New Mexico Behavioral Health Collaborative Meeting

Thursday, July 14, 2016

Human Services Department
37 Plaza la Prensa
Santa Fe, NM

Video Conference Sites

Las Cruces CSED
Roswell CSED
Clovis CSED

New Mexico Behavioral Health Collaborative

Lynn Gallagher
Department of Health
Secretary Designate – Collaborative Co-Chair

Brent Earnest
NM Human Services Department
Secretary – Collaborative Co-Chair

Thursday, July 14, 2016
37 Plaza La Prensa
Santa Fe, New Mexico
1:00 p.m. – 5:00 p.m.

AGENDA

1. 1:00 – 1:15 p.m. **Call to Order**
   - Introduction of Collaborative Members/Recognize Remote Sites
   - Review/Approval of Minutes from April 14, 2016
2. 1:15 – 1:30 p.m. **Dr. Wayne Lindstrom, CEO Report**
3. 1:30 – 1:35 p.m. **Action Items:**
   BH Collaborative Strategic Plan 2016 -2018
4. 1:35 – 1:50 p.m. **BH Strategic Plan Implementation Update**
   Dr. Betty Downes, BHSD
5. 1:50 – 2:20 p.m. **Ten Years of Supportive Housing**
   Cynthia Melugin and Karen Meador, JD, BHSD
   Carol Luna-Anderson, CEO, LifeLink
   Rose Baca-Quesada, MFA
   Peer Representative
6. 2:20 – 2:35 p.m. **Centennial Care Update**
   Nancy Smith Leslie, MAD
7. 2:35 – 3:00 p.m. **Certified Community Behavioral Health Clinics Progress**
   Teresa Gomez, CCBHC Project Director
8. 3:00 – 4:00 p.m. **PAX Good Behavior Game Implementation and Results**
   Dr. Dennis Embry
9. 4:00 – 4:15 p.m. **Behavioral Health Planning Council (BHPC) Report**
   Carol Luna-Anderson, Co-Chair, Behavioral Health Planning Council
10. 4:15 – 4:30 p.m. **Local Collaborative Alliance Update**
    Rick Vigil, LCA Chair
11. 4:30 – 5:00 p.m. **Public Comment**
    Adjourn

Draft Meeting Minutes

New Mexico Behavioral Health Collaborative

April 14, 2016 · 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.newmexico.networkofcare.org/mh and www.bhc.state.nm.us

Topic	Discussion
Video Conferencing Sites	Farmington CSED, Las Cruces CSED, Roswell CSED, and Clovis CSED
Present were:	Brent Earnest/HSD, Monique Jacobson/CYFD, Lisa Lujan/DOH, Dr. Wayne Lindstrom/BHSD, Miles Copeland/ALTSD, Matt Kennicott/DOT, Rose Baca-Quesada/MFA, Karen Peterson/GCD, Ashley Garcia/PED, Tom Clifford/DFA, Heidie Todacheene/IAD Michelle Casias/NMHED, Richard Blair, DFA
1. Call to Order Review/Approval of Minutes	Brent Earnest, Chair, called the meeting to order at 1:00 p.m. • Introduction of Behavioral Health Collaborative Members • Since the last time we met, we have lost a member of the collaborative. We very much miss Retta Ward; I would like to have a brief moment of silence now. Thank you very much. • Introduction of participants and Video Sites-if any one joins us we will introduce them. • Any changes to minutes or agenda-No changes requested. Handout-DRAFT Meeting Minutes, New Mexico Behavioral Health Collaborative Meeting – April 14, 2016. A **MOTION** was made Secretary Miles Copeland and seconded by Secretary Tom Clifford to approve the minutes from April 14, 2016, Behavioral Health Collaborative Meeting. The **MOTION** was **PASSED** unanimously.
2. Behavioral Health Director and CEO Report	Dr. Wayne Lindstrom, CEO ➢ Strategic Plan: • The Strategic Plan is not on the agenda as an action item to be voted on. ▪ The Strategic plan will be an action item on the next Quarterly Collaborative Meeting. ▪ We are proceeding with the implementation plan and we have a presentation today with an update. • Agave Health ▪ April 1, 2016 Agave Health Issued their 90 day termination notice. ▪ Immediately called a meeting with payors to work collaboratively to plan transition services in an orderly and structured way to ensure that this is as seamless a transition as possible.

