New Mexico Behavioral Health Purchasing Collaborative Meeting

Thursday, February 27, 2014

Human Services Department
37 Plaza la Prensa
Santa Fe, NM

Video Conference Sites

Albuquerque
Farmington
Las Cruces
Las Vegas
Roswell
Silver City

New Mexico Behavioral Health Interagency Purchasing Collaborative

Yolanda Deines
Children, Youth and Families Department
Secretary – Collaborative Co-Chair

Sidonie Squier
NM Human Services Department
Secretary – Collaborative Co-Chair

Thursday, February 27, 2014
37 Plaza La Prensa
Santa Fe, New Mexico
1:00 p.m. – 4:00 p.m.

draft **AGENDA**

1. 1:00 – 1:30 p.m. **Call to Order**
   - Introduction of Collaborative Member/Recognize Remote Sites
   - Review/Approval of Minutes from August 15 and October 10, 2013 (decision item)

2. 1:30 – 1:50 p.m. **Crisis Systems of Care I: Community Collaboration in Action: TriCounty Community Services and Holy Cross Hospital**
   Kim Hamstra, CEO TCCS and partners

3. 1:50 – 2:10 p.m. **Crisis Systems of Care II: NM Crisis and Access Line Update**
   Rosemary Strunk and Protocall

4. 2:10 – 2:30 p.m. **Trauma and Severe Emotional Disturbance (SED) Criteria**
   Yolanda Deines, Secretary of CYFD and Staff

5. 2:30 – 2:45 **Update on Centennial Care Implementation**
   Julie Weinberg/MAD and Karen Meador/BHSD

6. 2:45 – 3:05 **Behavioral Health Planning Council (BHPC) Report**
   Lisa Trujillo, Chair, Behavioral Health Planning Council

   Local Collaborative Alliance Update
   Susy Ashcroft and Rick Vigil

7. 3:05 – 3:20 p.m. **Budget Updates**
   Collaborative Members

8. 3:20 – 4:00 p.m. **Public Input**

   4:00 **Adjourn**

Tab 1

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draft Meeting Minutes

New Mexico Behavioral Health Collaborative

August 15, 2013 · 1:00–4:00 p.m. · 37 Plaza La Prensa, Santa Fe, New Mexico

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

Topic	Discussion
Video Conferencing Sites	Farmington NM, Las Vegas NM, Las Cruces NM, Roswell NM, Albuquerque NM
Present were:	Retta Ward/DOH, Yolanda Deines/CYFD, Diana McWilliams/BHC, Aurora Sanchez/NMCD, Gino Rinaldi/ALTSD, Arthur Allison/IAD, Rose Baca-Quesada/MFA, Daniel Roper/DVR, Annjenette Torres/PED, Patrick Simpson/AOC, Tom Clifford/DFA (by phone)
1. Call to Order	The meeting to order at 1:05 pm without a quorum present. The Collaborative members introduced themselves.
• CEO Updates	*Handout-CEO Update* Diana McWilliams, CEO, Behavioral Health Collaborative reported on current issues with the behavioral health system. There was a referral of 15 agencies to the Attorney General's office for credible accusations of fraud so there is an investigation going on. We don't know where the AG is in that proceeding. We are making every effort to insure consumers are safe and that services are in place throughout the network. When an agency that has a pay hold in place and cannot meet payroll the State is fronting the payroll and making sure existing NM staff are getting paid. We are also making sure that organizations that can provide services that do not have a pay hold can provide services. In the case of the 12 that still have a pay hold in place for behavioral health we are in the middle of transition or have done transition, meaning also hiring staff with all but 2 agencies. Services to consumers and their safety is the State's number one priority. The transition agencies have been hiring on average 90% of the current staff in order for consumer's to see the practitioners that they are familiar faces and that services get rendered as they normally do. Crisis line number s were given out. Being that a quorum was now present, the meeting went on to the voting item.
• Review/Approval of Minutes from January 10, 2013	*Handout-DRAFT Meeting Minutes, New Mexico Behavioral Health Collaborative Meeting – April 11, 2013 and June 13, 2013* A **MOTION** was made by Gino Rinaldi and seconded by Retta Ward to approve the minutes from the April 11, 2013. Behavioral Health Collaborative Meeting. The **MOTION** was **PASSED** unanimously. A **MOTION** was made by Gino Rinaldi and seconded by Retta Ward to approve the minutes from the June 13, 2013.

	Behavioral Health Collaborative Meeting. The **MOTION** was **PASSED** unanimously.
2. Behavioral Health Planning Council Report	*Handout-Behavioral Health Planning Council Report 7/11/13* Lisa Trujillo reported on the following: • Audit and Response • Membership • Bylaws and Policies and Procedures • Block Grants • Training • Subcommittees • Changes • Local Collaborative Alliance • Mapping Project • LC Reports • Budget
3. Local Collaborative Update	*Handout-LC s 1-18 Quarterly Reports* Governor Rick Vigil reported on the Local Collaboratives' activities including the Local Collaborative Alliance. Also the following reports were submitted. • Quarterly reports were submitted by LCs 2, 3, 6, 10-14 and 16
4. Directors Reports/Data	*Handout: Director's Reports* Diana McWilliams reported that the director's reports that will be presented at the October 10 meeting will be more reflective of FY13. Until then, the following reports were provided to the Collaborative members: • Consumers Served by Ethnicity Statewide • Consumers Served and Expeditures, by Service - Statewide • Consumers Served and Expenditures by Fund Statewide
5. New Mexico Crisis and Access Line	*Handout: New Mexico Crisis and Access Line Bi-annual Report 7/12/2013* Troy Fernandez/OptumHealth; Phil Evans and Lindsay Branine/NM Crisis and Access Line • The New Mexico Crisis and Access Line Bi-Annual Report was presented to the Collaborative. Included was a breakdown by type for the 3,086 total calls. • Also clinical and demographic information was presented. • Last was outreach information was reported
6. Supportive Housing	*Handouts: Accomplishments and Updates on New Mexico's Supportive Housing Initiative* Jane McGuigan/BHSD and Joseph Montoya/MFA • The presenters gave an update on the supportive housing initiative. Included in the presentation:

	○ Review of what supportive housing is and what it means for consumers ○ Continuum of housing programs ○ Cost effectiveness of supportive housing
7. Public Input	Bruce Evans, representing LC1 • Compliments to Jane McGuigan and MFA for their work on housing for consumers and families • Mr. Evans expressed his concern with the Medicaid redesign and feels there are gaps, particularly in the lack of consumer and family member input. • Mr. Evans feels that relations between executive branch and the legislature are not good. • What will happen when short-term contract with the entities that have taken over for providers are over? Diana McWilliams responded by saying that the HSD contracts with these agencies are for transition costs, primarily to cover payroll of our existing clinicians in our present provider network and operational expenses as well as leases. OptumHealth NM is also contracting with them as part of the network so they can get up with billing Medicaid as soon as possible. Also while the transition agencies are getting credentialed they are also getting approached by the Centennial Care MCOs to also be in their network. On January 1st, the transition agencies will be part of our behavioral health care system. Martha Cooke, NAMI and LC1 • Ms. Cooke shared that there was a movie shown in Santa Fe about bi-polar disorder. There will also be a series of lectures by Ideas in Psychiatry program starting in October. • Ms. Cooke believes that the Crisis Line is a positive accomplishment. She feels that information about the Crisis Line is not getting out. The crisis line should not be a stop gap for the crisis that the state is going through because of the provider transition. Patrick Simpson/AOC and non-voting member of the Collaborative asked if the Public Consulting Group (PCG) contract was shared with the Collaborative. Larry Heyeck/General Counsel HSD and Diana McWilliams responded that because of the emergent nature of the situation, the Behavioral Health Collaborative Executive Committee decided that it was in the State's best interest to find an audit company to contract with that had no relationship with New Mexico or OptumHealth. PCG was referred to the State by SAMHSA representatives. Diana McWilliams added that because of the alleged allegations of fraud that is being investigated by the Attorney General's Office, it would be inappropriate and
8. Adjourn	The meeting was adjourned at 3:31.

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draft Meeting Minutes

New Mexico Behavioral Health Collaborative

October 10, 2014 · 1:00–4:00 p.m. · 37 Plaza La Prensa, Santa Fe, New Mexico

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

Topic	Discussion
Video Conferencing Sites	Farmington NM, Las Vegas NM, Las Cruces NM, Roswell NM, Albuquerque NM
Present were:	Retta Ward/DOH, Yolanda Deines/CYFD, Diana McWilliams/BHC, Aurora Sanchez/NMCD, Rose Baca-Quesada/MFA, Richard Blair/DFA, Erin Thompson/DWS, Muffet Foy-Cuddy/DOT
1. Call to Order	The meeting was called to order at 1:14 pm without a quorum present. The Collaborative members introduced themselves.
• CEO Updates	*Handout-Provider Key Issues* Diana McWilliams, CEO, Behavioral Health Collaborative reported on the transition of providers. The Attorney General's continues the investigation of 15 behavioral health agencies. There are full pay holds on 12 agencies and either full or partial pay holds have been lifted for 3 agencies. Ms. McWilliams reported that staff retention throughout the 15 agencies average 90%. Readiness activities for implementation of Centennial Care – HSD's Medical Assistance and Behavioral Health Divisions have been actively engaged in implementation activities since early January of 2013. State staff have reviewed deliverables from all four MCOs selected to participate.
• Review/Approval of Minutes from January 10, 2013	*Handout-DRAFT Meeting Minutes, New Mexico Behavioral Health Collaborative Meeting – August 15 and October 10, 2013* Since a quorum was not present, a vote on the minutes from the last meetings could not take place.
2. Behavioral Health Planning Council Report	*Handout-Behavioral Health Planning Council Report 10/10/13* Lisa Trujillo reported on the following: • Provider Transitions – Ms. Trujillo expressed the following concerns: continuity of care; workforce; consumer choice; trust issues; and traumatic effects • Centennial Care • Planning Council Membership • BHPC Retreat • Subcommittees

3. Local Collaborative Update	*No report was presented.*
4. Directors Reports/Data	*Handout: Director's Reports* Karen Meador/BHSD and Geri Cassidy/MAD briefed the Collaborative members on the following reports: • Consumers served and expenditures (yellow report) • Statewide expenditures (green report) • Consumers served by ethnicity (blue report); also includes breakout of males, females and age group • Total expenditure • Total dollars by age group • Total adult expenditure • Child total expenditure • Unduplicated consumers by age
5. Centennial Care Discussion	*Handout: Medicaid Managed Care Services Agreement for Centennial Care Amendment 1* Larry Heyeck, HSD Deputy General Counsel • Mr. Heyeck reviewed the amendment 1 to the Centennial Care Contract. The amendment further defines "over payment" and "credible allegation of fraud." Also, included, is language for the Behavioral Health Data Warehouse.
6. Public Input	Julie Teabrook, Mental Health Practitioner at UNM • Because of AMA CPT coding guidelines, Medicaid is not reimbursing this provider for services because the provider is being told that they can only bill for Psychotherapy and RN services. Ms. Teabrook requested direction. Diana McWilliams asked that she leave her contact information so someone could get back to her. Bruce Evans, LC 1 • The transition is going better than he expected overall. • In the southern part of the state, he is hearing there is resentment from providers toward HSD, BHSD and the Collaborative because of lack of due process. • Access is still an issue. • Need better transparency so there is better information.
7. Adjourn	The meeting was adjourned at 3:44.

Tab 2

Holy Cross Hospital and Tri-County Community Services, Inc.'s collaboration has expanded immensely in the past 2 years, including:

TCCS, the county's adult Core Service Agency, provides the following to Holy Cross Hospital:

- An embedded Licensed Independent Social Worker from 8-5, Monday-Friday, whose office is on Med/Surg Unit in the hospital. The LISW provides assessment, consultation, brief therapy and intervention, and emotional support to patients and their visitors. Holy Cross Hospital pay for a portion of the LISW's salary. This arrangement has allowed Holy Cross Hospital to have a full-time LISW during business hours, which would not have been possible without this collaboration. We are looking to possibly add a weekend LISW with the same format.
- TCCS's After-Hours Crisis Team serves the Holy Cross Hospital evenings, nights, weekends, holidays, providing for 24/7/365 face to face services coverage for psychiatric crises presenting at Holy Cross Hospital
- Holy Cross Hospital's Rural Health Clinic in Penasco is visited by a TCCS LISW and CCSS worker twice per month, to serve residents in the Penasco Valley in a co-located model. We are also looking at options to evolve this into a fully integrated model.
- TCCS's Assertive Community Treatment (ACT) team responds 24/7 to consenting ACT consumers who visit the Holy Cross Hospital Emergency Room, due to an IT communication innovation developed by Holy Cross Hospital that allows for automatic notification to ACT on-call workers.

