certification to the prevention training system. (prevention 5 year plan)

(h) OSAP will continue to increase the state’s capacity to meet the prevention needs of Native American populations for training, team building, assessment, planning, and evaluation. (prevention 5 year plan)

(i) OSAP sub recipients will participate with Local Collaboratives and other appropriate planning councils/coalitions that include planning for ATODA and health related issues. (prevention 5 year plan)

(j) OSAP sub recipients will incorporate sustainability into the planning process so that New Mexico and communities are planning for the future. (prevention 5 year plan)

(k) OSAP programs will use rigorous evaluation for all ATODA prevention programs. OSAP will provide technical assistance and training to maintain fidelity and program effectiveness when needed. (prevention 5 year plan)

Environmental:

(a) All OSAP programs will participate in Synar, a Federal amendment using an environmental approach to reduce tobacco sales to minors. The FY2010 New Mexico violation rate was 11.6%. New Mexico will work to even further reduce that rate over the next three years.

(b) All OSAP programs are required to devote no less than 10% of their SAPT funding to implement an environmental strategy in addition to Synar. Examples of environmental strategies implemented by OSAP subrecipients will include Sticker Shock, Alcohol Sales Report Cards, Responsible Retailing Forum, responsible beverage service model, Social Host Liability, increasing taxes on the sale of alcohol, controls on alcohol outlet location and density, and sobriety & traffic safety checkpoints.
The SEOW will work with the Cross-Site Evaluation Team (CSET) to develop evaluation tools and protocols to measure the outcomes of environmental approaches including change at the community level. (Prevention 5 year plan).

**Goal 3: Providing Specialized Services for Pregnant Women and Women with Dependent Children**
BHSD continues to enhance substance abuse treatment services for women, women with children and their families. BHSD has developed a model of evidence based practices to effectively treat women in residential setting that also take their children. This model includes the use of the following EBPs (Nurturing Parenting, Seeking Safety and Trauma Focused EBPs including Cognitive Behavioral Therapy and the development and implementation of a Cultural and Linguistic Competency training for all providers including those who serve Pregnant and Parenting women.

BHSD through our State Entity contractor has written in providers’ SOW a requirement to prioritize Pregnant and Post-Partum Women and also to account and provide interim services. BHSD is working at integrating a continuum of care utilizing the systems in place so that women have a warm-hand off back into their community.

BHSD will start to utilize both the ATR programs and the Core Service Agencies to ensure that the women served in residential have a warm hand of to the next level of care in their perspective home communities to ensure or aide in long term recovery.

**Goal 4: Services to Injection Drug Users (IDUs)**
BHSD contracted through the SE with three opioid replacement programs which provided services in Albuquerque (located in the central part of the state and largest urban area), Santa Fe, and Espanola. These areas have the highest incidence and prevalence in the State. Three programs were contracted to provide outreach to IDUs in Albuquerque and Santa Fe. The outreach efforts included survival kits; information on how to enter treatment; information about transmission of HIV, tuberculosis and sexually transmitted diseases, and how to access other recovery support services.

The SE monitors compliance for programs treating injection drug users must with the following policy:

- Within 7 days, notify OHNM whenever the program has reached 90 percent of its treatment capacity.
- Admit each individual who requests and is in need of treatment for intravenous drug abuse no later than 14 days after making the request or within 120 days of the request if the program has no capacity to admit the individual.
- The program is to make available, within 48 hours, interim services until the individual is admitted to a substance abuse treatment program.
- Offer interim services, when appropriate, that include, at a minimum, the following: counseling and education about HIV and tuberculosis (TB), the risks of needlesharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission

The following is based on the data from the BHSD 7 report provided by OptumHealth Services for persons with or at risk of having substance use and/or mental disorders: Persons who are IDU.

**Street Outreach to Intravenous Drug Users**
In FY 2012, the three Street Outreach providers supported with the SAPT Block Grant Fund were Albuquerque Healthcare for the Homeless (AHCH), St. Martin’s Hospitality Center and The Life Link, Inc. Each of the three providers submits data monthly to the Statewide Entity including the number and types of contacts, referrals for testing and services, and population demographics.

The year-end Street Outreach report reflected a total of 5207 new contacts/encounters and 6034 follow-up contacts. Prevention information was provided to 6717 persons and written substance abuse treatment information was provided to 5320 persons.