- .
- A workgroup has been put together to develop a RFI to quickly identify a provider organization in a given community service area that is potentially a good fit to assume Agave Health's service location(s) and staff and thereby keep active cases with the particular clinician and/or clinical services they were receiving . There are a number of candidates coming forward who are interested in assuming the services of Agave Health.
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- This has been considered an equitable methodology to select which providers will be able to take on the additional services in the respective service areas.
- Agave Health has operated in 12 different locations in 10 counties
- Agave Health did not provide an option to stagger the transition; it will be exiting NM within the 90 day time frame.

- Jeff Hunt, Oxford House
  - Oxford House is an ideal model because people that have initiated recovery and don't have a residence can in fact live in a self-governing environment. Residents gain employment within two weeks of residence
  - 17 Oxford Houses in NM with no cost to the public .
  - Jeff Hunt said he can no longer maintain a referral base that is adequate to sustain the houses and has a 75% vacancy rate in the houses. He is challenged to get residents employed. I would hate to lose this resource that we has been built over the last couple years.
  - Need providers to make referrals to Oxford House and Oxford House needs to partner with employment resources at the state and local communities levels to provide employment opportunities for Oxford House residents.
- Behavioral Health/Health Homes- we have launched two Behavioral Health/Health Homes.
- Behavioral Health Investment Zones
  - Rio Arriba County and McKinley County both submitted applications and the grants have been awarded.
- PAX Good Behavior Game
  - Long term outcomes include better graduation rates, reducing high school dropout rates, reducing disciplinary actions, etc.
  - Over 4500 children have been introduced to the Good Behavior Games.
  - Students and teachers fill out tootles which are expressions of gratitude either to their peers, to teachers, custodians, and/or food service staff, etc.
  - Tootles were passed out to the members of the Collaborative from teachers who have been trained in PAX Good Behavior Games.
  -
- Certified Community Behavioral Health Clinics (CCBHC)-There will be a presentation at the next Collaborative meeting to show the progress that has been made. Dr. Lindstrom thanked Theresa Gomez, Project Manager who oversees the project and her team
- Dose of Reality Public Awareness Campaign
  - Raised awareness in the overdose of prescription drugs and the opioid problem in the State
  - Increased awareness of naloxone, a medication used to reverse the effects of an opioid overdose.
  - Press conference in Albuquerque with City Counselor Diane Gibson and the Transit Authority. Posters are not on the

exterior and interior of the busses and at the bus stops in Bernalillo County. There are also publications at bus shelters, inside public busses and in community centers.

- FY 16 Withdrawn Initiatives due to State Budget Crisis
  - Prescription drug collection boxes, prescription drug incinerators, Mobile Crisis Response Teams, NM Supported Employment BH Center of Excellence, and NM Peer Empowerment Center,
  - Behavioral Health Planning Council (BPHC)-additional funding
  - Local Collaborative Alliance (LCA)-additional funding
  - Mesilla Valley Hospital Addiction Recovery Center-supported expansion of services

Dr. Wayne Lindstrom's report will be posted on the NM Network of Care and Behavioral Health Collaborative Website

3. Pull Together

Monique Jacobson, CYFD Cabinet Secretary

- CYFD Mission Statement-Improving the quality of life for our children.
  - Quality of Life
    - Be alive-prevent preventable fatalities
    - Be safe-children have to feel safe
    - Be nurtured-children must be cared for and loved. Create human connections.
    - Be a contributing member of society-preparing children to be contributing members of society.
    - Have connections
  - Strategic Planks
    - Shore up our core functions-go back to basics.
    - Prevention-as an agency we do as much as we can to prevent tragedies from occurring as we are as quick to respond.
    - Improve communications with law enforcement-work with and cross train with local law enforcement
    - Financial controls
    - Community engagement-if we really want to make a difference in the lives of the kids in New Mexico it takes community engagement
  - How do we engage all New Mexicans in our fight to decrease child abuse and make New Mexico the best place to be a kid?
    - Change people's minds
    - Make it easier to be a parent
  - Why does child abuse exist?
    - Poverty, substance abuse, mental health issues, etc.
  - Make New Mexico the best place to be a kid. We need to start shifting our mindset in regards to our responsibility to our children.
- Pull Together-we are working with the mindset pool and we are also working on how we can simplify how people navigate existing services. We can make New Mexico the best place to live and we can Pull Together. https://pulltogether.org/

"THE WORLD IS CHANGED BY YOUR EXAMPLE NOT BY YOUR OPINION"

