

Report and Plan for LC1 Rio Arriba Total Community Approach

Responding to BHC Questions
Goals for the Future

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I. OVERVIEW OF THE PLAN AND PLANNING PROCESS

What follows is a plan with capacity building strategies for Rio Arriba Providers, LC1. It also addresses questions outlined by the New Mexico Behavioral Health Collaborative (BHC) and Value Options (VO) in their proposal for the Total Community Approach (TCA) planning process. It raises some additional questions about structure very important to the future of the behavioral health network.

Providers, community members and consumers were all involved in the planning process, through interviews, surveys, focus groups and group planning sessions. BHC and VO representatives were also involved. This plan represents the shared priorities and strategies of this diverse constituency group.

Where opinions differed based on the group, these are identified and analyzed by the group type.

All interview information from individuals and agencies is confidential, reported in the aggregate.

Service and funding data was provided by the majority of the Rio Arriba based providers. And financial and service delivery data was provided by Value Options, and data analysis was conducted using this data; key issues and trends were identified.

The report contains two sections:

1. A report which provides research, analysis and recommendations in response to the questions from the state Behavioral Health Collaborative
2. A set of goals to guide the implementation of the recommendations.

The report analyzes funding for services, the mix of services in the continuum of care, recommendations for shifts in services and funding, outcomes and other quality issues. Recommendations include some shifting of the service mix and funding, strengthening LC1 and the agencies within, working with leaders to build greater collaboration, building greater skills with outcomes, service and financial analysis, and working with LC1 to locate some new sources of ancillary funding.

New Ventures thanks LC1 leadership, providers, consumers and community members for being involved in the planning process, including many meetings. There were approximately 150 different people involved representing many different stakeholder groups. Additional stakeholder groups need to be involved as the plan moves forward. We would like to thank Value Options for providing data, answering questions and being involved in the planning at key points. We would like to thank the state's Behavioral Health Collaborative for providing staffing to the LC1, and helping to facilitate the process.

II. PROJECT RESEARCH & ANALYSIS

A. Methodology

As part of the planning, the consultant worked with the Rio Arriba contingent of the Local Collaborative (LC1), a planning committee that included providers and consumers, and the LC1 co-chairs. The consultants reviewed material available about BHC, the LC1, and earlier Rio Arriba County plans. We analyzed data from Value Options, to look at the funding levels for different services, types of services provided and outcomes.

We interviewed providers and consumers, to gather information about how they saw behavioral health care. In certain cases, consumers and providers agreed about a number of important issues, such as the need for a better mix of services in Rio Arriba, especially for youth. There was general agreement about the need for crisis response, and the need for more wrap around resources like transportation, housing, and job training. There was some disagreement as to prioritizing these different needs, and mixed reviews about provider service quality.

We held a number of meetings with LC1 and the planning committee, and also held multiple community meetings with providers, consumers, community members, community leaders, elected officials and the media. Meetings were as follows:

- 5 Meetings with LC1 steering committee and providers;
- 4 Conference call meetings with the TCA planning committee;
- 4 Planning meetings with consumers, community members and providers;
- 15 Individual interviews.

B. Summary of Stakeholder Comments

A summary and analysis of their responses in meetings follows. People involved in the planning process included 15 consumers and family members; 10 community members; 8 elected and appointed officials; 2 newspapers and 27 LC1 provider and other agency staff (there were multiple people from some agencies). Here are some key points made in meetings, clustered in topical areas:

Youth Services

- There aren't enough resources in the county, especially for youth.
- We need to find a way to more effectively reach youth, and develop closer relationships with schools.
- Young adults should be a priority; but they are hard to target successfully because they are a more dispersed population; they're not in one place.
- As family members, we can't travel long distances to see our kids in treatment.
- When people (primarily youth) leave a treatment center and come back home, they need follow up. It's too easy for them to be dumped back home, and they drop into a negative spiral. There needs to be coordination between the treatment center and some local designated agency.
- Right now, our organization is 'maxed out.' Staff are working at capacity. We can't add any more prevention work and outreach to youth without more funds.

Service Delivery & Coordination

- Some of us have had a hard time finding or accessing services, or the right services. We get referred around, or made to wait.
- Local and state leaders are getting tired of hearing about problems, and seeing money spent with little reported about results. The network needs to report on its work, progress and outcomes so that we know how money is being spent.
- There needs to be a way to collaborate better, work together.
- We need centralized intake for county residents, so that we can ensure people reach us more easily, get the referral that is appropriate. With centralized intake, we can monitor who is coming into our system and where they go, and ensure good care.
- The support I received from case management was great – could not have made it without it.
- I am in good shape now, but my experience with the XYZ agency was really difficult. They didn't help me at all, and they were rude.
- More case management (CCSS) is needed – people coming to us from treatment or jail have so many needs. There are more people in need, and more time required to help people with complex problems that staffing allows.
- Many of the local employers and landlords are not interested in renting to our consumers, especially when they hear about their situations. It's very hard to help consumers put the pieces in place, but if they stay sober and keep trying, many succeed.
- We provide a range of services to consumers, want to make sure we meet their needs.
- Our community members need more help with transportation, housing and jobs. It's really tough.
- Some people want services at home, others don't want people to know their business. It's good to have both.
- Intensive therapies are needed by some people, and we need to have intensive outpatient and residential treatment available.

C. Main Themes

The main themes expressed by people in meetings include concerns that:

1. According to all stakeholder groups, there is concern that the service delivery system is thin, fragmented and frail, with much needed in the way of capacity building both in terms of adding services, centralized intake, crisis response, and strengthening the agencies themselves.
2. There are very few services for youth. Consequently youth end up in treatment centers far away from home, with few supports for families and re-entry. Consumers, community members and providers would like to develop a mix of services for youth and their families, perhaps on a pilot basis.
3. Adult consumers trying to affect a successful re-entry following residential treatment or incarceration find it difficult to access housing, transportation, employment and social services. According to consumers, case managers have been extremely helpful and instrumental in helping people make transitions, and consumers ask that more resources be made available.
4. Lack of understanding of prevention and awareness of prevention services available.

The three major stakeholder groups involved had some similar and different perspectives on behavioral health care, and those are summarized based on each group (see Fig. 1) next page.

STAKEHOLDER COMMENTS TABLE			
Fig. 1	Consumers	Community Members and Leaders	Providers
<u>Positive Comments</u>	There are some excellent resources; Case management has been especially helpful. We have been able to get back on our feet, with help.	Agencies have been working hard to build capacity and strengthen quality. There are some excellent resources in the county.	Agencies are improving services and working together more.
<u>Concerns</u>	Some providers have been hard to access, especially to get appointments without a long wait time. Some agencies are difficult to deal with, or not helpful to consumers trying to get sober. This often includes being short or rude, outlining requirements in a "bossy" way and other issues. There is not enough help for someone in crisis; they go to the hospital and are turned away. Sometimes they can go to St. Vincent's – sometimes they just get in worse trouble. People need more help, and more resources, especially with jobs, housing and transportation.	The public is often not aware of the resources that do exist and how to find them. Although some agencies provide quality services, other agencies do not have the reputation for quality, which is a concern. The network has a reputation for doing a lot of planning and then not following through. There are concerns about the gaps in service, and the need to address those. We need to do more here at home.	There are too few services being delivered in Rio Arriba County. There are so many youth in need in the county, and too many youth travel for some distance to receive services because few services are available in county. Services are fragmented. Interagency disagreements have undermined collaborative relationships and building the LC1. There is interagency competition for services like case management (CCSS) or counseling, unclear who does what. Different agencies hear negative things about other agencies, and it is hard to know what to think about the quality of care. Many agencies don't have requisite skills in outcome evaluation, and the network does not have an evaluation framework. Providers need more financial and service data and analysis from VO, and more help is needed to do data analysis. Some providers have lost funding and are stressed to provide services.
<u>Needs</u>	Many people need housing if they have separated from families or just out of jail. Transportation is critical and we don't have much public transportation. Jobs are hard to find, and often the only ones available are low wage where you can't manage.	Large numbers of people have alcohol and drug problems, but these are often hidden (alcoholism is still stigmatized here; it is better to tell someone you have a mental health problem than a substance abuse problem.) We need a better mix of services to address our community needs. We need to get all key segments of the community involved in developing and implementing the plan. The community needs to be more aware of the problem, and be more involved and supportive.	Centralized intake would facilitate access to care, and tracking consumers to ensure they receive the care and referrals they need. Crisis Response is an important resource needed in the county. Currently, people going to the hospital are often sent away – back home or to St. Vincent's. There is no resource to help people in crisis get to where they need to be. Agencies need to make agreements with one another regarding services to be provided, interagency referrals, and handling of disagreements. More case management is needed, as consumers require a lot of help with social and job skills, finding a job, housing and transportation. Agencies need support to build a strong network.
<u>Suggestions</u>	Develop a way to respond better to people in crisis. Make resources more local and accessible; family members often cannot travel far, and that has an impact on care. Expand case management. Look into supported housing, job training and some type of van transportation. Make resources more consumer friendly and accountable to the community.	Have more public outreach and public awareness messages about substance abuse and resources available. Develop a more responsive mix of programs and services. Engage more elements of the community to implement the plan (jail, judges, hospitals, schools). Find new ways to engage the community and involving them in responses to substance abuse (Health Council).	Develop and pilot centralized intake, handled locally working with CARE Connection to facilitate development. Create a Crisis Response, based on the Santa Fe model, involving the hospital if there can be agreements and change w/ services they offer (w/ LC1 providers). Expand case management to more consumers; change the en-situ requirements as they are currently not financially feasible. Hire a network coordinator, with preliminary support and agreement to goals by the LC1 agencies. Coordinator would oversee centralized intake, crisis response, quality management and outcome work, strengthening services, enhancing service mix, and new funding opportunities.