Holy Cross Hospital provides the following to TCCS:

- Streamlined Presumptive Eligibility for Medicaid for eligible consumers, in addition to staff support about Medicaid/Medicare/insurance issues and PE/MOSAA enrollments
- Parenting classes (Circle of Security) located at TCCS, per their consumer request
- An ally and advocate for behavioral health integration, without duplication of their services

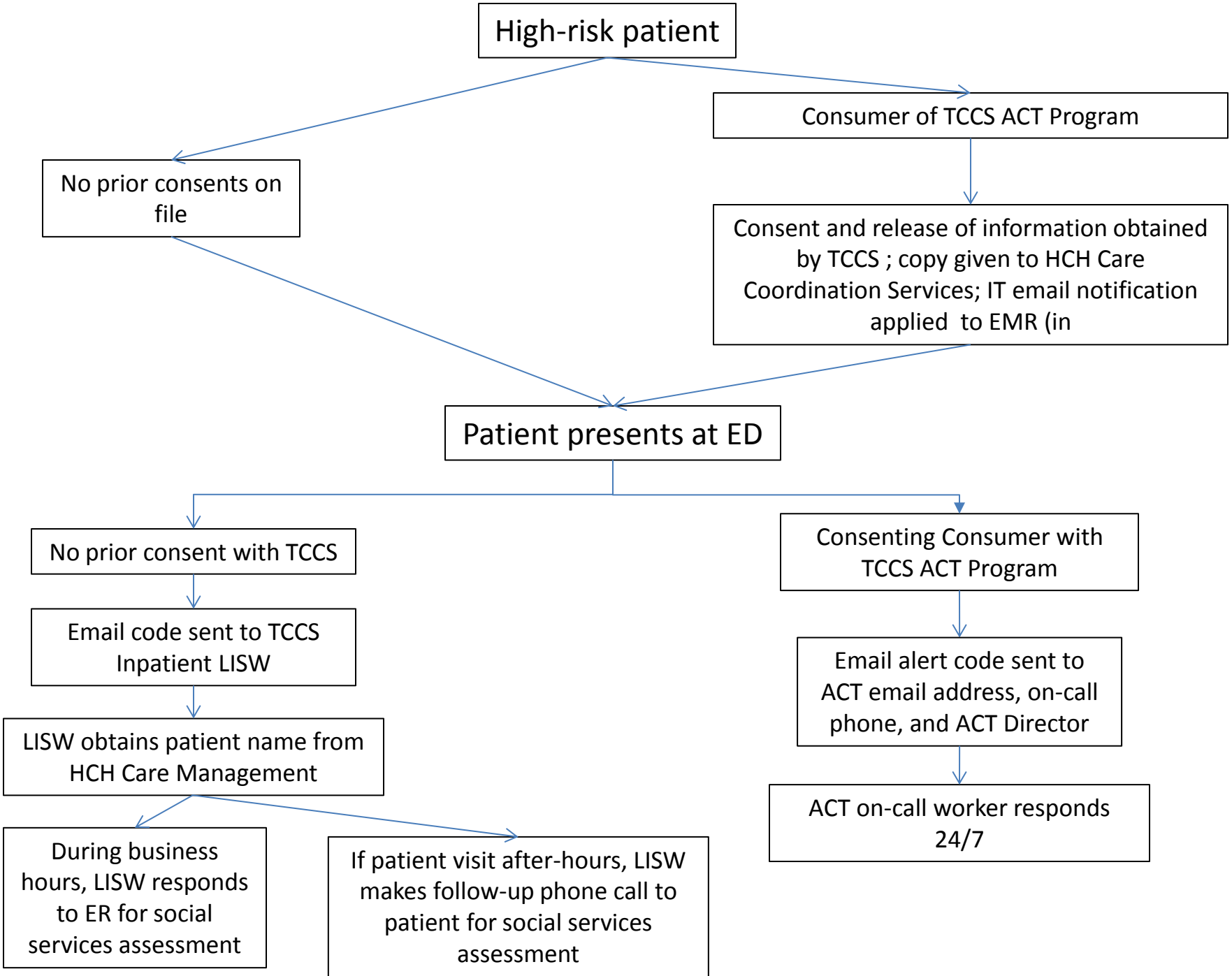
What is the next step? The DREAM

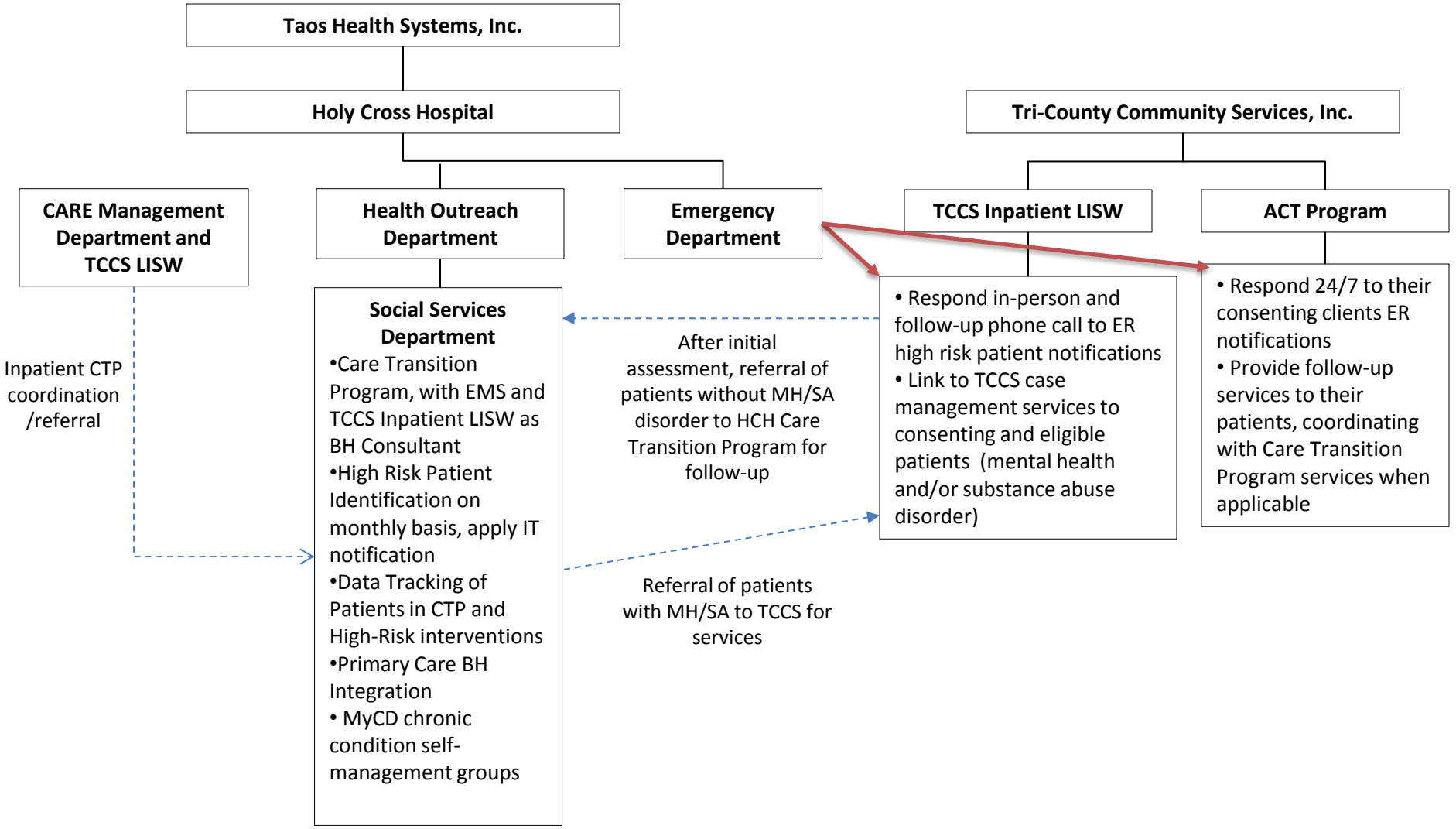
- TCCS To hire a LISW to work 9-6 Saturday and Sunday at Holy Cross Hospital.
- TCCS , HCH and police to implement a mobile crisis team.
- TCCS to implement a Taos County Intake clinic that would support appropriate and timely referrals and follow-up. To refer to TCCS and other providers.
- TCCS to implement a peer specialist check in service to contact people that no show appointments.
- TCCS and HCH to jointly open a Medical Detox program in HCH.

How to Call for Social Work and Psychiatric Consult for ER/Med-Surg/ICU

All calls to 779-3920	**Business Hours** Mon-Fri 8am to 5pm	**After Hours** 5pm to 8am and weekends	**High Risk Patient Response** Business Hours Mon-Fri 8am to 5pm	**High Risk Patient Response** After Hours 5pm to 8am and weekends
Psychiatric Crisis Consult • Suicidal • Homicidal • Psychosis • Danger to self/others	TCCS Inpatient LISW will respond to call.	TCCS Crisis Team on-call clinician will respond to call.	If patient is in crisis, call for psychiatric crisis consult.	
Social Work Consult • Accessing substance abuse treatment/Detox • Accessing community mental health and other social services • Brief therapy intervention • Domestic Violence concerns	TCCS Inpatient LISW will respond to call.	No in-person response– TCCS After Hours Crisis Team ***responds to psychiatric crises after hours only***	TCCS Inpatient LISW will respond to the email notifications of high risk patients during business hours.	TCCS Inpatient LISW will attempt phone contact with patient within 24 hours of ER visit (or on Monday, if patient's visit was Friday evening-Sunday)

TCCS Inpatient LISW = Tri-County Community Services, Inc.'s Licensed Independent Social Worker who is embedded/co-located at Holy Cross Hospital, with office in Med-Surg.


High-risk patient
Consumer of TCCS ACT Program
No prior consents on file
Consent and release of information obtained by TCCS ; copy given to HCH Care Coordination Services; IT email notification applied to EMR (in
Patient presents at ED
No prior consent with TCCS
Email code sent to TCCS Inpatient LISW
LISW obtains patient name from HCH Care Management
During business hours, LISW responds to ER for social services assessment
If patient visit after-hours, LISW makes follow-up phone call to patient for social services assessment
Consenting Consumer with TCCS ACT Program
Email alert code sent to ACT email address, on-call phone, and ACT Director
ACT on-call worker responds 24/7


Taos Health Systems, Inc.
Holy Cross Hospital
Tri-County Community Services, Inc.
CARE Management Department and TCCS LISW
Health Outreach Department
Emergency Department
TCCS Inpatient LISW
ACT Program
Social Services Department
•Care Transition Program, with EMS and TCCS Inpatient LISW as BH Consultant
•High Risk Patient Identification on monthly basis, apply IT notification
•Data Tracking of Patients in CTP and High-Risk interventions
•Primary Care BH Integration
• MyCD chronic condition self-management groups
Inpatient CTP coordination /referral
After initial assessment, referral of patients without MH/SA disorder to HCH Care Transition Program for follow-up
Referral of patients with MH/SA to TCCS for services
• Respond in-person and follow-up phone call to ER high risk patient notifications
• Link to TCCS case management services to consenting and eligible patients (mental health and/or substance abuse disorder)
• Respond 24/7 to their consenting clients ER notifications
• Provide follow-up services to their patients, coordinating with Care Transition Program services when applicable