Secretary Jacobson's report will be posted on the NM Network of Care and Behavioral Health Collaborative Website

4. Centennial Care

Nancy Smith-Leslie, MAD
Karen Meador, BHSD

- Centennial Care Enrollment - 662,205 total members in Managed Care.
  - Utilization Data (per 1,000 members)-Behavioral Health Services-All Populations
    - Service Grouping
      - Inpatient admissions - .05 admissions per member per year, inpatient days-3 days,
      - BH Practitioner services - 1/2 visit per person per year,
      - Core Service Agency services - .45 per member per year,
      - BH outpatient/clinic - 2.12 services, pharmacy 1.9 scripts.
    - Pharmacy Classification
      - Script utilization for the BH population is 6% for Brand and 94% for generic.
- FY 17 Cost Containment - $85 million deficit in SGF. Total deficit is $417 million to be cut from Medicaid expenditures in FT17.
  - Medicaid Advisory Committee Members-Subcommittees
    - Provider Payments Cost-Containment Subcommittee
      - Target $30 million in payment reductions. Subcommittee came up with approximately $20 million. (recommendations are available online on the website)
      - HSD will be reviewing recommendations and will propose the final decisions by either rule promulgations or submission of state plan amendments to CMS
      - After submission the public will be able to comment
      - Committee will continue to meet
    - Benefit Package, Eligibility Verification and Recipient Cost-Sharing Subcommittee
      - Members will be appointed
      - Recommendations will be submitted for achieving cost saving in Medicaid benefits, eligibility verification measures and recipient cost sharing, including premiums.
    - Long Term Leveraging Strategies Subcommittee
      - Currently being appointed
      - Recommendations for longer-term innovative strategies, including ways to leverage Medicaid differently

- MCO Administrative Reductions and Contract Changes
  - January 1, 2016 - MCO capitation rates changes with increases in some cohorts and decreases in others for net reduction of 3.4%
  - Changes to care coordination programs
  - Changes to member rewards program to reduce administration costs.
  - Estimated savings of a total of $15 million.

- Contract Changes: 2016 Delivery System Improvement Targets
  - New measure in Behavioral Health - 7 day follow up visits into community based BH care for child and for adult members released from inpatient psychiatric hospitalization.
- Health Home Implementation
  - Target Populations: adults with serious mental illness (SMI) and children with severe emotional disturbance (SED)
  - State Plan Amendment was submitted to CMS for approval. The amendment was approved on March 16, 2016.
  - Implementation date was April 1, 2016
  - San Juan and Curry Counties are the two counties in which Health Homes have been implemented.
  - Two health homes who applied and were accepted were Presbyterian Medical Services in San Juan County and Mental Health Resources (MHR) in Curry County. The two are reaching out to potential Health Home members by letters, telephonically, and by members who have come into their offices.
  - In the first couple of days that the Health Homes were operational MHR has enrolled 97 members who have chosen to be Health Home members.
  - Estimate enrollment by end of 2016 – 800 members.
- Care Coordination for Jail-Involved
  - Molina has taken the lead in care coordination for the jail and has initiated a pilot project with Bernalillo Detention Center
  - Video conference technology is being used to connect with the care coordinator. The care coordinator can get the referrals and start getting services in place with inmates prior to release.
  - The goal is to have all MCO's participating by the end of this calendar year on this project.
- Pilot Project on Super-Utilizers
  - MCO's reviewed the top ten super utilizers of the emergency room.
  - MCO's were asked to implement interventions to reduce ED Utilizers for the top 10 members and develop recommendations for better management of super utilizers. There has been significant reduction on EDU since the launch in July thru December 2015.
- MCO Efforts to Reduce ER Visits
  - Workgroups that include the NM Hospital Association
  - Community Health Workers are being used to identify high ER utilizers.
  - EMT Technicians visit members in their homes who have a high utilization of the ER
  - Purchasing EDIE software where we receive instant notifications when a member is in the emergency room. The Care Coordinator will be notified and can start working with the member right away.
  - Launching of "Video Visits" which is an app that can be accessed through their smart phones.

Dr. Lindstrom: On contract changes, I think a significant change particularly for our BH is the delegation of care coordination. This is an opportunity for the MCO's to push care coordination down to the ground level where services are being provided. I think this will be a significant development.

Secretary Earnest: The only thing that I would add is, as we move forward, is how do we focus on the short term challenge of meeting insufficient budget for a program that is projected to grow while keeping an eye on the long term goals overall of producing better outcomes at lower costs.