The picture that consumers, providers and community members draw is of a system that is not well known by the public. Services are sometimes difficult to reach and vary in quality. There is a fair amount of quiet talk about agencies, especially discussion about problems with different agencies. The picture given by different stakeholder comments outlines a system which is really less a system, and more a collection of agencies. These agencies do not work altogether collaboratively, but they share common concerns about community needs and have articulated a desire to develop resources to respond to those needs.

What we see is an articulation of significant community needs being met with limited resources. LC1 members an alcohol-saturated culture and an environment filled with alcohol outlets and illegal drugs. They describe serious needs that jibe with the demographic research described later in this plan. And the reader will see these needs, services and resources identified in depth throughout the report. This plan analyzes the services provided, service levels, funding and service outcomes.

D. Services Funded and Available; Services Needed

1. Where Services are Provided

One of the most important questions asked by the BHC and Value Options was about funding levels for Rio Arriba and the network, and how services were funded and funds used. A total of \$8.8 million was expended by Value Options during FY 2006, FY 2007 and a few months of 2008 for all residents of Rio Arriba County for all services, according to Value Options service and funding data, which was analyzed by our data expert. Prevention services were included (as defined by OSAP/VO); assessment, screening, a wide range of therapeutic services and medication. And there were additional expenditures by the county for housing, incarceration and other services. The total may seem sufficient or even high for funding a small county with just 41,190 people in the 2000 census. However, when the figures are analyzed, one comes to realize that approximately 75% of the \$8.8 million is spent by Rio Arriba residents outside of the county, with out-of-county providers for services not available in Rio Arriba County. Approximately half of the \$8.8 million is spent for youth residential services, primarily in Santa Fe, Las Cruces, and Taos counties. And there are also outpatient, psycho-social rehabilitation, intensive outpatient and other services provided to Rio Arriba residents by out-of-county providers. This comes from a straightforward analysis of the data provided by Value Options, analyzing billing data by provider location. A breakdown is provided in Figures 2, 3 and 4 on the following pages.

2. Underserved Youth and Services Needed

Rio Arriba has few specialized and intensive services, especially for youth. Families and providers have expressed concern about the lack of services for youth. And the data validates this concern, demonstrating that youth go to many different parts of New Mexico for residential treatment. If there were a mix of services for youth developed in Rio Arriba County, would this meet more of the needs of youth and their families, and keep more youth closer to home, family and school for the period of their treatment? Would having a mix of services for youth enhance transitions back to home, school and community and facilitate interagency collaboration. The model of the children's medical home used by Su Vida and others emphasizes the importance of providing a mix of services in the community. As part of Total Community Approach planning, LC1 would like to determine whether a service mix for youth would meet needs, and be a successful addition to current services.

Rio Arriba youth have many high risks and unmet needs, and as the reader reviews information about target populations, it becomes increasingly clear that the youth of the county are at very high risk. Youth in the county have lived with many high stress and high risk behaviors for decades, and continue to be among some of the youth at gravest risk in the state. (See the Target Population Section for details.) Meeting the needs of youth was identified as a very high priority for Rio Arriba County by consumers, providers and

community members. Many would like to see the development of a mix of services as soon as possible. It certainly makes sense to move forward with a mix of community-based youth services in FY 2009, after the centralized intake pilot is completed. The children's therapeutic home model (Su Vida) and the values and priorities identified by the Children's Behavioral Health Collaborative can provide some guidance. Initial funding for pilot activities would come from TCA funds, and growth would be funded through a combination of the billing system; VO special funding initiatives; county support; and foundation funding.

3. Access to Community Resources for Those in Transition

Another area of concern discussed by providers and consumers was that of people moving from incarceration or residential treatment back into the community. Many have barriers to transitional and affordable housing and employment beyond minimum wage work. Transportation is very difficult for those without a car despite the newly developing regional public transportation system. Case managers and consumers have suggested that the LC1 and other networks within the county look at these important systemic barriers, and develop some additional resources for reintegration services such as housing, employment and transportation. There are some faith communities and a community corrections system working with case managers to provide access to resources for those in transition but services are uncoordinated, limited or underdeveloped.

Case managers and consumers have both mentioned that when there are very difficult barriers to finding housing, employment and transportation, these barriers serve as very real impediments to continued recovery and social rehabilitation. Consumers and case managers say that the support network and ongoing recovery work are absolutely essential for successful re-entry, and the most important indicators of future success. However, many consumers have found themselves derailed because the barriers seemed too daunting. For a county with a strong culture of high crime rates and substance abuse and all too plentiful liquor stores, the risks accelerate when transition is hard.

Providers have discussed developing an interagency county effort between the LC1, DWI Task Force, government housing, other government entities, faith communities and employers to leverage the resources that currently exist, and develop new ones. These barriers are large systems issues, and cannot be solved by the LC1 alone. However, they represent very basic, critical issues that facilitate or impede successful sobriety and pro-social behaviors. It might be important for the LC1 to build an interagency group, and start with some small pilot activities that are funded by multiple sources. Initial pilot funds should come from a combination of sources most closely involved: LC1 and VO, DWI Task Force, county, law enforcement, employers, faith communities, and community corrections.

4. Centralized Intake and Crisis Response Needed for High Risk Population

The overall population of Rio Arriba County is more at risk of substance abuse and related problems than populations of almost all of the other counties. And, many consumers from Rio Arriba County find resources outside the county. The combination of high risks, high needs and a pattern of scattered service utilization all indicate that centralized intake and crisis response services are needed and appropriate for development as soon as possible. Consumers, community members and providers are concerned that there is no centralized intake or crisis response available for Rio Arriba County such as the Santa Fe Crisis Response and Santa Fe CARE Connection.

All stakeholders are concerned that people in need go to the hospital and cannot receive behavioral health treatment when in need or crisis; they are usually referred to St. Vincent's or home. Rio Arriba County youth and adult residents have some of the highest alcohol and drug related problems in the state (DWI statistics, incarceration statistics and health statistics). Having a crisis response could be a very important resource to meet a high risk need. (Details on risk factors are outlined in the Target Population Section.)

Given the many risk factors of all elements of the Rio Arriba County population, the economic stressors which are greater in Rio Arriba, and the lack of some critical elements of behavioral health care (hospital), it makes sense to develop some type of centralized intake to facilitate care, and crisis response system to address high risk crisis issues. There are a number of different models: the Santa Fe CARE Connection for centralized intake and Santa Fe Crisis Response for crisis response.

The LC1 TCA Committee and LC1 Steering Committee believe that the best way for Rio Arriba to develop the most needed resources is to work in phases: first, to develop centralized intake; then to develop crisis response and a mix of youth services. More information about the rationale, strategies and costs are outlined in later sections of the plan.

The CARE Connection can be a resource, if not a contracted entity. The CARE Connection Director has expressed interest in working with Rio Arriba County, in whatever way would be most effective for meeting consumer needs. The expertise of the CARE Connection could make the difference between a difficult pilot development, and a relatively easy pilot that builds upon the strengths of the CARE Connection and local agencies. These local agencies already have a relationship with the CARE Connection, making for an easier collaboration.

Developing a pilot for centralized intake, working with the CARE Connection, will allow Rio Arriba County to make maximum utilization of and progress with community resources. And, as Rio Arriba County provides centralized intake during the pilot to area adults with substance abuse and related issues (as defined in the ASI), they will gather important information about consumer needs and community resources. Since the CARE Connection is already working with most of the Rio Arriba providers, this knowledge base will also facilitate a successful pilot, and expansion of services.

This way, the Rio Arriba providers are moving forward with strong community involvement. The new Rio Arriba Health Council is reaching out to an expanded universe of stakeholders, and will help to bring these stakeholders to the table for planning and pilot development. At a minimum, the judicial system, hospital, school, and county should be involved and supportive of the pilot. If LC1 develops centralized intake as its first priority for pilot, it should build a base to make it easier to add more complex services which are also priority needs: a crisis response and a mix of services for children and youth.

5. Systems Issues

Finally, there are important systems issues to be addressed in order for the LC1 to operate more effectively as a network. Providers have expressed an interest in developing a centralized intake. This would allow LC1 to advertise more widely using one primary number. Consumers could be better followed and supported, ensuring they receive the referrals and care they need. The providers also discussed the need to have a part-time or full-time staff manager for the network, to handle outreach and promotion, quality improvement and interagency collaboration.

This system development is probably a longer term effort, built along with the growth and development of new initiatives that respond to community needs. It would most likely be funded in part through a reallocation of VO revenues that are not fully utilized in certain areas; in part through new funding initiatives including county support; other state funds and foundation support focused on community-based system development.

6. Summary

Stakeholders in Rio Arriba County are agreed in their concern about community members who are at risk and need services, especially youth and those transitioning from institutions back to the community. Consumers and providers alike talked about the need for centralized intake, crisis response, and a better coordination of services. And, a number of different stakeholders talked about the importance of having agencies demonstrate they provide quality services, and who are well known, respected and supported by the community.

Total Community Approach Planning Committee and the LC1 felt strongly that the LC1 Rio Arriba needs to start with a pilot focused on responding to key community needs in a way that is feasible for the 3-4 month pilot period. The LC1 chose to develop a centralized intake perhaps with some crisis response capacity as the first priority for pilot work. The centralized intake would be developed working with the CARE Connection, and there have already been preliminary discussions. The centralized intake would gather resource information which could be placed on the county website as a resource directory. The process of building the centralized intake would include additional needs/gaps analysis, based on the feedback of consumers and providers. The prevention component will have 20% of the implementation funds set aside specifically for prevention, as defined by OSAP/VO).

This particular pilot would allow for building a strong base, responding to community needs, and developing capacity by working with the recognized regional experts. This would provide for a more successful and rapid implementation, utilizing the expertise of this key resource, and building a mix of community youth services and crisis response on that pilot base, during the next fiscal year. During the 3-4 month pilot, the LC1 would widely publicize the pilot, asking community members to call for information and referral. The pilot project would gather information about the needs of community members calling, referrals made, and follow-up to check on the referral. The project would also complete the preliminary map of community agencies and resources, to continue to define where resources exist, their effectiveness according to consumers, and other resources needed. LC1 meetings will focus on responding to needs, referrals, and building the system itself. This will then enable LC1 to strengthen the service delivery system, and its readiness to build a broader mix of services for youth, and crisis response for adults in FY 2009 and FY 2010.