Tab 3

New Mexico Crisis and Access Line:
2013 Annual Report

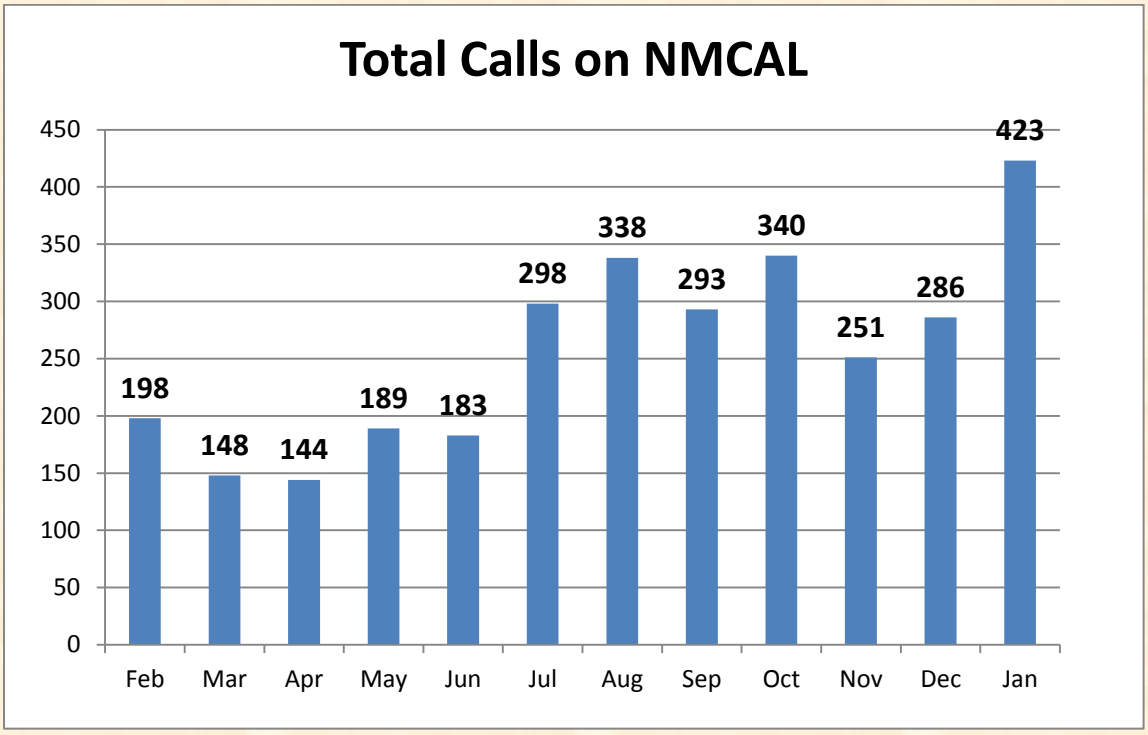
The New Mexico Crisis and Access Line completed its first year of operation on January 31st, 2014. In that year, 3093 calls have been answered on NMCAL. Under separate contracts, an additional 3711 calls were answered for CSA crisis lines in New Mexico during that time.

Feb 2013 - Jan 2014: Calls Answered by Type	
NMCAL CALLS	**3093**
Inbound Clinical Calls	1974
- Calling about Self	1522
- Calling about a Child	84
- Calling about another Adult	368
Outbound Calls	226
Information/Referral Calls	193
Seeking information about NMCAL	113
Administrative	69
Hang-ups/Wrong #s/Internal Test Calls	518
CALLS ANSWERED FOR CSA CRISIS LINES	**3711**
TOTAL CALLS ANSWERED FOR NEW MEXICO	**6804**

The following tables and charts provide specific information about the calls handled on the New Mexico Crisis and Access Line from February 2013 through January 2014.

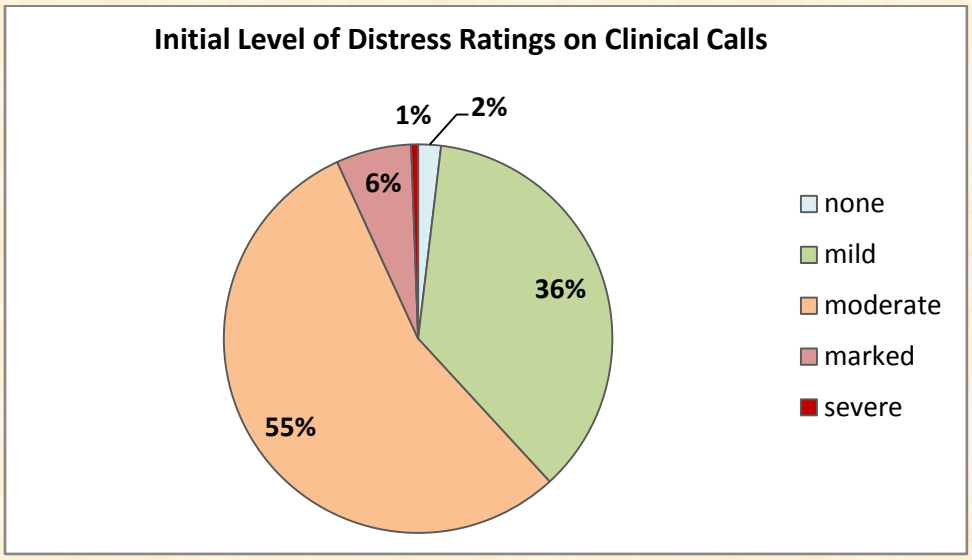
CALL VOLUME

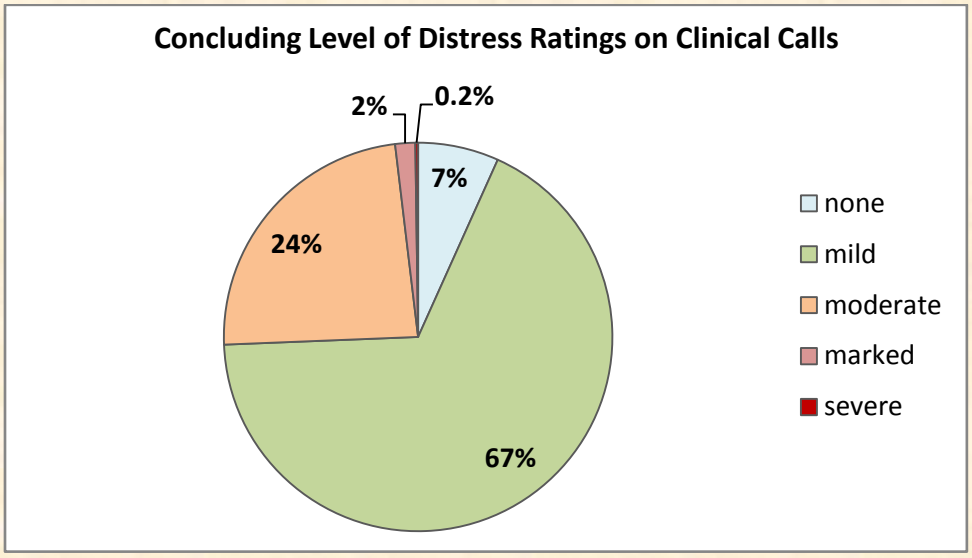
NMCAL call volume has increased significantly over the past year, with spikes in calls corresponding with NMCAL outreach efforts. It seems likely that call volume will continue to increase as more consumers learn about the availability of the New Mexico Crisis and Access Line.



CLINICAL INFORMATION

Our clinicians rate initial and concluding level of distress on every clinical call. Level of distress is based on both the caller's presentation or overt behavior, and on an assessment of their clinical situation. Even if a caller is not emotional or upset, their level of distress is rated higher if their clinical situation is acute.





In 62% of clinical calls, level of distress was initially rated as moderate or higher. In 67% of those calls, the level of distress was reduced by the end of the call.

Level of Care of Clinical Calls	
Routine	65%
Urgent	32%
Emergent	3%

Primary Presenting Problem in Calls	
Alcohol/Drugs	10%
Anger Management	1%
Anxiety	30%
Child	3%
Danger to Others	1%
Depression	11%
Family	5%
Grief/Loss	2%
Medication	2%
Relationship/Marital	4%
Suicide	7%
Other	24%

While it was not always the presenting issue, concerns related to suicidal thoughts were reported on 29% of clinical calls. Concerns related to drug or alcohol abuse were reported on 28% of clinical calls.

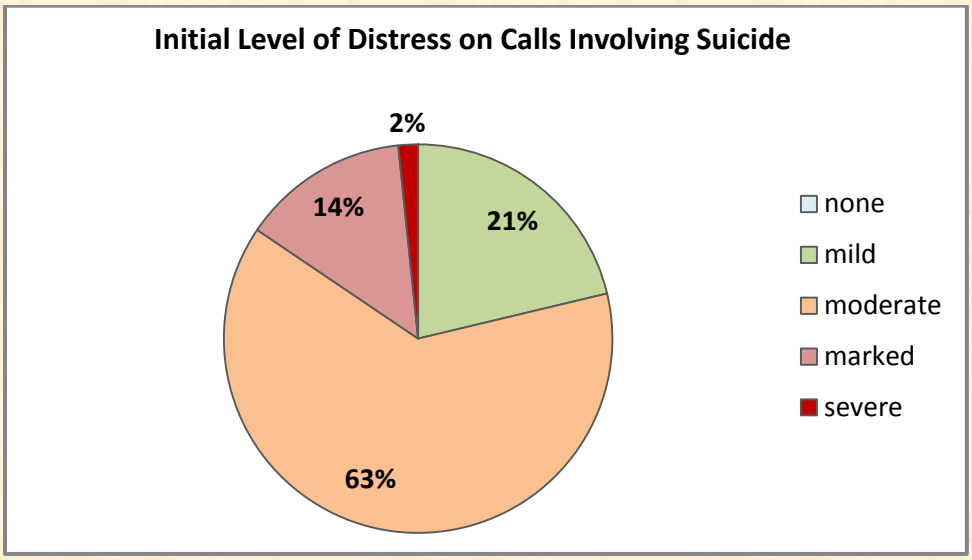
For every clinical call, we track whether the situation could be stabilized by the clinician, or if a more restrictive level of care was necessary. Restrictive outcomes include a caller voluntarily going to a hospital or calling 911, our transferring a caller to emergency services, making an abuse report, or dispatching police (with or without caller's

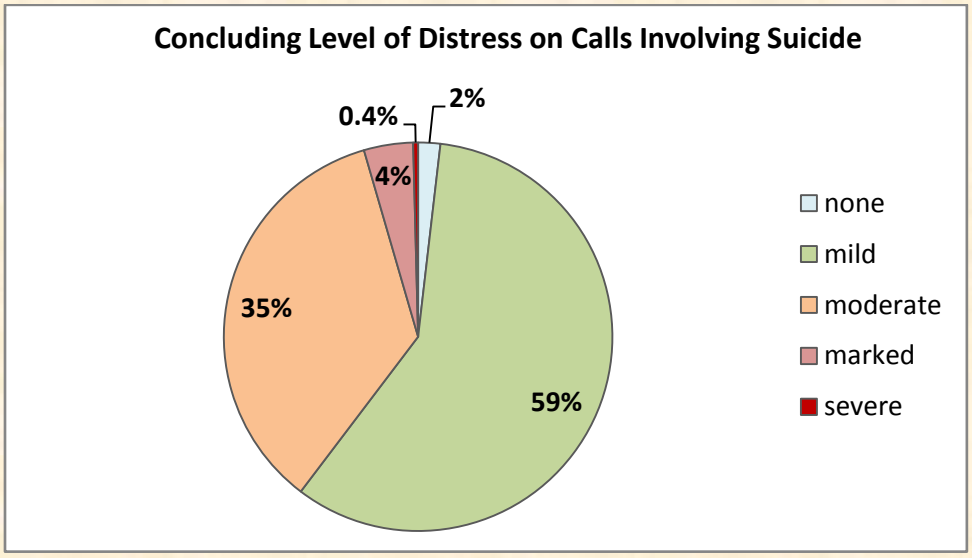
consent). These are the clinical outcomes of the NMCAL calls taken over the past year.

Clinical Disposition of All Counseling Calls	
Caller stabilized by clinician, and referred to community resources if appropriate.	95%
Clinician made a child abuse report.	0.3%
Caller agreed to go to the hospital.	1%
Caller agreed to take person of concern to the hospital.	1%
Caller agreed to call 911 regarding immediate danger to the person of concern.	1%
Caller conferenced to 911 due to immediate danger.	1%
Clinician contacted police with caller's consent.	0.1%
Clinician contacted police without caller's consent.	0.5%

We look closely at the outcome of calls where concerns about suicide are discussed. In NMCAL's first year:

- 513 NMCAL callers reported concerns about suicide – either for themselves, or for another person of concern.
- In 304 of these cases, the caller reported thoughts of suicide for him or herself.
- In 171 cases, the caller was relaying concerns about another adult.
- In 38 cases, the caller was relaying concerns about a child.
- In **88%** of calls related to suicide, the NMCAL clinician was able to stabilize the caller and plan for safety during the phone call, without needing to involve police, a hospital, or other more restrictive options.





In 79% of calls involving suicide, the level of distress was initially rated as moderate or higher. In 65% of those calls, the level of distress was reduced by the end of the call.