Mr.Blair: On the rollout of the super utilizer project you addressed the top 10 utilizers of the emergency department. Were only the top ten utilizers addressed and were these sent out to all the MCO's?
Ms. Smith-Leslie: Yes, we only focused on the top ten utilizers. Given the impact we have made, we are planning on focusing next on the top 25 utilizers. We have purchased software that we are usingthat will allow us to look deeper into those areas and see who is costing more money.
Mr. Blair: It is not just Behavioral Health? Is it within the existing MCO contracts? It is showing significant improvement in the six months.
Ms. Smith-Leslie: Yes, it is showing progress in the ER reductions for the top 10 super utilizers with the MCO's. Yes, it is in the MCO contracts. With the new software it shows us which members are not being managed well.
Centennial Care Presentation will be posted on the NM Network of Care and Behavioral Health Collaborative Website

5. <u>New Mexico Suicide Prevention/National Strategy for Suicide Prevention (NSSP)</u>

Jackie Nielsen, Project Director
Megan Phillips, Program Manager

- BHSD was awarded a grant by SAMHSA, Sept., 2014.
  - As a result, BHSD created a position dedicated to suicide prevention. The New Mexico Suicide Prevention Program:
    - Implemented pilot sites in the Northern, Eastern, and Southern regions.
    - Completed various suicide prevention trainings within the pilot sites for BH providers.
      - Now launching primary care and emergency department trainings, which go beyond the pilot site areas.
    - Integrated with the Health Homes initiative and also Screening Brief Intervention Referral to Treatment (SBIRT) and Certified Community Behavioral Health Clinic (CCBHC) Initiatives.
    - Embarking on year three, the focus is on embedding the suicide prevention protocols they developed.
  - National rates of suicide
    - Nearly 40,000 people die from suicide every year
    - The highest number among both men and women, ages 45 to 54.
    - 3.6 men kill themselves for every woman who does.
  - Suicide is a significant issue in New Mexico.
    - The fifth highest suicide rate nationwide.
    - This rate is more than 50% higher than the US rate.
    - In 2014, 450 New Mexicans died by suicide.
    - Suicide is the seventh leading cause of death in NM.
    - Suicide is the second leading cause of death among New Mexico residents 10 to 39 years old (leading cause of death is heart disease followed closely by cancer). This is steadily increasing.
  - NM's grant efforts are focused to working-age adults ages 25-64.
  - Providers see people at risk. Below are the percentages of those who saw their providers:
    - Within a month prior to their suicide, 50% who killed themselves had seen a primary care provider. They will often go for another reason than suicide ideation and won't talk about it.
    - In the year prior to their suicide, 80% who died of suicide had seen a primary care provider.

        - Within one month prior to their suicide, 20% had been to a behavioral health provider. This is a lower percentage than who saw their PCP and died of suicide, but still significant.
        - In the two months prior to their deaths, 10% had visited the Emergency Department.
    - Providers can be trained to ask about this.
    - Some people are not asked if they feel suicidal. Nor are they asked what makes them feel this way. However, treating depression is likely to make them feel less suicidal.
    - Myths About Suicide (all false):
- "Asking a depressed person about suicide may put the idea in their head."
- Actually open discussion is likely to be experienced as a relief.
- "There's no point in asking about suicidal thoughts, if someone's going to do it, they won't tell you."
    - Ambivalence is characteristic
    - Contradictory statements and behavior are common.
    - Many give hints.
- The NSSP grant (2014-2017) focuses on Goals 8 & 9.
    - Goal 8: Promote suicide prevention as a core component of health care services. How?
        - Develop partnerships (identify key state agencies and stakeholders, clinical providers and organizations, as well as community collaborators).
        - Establish cross-system relationships and processes that can ongoing delivery of suicide prevention.
        - Identify existing efforts in order not to duplicate.
        - Identify ways policy and regulation needed to change to sustain suicide prevention.
        - Identify training, not just in BH but also emergency departments and primary care.
        - All health providers are willing to ask the sometimes difficult questions.
    - Goal 9: Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behavior. How?
        - Implement training for providers to be able to screen, refer, treat and follow up.
            - Training includes approaches like: Mental Health First Aid, QPR (Question, Persuade, Refer), and Cognitive Therapy for Suicide Prevention.
            - Once trained providers and communities can implement SP protocols. The goals also include plans for sustainability.
- NM Suicide Prevention Efforts
    - Three pilot sites.
        - NM SP chose the Zero-Suicide Model, which aims to improve outcomes for at-risk individuals.
        - https://www/youtube.com/watch?v=6L3AeGnUbuQ
    - Grant efforts Y1 dedicated to create awareness of the model, develop partnerships, inventory existing resources/ processes, and securing agreements with community partners to implement the Zero-Suicide Model.
    - Grant efforts Y2 continue to identify resources/ stakeholders such as survivors or yourselves as cabinet members. Also training clinical and non-clinical staff.
    - Pilot sites focused on public education especially for "gatekeepers." Gatekeepers are people strategically positioned to