This plan that can be implemented with strong collaborative work by members of the LC1 network. Success will rest on knowing more about why there is so much service utilization out of county, responding to those issues in plans, and in coordinating an approach through the LC1 that supports and strengthens providers to work together for interrelated goals. If Rio Arriba providers have or can build the capacity, shifting the mix of services and funding makes good sense, and will bring more resources to the county and its residents, improving local access to a better range of services. Youth and families will have resources available in place, and the LC1 can develop a Community Reinforcement Approach (CRA) that has been shown to be effective in working with youth and adults at risk (more about CRA in Section 3).

This report and plan provides research and analysis to address these community needs and concerns, and goals to strengthen and expand the Rio Arriba Local Collaborative. Agencies will be called both providers and agencies in this report, and names will be spelled out, and then referred by acronym.

1. Total amount of dollars to Rio Arriba providers for the past 5 years. to include all funding streams (Foundations, Federal Grants, State, County, City) for youth (13-18) and adult providers

The LC1 providers in Rio Arriba County have the vast majority of their funding from BHSD through Value Options. The providers, in general, have tight budgets. Many have experienced budget cuts during the past five years. The consultant administered a web-based survey which was completed by a majority of providers based in Rio Arriba County (n=11). All providers except for one receives BHSD funding through Value Options. A total of just 27% of the providers receive some type of other local government funding outside of BHSD, and 27% of providers receive some type of state government funding outside of BHSD. Funding from private foundation sources is the exception for behavioral health providers, and there are few private foundations that provide funding for behavioral health although there are some options outlined in the goals section.

Basic Breakdown of Value Options Funding for Rio Arriba Residents

Fig. 2

	Amount Billed	Percentage of Total
In County (all services)	\$2,227,522.51	25.22%
Non-Specialized Out of County	\$2,058,771.17	23.31%
Specialized Out of County	\$4,152,326.04	47.05%
Private Independent Practitioners	\$391,180.13	4.43%
TOTAL	\$8,829,799.85	100.00%

Data was not available from R2BHP for the period prior to Value Options.

Out of the \$ 8.8 million expended by BHSD through Value Options for Rio Arriba Residents in just over two years (FY 2006, FY 2007 and a few months of FY 2008), about 75% is spent on services outside of Rio Arriba County. Many of the services sought by families outside of Rio Arriba County are because there are no equivalent services in the county. Why is so much spent outside the county, and what services are being sought? There will be a study to determine more about the reasons why consumers seek services where they do, and what they say about Rio Arriba services.

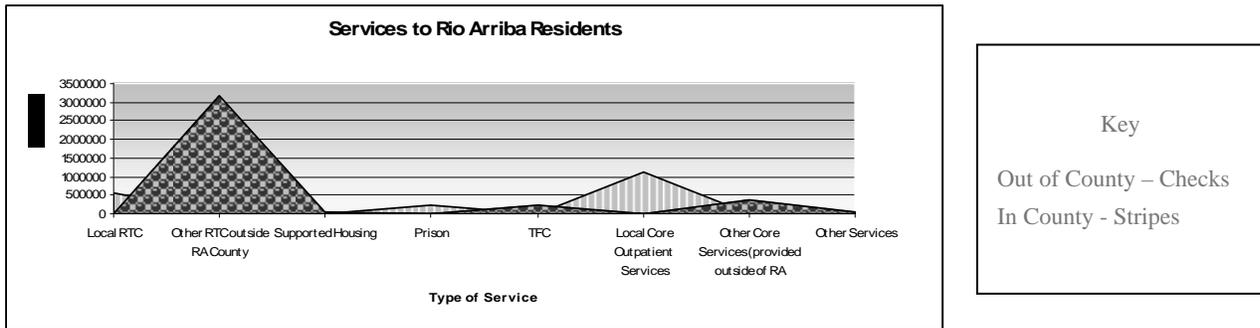
The vast majority of funds spent outside of Rio Arriba (\$3.5 million) are spent on youth residential treatment (RTC-Y) and treatment foster care (TFC) (see Fig. 3). There are no RTC-Y or TFC services or facilities in Rio Arriba County, thus, county residents seek resources outside of Rio Arriba for care. Currently 25% of the overall funding remains with the agencies in the county, to develop a system of care. If more youth services (and to some extent specialized services) were available in the county, it is expected that a wider range of services and resources would available, fewer youth and families would need to travel to Taos, Santa Fe or Las Cruces, and transitions could be eased. But, LC1 providers should anticipate a certain amount of youth traveling through different facilities, according to an Executive Director of a well known and respected youth providing agency. However, as long as youth and families are unable to find the appropriate, needed resources locally, they will go out of county, and the funding will follow.

Consultants identified all Rio Arriba providers and out-of-county providers that billed VO frequently in FY 06 – 07). We analyzed the service definitions, developed clusters representing key services in the continuum of care. We analyzed whether or not those services are being provided within the county. These totals are less than those from the entire list, as we did not include every out-of-county provider, and included none of the private practitioners. Any additional out-of-county VO providers, if added, will make the financial ratios lower for use in Rio Arriba County, and higher for out-of-county.

Fig. 3

	Other Hosp (Outside of RA County)	Local Primary Care	Other Primary Care	Local RTC	Other RTC outside RA County	Supported Housing	Prison (Correc)	TFC	Local Core Outpatient Services	Other Core Services (provided outside of RA)	Other Services	Total
In		\$139,511		\$579,830			\$231,705		\$1,141,640			\$1,783,779
Out	\$ 789,072		\$801		\$3,182,137	\$29,192		\$240,647		\$360,897	\$48,832	\$4,959,682

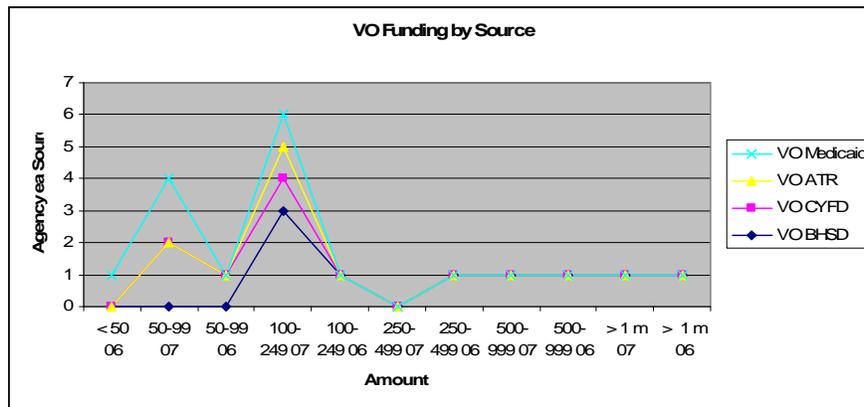
Fig. 4



Provider Key Categories of Funding

Rio Arriba providers responded to a survey about their funding; there were just 11 respondents which represents a significant portion of the in county provider network, but is a small sample for analysis. Most received Value Options funding from more than one stream (BHSD, CYFD, ATR or Medicaid). There were 11 respondents, and all did not answer in each category. The following graph (Fig) for FY 2006 - FY 2007 shows that, of those agencies responding, the highest levels of VO funding overall came from Medicaid, followed by BHSD (subcategories in VO data). The levels of funding most frequently provided to agencies was in the \$100,000 to \$249,000 range. Tables in the appendices provide more details by comparing funding by source and year, FY 2003 – 2007).

Fig. 5

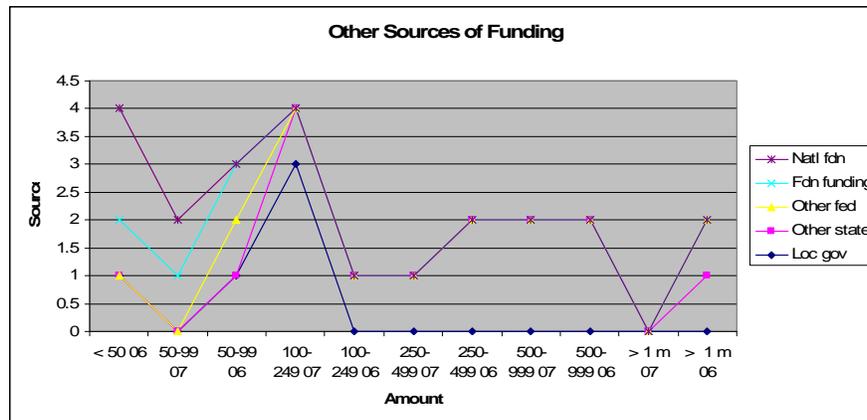


The survey (Fig. 5-6) showed that providers receive the vast majority of their funding from Value Options, across all levels of funding and types of service. Value Options funding comes from the Behavioral Health Collaborative (BHC) within which are subcategories or streams of funding, to include CYFD, Medicaid, ATR and BHSD. These are the subcategories taken from the categories in Value Options

data. Other local government funding was the second most frequent funding source. Medicaid is clearly the largest subcategory within VO funding.

The following graph (Fig 6) demonstrates the scope of additional funding received by all providers in FY 2006-FY 2007. There is funding represented from most areas, including national and local foundations, state and local government, and some federal government. Other state grants and contracts represents the bulk of all additional funding, with strong support also seen from some local government funding. There is minimal foundation support. Almost all of the funding is clustered in the low end of the spectrum, with the bulk of funding in grants ranging from \$50,000 to \$249,000.

