<table>
<thead>
<tr>
<th>Rank</th>
<th>Priority Description [and Funding Amount if Known]</th>
<th>How Many People Will be Served: (by proposed program annually)</th>
<th>Strategic Plan Goal</th>
<th>Service Category [check one]</th>
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<tbody>
<tr>
<td>1</td>
<td>(Short title) SUSTAINABILITY AND GROWTH OF EXISTING BEHAVIORAL HEALTH SERVICES.</td>
<td>II.1 II.2 V.1</td>
<td>Maintenance of Effort</td>
<td>Expans ion of Existing \</td>
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<td>II.1</td>
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11.1 – Behavioral health services are readily accessible and responsive to consumers’ needs.

There is inadequate funding for a full array of core community outpatient services and a need for an increased number of substance abuse beds and establishment of local stabilization beds for mental health patients. We need tailored services with specialized training and funding for agencies to provide the necessary training. There should be stipends with commitment for psychiatrists or psychologists to practice in rural areas. There has not been a significant influx of dollars into the core outpatient services delivery system in fifteen (15) years. In that same period the cost of delivering those services has increased between 25 and 35 percent.

Local Collaborative 12 requests that the provider contract and billing rates be increased in increments of ten (10) percent the first year and five (5) percent for each of the following four years. This should also be tied to a cost of living increase each year to match inflation rates.
Most importantly, there needs to be an increase in rates from all payor sources to match inflationary costs to providers with a special consideration of differential rates to rural and frontier areas.
COST: *$804,440 first year (this includes cost of increasing substance abuse beds and establishing mental health stabilization beds).
  *$150,000 (approximately) for years two through four.
  *Inflation percentage linked to the national rate ongoing.
The cost of liability/malpractice insurance needs to be changed (look at mediation model in California). There is lack of adequate prevention services for substance abuse in this area.

II.2 – Persons needing services, no matter where they live, easily access a community-based service system that is clinically sound, utilizes evidenced-based practices, as appropriate, and is culturally competent.

Transportation is needed in order to get consumers to their service system or for providers to get to the consumers. Providers need to be able to offer reliable, safe, affordable, consistent transportation. Many clients are in remote locations and need transportation to and from services. The current system falls woefully short of adequacy for accomplishing this task, and this is especially true for outlying areas. If funding is available to provide transportation for minors, that funding should include transportation for the minor’s parent/guardian. Providers have tried to have clinics in outlying towns, such as in Carrizozo, but have been unable to arrange for a consistent location for the clinics.
COST: $24,000 – including travel to see clients in rural areas including Carrizozo, Capitan, Ruidoso, Cloudcroft, and Tularosa, among others.

V.1 – Consumers and providers are part of the process of using data to continually improve the efficiency and effectiveness of services and track consumers and services across all funding streams.

Quality Assurance programs are required but there is no payment for these services. This is also true for administrative costs. VO receives monies for this but providers do not, though providers continue to provide all the required information to VO. VO collates the information gathered and sent in by providers, but providers do not get paid for the administrative costs necessary to gather and provide the information. This service is outside of any current rate consideration.

COST: $81,600 for QI Programs.

2 (Short title) CROSS TRAINING OF STAFF OR SERVICES AREAS.

IV.1.b – Recruit and retain behavioral health professionals with particular focus for those in rural and frontier areas.

It is very difficult to recruit, train and maintain professionals, particularly in rural areas. Providers continually lose practitioners to the private sector, government, schools, and to VO, often along with paying clientele who follow the practitioners. The rates at which
Providers are reimbursed have not been raised in approximately 12-15 years, yet salaries have had to go up in that same time frame in order to hire personnel. It has become necessary to promote from within and pay for training in order to recruit professionals.

**COST:** $9,000 annually to advertise and recruit (TCC) 20 hours of CEU’s required per year for counselors. 20 hours of crisis training. CEU’s offered locally is bare minimum of needs. Any specialized training is nowhere nearby. Need to pay for training, lodging, per diem, etc. Over the years the funds for training have gone away but the requirements have not only not gone away, they have increased.

Training Costs: $38,000 plus billing income lost

**IV.2** – Consumers of all cultures across the state have access to evidence-based behavioral health practices and programs.

Specialized cultural and evidence-based programming and training is quite expensive and beyond the reach of most, if not all, not-for-profit providers.

**COST:** Example: MST is over $200,000 to get certified, plus it is a franchised commodity, with annual maintenance costs of up to $25,000.

**IV.3** – Behavioral health providers readily access Telehealth options for service delivery and professional education.

Cannot currently use Telehealth because most agencies are not set up to access it. Many agencies cannot communicate
with each other because of firewalls.

**COST:** Possible cost of up to $45,000 to set up access to Telehealth, including TI line, depending upon location of site, and basic equipment and training needs.