recognize and refer someone at risk for suicide (parents, friends, teachers, caseworkers, police officers, and firefighters).
- Grant efforts in Y3: focus on embedding these protocols within the pilot site communities and beyond.
- We've now built a website at www.zerosuicide.com which contains tools for organizations.

➢ Mike Hogan Zero Suicide Video:
- We want to make health care suicide safe. We call our approach Zero Suicide. Health care has not focused on suicide, nor has suicide treatment focused on health care, which isn't safe.
  - It was said years ago that 100,000 Americans died of errors in the health care (HC) system, mostly errors of commission, failure to follow through, but also failures of omission. We fail to ask, follow up, or develop a personal plan. This is no longer acceptable.
  - Making health care suicide safe is perhaps most important in mental health programs, not all of which are set up to pay attention to this.
  - A giant area of concern is primary care. For older men, 70% who die by suicide had seen a PCP in the last 30 days.
    - Primary care operates at a fast speed. It's important to introduce people in behavioral health into PC.
    - HC organizations should work to make themselves suicide safe across their whole continuum we feel.
    - We've now built a website at www.zerosuicide.com which contains tools for organizations.
  - This is an approach whose time has come.

➢ Presentation Continued
- Collaboration and Support: We all play a role to continue a suicide prevention model post-grant.
- The NSSP team welcomes collaborators and can assist you by:
  - Meeting and brainstorming with your teams about current/ future SP efforts
  - Co-review policies and procedures
  - Put you in contact with key players around NM
  - Welcome participation on the pilot site steering committees by a representative in your department.
  - Provide/ connect your program staff to SP training.
- Who will be your partner designated?

ACTION: Megan Phillips will be contacting your respective Departments.

➢ James Wright, LCPC from SAMHSA
- They've now built a website at www.zerosuicide.com which contains tools for organizations.
- He can see areas drastically impacted by suicide, personally or through their organization.
- NM has been awarded the following: 2015 Planning Grant Certified Community Behavioral Health Clinics, 2014 National Strategy for Suicide Prevention, 2012 Garrett Lee Smith Youth Suicide Prevention (DOG), and additionally we have our Block Grant Suicide Prevention Requirements.
- He reviewed the National Action Alliance for Suicide Prevention's org. chart. SAMHSA is proud to be supporting this, a public/public partnership. Everyone can champion this.
- The goal is to save 20,000 lives in five years, a big goal because every year we see suicides increase.

- The nearly 40,000 who die by suicide equate to about 750,000 attempts each year.
- Task forces organized around infrastructure (data/ surveillance), high-risk populations (Native American, military/ veterans, attempt survivors, and survivors of suicide loss), and interventions (clinical workforce preparation, crisis, faith communities, public awareness, and workplace). These are just a couple, we have fifteen task forces, including:
    - National Strategy for Strategic Planning
    - Crisis Service Task Force - a document the start of a blue print of what they will be pushing, what your organization can use to embed this.
    - Zero Suicide, almost two years old. So many people think mental health needs to deal with this but these suicides are people in primary, not behavioral, care.
- James reviewed the Zero Suicide model and reviewed statistics. About the Zero Suicide model:
    - An aspirational goal. Not every death is preventable at all times, but are you looking at this as a core priority, not as a passive activity? Most haven't been trained to identify, assess, treat, and refer.
    - Makes suicide prevention a responsibility of health care.
    - The Joint Commission just released Sentinel Event #56, what health care systems should be doing to be moving forward, which he reviewed.
        - Review each patient's individual and family health care records.
        - Screen every single patient using a brief, standardized tool. (Identification rose 50% doing this, asking the question with empathy and caring).
        - Review screening tools before the patient leaves.
        - Building a safety plan.
        - One area where NM excels is that every single patient and family member identified as being at risk gets the crisis hotline/ suicide prevention line number.
    - Fundamental components: leadership, training staff, identify, engage, treating them (where they are, not as a secondary or passive activity), transition, and improve (data-driven quality improvement). The MCO's are doing important work here with care coordination. When you refer someone, whose patient are they? Those who don't get to the next provider after a referral (which 50% don't) are at greater risk, this is the highest time they might harm themselves.
    - Resources can be downloaded free (organizational survey, workforce study, and data elements worksheet)
    - Technical assistance available!
- The purpose is to look at state systems, ultimately moving toward impact and outcomes. How do you know the training filtered down to the end user?
- **www.sprc.org** is where they provide support. They're the ones who look at best practices along with the SAMHSA registry for suicide specific data.
- Also there are state prevention plans. Right now there is a preventative plan but NM doesn't have a state plan identified. How do we do this? This is one of the states that actually doesn't have this which needs to be addressed.
- National Suicide Prevention Lifeline: 1-800-273-TALK (8255), operating since 2005.
- The first year they took 48,000 calls and last year 1.5 million calls. Almost all are being answered by the three crisis centers in NM.