Fig. 6



Agencies reported on funding received in the small, middle and large grant/contract areas from sources other than Value Options. As the reader can see, the funding has diminished from 2003, when 11 different grants and contracts were awarded (primarily from state and local government) to 2007, when 5 were reported. The group of 11 agencies also reported that the greatest number of grants were large grants, followed by small grants; grants in the middle range ranked a distant third. That also appears to be the trend in many of the earlier years, which is interesting. Since these figures come from a small group, they are not as reliable as those from a group of 25-30 or more. However, there may be a trend

Fig. 7

	Under \$50 K	\$250K-\$499K	Over \$1 M	Total
2003	6	1	4	11
2004	5	1	3	9
2005	4	2	3	9
2006	4	2	3	9
2007	3	1	1	5
	17	7	14	

Almost all of the Rio Arriba providers receive funding from Value Options through one or more of its funding streams (BHC, CYFD, ATR, Medicaid). Some agencies receive VO funding from just one source. In fact, providers that receive resources from, for example, Medicaid, CYFD and ATR subcategories are much more stable than an agency that receives funding solely from a CYFD or a Medicaid stream. Funding from Value Options is core funding for most, and the only funding for many. Those that receive funding from other sources receive between \$50,000 and \$250,000 to \$499,000 from local and state government and private foundations. It is important to note that grant and contract funding from other sources has dropped from 11 in 2003 to 5 in 2007. It would be important for the LC1 to find out why. Some of the reduction in funding might be due to funding cuts or consolidation at state or county levels; and

foundations often fund just one time in many years. However, if agencies could contact prior funders to find out why funds were not renewed, this could provide extremely important information for agencies and the local collaborative. Grantmakers always recommend going back to a funder to find out why something was not funded, and often say that this feedback is some of the most important feedback.

Some of the other state funding includes additional revenues from state bureaus, primarily DOH and CYFD. These represent state initiatives that are outside of the Value Options BHC funding mechanism. They could include such things as funding for early intervention programs for children, tobacco cessation, health councils and the like. Some of these revenues are short term projects, while others represent initiatives that have ongoing funding. Anything other than ongoing funding has the capacity to only support special initiatives. Only ongoing funding at a significant level could provide system support. It is important to note that there are a few agencies that receive significant additional revenues from the state, whereas most agencies do not.

There is a little bit of foundation funding available, primarily for special projects or special initiatives, for certain prevention activities, children and youth programs and nontraditional therapies. Foundation funding is typically from one to three years, to projects that fit the foundation's priorities, and agencies that foundations consider to be effective. The Frost Foundation and Daniels Fund are providing funding to at least one provider, and Frost and Daniels remain core funders for children and youth. The Kellogg Foundation provided the New Mexico Community Foundation and the New Mexico Forum for Children and Youth with a \$5 million dollar award for initiatives for children and youth in the state. It might be possible for the LC1 Rio Arriba providers to look at possible funding from that network.

There is very little federal funding for behavioral health work. However, the Federally Qualified Health Centers have federal funding, and there has been funding for special initiatives in the past, like Black Tar Heroin and Cocaine projects.

An analysis of the behavioral health services funded indicates that there is a very large core of funding from BHC through Value Options, and these agencies rely on this state funding for the vast majority of the support for their services. Were there to be cuts, the agencies would not be able to replace this funding with other funding, primarily because replacement funding of this magnitude does not often exist in other parts of the government and foundation sectors, and because many of the agencies do not have the capacity to add a development function to their already overworked staff.

However, as a collaborative with well developed services, Rio Arriba LC1 could make a case for additional local, state, federal and foundation funding. The Rio Arriba Providers should look for opportunities for funding that would support priority initiatives, such as prevention, asset based youth and family development, centralized intake and crisis response, and skills training for job development and other skills for people in transition. For example, a mix of youth services based on the Children's Behavioral Health Collaborative priorities, the children's medical home model and using a Community Reinforcement Approach (CRA) could apply for a range of grants that focus on asset based youth development: Kellogg Foundation's New Mexico Initiative, Casey Foundation, Daniels Fund and others (see Plan Section III Goals).

See Chart 1 in the Appendices for additional information about funding sources and levels.

See Chart 2 in the Appendices for a list of potential funding sources.

2. Who is the target population, or population in need (reference EPI, law enforcement, DWI, etc. data)?

LC1 in Rio Arriba County has identified a number of target populations in need of services. These include adults moving from institutions transitioning back into the community, who need more case management (CCSS), support services and resources, and a mix of services to facilitate maintaining sobriety and pro-social behaviors. Youth are another priority population, often with high risk behaviors but hard to reach. An increase in prevention services would address this issue with the long term goal of reducing high risk behaviors and the need for institutionalization. With the demographic profile of many high risk youth and adults, LC1 would like to see a comprehensive array of services from prevention to aftercare. The county would like to see fewer resources being spent on incarceration and institutionalization, and more on prevention, treatment, community supervision and supports. Finally, all stakeholders expressed deep concern that youth and families do not have resources available locally for much of the care they need, and go elsewhere for residential treatment and specialized services. The LC1 would like to focus first and primarily on building a mix of youth services, to reach the youth at need. As you review the demographics described in this section, you will find that youth are at extremely high risk, with few resources, and devastating results when needs go unmet.

The New Mexico State Epidemiological Profile, 2005 reported that “the consequences of alcohol abuse are severe in New Mexico, which has consistently had the second highest state rate (after Alaska) from alcohol-related causes. The devastation caused by alcohol abuse in New Mexico is not limited to death, but can also be linked to domestic violence, crime, poverty, and unemployment, as well as chronic liver disease, motor vehicle crash and assault injuries, mental illness, and a variety of other medical problems.”

Between 1999 and 2003, Rio Arriba county had a rate of alcohol related deaths as follows: 42.3 per 100,000 of Whites die from alcohol related causes; 90.1 per 100,000 Hispanics die from alcohol related causes, and 168.8 per 100,000 Native Americans die from alcohol related illnesses.

Alcohol Related Deaths per 100,000	White	Hispanic	Native American
Rio Arriba	42.3	90.1	168.8
New Mexico	43.1	63.6	119.1

Rio Arriba County has the 3rd highest overall number of alcohol related deaths in New Mexico, behind McKinley and Cibola Counties. And, according to the 2003 New Mexico Social Indicator Report, the county has had the highest combined alcohol and drug related death rate in the state. The report notes that the alcohol related death rate is higher for males than for females. And, alcohol takes an extremely high toll on Hispanics, and especially upon Native Americans. Rio Arriba County also has one of the highest alcohol related motor vehicle crash rates, driven in part by the high proportion of Hispanic and Native American populations in the county. Rio Arriba County has the second highest rate of 20.7 per 100,000, following McKinley County,

According to the report, New Mexico has the highest drug-related death rate in the nation, with significant consequences for our communities. Like alcohol abuse, drug abuse is associated with many social problems, including crime, domestic violence, unemployment and other family and community problems, including health problems and drug-related suicide. Like with alcohol, males are more likely to be affected than females. Analyzing data from 1999-2003, the report demonstrates that Rio Arriba County has the highest number of drug related deaths in New Mexico, a total of 44.3 per 100,000, twice the number of the second highest county.

The Burden of Substance Abuse in New Mexico, 2004 reports that in Rio Arriba County, 50% of arrestees were determined to be drug dependent and 56% to be alcohol dependent, according to the ADAM survey

which determines alcohol and drug dependence. This group is at high risk for continued substance abuse, and in need of treatment services.

The 2004 report also indicates that, for New Mexico in 2002, 95% of the domestic violence cases included some suspected use of alcohol or drugs. This translates to over \$19 million in health and mental health care and economic losses, including lost work.

A just released 2008 JJS County Profiles Report from CYFD's Juvenile Justice Services reports that there were 5,354 youth aged 10-17 at risk in Rio Arriba County, from July 2006 to June of 2007 (FY 2007). There were 484 arrests and 272 referrals to juvenile court. Charges were filed in 187 cases; delinquent findings in 111 cases; and secure detention in 92 cases. Hispanic youth represented 4,155 of the total, and Native American youth 776. CYFD's 360 Degrees County Profiles 2008 reports that Rio Arriba County had 152 children in some form of protective custody in the past fiscal year.

Suicide is closely associated with substance abuse and mental health conditions, and can be seen as one indicator of potential problems in a community New Mexico has a suicide rate roughly 1.5 to 2 times the national average, and Rio Arriba's suicide rate is higher than the state average. The suicide rate is higher among men, middle aged White (non Hispanic), and especially high among Native Americans.

Drinking is high among school aged youth in grades 9-12. In New Mexico, 70% of youth report that they have tried drinking, and just under 50% report trying marijuana or cocaine. (The Burden of Substance Abuse in New Mexico). Binge drinking (having 5 or more drinks) is especially prevalent among high school youth, especially Hispanic youth. Rio Arriba County had a youth binge drinking rate of 42 per 100,000, behind seven other counties. SAMSHA studies have determined an important correlation between youth drinking and adult drinking, and the age of onset of the first drink, according to the study. Youth in Rio Arriba also have a high level of youth drinking and driving (22.3 per 100,000) Given these statistics and trends, youth in Rio Arriba County are significantly at risk for alcohol abuse and other risks.