Clinical Disposition of Calls Involving Suicide	
Caller stabilized by clinician, and referred to community resources if appropriate.	88%
Caller agreed to go to the hospital.	2%
Caller agreed to take person of concern to the hospital.	2%
Caller agreed to call 911 regarding immediate danger to the person of concern.	3%
Caller conferenced to 911 due to immediate danger.	3.5%
Clinician contacted police with caller's consent.	0.5%
Clinician contacted police without caller's consent.	1.5%

DEMOGRAPHIC INFORMATION

The following tables summarize the descriptive information gathered from NMCAL callers between February 2013 and January 2014. All information was not gathered on all calls: information was not gathered if the caller did not wish to answer a question, if the caller didn't know the answer to a question, or if the counselor did not ask the question due to the nature of the call. All demographic information is based on callers' self-report, and was not externally verified.

Like most crisis lines, NMCAL has a small number of consumers who contact us frequently. In fact, 1% of the individual callers account for 17% of the total NMCAL calls. Because of this, descriptive data is presented both for total calls, and for identifiable unique callers.

In its first year of operation, NMCAL received calls from residents of 32 of New Mexico's 33 counties.

County of Residence	Total Calls	Individual Callers
Bernalillo	716	437
Catron	4	4
Chaves	44	17
Cibola	26	10
Colfax	2	2
Curry	7	7
Dona Ana	87	70
Eddy	46	21
Grant	351	39
Guadalupe	3	2
Harding	3	1
Hidalgo	5	3
Lea	4	2
Lincoln	70	8
Los Alamos	12	10
Luna	28	13
McKinley	33	17
Mora	1	1
Otero	35	19
Quay	2	2
Rio Arriba	19	16
Roosevelt	4	4
San Juan	57	27
San Miguel	106	24
Sandoval	70	55
Santa Fe	144	86
Sierra	9	6

Socorro	5	3
Taos	9	8
Torrance	10	6
Union	3	3
Valencia	38	28
(outside New Mexico)	17	11

Consumer Receiving Behavioral Health Treatment?	Total Calls	Individual Callers
Yes	60%	35%
No	40%	65%

Consumer's Health Insurance	Total Calls	Individual Callers
Medicare/Medicaid/VA	64%	45%
None	24%	33%
Private insurance	9%	16%
Insured, but type unknown	3%	6%

Only 15% of callers without health insurance reported that they were receiving behavioral health treatment, as opposed to 35% of total callers.

Consumer's Housing Status	Total Calls	Individual Callers
Has permanent housing	88%	86%
Has temporary housing	6%	3%
Resides in a residential facility	1%	3%
Homeless	5%	8%

12% of homeless callers reported that they were receiving behavioral health treatment, as opposed to 35% of total callers. 32% of homeless callers reported that they had health insurance coverage, as opposed to 67% of total callers.

How did the Caller Hear About NMCAL?	Total Calls	Individual Callers
Counselor/Therapist	37%	17%
Internet	13%	16%
Medical or Behavioral Health Facility	8%	13%
Nurseline	11%	13%
Family/Friend	10%	13%
Crisis Line or Warmline	4%	6%
Governmental or Public Service Agency	4%	6%
Magnet/Flyer/Wallet Card	5%	5%
Media	3%	5%
Consumer Support Group	4%	4%
Other	1%	2%

Consumer's Primary Language	Total Calls	Individual Callers
English	88%	94%
Spanish	3%	3%
English/Spanish Bilingual	8%	2%
Other	1%	1%

Consumer's Race/Ethnicity	Total Calls	Individual Callers
Hispanic	30%	43%
White/Caucasian	38%	43%
Multiracial	23%	4%
American Indian or Alaskan	5%	6%
Black or African American	2%	3%
Asian	1%	1%
Other	1%	1%

Age of Consumer	Total Calls	Individual Callers
Under 18	5%	10%
18-24	8%	12%
25-34	17%	22%
35-44	17%	18%
45-54	22%	19%
55-64	28%	15%
65+	3%	5%

Gender of Consumer	Total Calls	Individual Callers
Male	53%	47%
Female	47%	53%

OUTREACH INFORMATION

Over the past year, NMCAL administrative staff and clinicians have been actively involved in community outreach. Our goals have been to increase community awareness and utilization of NMCAL, and to create relationships with other agencies in the state. This is a summary of our outreach activities:

I. We have launched a website for the New Mexico Crisis and Access Line: www.nmcrisisline.com

II. We created informational materials about NMCAL: refrigerator magnets, brochures for professionals, "Concerned About a Loved One?" brochures for lay people, posters including "Reasons to Call…", and pens. We have distributed these widely, including:

- **8250 magnets, 11,000 brochures for lay people, and 2750 brochures for professionals** have been distributed in mailing kits. These have been sent to

  - All New Mexico medical facilities with emergency departments
  - All New Mexico Core Services Agencies
  - Behavioral health systems, state services, and consumer advocacy programs across the state.

- **7500 magnets, 5500 brochures for lay people, and 400 posters** have been distributed to many stakeholders statewide including:

- Youth Suicide Prevention Program for Department of Health
- NM Suicide Prevention Coalition
- All MCOs: United, Molina, Presbyterian, BC/BS
- NM Behavioral Health Collaborative
- CYFD
- Mental Health First Aid
- School-based Health Clinics
- Survivors of Suicide: ABQ, Los Alamos, Las Cruces
- NM Association of Counties
- NAMI Westside, ABQ, Santa Fe, NM
- Department of Indian Affairs
- Senior Health Fairs Espanola and surrounding areas
- VA Hospital ABQ
- Statewide Nurse Advise Line
- Children's Grief Center
- Prevention New Mexico
- New Day Youth and Family Services
- Albuquerque Public Schools
- Los Alamos Police Department
- Los Alamos Working Group on Suicide Awareness and Prevention
- Many individual providers of behavioral health services

III. We have represented NMCAL at conferences, exhibits, events, and presentations, including:

- Exhibit at Head 2 Toe 2013 and upcoming in May 2014

- NMCAL will host a presentation: *Not Another Life to Lose! Lessons from the National Action Alliance for Suicide Prevention's Zero Suicide in Healthcare Initiative* at Head 2 Toe, as presented by Mr. David Covington.

- NAMI Santa Fe, NAMI Walk Albuquerque

- Survivors of Suicide Albuquerque
- CYFD Seminars
- Mental Health First Aid Instructor Summit
- Court, Corrections, and Justice Committee
- Albuquerque PD Crisis Intervention Team
- Public Safety Conference
- Aging and Long-term Services Training
- New Mexico Highlands University Student Training
- UNM Psychiatric Services
- Behavioral Health Day at the Legislature
- Leadership Conference in Taos
- Communities of Care Summit
- NFSP Out of the Darkness Walk

IV. NMCAL was called upon, responded, and was immediately available to support anyone who had been affected by the recent school shooting in Las Cruces, local crises including suicides, wild fires, and provider transitions statewide.

Tab 4

Severe Emotional Disturbance (SED)
CRITERIA CHECKLIST

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

☐ 1. **Age:**

☐ be a person under the age of 18;

OR

☐ be a person between the ages of 18 and 21, who received services prior to the 18th birthday, was diagnosed with a SED, and demonstrates a continued need for services.

☐ 2. **Diagnoses:**

Must meet A *or* B.

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

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

Disorders usually first diagnosed in infancy, childhood, or adolescence

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

☐ Attention-Deficit and Disruptive Behavior Disorders — All included (except NOS Disorder 312.9): 314.00 and 314.01, 314.9, 312.81, 314.82, 314.89, 313.81

☐ Feeding and Eating Disorders of Infancy or Early Childhood: 307.52, 307.53, 307.59

☐ Tic Disorders — All included (except NOS Disorder 307.20): 307.23, 307.22, 307.21

☐ Elimination Disorders: 787.6, 307.7, 307.6

☐ Other Disorders of Infancy, Childhood or Adolescence — All included (except NOS Disorder 313.9): 309.21, 313.23, 313.89, 307.3

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

☐ **Substance-Related Disorders**

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

Other Diagnostic Categories

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

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

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

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

☐ Factitious Disorders: 300.16 (NOS Disorder 300.19 is excluded)

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

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

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

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

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

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

continued on next page

Other Conditions That May Be a Focus of Clinical Attention are excluded and qualifying Axis I primary diagnosis is required.

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

In order to qualify as a complex trauma diagnosis the child must have experienced one of the following traumatic events:

- ☐ Abandoned or neglected;
- ☐ Sexually abused;
- ☐ Sexually exploited;
- ☐ Physically abused;
- ☐ Emotionally abused; or
- ☐ Repeated exposure to domestic violence.

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

☐ 3. **Functional Impairment:**

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

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

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

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

☐ *Functioning in the family:*
Impairment in family function is manifested by a pattern of significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents and/or caretakers (e.g., foster parents),

continued on next page

disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable expectations that may result in removal from the family or its equivalent). Child-caregiver and family characteristics do not include developmentally based adaptive patterns that support social-emotional well-being. For early childhood functioning, major impairments undermine the fundamental foundation of healthy functioning exhibited by:

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

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

☐ 4. **Symptoms:**

Symptoms in one of the following groups:

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

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

☐ *Trauma symptoms:*
Children experiencing or witnessing serious unexpected events that threaten them or others. Children and adolescents who have been exposed to a known single event or series of discrete events experience a disruption in their age-expected range of emotional and social developmental capacities. Such children may experience:

- a disruption in a number of basic capacities such a sleep, eating, elimination, attention, impulse control, and mood patterns
- under-responsivity to sensations and become sensory seeking, physically very active, aggressive and/or antisocial
- under-responsivity to sensations but not sensory seeking and may shut down further and become lethargic or depressed and difficult to arouse
- over-responsivity to sensations and become hypervigilant or demonstrate fear and panic from being overwhelmed
- episodes of recurrent flashbacks or dissociation that present as staring or freezing

☐ 5. **Duration:**

☐ The disability must be expected to persist for six months or longer.

Purchasing Collaborative Meeting Handouts

February 27, 2013

“HEALTHY FAMILIES, SAFE KIDS”

In support of the inclusion of child trauma as a qualifying condition for SED eligibility, note the following three premises, and one suggested method to address the problem:

1. Early childhood trauma of all sorts--physical abuse, emotional abuse, neglect, exposure to domestic violence and molestation--alters crucial brain development in a way that substantially impairs the later capacity for attachment, empathy, impulse control, mood stability, learning, and abstract thinking. It leaves the child vastly more at risk for later conduct problems, antisocial behaviors, severe depression, disabling anxiety, personality disorders and substance abuse. In short, childhood trauma results in a serious and disabling brain disorder.
2. The developmental brain disorder that results from childhood trauma, if untreated and especially if unrecognized, has a huge personal and social cost in terms of later physical illness, low productivity, and other psychiatric disorders. The findings of the ACE Study confirm that adverse childhood experience – i.e. trauma – is the leading cause of illness, death and poor quality of life in the United States. For example, those individuals with Adverse Childhood Experience scores of 4 or more had significantly higher rates of heart disease and diabetes than those with ACE scores of zero. The likelihood of chronic pulmonary lung disease increased 390 percent; hepatitis, 240 percent; depression, 460 percent; suicide, 1,220 percent. Those with an ACE score of 6 had a 4,600 percent increase in the likelihood of becoming an IV drug user. The later consequences of early childhood trauma fill the case loads of psychologists, psychiatrists, social workers, and juvenile probation officers.
3. The results of early childhood trauma can be recognized, quantified and treated. That is, if it is not misdiagnosed as delinquency, ADHD, Bipolar Affective Disorder, learning disability, or simple familial anxiety and depression, and then it is treated with evidence based treatments, the outcome can be greatly improved. This is an ongoing research enterprise.
4. The instrument that Children, Youth and Families has chosen to assess childhood trauma and to create treatment plans specifically addressed to treat it, is the Neurosequential Model of Therapeutics (NMT), which was designed and developed by Bruce Perry, MD, through the Child Trauma Academy. Review the attached NMT Clinical Metric.

Neurosequential Model of Therapeutics : Clinical Metrics

A Brief Introduction:

The Neurosequential Model of Therapeutics (NMT) is an approach to clinical work that incorporates key principles of neurodevelopment into the clinical problem-solving process. The NMT Metrics are tools which provide a semi-structured assessment of important developmental experiences, good and bad, and a current "picture" of brain organization and functioning. From these tools estimates of relative brain-mediated strengths and weaknesses can be derived. This information can aid the clinician in the ongoing therapeutic process.

The results from the NMT Metrics should not be viewed as a stand-alone psychological, neuropsychological, psychiatric or psychoeducational evaluation. These reports are intended to supplement the clinical problem solving process and provide broad direction for the selection and sequencing of developmentally appropriate enrichment, therapeutic and educational activities.