The three Street Outreach programs also reported referring 3112 persons for testing of communicable diseases, to include HIV, TB and Hepatitis C, 4602 persons for STD risk reduction counseling, and 2032 persons for medical intervention.

The demographics reflect IDU outreach to 3225 women and 6444 men, of which 5407 identified as Caucasian, 5976 identified as Hispanic, 1904 identified as Native American and a much smaller number of persons identifying as Black, Asian or Other. During the year a total of 1213 veterans received Street Outreach services.

Needs are identified: Following a site visit in December 2012 with The Life Link in Santa Fe and reviewing the Scope of Work, we learned that the area to be served with the BG funds is limited to Santa Fe County. It was the belief of the team that the SOW covered both Santa Fe and Rio Arriba Counties, with Rio Arriba County being of the highest need.

Plan: BHSD met with the SE and the SOW will be revised to either include Rio Arriba County or to focus solely on Rio Arriba County as deemed most appropriate for the next FY contract.

Goal 5: Tuberculosis (TB)

All persons seeking substance abuse services through the SE or other BHSD-contracted substance abuse providers were offered TB services. TB information was shared with clients in educational sessions, dissemination of pamphlets and other media, and as part of substance abuse counseling. Clients were screened for possible risk for TB and, if found at risk, received information regarding the risk factors and offered on-site testing or referral for testing. If necessary, clients were accompanied to the public health or primary care setting for testing or, when necessary, for follow-up testing and indicated medical treatment.

Active TB is a mandated reported condition in New Mexico under 7.4.3.12 New Mexico Administrative Code. Latent TB Infection is not currently a mandated reportable condition. The TB Program collects data passively for latent TB Infection. Beginning in 2013, the TB Program will initiate a LTBI registry to collect data and track the number of LTBI infections throughout New Mexico. The program will be able to track the number of LTBIIs that are passively reported to us from drug treatment centers and other entities. However, this data will be on a reflection of the number of LTBI cases since reporting is not mandated.

For 2012, New Mexico had 40 active TB cases. This is a 20% drop from 50 cases in 2011. NM is considered a low incidence state in regards to the number of TB cases. While the number of cases of active TB disease is dropping each year, the individuals that are diagnosed with tuberculosis currently have many additional risk factors and co-morbidities. Out of the 40 cases diagnosed in 2012, 20%
indicated they had both injection/non-injection drug use and 18% had excess alcohol intake within the past year. There were no cases that were reported to the NM Department of Health that were diagnosed with active TB disease or drug treatment center.

The TB Program is collaborating with the SAPT program on how best to assist them with facilitating the needed testing for latent TB infection and active TB disease for client’s entering their facilities.

The SE tracks compliance of programs through its policy that programs - Offer interim services, when appropriate, that include, at a minimum, the following: counseling and education about HIV and tuberculosis (TB), the risks of needle sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission

Consumer Infectious Disease Education: The Provider must have a process for dissemination of education on the following topics:
- Acquired Immunodeficiency Syndrome (AIDS)
- Tuberculosis (TB)
- Human Immunodeficiency Virus (HIV)
- Infectious diseases

**Goal 6: HIV Services**
New Mexico is not currently an HIV designated State.

**Goal 7: Development of Group Homes**
SAMHSA permitted New Mexico to discontinue the development of group homes for substance abusers in recovery in FY 2008. The Center for Substance Abuse Treatment (CSAT) agreed that reporting under this requirement would no longer be required unless the State decides to re-implement the project. Re-implementation would mean the State is required to reimburse SAMHSA for the Federal funds used to originally establish the project. The State has chosen not to do so.

**Goal 8: Tobacco Products**
The State of New Mexico has in effect the New Mexico Tobacco Products Act. The Act was first adopted in 1978 and amended in 1997 to conform to the Synar mandate. The Act regulates all aspects of underage youth access to tobacco products available through tobacco merchants. It was again amended in FY 2003 to eliminate self-service displays of cigarette and smokeless tobacco products, and to regulate youth access to vending machines.

The State’s FY 2013 Annual Synar Report was submitted in the format now established by the Center for Substance Abuse Prevention/Synar in December 2012.