Rio Arriba providers have grown increasingly committed to working collaboratively with the DWI task force and staff. Dealing with the problem of driving while intoxicated is a real priority for LC1. Between 2001 and 2005, there were 102 substance abuse related auto deaths; 497 substance abuse related auto injuries, and 300 substance abuse related disabilities. 22% of all county crash related injuries are related to alcohol. More drunk drivers are being adjudicated, the judicial system is providing more serious penalties; and there are in jail and after jail programs for those adjudicated with substance abuse problems. The providers need to continue to build interagency collaboration. (NM DWI statistics)

Teen violence, gang activity and substance abuse have also been priorities for Rio Arriba for many years. The death rate for teens aged 15-19 in Rio Arriba is more than double the state average, according to NM Department of Health Vital Records and Health Statistics (243.8/100,000 RA vs. 91.5/100,000 NM). Cocaine and black tar heroin activity in Chimayo and Espanola have received national attention, and special funding support for initiatives to address these issues. Rio Arriba County has a high proportion of youth under the protective custody of CYFD. Many of these are in and out of homes in the county; and many go to New Day and Youth Shelters facilities. Rio Arriba providers would like to reach more of these teens, however there needs to be a great mix of youth programs available, closer collaboration with specialty providers like Youth Shelters, and most importantly, closer collaboration with CYFD staff case managers. (CYFD statistics; statistics from NM Voices)

According to the New Mexico Youth Risk and Resiliency Survey, 2005, motor related accidents represent the primary cause of death for all youth in the United States, and substance abuse is involved in many of the cases. In Rio Arriba County, youth have some of the highest substance abuse rates in the state. Some of the social risk factors that accompany youth at risk include: a high incidence of fighting, threats and feeling

threatened; firearms in almost 50% of homes; almost one third report feelings of sadness or suicidal ideation, with a much higher rate among girls.

One of the most important findings in the report is that “youth who drink alcohol are more likely to experience school and social problems; legal problems such as arrest for driving or physically hurting someone while drunk; unwanted or unplanned or unprotected sexual activity; physical and sexual assault; and a higher risk for suicide and homicide. They are also more likely to be in an alcohol-related car crash and suffer other unintentional injuries...” These YRRS findings are consistent with findings of the Search Institute, which has identified youth risk factors, resilience factors, and key strategies for building resiliency (or protective factors).

Rio Arriba County has higher rates of poverty than the state as a whole, and the average worker earned \$22,153 in 2001 compared to the state average of \$28,701. The levels of unemployment for Rio Arriba County are higher than for the state at large; in 2002, there was an average 7% unemployment in Rio Arriba, and 5.4% in New Mexico. In addition, many people who live in Rio Arriba work in Santa Fe or Los Alamos, and have additional stresses and expenses related to commuting.

Poverty is higher in Rio Arriba County. In 2002, an average of .9% of New Mexicans receive TANF assistance and 3.9% receive food stamps, whereas 1.1% of Rio Arriba residents receive TANF assistance and 4.8% receive food stamps. In 1999, just under 20% of Rio Arriba residents lived below the poverty line, and more than 25% of children lived below the poverty line.

Levels of education are lower in Rio Arriba County than in the state as a whole. This has many consequences, from lower wage jobs to fewer social and living skills. UNM's Bureau for Business and Economic Research (BBER) has data showing that there are more people in Rio Arriba County who attend high school but do not graduate than the state at large; there are fewer who attend college and fewer who graduate from college.

Earlier county needs assessments by the county and the Rio Arriba Family Care Network (RAFCN) focused on health needs and health disparities in the county population as well as family poverty and violence. In Rio Arriba County in 2003, a total of 54% of the population or 41,190 fell within 200% of poverty. RAFCN and the Maternal and Child Health Council (a committee of RAFCN) focused on poverty and access to care as critical issues for the community and its leaders.

A county health plan was developed for Rio Arriba County as part of the development of the Rio Arriba Family Care Network (RAFCN) in 2000. RAFCN was dissolved in the mid 2000s, and is now being reformed, with an update to the health plan. Here are some pertinent sections from the plan:

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many go to New Day and Youth Shelters facilities. Rio Arriba providers would like to reach more of these teens, however there needs to be a great mix of youth programs available, closer collaboration with specialty providers like Youth Shelters, and most importantly, closer collaboration with CYFD staff case managers. (CYFD statistics; statistics from NM Voices)

Those moving from jail to community represent a higher proportion of the population in Rio Arriba than in most other counties, and Rio Arriba has been chosen by the state as one of five high risk counties for collecting in-depth data. The DWI Resource Center reported that between 1999 and 2001, there were approximately 1,000 arrests, with a recidivism rate of approximately 10%. Those moving from jail to community are a priority target because reaching them through programs like those in LC1 can work with an interagency team to help probationers maintain sobriety and re-enter more successfully. This is a significant cost savings to the county and the state.

Over the past five years, the target populations for behavioral health services have been primarily the working poor who are uninsured. Within that large group are a number of subgroup targets, including youth at risk, the dually diagnosed; mothers with children; incarcerated and those just released; and those who have tried to get sober at least once.

As the LC1 providers discussed target populations as part of the planning, they reiterated the longstanding commitment to the primary target populations: families living below the poverty line, youth at risk, the incarcerated and those just released from institutions, the dually diagnosed and those who have tried to get sober before. These are priorities for prevention, outreach and treatment services. Another priority includes young adults aged 17-24 (who are much harder to reach than teens). A subset of the incarcerated population includes those that have been adjudicated to drug court along with other groups. They are high risk, currently being served by a primary agency, with a focus on a highly structured matrix model with incentives and disincentives.

Youth are the primary focus for the LC1 expansion of services for the following reasons:

- a. They have a very high risk profile, many needs, and require a range of services near to home which are currently not available;
- b. Adequate services are not available in the county,
- c. A mix of home based services using the community approaches described in the previous section could make a significant difference in helping youth build sober and successful lives;
- d. A number of local providers have the requisite expertise to provide leadership in building a community-based pilot.

Rio Arriba providers would like to respond the extremely high risk youth in the county by developing a pilot which is based on the children's medical home model and priorities of the Children's Behavioral Health Collaborative. This would include a Community Reinforcement Approach involving key community stakeholders in building and supporting the model (schools, youth organizations, faith communities, judicial system, employers, etc.). There would be a range of prevention, outreach, asset development and skill building, counseling and intensive services to cover a spectrum of care. These would include youth and families, and would operate from an asset development and multisystemic approach. There are already some very strong children and youth providers in the county and therapeutic resources that could provide strong leadership for this. One primary care agency has partnered with the children's medical home model in another county. And, LC1 could work with model agencies like Su Vida to implement a pilot to begin responding to youth needs as soon as the spring and summer of 2008.

3. What array of services has been purchased with the dollars, and how are services provided?

The array of services that have been purchased by the dollars for residents of Rio Arriba County includes the standard array of behavioral health services for adults, children and youth on the continuum of care. However, services are thin in a number of areas, and there are significant gaps in others. This section will outline (a) services purchased, the continuum of care, and (b) methods used in the service delivery system.. There is a range of services for adults in the county.

a. Service Delivery System and Continuum of Care

Because the service delivery system is thin and fragmented in Rio Arriba, there are certain services needed by families and youth not available in Rio Arriba County. The array of services purchased from providers based in county represents a much thinner and more fragmented cluster of services than the total array purchased for \$8.8 million (FY 2006, FY 2007 and a few months of FY 2008). Approximately 25% of the \$8.8 million allocated to behavioral health services for Rio Arriba residents is spent on providers based in the county. Approximately 75% of the funds go to specialty services outside of Rio Arriba County. Much of that is for services for youth. These are for all populations. Data provided did not separate populations by youth and adult; the only dimensions were type of service, amount billed and provider.

Therefore, the predominant array of services purchased from Rio Arriba providers includes prevention services for youth, children's services, case management (CCSS), counseling and therapy, psychosocial rehabilitation, intensive outpatient, residential treatment for adults, and medication. Other services purchased for Rio Arriba residents from providers outside of the county include residential treatment for youth, treatment foster care, counseling and therapy, psychosocial rehabilitation and hospitalization. Figs. 2 and 3, in Q1 describe this in more detail, so further explanation would be redundant. Many of these out of county services and costs are residential services for youth, including the Taos Group Home, and the Peak based in Las Cruces. Other specialty services for youth include an array of shelter, counseling, intensive counseling, and reintegration by Su Vida and Youth Shelters. There are other counseling, psycho social skills development and case management services provided by agencies in Santa Fe, such as Community Guidance Center. And, youth are in juvenile justice facilities, especially in areas that have limited behavioral health resources, according to the Interim Report of the Juvenile Justice Commission.

A summary of services purchased is as follows:

- 25% of the \$8.8 million was billed by Rio Arriba providers for a mix of services;
- 75% of the \$8.8 million was billed by other providers outside of Rio Arriba County;
- All core outpatient services (treatment planning, screening, counseling, psychosocial rehabilitation, etc.) totaled \$1.14 million excluding individual clinicians.
- Two thirds of all counseling and treatment were provided in Rio Arriba County (\$1.154 million) which includes providers and independent clinicians providing individual, family and group counseling);
- Multisystemic therapy for youth and families was provided in Santa Fe County (\$445,340).
- Crisis intervention, provided mainly outside of Rio Arriba (\$2,558) and crisis respite (\$189,232) provided by the children's provider;
- Case management (\$334,202) was spread among multiple providers in Rio Arriba County, and a number of agencies outside of the county, with much going to agencies outside of Rio Arriba County.
- Prevention services in multiple sites throughout the county.

Studying just the data alone, and looking at service utilization and expenses over against an ideal continuum of care, it appears that there has been a disproportionate utilization of out of county RTC and TFC services for youth, especially RTC services for youth. Since the needs and risk factors of the youth of

Rio Arriba County are so high, it seems important to have more resources for youth closer to home, beginning with prevention and including a mix of asset-based and therapeutic services. Some out of county providers billed over a million dollars for RTC services to youth, and it is not clear how many patients were seen, or the average length of stay. It was not possible to obtain that data. However, looking just at summary service and expense data alone, the sheer proportion of expenditures for youth RTCs at Taos Group Home, the Peak and others overweight that part of the continuum of care to such an extent that there are fewer resources available for outpatient, intensive outpatient, case management and other services. If there were fewer residential level, intense services, it would be possible to create a greater, overlapping mix of services closer to home, which could be more therapeutically and financially effective.