Client Data

Client: Chase
Age: 14 years, 3 months

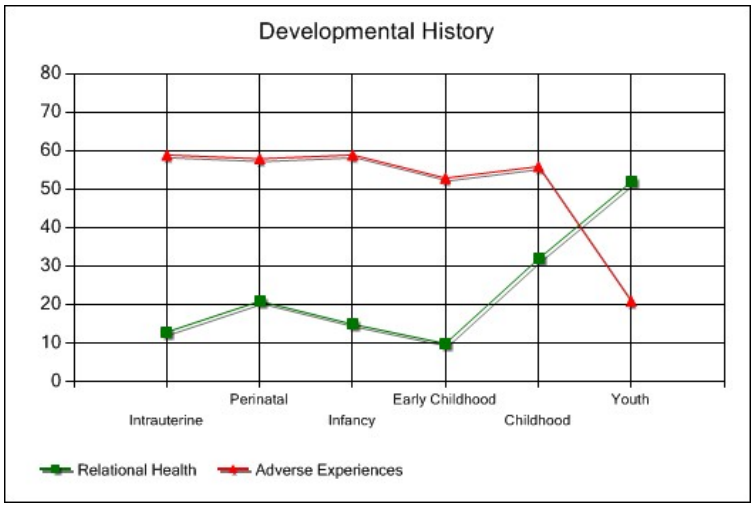
Case ID: slawrence

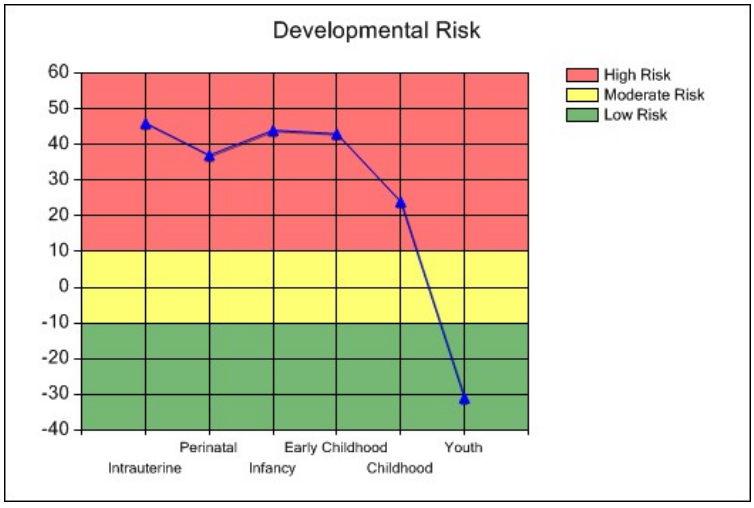
Report Data

Clinician: George Davis
Report Date: 12/4/2010
Time: 1
Site: Albuquerque

Developmental History

A brief introduction





Adverse Experience Confidence: High
Relational Health Confidence: High

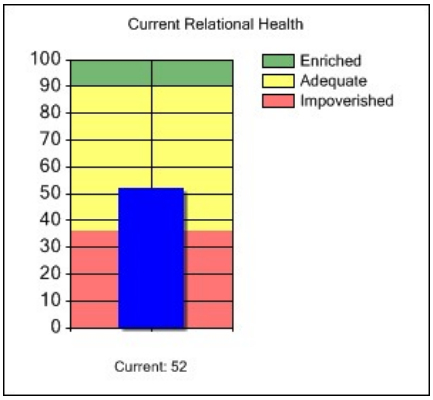
Developmental History Values

	Adverse Events	Relational Health	Developmental Risk
Intrauterine	59	13	46
Perinatal	58	21	37
Infancy	59	15	44
Early Childhood	53	10	43
Childhood	56	32	24
Youth	21	52	-31

Current CNS Functionality

	Brainstem	Client	Typical
1	Cardiovascular/ANS	9	12
2	Autonomic Regulation	6	12
3	Temperature regulation/Metabolism	8	12
4	Extraocular Eye Movements	10	12
5	Suck/Swallow/Gag	4	12
6	Attention/Tracking	4	12
	DE/Cerebellum		
7	Feeding/Appetite	6	12
8	Primary Sensory Integration	4	12
9	Fine Motor Skills	11	12
10	Coordination/Large Motor Functioning	3	11
11	Dissociative Continuum	5	11
12	Arousal Continuum	2	11
13	Neuroendocrine/Hypothalamic	10	11
14	Sleep	3	12
	Limbic		
15	Reward	8	12
16	Affect Regulation/Mood	1	11
17	Attunement	3	11
18	Psychosexual	8	10
19	Relational/Attachment	3	11
20	Short-term memory/Learning	8	12
	Cortex		
21	Somato/Motorsensory Integration	7	12
22	Sense Time/Delay Gratification	2	10
23	Communication Expressive/Receptive	10	12
24	Self Awareness/Self Image	6	10
25	Speech/Articulation	11	12
26	Concrete Cognition	10	11
	Neocortex		
27	Non-verbal Cognition	7	10
28	Modulate Reactivity/Impulsivity	2	10
29	Math/Symbolic Cognition	8	10
30	Reading/Verbal	2	10
31	Abstract/Reflective Cognition	4	10
32	Values/Beliefs/Morality	9	10
	Total	**194**	**358**

Current CNS Confidence Level: High



Current Relational Health Confidence Level: Moderate

Functional Brain Map(s) and Key

Client (14 years, 3 months) **Report Date: 12/4/2010**

4	8	7	2	2	9
11	10	7	2	6	10
3	3	8	1	8	8
	10	5	2	3	
	11	6	4	3	
		4	4		
		8	10		
		9	6		

Age Typical - 14 to 16

10	10	10	10	10	10
12	12	12	10	10	11
11	11	12	11	10	12
	11	11	11	12	
	12	12	12	11	
		12	12		
		12	12		
		12	12		

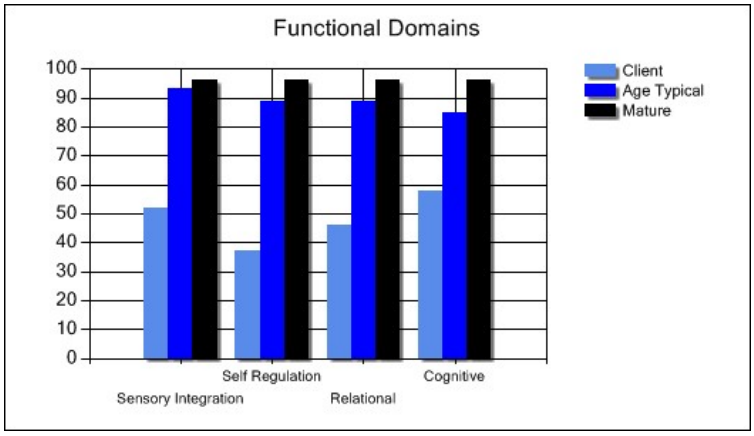
Functional Item Key

ABST (31)	MATH (29)	PERF (27)	MOD (28)	VERB (30)	VAL (32)
SPEECH (25)	COMM (23)	SSI (21)	TIME (22)	SELF (24)	CCOG (26)
REL (19)	ATTU (17)	REW (15)	AFF (16)	SEX (18)	MEM (20)
	NE (13)	DISS (11)	ARS (12)	SLP (14)	
	FMS (9)	FEED (7)	PSI (8)	LMF (10)	
		SSG (5)	ATTN (6)		
		MET (3)	EEOM (4)		
		CV (1)	ANS (2)		

Functional Brain Map Value Key

DEVELOPMENTAL
Functional

12	DEVELOPED
11	TYPICAL RANGE
10	
9	EPISODIC/EMERGING
8	MILD Comprimise
7	
6	PRECURSOR CAPACITY
5	MODERATE Dysfunction
4	
3	UNDEVELOPED
2	SEVERE Dysfunction
1	



Functional Domains Values

	Client Age	Age Typical	Mature	% Age Typical
Sensory Integration	52	93	96	55.91
Self Regulation	37	89	96	41.57
Relational	46	89	96	51.69
Cognitive	58	85	96	68.24
Cortical Modulation Ratio	0.94	9.67	49	9.69

General Summary

Recommendations are based upon data provided by the clinician when completing the NMT online metrics. Based upon the data provided, cut off scores are used to indicate whether activities in each of the 4 areas are considered essential, therapeutic or enrichment. Activities selected for each category should be age appropriate, positive and provided in the context of nurturing, safe relationships.

Essential refers to those activities that are crucial to the child's future growth in this particular area. In order to fall into the essential category the child's score must be below 65% of the age typical score. It is our belief that unless functioning in the essential area is increased the child will lack the foundation for future growth and development in this and other areas.

Therapeutic refers to those activities aimed at building in strength and growth in the particular area. Scores that fall within 65 to 85 percent of those typical for the child's age are considered appropriate for more focused treatment. Therapeutic activities are viewed as important for the child's continued growth and improvement in the area.

Enrichment refers to activities that provide positive, valuable experiences that continue to build capacity in the given area. Children who fall into the enrichment category are at or above 85 percent of age typical functioning. Activities recommended in this category are designed to enhance and reinforce strengths previously built into the particular area of focus.

The information below is designed to provide the clinician with broad recommendations based upon the NMT approach. These recommendations should be used as guidelines for the treating clinician when considering particular therapeutic activities. Final treatment decisions must be based upon the clinical judgement of the treatment provider. The CTA cannot be held responsible for any of the treatment decisions made by the clinician based upon their own interpretation of NMT principles or recommendations.

Sensory Integration

Client Score: 52 Age Typical: 93 Percentage: 55.91

Essential: (below 65%) – Scores below 65% of age typical functioning indicate poorly organized somatosensory systems in the brain. The introduction of patterned, repetitive somatosensory activities weaved throughout the day have been shown to lead to positive improvements. These activities should be provided multiple times each day for approximately 7-8 minutes at a time for essential reorganization to occur. Examples of somatosensory activities include massage (pressure point, Reiki touch), music, movement (swimming, walking/running, jumping, swinging, rocking), yoga/breathing and animal assisted therapy that includes patterned, repetitive activities such as grooming.

Self Regulation

Client Score: 37 Age Typical: 89 Percentage: 41.57

Essential: (below 65%) – Scores below 65% of age typical functioning suggest the child has poor self-regulatory capabilities. These children may have stress-response systems that are poorly organized and hyper-reactive. They are likely impulsive, have difficulties transitioning from one activity to another, and may overreact to even minor stressors or challenges. Children in this category require structure and predictability provided consistently by safe, nurturing adults across settings. Examples of essential activities in this category include: developing transitioning activity (using a song, words or other cues to help prepare the child for the change in activity), patterned, repetitive proprioceptive OT activities such as isometric exercises (chair push-ups, bear hugs while child tries to pull the adults arms away, applying deep pressure), using weighted vests, blankets, ankle weights, various deep breathing techniques, building structure into bedtime rituals, music and movement activities, animal assisted therapy and EMDR.

Relational

Client Score: 46 Age Typical: 89 Percentage: 51.69

Essential: (below 65%) - Scores below 65% of age typical functioning suggest the child has poor relational functioning. Children who have a history of disrupted early caregiving, whose earliest experiences were characterized as chaotic, neglectful, and/or unpredictable often have difficulties forming and maintaining relationships. In order to make sufficient gains in relational functioning, essential activities must include interactions with multiple positive healthy adults who are invested in the child's life and in their treatment. Examples of essential relational activities include: art therapy, individual play therapy, Parent-Child Interaction Therapy (PCIT), dyadic parallel play with an adult, and when mastered, dyadic parallel play with a peer. Once dyadic relationships have been mastered supervised small group activities may be added. Other examples of essential activities include animal assisted therapy and targeted psychotherapy.

Cognitive

Client Score: 58 Age Typical: 85 Percentage: 68.24

Therapeutic: (65% - 85%) – Scores between 65 and 85 percent suggest that the child has some difficulty with cognitive functioning. Once fundamental dyadic relational skills have improved, therapeutic techniques can focus on more verbal and insight oriented or cortical activities. Examples of therapeutic activities include: insight oriented treatment, cognitive behavioral therapy, reading enhancements, and structured storytelling.