- We have seen support from the highest level of government and this is one program accepted that cannot be shut down even if the government shuts down because it has been linked with life saving capabilities. We encourage communities to take ownership.

Summary: We need to move away from suicide being a BH problem toward a unified healthcare approach, from acute to routine care. Those who participate in the PAX Good Behavior Game, for example, reduced rates by 50% for those who went through, over their lifespan. Also crisis centers are an incredible component.

Pilot sites: Bernalillo County; Otero County through Alamogordo; and Curry County, in Clovis.

New Mexico Suicide Prevention/National Strategy for Suicide Prevention (NSSP) Presentation will be posted on the NM Network of Care and Behavioral Health Collaborative Website

6. Behavioral Health Strategic Plan

Behavioral Health Strategic Plan
Karen Meador, BHSD
Betty Downes, Ph.D.

- We want to get you to able to vote and make sure you have all the information and update you on efforts since we gave the draft plan.
  - The three goal areas: finance (3 goals), regulation (2 goals), workforce (4 goals).
  - Next a narrative you were given in Jan. the result of the process of several workgroups and eighty stakeholders.
  - They built an information matrix and are beginning to dive down from idea to action.
- Dr. Lindstrom has been working with an executive level team to identify initial steps. In cases groups and individuals will be identified to take it forward, to leverage what's in place wherever possible to help them be the leads in content. In other areas, it will take working with a range of stakeholders.

- Regulatory
  - All the Collaborative agencies will be approached to do a self-inventory.
  - We will be looking to affect regulatory changes, looking for where to better align, reduce, and eliminate cascading effects.
  - CYFD and DOH partners will be involved.
  - Will be working with the NM BH Provider Association for opportunities to consolidate audits.

- Finance
  - The Medical Assistance Division is making strides toward goal of value based purchasing. We are expecting to hear from and learn from the CCBHCs and the two Health Homes.
  - Recognition of cross governance partners. To be developed/ targeted areas were represented in planning, discussion on how to better explore initiatives/ innovations going on within the counties. Working with the Association of Counties and also partnership with Bernalillo County who has taken a strong lead in using tax revenues toward BH.

- Workforce
  - Partners in higher education a web-based clearing house for internships.
  - Colleges and universities, working with students graduating or moving up, do a smarter job with them bridging that transition to

working in the system.
- Licensing boards about supporting reciprocity for those potentially seeking to relocate here from other states.

➢ These are just some examples. This is your strategic plan and it will take some building.

➢ Question about finance and coordination with local governments, what's the umbrella for that?
Answer: It's not like the local government division but more on the lines there are a lot of activities at local levels, counties, things we should be doing together. Bernalillo is the most recent, highest profile example, talking about their tax initiative, through which process the state has worked with them. Also BH Investment zones are an example, where BHSD is working with local bodies to implement in high need areas, McKinley and Rio Arriba Counties.
- How to leverage Medicaid is what consistently came up in the workgroups for the strategic plan. Could Bernalillo County's tax initiative provide the match? (This is anticipated to bring in $17 million in new money for behavioral health).
- We haven't yet figured out the mechanism, but it's something the workgroups wanted us to take a serious look at.