What we are recommending is that LC1 work with Value Options to shift the balance of resources on the continuum of care so that LC1 develops a mix of services for youth at home, using the CRA and medical home models. The ideal continuum of care should have the following key elements present, at a minimum:

- Range of services to meet community needs which begin with prevention, include asset based and therapeutic programs, delivered locally;
- Partnerships with appropriate community entities, including justice, schools and other nonprofits;
- Services provided that meet BCH and VO standards and quality criteria;
- A mix of service types an options that spread through the continuum of care;
- Easily accessible services in or near to the community.

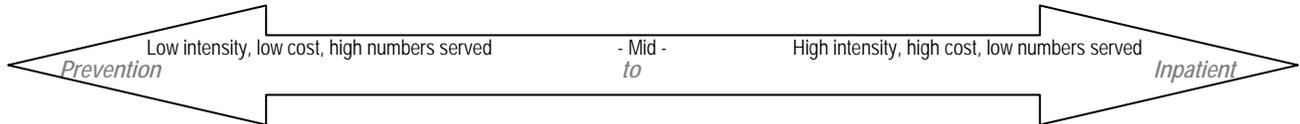
Below, you will find a framework for an ideal spectrum of services (Fig. 9 with a listing of services and types along the spectrum of care, from lower level of intensity to higher levels of intensity. This continuum of care is very similar to the Children’s Behavioral Health Collaborative Continuum of Care, shown in the Appendices following this report. There is also a framework which describes the current continuum of care provided for Rio Arriba residents (Fig. 10), with both in county and out-of-county providers listed. Light colored grey boxes indicate a low number of units of service offered for that type of care; darker grey indicates a greater level of care available and provided.

Ideally, Rio Arriba providers would provide maximum level of prevention, case management, outpatient, intensive outpatient services and some residential treatment possible within the infrastructure. Out of county resources would primarily be those specialized services or highly intensive therapies too expensive to maintain in every county, and offered for nearby counties in hub communities. The figures below demonstrate that the ideal continuum of care would have heavy utilization of outpatient and intensive outpatient services locally, along with some selected higher intensity services like RTC and hospital care. The actual situation is quite different, with many holes and weak areas in the Rio Arriba system along with some strong areas as well. Out of county provides a disproportionately high level of service in all areas, but especially in the intensive and residential treatment.

These charts further demonstrate the impact of having youth residential treatment and other specialty care outside of the county because these are not available in Rio Arriba.

(Fig. 9)

IDEAL	Pr P V	Centr Intake	Crisis Resp	Screen Assess	Psych Eval	Case Mgmt	Meds	Activity Therapy	Psycho Social Rehab	Couns and Therapy	Skills Dev	Corr Jail	Intensive OP	Prmy Care	Tmt Foster Care (TFC)	Res Tmt (RTC)	Hosp Care
In County	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Out of County	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■



(Fig. 10)

RA REAL	Pr P V	Centr Intake	Crisis Resp	Screen Assess	Psych Eval	Case Mgmt	Meds	Activity Therapy	Psycho Social Rehab	Couns and Therapy	Skills Dev	Corr Jail	Intensive OP	Prmy Care	Tmt Foster Care (TFC)	Res Tmt (RTC)	Hosp Care
In County	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Out of County	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■

These charts above show that, rather than having a continuum of services, the Rio Arriba network does not provide a significant level of low-intensity services onsite, and there are serious gaps in higher intensity services, especially for youth. Rather, some of these are also provided out of county, bifurcating the services at the lower end of the continuum. And, some services are not provided in the county, like activity therapy. Services in the middle of the continuum are all provided in county, however, all of those services are also provided elsewhere, in Santa Fe, Los Alamos and elsewhere. As a consequence, the services are fragmented. It is at the upper end of the service continuum that services really fall apart. Intensive outpatient has been weak, but is building; and there are few youth services other than prevention.

The following is a listing of service clusters and funding sources:

Fig. 11

Type of Service	Funding Sources
Prevention/Outreach	VO – Primary and Core Some funding available from other state DOH and CYFD programs. Some funding available from local foundations. Slim possibility of connecting with the Kellogg – NM Community Foundation asset based youth initiative.
Case Management	VO – Essential Very little other government funding will be available for this service, and even less foundation funding. There is a possibility that some limited state government funding might be available when case management is part of a special community initiative to reach specific groups.
Outpatient Therapies	VO – Essential Very little if any funding is available for outpatient therapies. Foundations won't fund this area, and usually see it as a government responsibility.
PsychoSocial Rehab	VO – Essential Very little if any funding is available for outpatient therapies. Foundations won't fund this area, and usually see it as a government responsibility.
Skills Development	VO – Essential Very little if any funding is available for outpatient therapies. Foundations won't fund this area, and usually see it as a government responsibility.
Intensive Outpatient	VO – Essential Very little if any funding is available for outpatient therapies. Foundations won't fund this area, and usually see it as a government responsibility.
Residential Treatment	VO – Essential Very little if any funding is available for inpatient therapies. Foundations won't fund this area, and usually see it as a government responsibility.
Medication	VO – Essential and Only Few other resources will support medication regimens
Special Community Initiatives	VO Support – Special initiatives to address the needs of specific population groups (youth, released from jail, mothers, etc) could draw additional funding from other state and local government
Collaborative Strategies and System Development	VO Partnership – Collaboration and system development could and should receive some county funding along with VO support; and additional state or foundation funding might be available to the extent that this work supports special initiatives.

The behavioral health network has approximately 85%-90% of its programs funded by the State of New Mexico, through Value Options. There have been some creative uses of foundation support, primarily for prevention and children's programs. To be effective, the behavioral health network will need to maintain at least the current level of funding from VO, as that is the core, essential funding for programs, and because the other possible funders look to see that there is strong, core funding and diversification with other funding. Foundations do not want to fund what they see as government responsibility. (Independent Sector; research papers, 1980, and periodically 1984-2000)

The primary areas of the behavioral health continuum that should be optimistic about local foundation funding are prevention outreach and asset based programs, which could be eligible for some of the Kellogg Funds which are administered by the New Mexico Community Foundation in partnership with the New Mexico Forum for Youth & Community. Traditional healing programs developed by one agency have received additional funding, and the area of traditional community development, cultural asset based programs and traditional healing all have potential for funding from the foundation community. Programs

for children and youth and their families are usually well positioned for additional funding either other government agencies or initiatives, or private foundations like Daniels, Frost, LANL and the Santa Fe Community Foundation. And, services that tie into economic development could be eligible for government funds and support from selected foundations concerned about economic development, like the McCune Foundation. “Green” jobs and job training might be of interest to foundations like Messengers of the Healing Winds, which funds environmental causes and the arts. Then, there is some local funding available through United Way and the LANL Foundation.

However, the general continuum of behavioral health care is only somewhat funded by other state government entities for project funding, and it is not something funded by most New Mexico foundations. However, there could be some federal and national foundation funding if the LC1 is able to build some innovative community based elements of care, utilizing case management, peer-to-peer programs and culturally based asset development. The LC1 RA network would need to be much stronger and better integrated before it could move forward seeking some of these national opportunities. The third section of this report provides additional strategies for funding.

b. Methods Used in Services Provided: Evidence Based, Effective Practices and Models

Within the services that are offered by Rio Arriba providers, we find the use of evidence based practices (EBPs), the Matrix Model and Multisystemic Therapies, but the use is sporadic and not widely shared throughout the network. A number of providers have been using the ASI as a treatment planning tool, identifying information about the consumer’s scores on the different domains, however, few providers have been able to download and use the ASI data and analysis provided by Inflexxions to use for a deeper study of the progress of consumers, areas of greatest growth and difficulty, and any trends.

Prevention providers use a different taxonomy from therapeutic providers in terms of domains of behavior and assessment tools, a taxonomy which is very strongly evidence based. The prevention work is grounded in the methodology of asset based youth development (pioneered by the Search Institute which developed 40 domains or assets important to successful youth development). Most prevention providers use the nationally recognized YRRS or the NM Strategies for Success as assessment tools. Normally, the tool is administered at initial group contact, and then later to measure change in attitudes about substance abuse, behavior and self image. Programs are geared toward informing youth about the dangers of substance abuse, identifying risk behaviors and substituting positive activities and asset building behaviors for risk behaviors. Assessments like YRRS and NM Strategies for Success measure progress with attitudes and behaviors. The DOH Prevention Department has worked with each funded provider and with the network of prevention providers to identify and report outcomes, and strategies used to reach outcomes. The summary outcome framework is published by DOH, and should be a helpful resource not only for prevention providers, but as a possible model for LC treatment providers.

Programs in Northern New Mexico also develop relationships with parents and measure progress with family relationships. They work with other organizations and community leaders to reduce the level of alcohol, tobacco and drugs in the community. Many programs are developed in partnership with schools for both in-school and after-school activities. One agency executive reports that collaboration with schools is becoming more difficult because of the many requirements that continue to be required of school systems by federal and state government. She explained agencies need to become increasingly creative, and more knowledgeable about state requirements so that they can demonstrate to school leaders how youth program partnerships help schools meet NM Standards and Benchmarks.

Children’s providers include those that offer services to disabled children and other agencies involved with providing counseling and support to middle school and high school students. Because the services are quite different, the domains identified and assessment tools are different. The primary children’s provider uses the nationally recognized Ages & Stages ASQSE assessment tool for initial assessment. This tool measures

the child's developmental capabilities over against national norms, and provides the practitioner with a picture of each child, and their developmental capabilities in all major areas. Other tools used by the children's provider include the Infant and Toddler Developmental Assessment (IDA). Therapists videotape certain sessions and activities, utilizing evidence based practice in working with children and families. The staff can then develop their Individual Family Service Plan and goals from the assessment. Staff use checklists to track progress with children and their parents or caregivers, including improvements in emotional responses, attachment and other activities that are part of early childhood therapeutic evidence based practices. And, a rather broad measure of success in working with children and families is the extent to which these families require less CYFD involvement.

Another provider offers counseling at Espanola area schools, working in collaboration with senior school staff who help identify children at risk and in need of counseling. The counselor is also available for those that want to discuss a concern. (CFARS is an important resource.)