Cortical Modulation refers to the capacity of important cortical networks to regulate and modulate the activity and reactivity of some of the lower neural systems. As the brain organizes and matures, this capacity increases and the Cortical Modulation Ratio (CMR) increases. The CMR reflects both cortical "strength" and over-reactivity in lower neural systems involved in the stress response. Any Cortical Modulation Ratio below 1.0 suggests that the individual

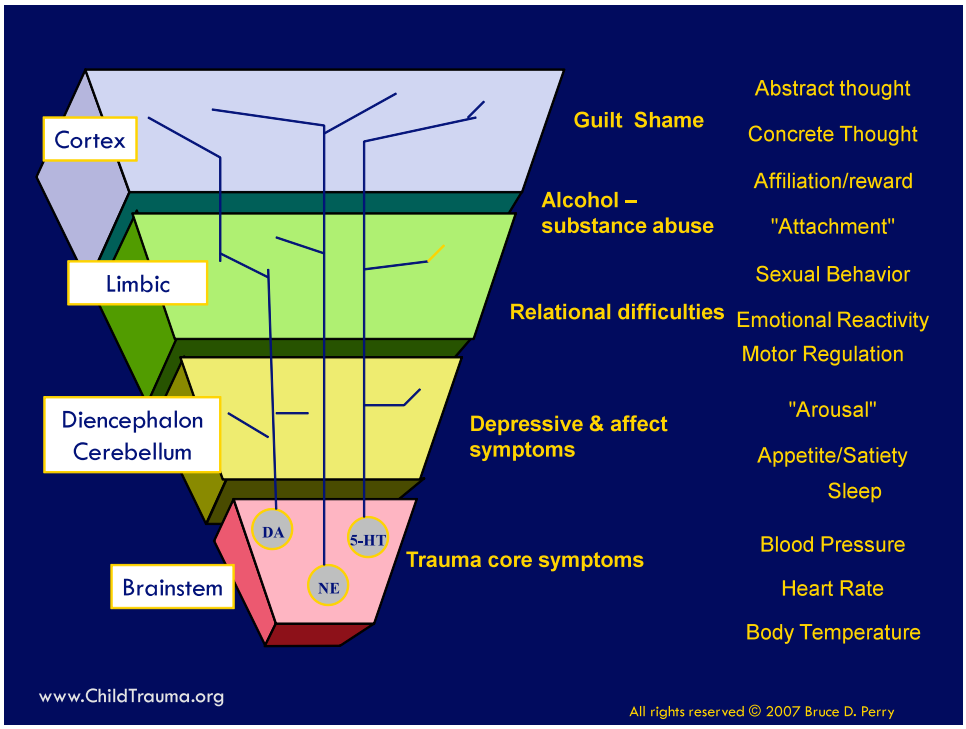


Figure 1. Brain organization and monoamine systems: The human brain has a hierarchical organization. The multiple parallel systems in the brain are organized in various brain regions with the most simple in the brainstem and the most complex in the cortex. While somewhat simplified, it is clear that functional complexity correlates with the organizational complexity of the brain, with the most simple regulatory functions mediated by the lower less complex brainstem and the most complex functions - those functions that confer the most unique human properties - are in the cortex. The brainstem and diecephalic originating monoamine systems (DA: dopamine; NE: norepinephrine: 5-HT: serotonin) project up (and down) throughout the brain.

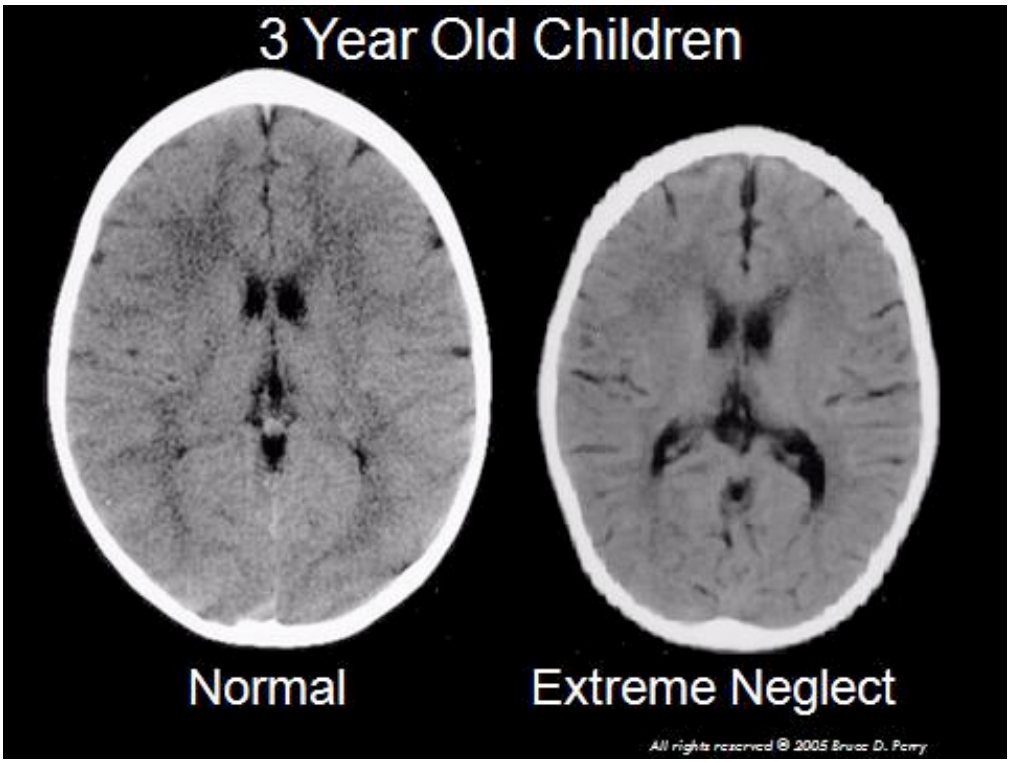


Fig. 2: Impact of neglect on brain development: These images illustrate the impact of neglect on the developing brain. The CT scan on the left is from a healthy three year old child with an average head size (50th percentile). The image on the right is from a three year old child following total global neglect during early childhood. The brain is significantly smaller than average and has abnormal development of cortical, limbic and midbrain structures.

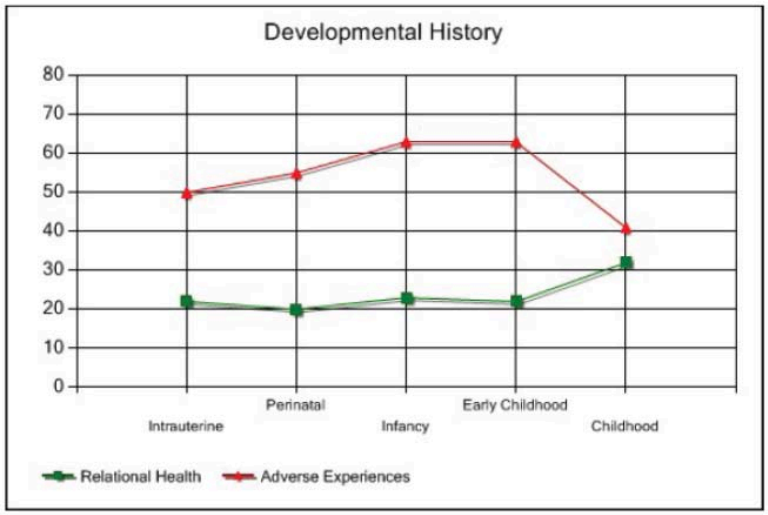
	Event-Related Factors	Individual Characteristics	Family and Social
<u>Increase Risk</u> (Prolong the intensity or duration of the acute stress response)	♦ Multiple or repeated event (in this case, ongoing threat) ♦ Physical injury to child ♦ Involves physical injury or death to loved one, particularly mother ♦ Dismembered or disfigured bodies seen ♦ Destroys home, school or community ♦ Disrupts community infrastructure (as Katrina) ♦ Perpetrator is family member ♦ Long duration, difficult recovery (as in Katrina)	♦ Female ♦ Age (younger more vulnerable) ♦ Subjective perception of physical harm ♦ History of previous exposure to trauma ♦ No cultural or religious anchors ♦ No shared experience with peers (experiential isolation) ♦ Low IQ ♦ Pre-existing neuropsychiatric disorder (especially anxiety related)	♦ Trauma directly impacts caregivers ♦ Anxiety in primary caregivers ♦ Continuing threat and disruption to family ♦ Chaotic, overwhelmed family ♦ Physical isolation ♦ Distant caregiving ♦ Absent caregivers
<u>Decrease Risk</u> (Decrease intensity or duration of the acute stress response)	♦ Single event ♦ Perpetrator is stranger ♦ No disruption of family or community structure ♦ Short duration (e.g., tornado)	♦ Cognitively capable of understanding abstract concepts ♦ Healthy coping skills ♦ Educated about normative post-traumatic responses ♦ Immediate post-traumatic interventions ♦ Strong ties to cultural or religious belief system	♦ Intact, nurturing family supports ♦ Non-traumatized caregivers ♦ Caregivers educated about normative post-traumatic responses ♦ Strong family beliefs ♦ Mature and attuned parenting skills

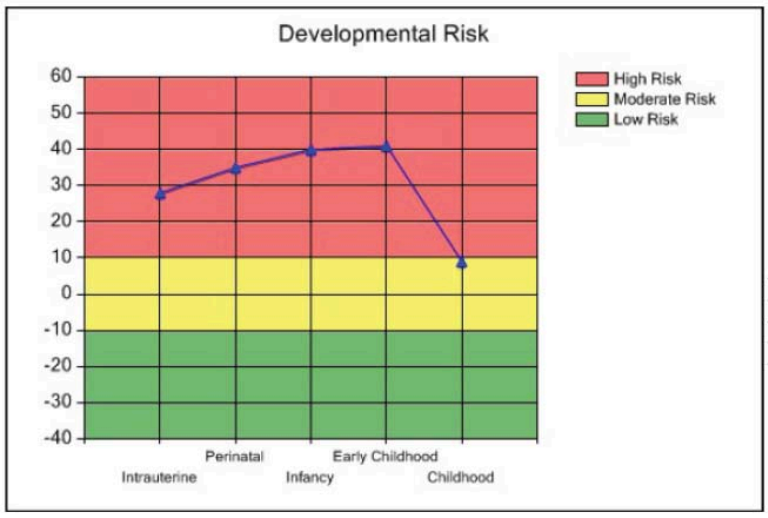
Table 1. Risk and attenuating factors for the development of psychopathology following trauma.

The Neurosequential Model of Therapeutics © as Evidence-based Practice

The Neurosequential Model of Therapeutics (NMT) is a developmentally sensitive, neurobiology-informed approach to clinical problem solving. NMT is not a specific therapeutic technique or intervention. It is an approach that integrates core principles of neurodevelopment and traumatology to inform work with children, families and the communities in which they live. The Neurosequential Approach has three key components – training/capacity building, assessment and then, the specific recommendations for the selection and sequencing of therapeutic, educational and enrichment activities that match the needs and strengths of the individual.

As described by Brandt and colleagues (2012) – *"The Neurosequential Model of Therapeutics (NMT) (Perry, 2006) provides an integrated understanding of the sequencing of neurodevelopment embedded in the experiences of the child, and supports biologically informed practices, programs, and policies. As a global evidence-based practice (EBP) and coupled with the NMT's brain mapping matrix, the model supports providers in identifying specific areas for therapeutic work and in selecting appropriate therapies, including evidence-based therapies (EBTs), within a comprehensive therapeutic plan. Organized NMT-based intervention models, such as NMT therapeutic child care, can be EBTs."*

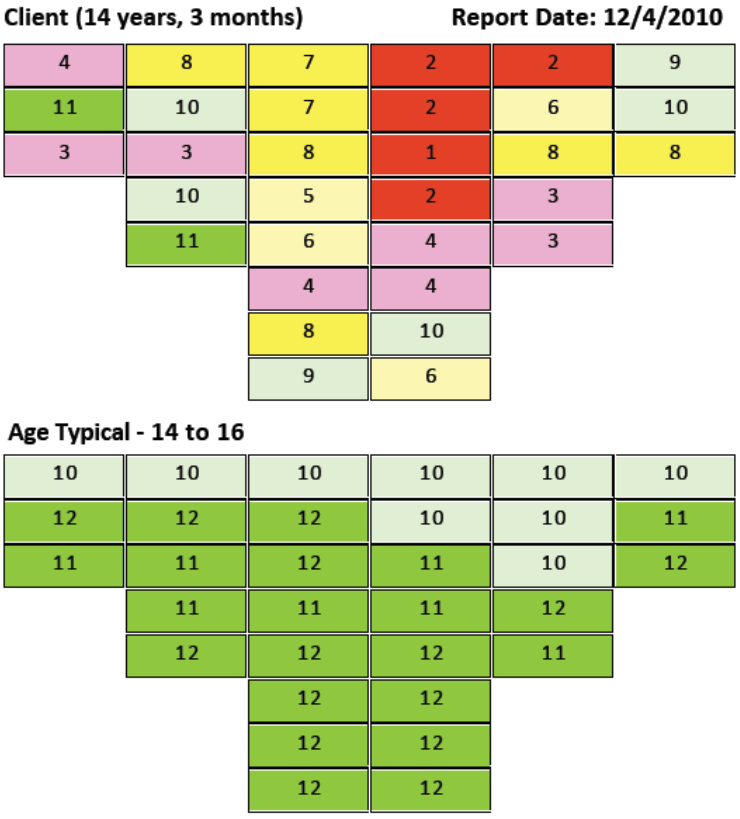




A more detailed overview of the NMT will help articulate why NMT is an EBP. The NMT assessment process examines both past and current experience and functioning. A review of the history of adverse experiences and relational health factors helps create an estimate of the timing and severity of developmental risk that may have influenced brain development (see graph). In the sample graph, both the timing and severity of risk and resilience factors are plotted (top graph) to generate an overall developmental risk estimate (bottom graph). In this case this individual was at high risk for developmental disruptions – with potential significant functional consequences – during the entire first five years of life.