➢ Question: about integration of private actors/ providers. Do we have an ongoing advisory body hoping to get input?
Answer: There are several you already get presentations from beginning with the BH Planning Council and their sub committees. Also, the NM Providers' Association is very involved. The Local Collaborative Alliance has monthly meetings now, another place providing input.

➢ Question: What interaction do you have with tribal governments?
Answer: One of the places is the Native American sub committee of the BHPC. Secretary Zunie chairs. Also the regular tribal consultation takes place between HSD and tribes.

Behavioral Health Strategic Plan Presentation will be posted on the NM Network of Care and Behavioral Health Collaborative Website

7. Behavioral Health Planning Council (BHPC) Report Local Collaborative Alliance Update

➢ **Behavioral Health Planning Council Report, Cathi Valdes, BHSD and Chair of the ASAM**
- Ms. Valdez acknowledged being in long-term recovery and is hoping to pass the test and become a Certified Peer Support Worker.
- In January 2016, the BHPC by-laws were changed so we have three seats for each of the six BH regions. Some collaboratives are not as active as others and we wanted statewide representation.
- BH Summit and BH Day in late January was very successful. We honored 39 stars from throughout NM, two Lifetime Achievement winners and one John Henry award, which goes to a service animal (this year a therapy horse was awarded).
- Winter Storm Goliath which hit New Mexico last Christmas/New Year Holiday season and impacted the South East corner of the state.
  - When the Emergency Operations Center is activated, so are BHSD staff, to serve at the emergency operations center. They immediately notify the MCO's to be standby.
  - In the Roswell area many dairy cows were lost and ranchers made distress calls, this had a huge Behavioral Health impact on them. They gave the NM Crisis and Access Line to people to use.
  - The National Guard was asked to transport individuals on Methadone who could not get to the clinic. A nurse booked

a motel room to ensure he was able to keep the clinic open. They were both awarded and recognized as a BH Star.

- Carol Luna Anderson and Lynn Sanchez of the Life Link had a presentation on human trafficking. The victimization of these men, women, and children is just astonishing. NM is making an effort to find them and get them to safety. Most of the people have no support system, have been removed from family and friends. The long-term trauma is incredible. The Life Link goes in and tries to heal it.
- The Children and Adolescent Sub Committee (ASAM) has seen dwindling attendance and they are going to do a survey, to determine how to increase membership.
- The Native American Sub Committee (NASC) is working to support the NA LCs. LC-16 is planning a DWI Prevention Powwow and a Meet and Greet. They are very active and trying to help the other NA collaboratives.

➢ **Local Collaborative Alliance Update, Governor Frederick Rick Vigil, chair**

- From January, 2016to thepresent, the LCA has submitted a grant grant application to the Con Alma Foundation. The grant was awarded to collaborate with the Health Council to bring a relationship to consumers.
- Last year we sought for appropriations through our MCO partners, which in total generated $28,500 to continue our working efforts.
- Monthly meetings have been changed to a quarterly basis.
- We extensively worked on a scope of work and six or seven times came back to our conversation with Dr. Lindstrom to develop an outreach strategy.
- We assessed the map. We are the voice throughout the Collaborative. Some LCs have appropriate resources. Our relationship with other entities has enhanced their opportunity.
- The NASC sought the LCA's assistance. Secretary Zunie and Deputy Secretary Shije asked how they could provide assistance to the Native Local Collaboratives. They had revenue of $5,400. To ensure accountability of funds to where outcomes, they are now hosting a Meet and Greet with all the Native American LCs.
- LC-4 now in Las Vegas have a good relationship (with the LCA). The LCA came to a shortfall with the matching funds they were seeking to continue this effort. They began looking at strategy, one potential area DWI money the counties receive. Also he will reach out to the Los Alamos National Research Laboratory.
- Patricia Gallegos was working with the DOH is now the LCA's coordinator. She is knowledgeable about resources throughout the state.
- Governor Rick Vigil will continue to seek additional resources, and ensure they are shared with the local collaboratives . He looks forward to continuing to create the collaboration with departments, providing resources, either human or monetary. He has been following the proposed legislation. The White House is fishing for voices and people who have addictions in heroin, opioids, etc. Mr. Vigil, Congressman Lujan, and Congresswoman Grisham have discussed what they can do to bring resources to NM.

Question about why the LFC proposed cuts, where we ended up after the Senate, the Senate version of the Bill held the House bill flat. Why did they propose those cuts?

Answer: Medicaid expansion created the opportunity for savings in SGF. BHSD recognized some of that savings which were used to invest in needed areas such as:, supportive housing, supportive employment, etc..