**Goal 9: Pregnant Women Preferences**
The SE monitors compliance through policy that - at a minimum, the following interim services for all women must include:
- Education and counseling about Human Immunodeficiency Virus (HIV) and tuberculosis (TB), to include information on the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission does not occur;
- Referrals for HIV and TB testing and treatment, if necessary;
• Provision of supportive services that foster on-going engagement of women waiting to access substance abuse treatment services, including Comprehensive Community Support Services (CCSS);
• Referrals to primary medical care;
• Referrals to child care and/or therapeutic day care;
• Referrals to primary pediatric care for their children, to include immunizations; and
• Referrals based on individual assessments that may include, but are not limited to, self-recovery groups; sources for housing, food, and legal aid; additional CCSS; children’s services; medical services; and Temporary Assistance to Needy Families (TANF) services.

**Goal 10: Process for Referring**

BHSD intends to meet the requirement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual during FY 2014–FY 2015.

As the SE refines its network referral process, BHSD and Office of Substance Abuse Prevention (OSAP) staff will be provided training on this process. The State Entity (SE) staff, in coordination with OSAP staff, will then train the primary prevention providers on identification and referral of individuals and families, needing treatment services, who are being served through prevention curriculum by the following:

The SE will provide technical assistance to prevention providers on the referral process to treatment services for identified individuals with treatment needs, to occur through the CY 2013.

The SE will work with prevention providers to identify consumers in need of treatment, to occur throughout the CY 2013.

BHSD staff will continue monitoring the SE’s use of ASAM criteria for prior authorization and continued stay authorization for substance abuse Residential Treatment Centers (RTCs). This is to be an ongoing task.

**Goal 11: Continuing Education**

The New Mexico Behavioral Health Collaborative, in cooperation with the Behavioral Health Services Division of the New Mexico Human Services Department, Life Link, Optum Health and other stakeholders, brought together four behavioral health domains for a two-day symposium on August 15 & 16, 2012. The three domains; Recovery-Oriented System of Care, Trauma, and Regional Crisis Systems of Care, were chosen to promote the enhancement of practice within their communities. Also occurring during the symposium were two one-day meetings for Medication Assisted Treatment and Performance Outcomes.

Based on summary numbers, the Behavioral Health Collaborative Symposium was attended by 447 total attendees. Attendees were chosen by the committee, and were sent personalized invitations and individual registration codes. Because attendees were earmarked to attend a specific health domain, they were not allowed to switch tracks or have partial attendance in their meeting.

**Domain 1: Recovery Oriented Systems of Care**
Topics included: Platform for Treatment and Recovery from Addictions; Mind, Body and Soul-Holist Approach from a Native American Perspective; Oxford House Motivational Interviewing- Trainer Master Trainers in Motivational Interviewing; Family Support and Collaboration in Treatment; Recovery High; Adventure Therapy: Dynamic Treatment Modality; Learning Communities

Domain 2: Trauma

Topics included: Cycle of Trauma; Intergenerational Trauma- Native Americans; Trauma Informed Care for Sexual Assault Survivors: Drawing on the Past, Building Capacity for the Future; Trauma Informed Care System in NM; Childhood Trauma; Trauma Treatment; Multigenerational Trauma- Crossroads Pilot; Peer Supports;

Domain 3: Crisis Systems of Care

The Crisis Systems of Care track was set up as a 16-hour training with consultant Kappy Maddenwald. Co-presenters included consumers with lived experience of a behavioral health illness who shared their experiences with the audience. An overview of Mental Health First Aid was also presented.

Performance Outcomes

The Performance Outcomes track was an eight hour meeting presented on August 15, 2012. for the general session by a keynote from Dr. Bill Miller.

What's it Look Like When the ASI-MV is Done Well?

| Engaging and Bridging Treatment |
|---------------------------------
| Everything You Needed to know to Demonstrate Your Positive Changes! |
| Next Steps to Learning Communities |

Medication Assisted Treatment Training

The Medication Assisted Treatment Training track was an eight hour meeting presented on August 16, 2012. Attendees of the Medication Assisted Treatment Training were recruited heavily, and were offered cutting edge programming on Buprenorphine use, as well as continuing education in medicine credits