A review of current functioning identifies problems and

strengths in current functioning and helps generate a visual representation of the child's estimated current functioning organized into a neurobiological fashion; this generates a Functional Brain Map (see below). The NMT "mapping" process helps identify various areas in the brain that appear to have functional or developmental problems; in turn, this helps guide the selection and sequencing of developmentally sensitive interventions. These interventions are designed to replicate the normal sequence of development beginning with the lowest, most abnormally functioning parts of the brain (e.g., brainstem) and moving sequentially up the brain as improvement is seen. The NMT is grounded in an awareness of the sequential development of the brain; cortical organization and functioning depend upon previous healthy organization and functioning of lower neural networks originating in the brainstem and diencephalon. Therefore a dysregulated individual (child, youth or adult) will have a difficult time benefiting from educational, caregiving and therapeutic efforts targeted at, or requiring, "higher" cortical networks. This sequential approach is respectful of the normal developmental sequence of both brain development and functional development. Healthy development depends upon a sequential mastery of functions; and a dysregulated individual will be inefficient in mastering any task that requires relational abilities (limbic) and will have a difficult time engaging in more verbal/insight oriented (cortical) therapeutic and educational efforts.



The NMT Web-based Clinical Practice Tools (aka, NMT Metrics) help provide a structured assessment of developmental history of adverse experiences, relational health and current brain-mediated functioning. These NMT Metrics are designed to complement, not replace, existing assessment tools (e.g., CANS, CAFAS) and psychometrics (e.g., CBCL, IES, WISC, WRAT). They are designed to allow use across multiple systems using multiple assessment packages. The primary goal of

the NMT Metrics and assessment is to ensure that the clinical team is organizing the client and family's data (and planning) in a developmentally sensitive and neurobiology-informed manner.

Above is an example of a functional brain "map" produced by the web-based NMT Clinical Practice Application. The top image (with the red squares) corresponds to a client (each box corresponds to brain functions mediated by a region/system in the brain. The map is color coded with red indicating significant problems; yellow indicates moderate compromise and green, fully organized and functionally capable). The bottom map is a comparative map for a "typical" same-aged child. The graphic representations allow a clinician, teacher, or parent to quickly visualize important aspects of a child's history and current status. The information is key in designing developmentally appropriate educational, enrichment and therapeutic experiences to help the child.

This clinical approach helps professionals determine the strengths and vulnerabilities of the child and create an individualized intervention, enrichment and educational plan matched to his/her unique needs. The goal is to find a set of therapeutic activities that meet the child's current needs in various domains of functioning (i.e., social, emotional, cognitive and physical). An individual demonstrating significant problems in brainstem and diencephalic functions may end up with recommended activities that are primarily rhythmic, repetitive and somatosensory in nature such as music, dance, yoga, drumming, various sports, therapeutic massage or more traditional play therapy, sand tray or other art therapies. Later in the treatment process, with improved somatosensory processing and self-regulation, the treatment recommendations would shift to more relational and cognitive-behavioral focused interventions including a range of EBTs such as PCIT or TF-CBT.

NMT Training and Certification

The NMT training and capacity building component (NMT Certification) is a manualized yet flexible process that involves a minimum of 90 hours. Certification incorporates didactic teaching with web-based sessions using clinical cases presented by participating clinicians. It also incorporates multimedia and reading materials that focus on child development, neurobiology, traumatology, attachment theory and a host of related areas relevant to understanding the impact of maltreatment and other developmental insults on the developing child. The CTA has developed an NMT training certification process for individual clinicians and organizations. This training process provides the necessary exposure to the core concepts, practical application and use of the web-based NMT Metrics to establish and maintain fidelity required for examining clinical outcomes and conducting research using the NMT Metrics as part of the evaluation package. Certified clinicians from across the world demonstrate high fidelity and inter-rater reliability when "evaluating" and scoring the same client data.

The NMT is widely applicable to a variety of clinical and educational environments and has been integrated into a variety of settings across the full life cycle – infants through adults - including therapeutic preschools, early head start programs, infant mental health, ECI programs, residential treatment centers, schools and in numerous private and outpatient clinical practices working with young children, youth and adults. Several large public child protective services and child mental health settings have become certified and routinely use the NMT to help guide clinical decision-making.

Evidence-based Practice and the NMT

Over the past decade there has been a movement toward practice accountability from federal, state and foundation funding sources demanding proof of the effectiveness for specific interventions (Austin & Roberts, 2002). This increased interest in accountability has led toward more "evidence-

based" work throughout various disciplines. Similarly, evidence-based medicine (EBM) refers to aspects of medical care in which the scientific method is applied to certain parts of medical practice. It seeks to assess the quality of evidence relevant to the risks and benefits of treatments (including lack of treatment). Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients (Sackett, 1996). The NMT adheres to these principles and as this relatively "young" approach to clinical work is disseminated, an impressive body of evidence is accumulating (see references below); some of this has been published, and much of it is in the process of being prepared for publication.

There are various levels of "evidence" which are to be considered when making the designation of "evidence-based." For example the U.S. Preventive Services Task Force uses the following to ranking evidence about the effectiveness of treatments:

> *Level I: Evidence obtained from at least one properly designed randomized controlled trial.*
> *Level II-1: Evidence obtained from well-designed controlled trials without randomization.*
> *Level II-2: Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group.*
> *Level II-3: Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled trials might also be regarded as this type of evidence.*
> *Level III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.*

The Neurosequential Model of Therapeutics currently meets criteria for Level III, Level II-3, Level II-2 and Level II-1. Several of the NMT Certification Sites have plans for studies that are randomized, controlled trials.

The NMT has the following EBP elements:

1.) Multiple sites participating in NMT Training Certification gather data that is used to determine efficacy of the model. The NMT model in these sites is employed in therapeutic preschools, residential treatment facilities, out-patient clinical settings, and large state child welfare systems. There are several cross-validation projects underway to compare NMT Metrics with a variety of other common metrics (e.g., CAFAS, CBCL, TSC).
2.) There are several reports from independent groups using the NMT that have demonstrated positive outcomes.
3.) All NMT-certified sites have demonstrated improved outcomes (using both NMT and non-NMT metrics such as incident reports, restraints, changes in CAFAS). In cases where the data were collected in systematic fashion these outcomes are statistically significant when compared to previous "treatment as usual" at the same site or organization.
4.) NMT metrics have been shown to be valid (both face valid and cross-validity have been examined) and reliable. There is a network wide inter-rater reliability process and ongoing "ratings meeting" to allow ongoing correction and supervision.
5.) The Certification and training process are manualized.

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For more information visit The ChildTrauma Academy website:
www.ChildTrauma.org

Severe Emotional Disturbance (SED)
CRITERIA CHECKLIST

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

☐ 1. **Age:**

☐ be a person under the age of 18;

OR

☐ be a person between the ages of 18 and 21, who received services prior to the 18th birthday, was diagnosed with a SED, and demonstrates a continued need for services.

☐ 2. **Diagnoses:**

Must meet A *or* B.

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

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

Disorders usually first diagnosed in infancy, childhood, or adolescence

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

☐ Attention-Deficit and Disruptive Behavior Disorders — All included (except NOS Disorder 312.9): 314.00 and 314.01, 314.9, 312.81, 314.82, 314.89, 313.81

☐ Feeding and Eating Disorders of Infancy or Early Childhood: 307.52, 307.53, 307.59

☐ Tic Disorders — All included (except NOS Disorder 307.20): 307.23, 307.22, 307.21

☐ Elimination Disorders: 787.6, 307.7, 307.6

☐ Other Disorders of Infancy, Childhood or Adolescence — All included (except NOS Disorder 313.9): 309.21, 313.23, 313.89, 307.3

continued on next page

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

☐ **Substance-Related Disorders**

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

Other Diagnostic Categories

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

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

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

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

☐ Factitious Disorders: 300.16 (NOS Disorder 300.19 is excluded)

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

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

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

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

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

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

continued on next page

Other Conditions That May Be a Focus of Clinical Attention are excluded and qualifying Axis I primary diagnosis is required.

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

In order to qualify as a complex trauma diagnosis the child must have experienced one of the following traumatic events:

- ☐ Abandoned or neglected;
- ☐ Sexually abused;
- ☐ Sexually exploited;
- ☐ Physically abused;
- ☐ Emotionally abused; or
- ☐ Repeated exposure to domestic violence.

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

☐ 3. **Functional Impairment:**

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

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

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

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

☐ *Functioning in the family:*
Impairment in family function is manifested by a pattern of significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents and/or caretakers (e.g., foster parents),

continued on next page

disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable expectations that may result in removal from the family or its equivalent). Child-caregiver and family characteristics do not include developmentally based adaptive patterns that support social-emotional well-being. For early childhood functioning, major impairments undermine the fundamental foundation of healthy functioning exhibited by:

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

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

☐ 4. **Symptoms:**

Symptoms in one of the following groups:

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

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

☐ *Trauma symptoms:*
Children experiencing or witnessing serious unexpected events that threaten them or others. Children and adolescents who have been exposed to a known single event or series of discrete events experience a disruption in their age-expected range of emotional and social developmental capacities. Such children may experience:

- a disruption in a number of basic capacities such a sleep, eating, elimination, attention, impulse control, and mood patterns
- under-responsivity to sensations and become sensory seeking, physically very active, aggressive and/or antisocial
- under-responsivity to sensations but not sensory seeking and may shut down further and become lethargic or depressed and difficult to arouse
- over-responsivity to sensations and become hypervigilant or demonstrate fear and panic from being overwhelmed
- episodes of recurrent flashbacks or dissociation that present as staring or freezing

☐ 5. **Duration:**

☐ The disability must be expected to persist for six months or longer.

Tab 5

No handouts available.

Tab 6

BEHAVIORAL HEALTH PLANNING COUNCIL REPORT
TO THE PURCHASING COLLABORATIVE
2/27/14

SENATE MEMORIAL 79

This memorial passed through the Senate Public Affairs Committee and the full Senate without any votes in opposition.

The Council as it now exists was created as part of an initiative that emphasized collaboration on all levels – Local Collaboratives were formed as well as the Purchasing Collaborative. The Council was able to help bring information and ideas from all over the state, by means of the LC's, to the Collaborative. I would say that, over time, the LC's and the Collaborative have become less invested in those collaborative efforts, either at the state level, or at the local level.

The memorial is an effort to help local communities develop the partnerships they need to address the issues that they find themselves facing. We'd also like to enhance the existing partnerships: LCs, Communities of Care, and a number of other such efforts, by helping them connect with new members of their communities who might help them identify and address local problems.

Central to all of this is that the voices of the people affected, Consumers, Family Members and Youth, play a vital role in these community partnerships. Our experience over the last decade with LC's and with Systems of Care means we have lots of experience with helping those voices effectively inform the systems they are involved with. We know what the benefits are and we know the frustration people experience when their voices aren't heard.

The memorial calls for a specific list of groups that represent the local partners we would like to bring together. We will be working closely with the Local Collaborative Alliance to plan the task force's meetings. We are also asking for your support in this as we move ahead in this effort.

CENTENNIAL CARE

We have been learning about these first couple of months of the implementation of Centennial Care. We have heard about the statewide efforts being made for those who are newly qualified for Medicaid to get signed up. We are learning about some confusion in transferring over from the old system and about people finding themselves in Family Planning while they wait for the system to properly assign them. We are hearing concern over whether our providers can manage, or even survive with any break in payments as they work with the new MCO's billing systems. We are also happy to hear that there haven't been large numbers of access-related crises for Behavioral Health Medicaid folks as the transition has been unfolding.