- Becausethere was a significant increase in the utilization of BH services under Medicaid, there was an idea that now the BH

8. Public Input

needs of NM have been met and why do we need this much money from the SGF going into BH?

- Medicaid is not comprehensive coverage for behavioral health services and not everyone qualifies for Medicaid coverage.

Behavioral Health Planning Council and LCA Presentation will be posted on the NM Network of Care and Behavioral Health Collaborative Website

- **Public Input**
  - Dr. Peter D. Benavidez (handout: Alcohol Taxes Save Lives & Money):
    - He writes alcohol prevention curriculum for his paid job. His volunteer work is to raise alcohol taxes 25 cents per drink in NM.
    - He provided a "thank you" for your workto members of the Collaborative. He travels all over and sees the work people get/ don't get in different states. You all make him proud.
    - The bottom line is there's all this talk about cutting Medicaid funding which is putting the cart before the horse. We are subsidizing excessive drinking alcohol consumption.
      - Whether or not you drink, you pay $400 in GRT (gross receipts) and PIT (personal income tax) to subsidize abusive drinking in the form of police, detention, court cases, emergency room, and indigent funds we have to pick up. This talk about being against taxes we keep hearing from political entities is not real, they are more than happy to tax us so long as the taxes are hidden. They are not willing to put the burden on the people causing the problem, which are excessive drinkers and this tax would do that.
    - This report is serious economic modeling, reviewed by Dr. Jernigan John Hopkins Medical School and three UNM professors. It concludes:
      - A 25 cents per drink tax would produce $154 million per year in new revenues, which would make up for the Medicaid match, which means we can keep having health insurance for the 250,000 new enrollees versus telling them we need to cut services because we don't know where money is coming from.
    - He was at the Alcohol Policy Conference in DC last week talking with some researchers from the Boston University Medical School figuring out how much to lower the burden to Medicaid.
      - Now we are number one in the nation in alcohol related deaths (1 out of 6). We suspect we will see upwards of $100 million in savings to the Medicaid fund because we won't have to treat these things. He didn't have the numbers yet but they look promising.
    - He wants to talk with people here, the MCO's, the State, and us here to get news to the Legislature. He is not okay with slashing services for BH while we tax everyone $400 a year for drinking.

- Chris Wendel, and Tom Starke, Recovery Santa Fe Co-Founders
  - Chris is in long-term recovery. She is here today as one of the co-founders of Recovery Santa Fe, they are about bringing forth the face of recovery, bringing forth the hope, not just talking about addiction.
  - They have a celebration in Sept. She showed the video from last year's Recovery Day Celebration. A couple of highlights:
    - Recovery is a destination, a deep connection with others.
    - Almost everyone is affected by addiction.
    - An individual is not the problem, the disease is. This connection helps fight the disease.

    - Mayor Gonzales and the Friendship Club sponsored this to celebrate the 10,00 people in Santa Fe in recovery.
- Santa Fe's Recovery Celebration will be Sept. 25 this year, a Sunday, 11am-2pm. It will be a BBQ.
- Tom is involved with/ put together the Santa Fe Behavioral Health Alliance, criminal justice, service and treatment providers and others with the goal of getting people with mental illness and co-occurring disorders out of the criminal justice system and into the community where they can achieve their potential and not be a burden but contributing members.
- They worked very hard this year on trauma:
    - Most of these individuals they are trying to get out of the criminal justice system carry trauma from past experience and when they get into interacting with your agencies they are frequently re-traumatized by interactions with people and also because the systems are unaware they are carrying trauma. These systems can re-traumatize them and greatly reduce their ability to function and take advantage of the resources you are trying to provide them because, without realizing it, they are pulling these people's abilities to function way down (through these interactions).
    - Furthermore, people working in your organizations can be traumatized by dealing with these clients, and not realize it. A big source of burnout, people exposed constantly to trauma can catch it, it's almost like a virus, the front line staff.
    - They tried to get a SAMSHA training for all Santa Fe front-line workers, to train twenty trainers and have them fan out and train more.
    - He asks you to consider all of your staff, not just those in Santa Fe but all over NM, whether to train that staff would be helpful. Thank you.

A **MOTION** was made Secretary Miles Copeland and seconded by Secretary Tom Clifford to adjourn the meeting. The **MOTION** was **PASSED** unanimously. Meeting was adjourned at 4:15 p.m.