- Historic Overview of the Development of Buprenorphine and the Rationale for its Use
- Impact of Health Care Reform and Behavioral Health Integration on the Need for Addiction Treatment in Primary Care
- Epidemiology of Opioid Addiction in New Mexico
- The New & Improved Common Prior Authorization Process for Buprenorphine Treatment
- Care Coordination of Opioid Addicted Patients
- Suboxone Diversion: Magnitude and Causes
• Use of Prescription Drug Monitoring Program to Reduce Diversion
• Utilization of Urine Drug Screens to Promote Treatment Adherence
• The State Buprenorphine Guidelines Manual
• UNM Project Echo Integrated Addiction & Psychiatry Clinic, and the Support Role of Midlevel Providers
• Working with Community Health Workers to Provide Case Management and Psychosocial Support
• Physician Provider Panel: Who We Treat and How We Do It- Experiences of MAT Buprenorphine Providers

The synergy of the Symposium continues through monthly videoconference and teleconference workshops sponsored by BHSD. Provider agencies from across the state share their evidence based practices and insight with each other and other interested stakeholders. Held during the lunch hour, participants are provided light refreshments and are able to participate actively in the presentations and discussion.

See Planning Narratives for more detailed descriptions of activities that took place in 2012-2013.

**Goal 12: Coordinate Services**
The Human Services Department/Behavioral Health Services Division (BHSD) in its role as the SAPT Block Grant Single State Authority monitored the SE’s activities. The BHSD Office of Substance Abuse Prevention (OSAP) monitored the SE’s activities in primary prevention. The SE had programming compliance responsibility for the behavioral health treatment services and prevention activities throughout its provider network.

The SE’s Specialized Care Coordination (SCC) system was fully implemented and operational. The Collaborative’s Oversight Team continued to monitor the SCC system through site visits and SCC chart audits, and provided technical assistance as needed. Care coordination services were also provided by the SE’s provider liaisons and field care managers. BHSD monitored the SE’s activities through its submitted reports and participation in the SCC site visits, chart audits, and technical assistance activities.

OSAP continued their participation in the New Mexico Tribal Data Collection Workgroup, sponsored by the Collaborative and the Robert Wood Johnson Foundation. Its purpose included addressing tribal concerns about research and evaluation processes, to build capacity in tribal communities, and develop a Native-driven approach. Its membership met bimonthly and included representation from the Indian Health Services Behavioral Health Programs, the Department of Health/Epidemiology and Response Division, the SE, University of New Mexico Center for Rural and Community Behavioral Health Services, Local Collaborative 14, Isleta Pueblo, Jicarilla Apache Tribe, To’Hajiilee, Santa Clara Pueblo, Acoma Pueblo, Tafoya & Associates and other stakeholders. The data was used for planning treatment and prevention programming to positively impact the health and future of tribal communities and the success of tribal programs. The workgroup’s first accomplishment was the development of a “Telling Our Story with Data, A Guide for and by the Tribes of New Mexico” document.
BHSD and OSAP worked with the SE to identify gaps in coordination of prevention activities and treatment services. Weekly meetings were held by OSAP and the SE to review the status of prevention activities. Also present at those meetings were researchers from the Pacific Institute for Research and Evaluation (PIRE), the Native American liaison Nadine Tafoya, and Michael Coop Consulting. The meetings were used to plan and design recipient meetings and the annual State Planning Meeting, coordinate the provision of technical assistance, and ensure that the State’s evaluation protocols were intact.

**Goal 13: Assessment of Need**
The Human Services Department/Behavioral Health Services Division (BHSD) continues to work with the Department of Health/Epidemiology and Response Division (ERD) to identify the SAPT Block Grant target population served by BHSD in order to assess this subpopulation’s service needs. Using the Behavioral Risk Factor Surveillance System (BRFSS), the State was able to identify the SAPT population: 18 and older, uninsured, and at or below 150% of the Federal Poverty Level.

The ERD actively participated in the Mental Health and Substance Abuse Prevention Block Grant application; providing data and analysis in the Unmet Needs narrative.

ERD epidemiologists continued to conduct surveillance of current and emerging substance related trends in NM, including alcohol-related data (i.e., binge drinking analysis using data from BRFSS and Youth Risk and Resiliency Survey (YRRS)) and an analysis of mental health data from the BRFSS. Data were provided for the State Suicide Prevention Plan. Drug use and overdose data were provided to the Collaborative to track accidental and intentional opioid overdoses, and over prescribed opioids by pharmacists.