We are trying to understand how the new care coordination service will be impacting people. We heard reports about how people were experiencing assessments, both from

the consumer's side and the providers' side, and we understand them to be time consuming and, hopefully, effective in guiding consumer care. And we are interested in learning about, and advising on, how the care coordination people from the MCO's will be coordinating efforts with the staff at the CSA's on individual cases.

MEMBERSHIP

Another member of our Council, Chris Wendel, has resigned. She was most recently our Vice Chair, but was the Chair of the Council for four years before I was elected to the position. She has had a tremendous impact on our work, making us a highly functional organization, and has been an inspiration in many ways, not just for me, but I think, for most of us who have had the opportunity to work with her. She will continue to work on our Mapping project, and will be a member of the Substance Abuse subcommittee, but plans on working on other efforts to help the recovery community besides the Council's work.

SUBCOMMITTEES

Adult, Substance Abuse, and Medicaid – Much of what these committees have been doing has been discussed already, as it has focused primarily on Centennial Care and the changes it brings.

Children and Adolescent – Has had discussion in preparation for providing feedback on the Children's Law Code, led by Valerie Palombi, and presentations on last year's Youth and Family Satisfaction Survey. There have been discussions on how to structure Communities of Care for effective family voice. And the Committee has been looking back at its priorities to identify progress and to make sure they are not overlooked.

The Native American Subcommittee – There have been presentations on Centennial Care and the NMHIX and Native American enrollment concerns. There was a presentation on elder abuse.

BH DAY / AWARDS DINNER – Behavioral Health Day at the Legislature and the Awards Dinner the night before went very well. We honored Nancy Passikov with our Lifetime Achievement award, a dog named Emma with the John Henry award, and 12 community Stars from our Local Collaboratives.

MAPPING – Work continues on this with the Aging and Long Term Services folks.

ATTACHMENTS:

BUDGET VARIANCE (January 31, 2014)

Local Collaborative Alliance

Integrating Communities in Behavioral Health Sponsorship Application

Date_____Amount Requested_____

Name of Organization_____

Contact Person_____E-mail_____

Organization Address_____

Phone_____website_____

Tax ID Number_____

Event Date_____

Describe the Event/Program:_____
_____
_____
_____

How does this event/program connect to Local Collaborative Alliance goal of fostering recovery and resiliency, improving Behavioral health, or promoting local community efforts?

_____
_____
_____
_____
_____

How will Local Collaborative &/or Local Collaborative Alliance be recognized as a sponsor?

_____
_____
_____
_____

Fax or e-mail this form to:
Attn: LC Alliance Integrating Communities in Behavioral Health
Fax: 505-827-1606
E-mail: rebecca.ballantine@comcast.net Patricia.gallegos@state.nm.us

LOCAL COLLABORATIVE # _____
PROGRESS REPORT TO THE Local Collaborative Alliance – FY14

Date:
Report provided by:

Business Items conducted at local collaborative meetings this quarter

Ongoing concerns, issues, etc. that this local collaborative is addressing include: concerns which the LC is addressing in collaboration other organizations

Special projects of your Local Collaborative currently (e.g. Mental Health 1st Aid, Communities of Care, Local Initiatives)

Presentations, Planning , Training or Technical Assistance needed by Local Collaborative/community overall.

Adjustments made by the LC to the budget during the quarter to extend the available funding.

Other:

Budget to date: $_____
($ amount; demonstrates how funding was spent on above projects)

February 2014

Local Collaborative Alliance Logo Contest

LCA

Date: March 31,2014

Time: 5:00 p.m.

Contact person: Deb Clark
vincedeb@live.com or Patricia Gallegos
patricia.gallegos@state.nm.us

Local Collaborative Alliance would like to invite you to design its Logo! This is your chance to be creative and join the competition. We need you! Show us what you've got.

The mission of the Local Collaborative Alliance (LCA) is to support the active participation of the communities of New Mexico regarding behavioral health services; and to forge a relationship between the Behavioral Health Collaborative and the local Communities to enhance and protect their voice through providing, and creating continuity.

Good afternoon,

I have received several requests from LC Alliance, MCO reps and individuals for meeting dates, locations, and names of LC (local collaborative) chairs or contacts to attend local community meetings. The LC Alliance Leadership would like to schedule time with LC's to visit face to face and have a conversation about your activities, concerns and technical assistance needs. They have a interest in responding to your requests and would like to share the mission of the LC Alliance to support the active participation of the communities of New Mexico regarding behavioral health services; and to forge a relationship between the BH Collaborative and the local communities to enhance and protect their voice through providing, and creating continuity. The LC Alliance is composed of all the existing LCs and active communities still involved in promoting behavioral health initiatives.

LC Alliance has reviewed and approved budget request for LCs 1, 3, 4, 5, 6, 8, 10, 11, 16, and 17 for $1,500.00. I would recommend that you contact Rick Vigil, & or Susy Ashcroft the co chairs of the LC Alliance, to ask how to participate in their regular meetings. *Please complete the attached LC Contact Information Sheet and return to me* so we can begin to communicate and further develop a relationship per the LC Alliance mission.

LC Alliance co-chairs: Rick's email is rvigil@puebllooftesuque.org. & Susy's email is skash52@hotmail.com

The LC Alliance Finance Committee co-chairs: Ferman Ulibarri ferman@bacavalley.com & Becky Ballantine rebecca.ballantine@comcast.net

The LC Alliance Operations lead is Deb Clark at vincedeb@live.com.

Patricia M. Gallegos, LMSW
Community Service Manager
DOH Health Systems Bureau Office of Primary Rural Health
1190 St. Frances SF NM 87502
Office: 505-827-2316
Fax: 505-827-1606

Your heart and mind are very old friends :)

LC# _____Contact Information Sheet -2014

LC Contact Name(s) (Leadership and Authorized LC Finance Representative)	**Email Address**	**Telephone Contact #**

When and where does your LC meet? Please specify dates and times.

Please return to Patricia Gallegos at patricia.gallegos@state.nm.us or FAX: 505-827-1606. If you have questions contact Patricia at 505-827-2316 or Natalie at Natalie.rivera2@state.nm.us or 505-476-9265

For More Information:

Rick Vigil Co-Chair
Local Collaborative Alliance
rvigil@puebloofesuque.org

Susy Ashcroft Co-Chair
Local Collaborative Alliance
skash52@hotmail.com

Deb Clark, Chair Operations Committee
vincedeb@live.com

Ferman Ulibarri
Co-Chair Finance Committee
ferman@bacavalley.com

Becky Ballantine
Co-Chair Finance Committee
rebecca.ballantine@comcast.net

Patricia Gallegos, Community Service Manager - DOH
Patricia.gallegos@state.nm.us

New Mexico Local Collaborative Alliance

Office: 505.476.9256
Fax: 505.476.9277

Human Services Department
37 Plaza La Prensa
Santa Fe, NM 87507

LOCAL COLLABORATIVE ALLIANCE

Do you have an interest in mental illnesses, developmental disabilities, recovery from substance abuse, or other behavioral health services?

Want to improve behavioral health services in your area?

Want to promote local community efforts?

BEHAVIORAL HEALTH LOCAL COLLABORATIVES:

THERE ARE 18 LOCAL COLLABORATIVES (OR LCS) AROUND THE STATE. THEIR PURPOSE is to develop strong local voices to guide behavioral health planning and services.

Local Collaboratives are a vital forum for the voice of the people of New Mexico who utilize behavioral health services.

Each Local Collaborative is asked to look at prevention, early intervention, health promotion, wellness, education and personal health responsibility, as well as workforce initiatives, facility infrastructure, and licensing and credentialing.

Local Collaborative Alliance (LCA)

The mission of the LC Alliance is to support the active participation of the communities of New Mexico regarding behavioral health services; and to forge a relationship between the BH collaborative and the local Communities to enhance and protect their voice through providing, and creating continuity.

It is the vision of the LC alliance to:

- To create a forum for the voice of the people of New Mexico who utilize behavioral health services.
- Support and assist in the creation of healthy pathways and systems for local Communities by promoting engagement and input into their needs.
- Assure that cultural appropriateness is used in all administration of services and to include representatives from all the Communities of New Mexico.
- Support collaboration in local Community efforts to bring people together and to assist their development and sustainability.
- Bring the voice of the people to the governmental agencies that monitor and provide programming to ensure that the resources are efficiently and effectively used.

LCA Goals

- **Connectivity**
- The LC Alliance will endeavor to connect the Local Collaborative and the communities and constituents they represent so as to provide support and provide a point of interaction to connect the needs of the community members. In providing this connectivity it will provide information which affects the communities and their purposes.
- **Inclusion**
- Through meetings and information sharing which affect all LC's, the Alliance will provide for communication, notice, and membership to those interested in participating
- **Sustainability**
- The Alliance will advocate for and equitably make available any resources meant for their purpose; they will reach out to agencies and providers that are able to assist with the needs.

LCA welcomes **ALL** Local Collaborative & Community members to our monthly meetings where we provide opportunities to pool resources and share information

Collaborate with the City, County & State to make **YOUR VOICE** heard

Please JOIN US and make YOUR VOICE heard!

For more information, contact Patricia Gallegos 505-827-2316 or any of LCA Officers

Local Collaborative Alliance

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The Executive team consists of two co-chairs Rick Vigil and Susy Ashcroft; two Finance Committee co-chairs Ferman Ulibarri and Becky Ballantine; and the LCA Operations Committee chair Deb Clark and staff support provided by Patricia Gallegos, Community Service Manager Department of Health. The LC Alliance is composed of all the existing LCs and active communities still involved in promoting behavioral health initiatives.

- LC Alliance Brochure drafted to include Mission, Vision and the LCA Logo contest is underway.
- LC Alliance has reviewed and approved budget request for LCs 1, 3, 4, 5, 6, 8, 10, 11, 16, and 17 for $1,500.00. LC's are required to report quarterly (attached is quarterly report template).
- The LCA Co-Chair Rick Vigil presented for the Alliance at BH Day at the Capital – LCA had an exhibit table at BH Day at the Legislature as well as Tribal Day at the Capital acting as a clearinghouse for recruitment to LC across the state. LC Alliance in partnership with the BHPC to create a statewide Task Force SM79 was passed pending signatures.
- LCA has established an Integrated Community in BH sponsorship mini-grant Application. Applicants must be LC's or be approved by LC's. (Amount to be discussed further at next LCA meeting).
- The LC Alliance Leadership will be conducting outreach & empowerment face to face conversations about LC activities, concerns and technical assistance needs. The Alliance is interested in local efforts & would like to share the mission of the LC Alliance to support the active participation of the communities of New Mexico.
- LC Contact Sheets are being requested by LC Alliance with contact information for each LC Leadership, dates, times and Location of Local Collaborative meetings.

Rick Vigil, Co-Chair Susy Ashcroft, Co-Chair Ferman Ulibarri, Finance Committee Co-Chair, Becky Ballantine, Finance Committee Co-Chair, Deb Clark Operations Committee Chair, Staff Support Patricia Gallegos, Community Service Manager DOH

LOCAL COLLABORATIVE # ___8___
PROGRESS REPORT TO THE Local Collaborative Alliance – FY14

Date: 02/24/2014
Report provided by: Ferman Ulibarri

Business Items conducted at local collaborative meetings this quarter

*LC8 Budget Reports
*Discussion on Centennial Care, Client Care and the MCO's
*Reporting on Taos Crisis System of Care Initiative – replication
*Reporting from the CSA's
*Begin Planning for Annual LC8 Conference
*The role/duties for Optum NM
*TCA grant application

Ongoing concerns, issues, etc. that this local collaborative is addressing include: concerns which the LC is addressing in collaboration other organizations

*How all of the recent changes are affecting client care.
*The affect of the Arizona companies having on client care.
*The changes on the TCA funding – removal of all of the community initiatives.

Special projects of your Local Collaborative currently (e.g. Mental Health 1st Aid, Communities of Care, Local Initiatives)

*Taos Crisis System of Care
*Behavioral Health Day at the Legislature nominees/winners Kim Hamstra (Tri-County Community Services) Taos Crisis System of Care and Nancy Passikoff, Life Time Achievement Award
*Mental Health Day
*Working to help establish LC State Alliance
*Apply for Mental Health 1st in the TCA grant but it was removed

Presentations, Planning , Training or Technical Assistance needed by Local Collaborative/community overall.

*This will be part of our annual conference

Adjustments made by the LC to the budget during the quarter to extend the available funding. Not Applicable

Other:

Budget to date: $____3,655.26____
($ amount; demonstrates how funding was spent on above projects)

*Consumer Stipends
*Computer Repair
*LC8 Representative Travel
*Food for meetings
*LC8 Administrative Aide (minutes, communication with LC8 members, etc.)

February 2014

Tab 7

No handouts available.