The Community Reinforcement Approach (CRA) had been adopted somewhat by the provider network. CRA is a comprehensive behavioral program for treating substance-abuse problems, based on the belief that the community environment can play a significant role to encourage or discourage substance abuse. In the overall planning process, providers and other stakeholders have focused on the many environmental factors in the county that affect substance abuse: prevalence of liquor stores, "drug culture," poverty and unemployment, social connections and family. The network is to be commended for its holistic focus on the community and its many positive and negative impacts on substance abuse. Many prevention providers and some other providers have worked to build a model that contains elements of CRA. However, clinicians and executives have not mentioned using the CRA guideline in clinical work or in overall program planning. Since the CRA is well tested and validated, it represents an important and useful tool.

The following explains the benefits of CRA:

"Once you complete your review of this guideline, you can expect to be better prepared to work with consumers using CRA for several reasons. First, by gaining an introductory understanding of the principles underlying CRA, you will have a theoretical foundation by which to base your practice of this method. Second, by following the procedures outlined in the clinical guideline, you will have a number of treatment strategies by which to develop and structure an effective intervention with a variety of consumers presenting with a diversity of needs. When learning any new treatment modality, it is essential to bear in mind that mastery comes only as a result of both study and practice. To that end, we have also provided you with a resource section that we hope will serve as a useful starting point in your effort to become more knowledgeable of, and efficient with, the practice of the Community Reinforcement Approach." (UNM Center on Alcoholism, Drug Abuse and Addictions)

Since the provider network and other stakeholders already share a community systems approach similar to CRA, it would benefit Rio Arriba consumers if LC1 providers were able to fully implement the CRA processes as part of treatment protocols, and to track how effectively CRA is working in Rio Arriba County. CRA could help agencies provide outreach and treatment with better results (efficacy) and lower costs (efficiency). It is a framework which fully complements the Total Community Approach for planning. Perhaps a UNM graduate student could work with LC1 to help with training, implementation and evaluation. Rio Arriba County should provide a very important research site for the UNM Center.

There is also a Children's Behavioral Health Collaborative (CBHC) that is developing a framework for children's services with a focus on developing a mix of services close to home. Their framework is compatible with the CRA, and in fact, benefits from a strong and engaged community. The continuum of services is very similar to that outlined in Section 1. The LC1 will want to work closely and collaboratively with the Children's Behavioral Health Collaborative. Appendix C provides the CBHC rationale, framework and continuum of care.

All of the providers that offer counseling use the ASI (outpatient, intensive outpatient and residential treatment). Clinicians use the ASI as part of initial intake and assessment. They report that they use the results of the ASI with each consumer to guide the treatment plan. Once a consumer has been involved with treatment for awhile, clinicians re-administer the ASI at recommended intervals. They review progress and use this to guide ongoing work with goals. During the past months, providers in LC1 have been introduced to a new web-based form of the ASI, which consumers complete onsite, which is transmitted to a contractor, Inflexxion. To date, Inflexxion states that there are about 700 ASI tests on file, with just over 40 of those representing re-tests. Providers are just beginning to learn how to use the web-based system, to review ASI reports to track progress of individuals as well as track trends in a group. Over the coming year, if providers receive ongoing training and support with the web-based ASI data analysis, clinicians will find that the analysis serves as an incredibly important tool that can help plan and direct the therapeutic process.

Many providers use the ASAM criteria as another tool, to determine the level of care. They see ASAM not as an assessment tool, but rather a helpful guideline.

Corrections counselors currently use the ADE and the ASI for intake and assessment, but not follow up. In addition, they use a corrections specific matrix focused on criminogenic factors and the development of certain pro-social skills and behaviors which relate to the ASI domains of substance abuse, employment, legal and social skills. Corrections consumers work to make and report progress on these domains, adhering to the treatment protocols.

Multisystemic therapy (MST) is an intensive family-based treatment that addresses the known determinants of serious antisocial behavior in adolescents and their families. The focus of MST is to identify and treat the factors in a youth's environment which contribute to behavior problems (family relations, friends, school, etc). Treatment goals are developed with the family, and rely on youth and family strengths, or assets. As such, MST is complementary to the Search Institute's 40 youth developmental assets. Although some of the prevention providers utilize developmental assets, the primary children's provider utilizes a family approach, and some youth and family therapy is provided by some local agencies, there isn't a concerted, well integrated MST approach in the county. One important reason for this is that there are very few behavioral health resources for youth, as has been outlined elsewhere in this plan. As Rio Arriba County develops its pilot for a mix of resources for youth, the MST approach should be central to the pilot development. Providers might need training and technical assistance in the MST framework, its interface with other frameworks, MST evaluation, and integrating this evaluation with other evaluations being used.

LC1 agencies and other stakeholders have indicated that they have been extremely concerned that youth go for residential treatment, away from family, friends and school. When they return, there is not connection or support set up for them. The current situation is antithetical to MST approach, to the children's medical home model and to the priorities of the Children's Behavioral Health Collaborative. As youth services are developed, they need to be grounded in these four complementary approaches, building assets and resiliency while reducing risks. (Federal Offices of Health Promotion and Juvenile Justice Prevention)

Intensive Outpatient Programs (IOP) use the Matrix Model for their goalsetting, treatment planning and clinical work with consumers. The goal of the Matrix Model has been to provide a framework within which substance abusers can: (a) cease use of substances, (b) retain in treatment, (c) learn about issues critical to addiction and relapse, (d) receive direction and support from a trained therapist, (e) receive education for family members affected by the addiction, (f) become familiar with the self-help programs, and (g) receive monitoring by urine testing.

“The Matrix model requires that the therapists use a combination of skills required to function simultaneously as teacher and coach. The therapist fosters a positive, encouraging relationship with the patient and uses that relationship to reinforce positive behavior change. The interaction between the therapist and the patient is realistic and direct but not confrontational or parental. Therapists are trained to view the treatment process as an exercise that will promote self-esteem, dignity, and self-worth. A positive relationship between patient and therapist is a critical element for patient retention. The model uses detailed treatment manuals that include work sheets for individual and family work, recovery skills groups, relapse prevention groups and others. IOP is successfully using the Matrix Model with good results. Data needs to be gathered and analyzed through the ASI and other benchmarks tracked by the Matrix Model. Other providers might find the Matrix Model provides a useful structure that guides the recovery process. LC1 might find it helpful to work with Value Options to see what data exists about Matrix Model results throughout the state, whether there is data to demonstrate comparable efficacy between alcohol and drug users in the program, and whether there is any state or national data comparing results using the Matrix Model in outpatient vs. intensive outpatient programs.” (National Institute on Drug Abuse, NIDA).

The primary focus of Functional Family Therapy is the family, and the therapeutic model looks at the youth consumer and the family as a unit, and seeks to identify family risk behaviors as well as family strengths or assets. FFT is multi-modal in that it includes youth and family assessment, counseling, home visits and other tools to help the family move in a positive direction through engagement, motivation, assessment and behavior change. The clinician works with other children in the family, to help prevent high risk behaviors. The purpose of this model is to reach the entire family system, rather than just the young person, and to prevent more intensive care for youth and/or family later on if the real issues are not addressed and remediated. Currently, CYFD staff provide the bulk of FFT within New Mexico (according to CYFD website). Although there is little discussion about FFT as such within LC1, the providers in LC1 certainly have a complementary view of mix of services needed locally for youth and their family, with a focus on youth, family, school, social networks and other important circles. It seems appropriate for LC1 to promote FFT, and encourage providers to develop this set of tools, perhaps with support from CYFD staff that use FFT. (Center for the Study and Prevention of Violence, University of Colorado and U.S. Office of Juvenile Justice and Delinquency Prevention)

Rio Arriba providers have used a number of evidence based practices (EBPs) and positive models for treatment. These include asset-based youth development frameworks in prevention based on the Search Institute’s developmental asset research, NM Strategies for Success and other prevention strategies that have been promulgated and supported by the NM Forum for Youth and Community. Another evidence based practice among youth prevention providers is partnering with key community institutions that serve youth, to create a joint initiative. This is an especially important strategy with schools, juvenile justice professionals and other youth serving organizations. Tracking progress has been part of the Northern New Mexico prevention plan submitted to DOH, and progress has been seen on a number of key dimensions identified, such as reduction in alcohol use and reduction in risk behaviors. (See Appendices for NNM Prevention Plan).

Children’s providers use Ages and Stages, which is similar to CFARS. Some might use CFARS, but the two are the primary assessment tools for children. In addition, children’s providers use evidence based practices such as developing a Family Service Plan with goals, involving families at every stage of a child’s treatment, and adhering to evidence based practices supported by early intervention practitioners and the NM early childhood network.

Case managers use practices that focus on helping consumers find ways to meet their basic needs, and operate from the perspective that if basic needs are not met, a consumer’s stress level increases and they are at greater risk for returning to substance abuse and other high risk behaviors.

Adult providers use ASAM criteria for determining level of care, which is an evidence based practice, and use the ASI for initial and subsequent assessments. Clinicians use ASI re-tests to determine progress or any areas of concern, and the data from the ASI helps to shape the trajectory of future therapy.

A key intensive outpatient provider uses the Matrix Model to guide individual, group and family treatment, which is a highly structured model that involves a mix of clinical and peer individual and group activities. The model requires that the consumer reflect on the past prior to getting sober, the importance of sobriety, and sober living skills. In addition to reflecting, consumers write and discuss issues. The Matrix Model is a multi modal successful model that represents an evidence based practice.

However, not all providers use all appropriate methods. And, individual providers have not yet come together in a systems approach within LC1 to build in a proactive way a Community Reinforcement Approach (CRA) and an asset-based framework that can help children, youth and adults.