**Goal 14: Hypodermic Needle Program**
No behavioral health service provider will participate in needle exchange using SAPT Block Grant funds, either funded directly by the Human Services Department/Behavioral Health Services Division (BHSD), the Behavioral Health Purchasing Collaborative (Collaborative) or as a subcontractor of the State Entity (SE). The Collaborative’s contract with the SE will contain the appropriate restrictive language and the SE will insert appropriate restrictive language in all SAPT-funded providers’ contracts, including renewals. Training on this requirement will be included in all Collaborative, BHSD, and SE workshops where appropriate. BHSD and the SE will monitor compliance of this requirement through the annual programmatic reviews and other processes. The SE will be responsible for assuring its staff is trained on this requirement. BHSD will be responsible for training State staff on this and other requirements as well as monitoring the SE for compliance. All non-compliance issues will be documented and reviewed at the appropriate system level and compliance will be required within 60 days of the findings.

**Goal 15: Independent Peer Review**
The Independent Peer Review process under this requirement is fulfilled by the Human Services Department/Behavioral Health Services Division (BHSD) and the State Entity (SE) through the activities of the New Mexico SAPT Independent Peer Review Committee (IPRC). It is facilitated and managed by the SE. BHSD will monitor progress of the SE and IPRC.
FY 2012-FY2013:
During FY2012, the IPRC completed onsite program reviews of six SAPT-funded programs throughout the State. One agency was reviewed in each of the five geographic regions. One serves primarily the Native American population.

The IPRC in collaboration with the SE submitted an annual report, describing their site review process and making recommendations for future process. See Attachment: IPRC

Recommendations and Comments of the Independent Peer Review Committee in the Annual Report included the following:

- Discuss, review and refine the audit tool for the next fiscal year, which will include a better tool for chart audit.
- Acknowledge that the review, while statutorily mandated, may require additional staffing to meet the goals, and has not been adequately funded.
- Explore ways to increase diverse representation on the Independent Peer Review Committee.
- Develop systems that will assure prompt response to issues identified through the Independent Peer Review process.
- Develop and implement technical assistance and training options as identified by the site visit Providers’ suggestions and recommendations.

Identified Needs in the IPRC Report

- Treatment partners report that funding continues to be an issue. Some services are funded and then shortly thereafter are not funded, for example CCSS. Obtaining prior authorizations are difficult and administratively burdensome. There are many essential services that are not funded such as Urine Drug Screens and transportation. Traditional practices are often not recognized as EBP and therefore often are not a recognized service.
- Treatment partners request more relevant clinical skills training be provided to them to meet the needs of diverse patient populations. Additional training identified included substance abuse and prevention training.
- The IPRC and treatment partners request feedback from Center for Substance Abuse Treatment (CSAT) as to how we are doing as a peer review committee and what they are doing with the information we provide them.
- The IPRC recommended that all providers who receive SAPT Block Grant funding be provided a copy of this document.

During FY14-15, the IPRC will evaluate and revise, as needed, the IPRC process annually. Revisions to the process will be discussed and agreed to by BHSD and the SE.

BHSD and the SE will provide technical assistance to the IPRC on including quality improvement questions in the program review tool.
Goal 16: Disclosure of Patient Records

The State of New Mexico intends to meet the requirement to ensure that the State has a system in effect that will protect patient records from inappropriate disclosure.

The Human Services Department current policy mandates that all its employees take the online HIPAA training and pass a test with 70% accuracy. BHSD further requires its employees to take an internal video training on 42 C.F.R. Part 2. A Pre and Post test is only required if the employee needs CEUs for licensing or certification purposes. The Collaborative’s contract with the SE contains language about this requirement, staff training, and monitoring of compliance. The SE includes both HIPAA and 42 C.F.R. Part 2 training in its 2-day New Employee Orientation. The SE also offers several online courses on both HIPAA and 42 C.F.R. Part 2 to both its staff and providers’ staff through the Essential Learning program. The SE reports to BHSD all training on a quarterly basis through the Critical Indicator (CI-21) report which is reviewed by the BHSD training coordinator.

The SE includes appropriate language in its contracts with BHSD-funded providers. Monitoring of SAPT-funded providers for compliance is done through the annual programmatic reviews conducted jointly by BHSD and the SE. BHSD assists the SE in bringing out of compliance providers into compliance through technical assistance, corrective action plans, and other mechanisms.

All providers are required to have signed consent to release of information forms that comply with 42 C.F.R. Part 2 and HIPAA requirements. Notification of Privacy Rights must specify how PHI may be used or disclosed and inform consumers of their rights under 42 C.F.R. Part 2. The State requires that both the SE and providers actually cite the regulations instead of using the generic term “federal regulations.”

HSD established policy that is documented in an agreement stating who is permitted to use or receive limited data sets. Safeguards have been established to prevent uses of disclosures of information that are inconsistent with the agreement. Both BHSD and the SE ensure that data are de-identified, e.g., stripped of individual identifiers, before data are shared in an aggregate manner.

BHSD and the SE staff monitor compliance with 42 C.F.R. Part 2 and HIPAA requirements by providers during annual onsite programmatic reviews. This includes written policy, notice to consumers regarding their rights under these regulations, staff confidentiality, and staff training.

HSD and BHSD have a variety of mechanisms in place to protect confidential client information. These include use of de-identified data sets, data sharing agreements, State regulations, contractual language, interagency memoranda of understanding, and formal training programs.

Goal 17: Charitable Choice

In FY 2012 this provision will not be applicable because the State did not fund any religious providers. Nevertheless, the Charitable Choice requirement was included in the FY2012 contract between the State, and the State Entity (SE).
The Human Services Department/Behavioral Health Services Division (BHSD) will monitor and oversee compliance to this requirement.

BHSD will work with the SE to ensure that religious organizations have an equal opportunity during the RFP process for funding available through the SAPT Block Grant.

The SE will develop and implement a mechanism to identify religious organizations throughout the state in order to inform them of the equal opportunity for funding.

BHSD will provide training and technical assistance to the SE and to providers on the Charitable Choice requirement.

BHSD will provide training and technical assistance to the SE and to providers on the reporting requirements to the State.

From the Oct-Dec 2012 OHNM report: The SE reported for FY12 that provider network agencies reported that Charitable Choice alternative services are publicized with posted signs, program outreach, brochures or other unspecified means. There were no referrals to Charitable Choice Alternative Services reported.

SAPTBG – Program Compliance Monitoring/Notification of Reaching Capacity:
The Collaborative and BHSD created a contract and Letter of Direction with the SE giving the SE responsibility for direct capacity monitoring while the State remains the primary responsible party for ensuring compliance. The current system meets the requirement for tracking and managing capacity for high-risk populations as specified in the SAPT Block Grant statute. The process has enabled the SE to identify and remedy widespread variations in practice and documentation, and performance reports demonstrated that reporting has improved, and staff members can now more easily identify providers who may require additional technical assistance.

The current policy tracked by the SE on the Maintenance of a Capacity Management System will ensure:
A. Reporting to OHNM by all substance abuse Providers, their service capacity, specifically, as to their ability to serve intravenous drug users, pregnant injecting drug users, and pregnant substance users;
B. Interim services are provided and appropriate referrals made when 90% capacity is reached by any individual substance abuse service Provider within federally prescribed timelines for all populations being served; and
C. Update OHNM on a weekly basis when Provider has reached 90% capacity.

In addition, policy also stipulates interim services to all individuals who cannot be admitted within 14 days. Interim services shall include, at a minimum, counseling and education about HIV, tuberculosis, risks of needle sharing, risks of transmission to sexual partners and infants, steps that can be taken to ensure that HIV transmission does not occur, and referral for HIV and/or TB treatment services.
The Provider shall establish a method of tracking all TB testing referrals and active and latent TB cases on their consumers.

In 2012, OHNM and BHSD staff held regularly scheduled meetings and conference calls with key staff from both organizations throughout the year. A written SAPT Block Grant Action Plan was followed: Corrective Action Plan and Women’s Services Polices were implemented. Providers received training and technical assistance as needed. As a result, providers consistently submitted reports and the quality of reports improved throughout the year. A SAPT webinar provider training was conducted by the SE and BHSD to provide a greater understanding of reporting for the SAPT block grant.

Providers who reported 90% capacity were reported to the OHNM regional directors and monitored by the OHNM Director of Block Grant Services. Programs received feedback on SAPT programmatic reviews and monthly reports. Programs also received individual technical assistance as needed.