However, many of the individual providers have pieces of the overall framework, and/or have been utilizing models and evidence based practices. It should be possible for LC1 to build this framework, perhaps with some support of Value Options and/or state staff. The CRA and related frameworks should be a priority for LC1's work both with providers and the larger community. And, LC1 should look at ways to incorporate the work of the Children's Behavioral Health Collaborative and other related initiatives.

4. Describe past and current outcomes.

Agencies in the Rio Arriba network use a number of evidence based practices, including the Matrix Model, the use of ASAM criteria for level of care, and ASI in assessments. Over the years, many of the providers have worked hard to build services around evidence based practices and to build quality through tracking outcomes. However, the network has not been able to articulate an outcome framework, and many agencies struggle to identify and track outcomes. This section outlines general outcome areas for the entire system, based on type or level of service, and then describes how the ASI provides specific outcome indicators and data. The following table outlines the range of outcomes and indicators in the system, by service type.

Fig. 12

Area	Outcomes	Key Indicators
Prevention	Increased awareness of substance abuse risks; decrease in reported risk behaviors; increase in reported asset based behaviors.	YRRS and Strategies for Success assessment; Too Good for Drugs Curriculum w/ feedback. Staff observations of progress in key areas.
Screening and assessment	Determine issues, strengths and weaknesses; diagnosis; information to help guide treatment plan.	Interviews, ASI, ADE on DWI offenders, and other assessments. Scoring on 7 ASI domains used to determine treatment level, and develop treatment plan goals. Retesting on ASI to track progress.
Psych evaluation	Psychiatric level - determine issues, strengths and weaknesses; diagnosis; medication needs; information to help guide treatment plan.	Psych interview/s and assessments; DSM diagnosis as appropriate; prescriptions.
Case management	Identify key issues, develop treatment plan with goals, implement goals (sobriety, support system, employment, housing, transportation), develop support networks, address progress in meeting goals.	Case management checklist of sobriety issues, goals set related to issues, recovery plan and goals set based on addressing issues and meeting challenges (similar to Matrix Model). Log of progress.
Medication	Provide medication (methadone) to facilitate maintenance of sobriety; monitor progress and provide case management support.	Medication regimen approved, administered. Consumer's progress monitored. Issues identified, referrals made. Medication levels tracked regularly.
Activity therapy	Provide activities that help consumers build self awareness and self esteem; increase readiness to address issues.	Therapy regimen developed. Consumers engage in activities, reflection and skill development. Progress tracked.
Psycho social rehab	Learn about skills needed; work to develop core skills; use skills in social and work situations; develop social supports.	Individual Service Plan (ISP); progress tracked through log.
Counseling	Develop treatment plan for sobriety; address issues w/ counselor; demonstrate progress on goals; maintain progress and sobriety.	ISP developed w/ goals; issues or challenges identified; progress tracked through log.
CBT Counseling and skills development (corrections).	Learn the framework and rules of the program, develop treatment plan for abstinence and pro-social behaviors; address issues w/ counselor; demonstrate progress on goals through regular reports; receive support from interagency team; maintain progress and sobriety.	Consumer program agreement and treatment plan goals set based on ASI. Progress on goals tracked through supervision and counseling/therapy. Goal progress log and reports, interagency team meetings, drug testing. Retesting w/ ASI to track progress.
Skills development	Assess skills needed, learn skills, practice skills, demonstrate new competence with skills.	Interview and ISP developed based on needs and ASI. Log of skill training, log of consumer's progress and competence. Retesting w/ ASI to track progress.
Intensive outpatient	Assessment indicates intensive OP appropriate; assessment identifies key issues; consumers learn structure of program, develop treatment plan with goals, practice new sober behaviors, use groups for support; track progress.	Intake, ASI and other assessments. Framework outlined and agreement made. ISP. Matrix model individual and group counseling, meetings, workshops. Therapist and consumer track progress with goals, using ASAM criteria and retesting w/ ASI.
Treatment foster care	Treatment foster family develops commitment, builds skills, TF family provides stable home.	Log outlining training of families, placement, ongoing support and skill development, crisis management.
Residential treatment	Assessment indicates need for intensive residential treatment and identifies key issues to address; therapy provides consumer with insights into drinking behavior; group activities develop social skills.	Initial interview and submission for approval from VO. Intake, ASAM, other assessments. Treatment framework and rules outlined and agreements made. ISP developed. Combination of workshops, individual and group counseling, psycho social rehab, skill development. Log tracks progress with goals.
Hospital	Diagnosis; triage and safety. Release or hospitalization in RA/SF or UNM. Most intensive form of protection, stabilization and support.	Screening, assessment and intake. Diagnosis and treatment plan. Treatment administered and consumer maintained, discharged or referred to another facility.

The ASI is perhaps the most important tool used in behavioral health outcomes measurement and is the tool used most frequently by clinicians. Children's serving agencies use Ages and Stages and CFARS, and prevention based youth providers use YRRS and New Mexico Strategies for Success. And, DWI treatment providers use the state-mandated ADE.

The ASI is used as an initial assessment in all levels of counseling to determine where a consumer falls on each of 7 domains of the ASI. Clinicians review the ASI results to determine a profile of the consumer's needs, strengths and weaknesses. And, with the consumer, the clinician develops a treatment plan with specific treatment goals meant to support the areas of strength indicated in the ASI and to develop and strengthen areas reported to be weak. During therapy and other activities (depending upon the level of treatment), the clinician makes notes about progress in each of the 7 domains. Consumers retake the test at prescribed intervals, and clinician and consumer track progress and identify areas where more work is needed.

Outcomes are demonstrated as progress made by consumers on at least 5 of the 7 domains of the ASI. The progress is tracked by consumer reflections, clinical observations and by ASI scores on test retakes. Scores provide the strongest numerical, documented progress. Clinicians are already using the ASI to track individual client progress on the following domains:

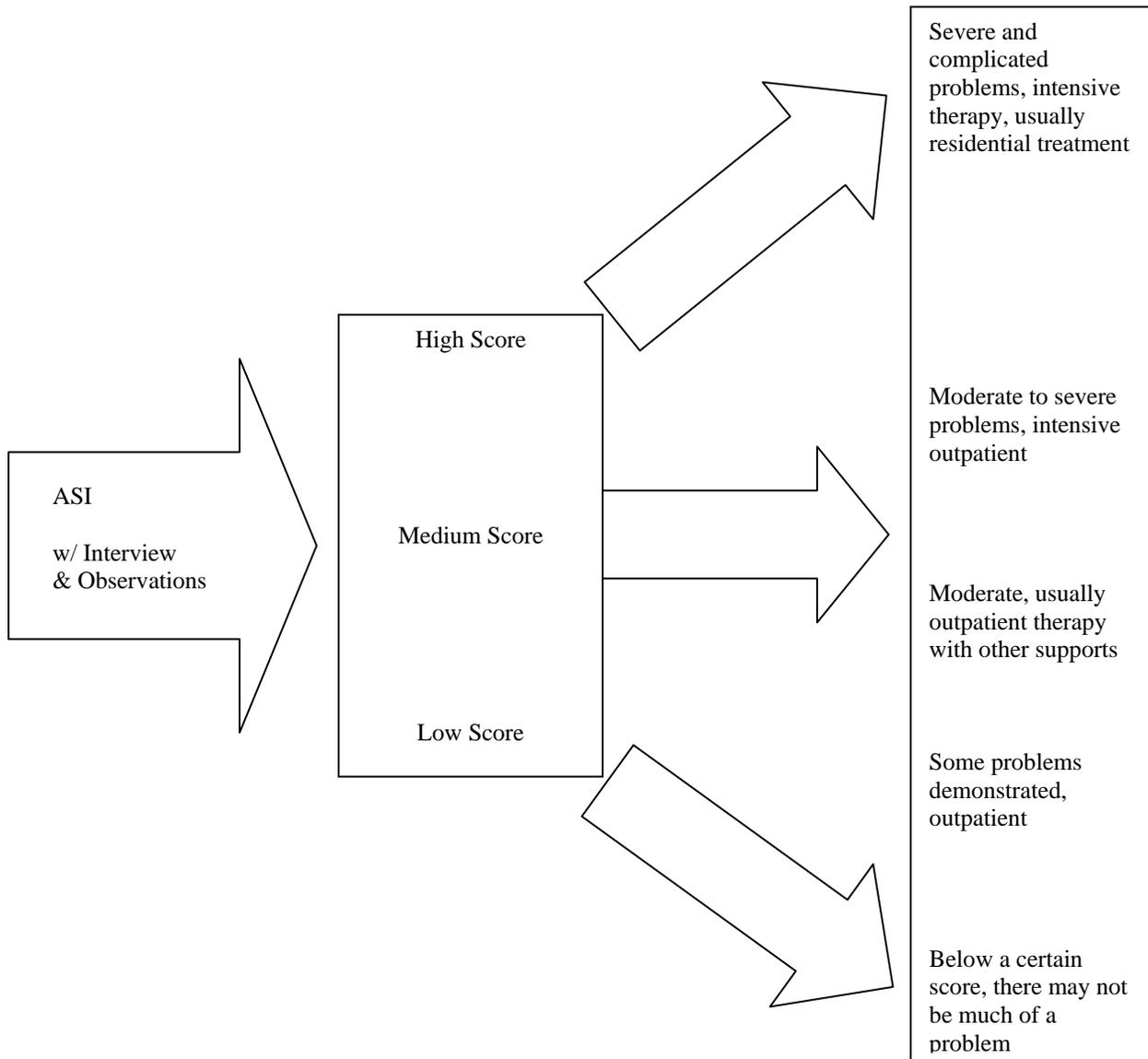
- Alcohol Use
- Drug Use
- Medical History
- Employment History
- Legal Status
- Social Status
- Psychiatric Status

Clinicians providing counseling in different settings from outpatient to residential treatment are using ASI scores to guide treatment, and using retest scores to track progress and guide further work. At least three of the providers outlined in some detail how they are tracking consumer progress on the domains, and how the ASI is one important measure of progress.

The ASI serves as a key yardstick to provide an initial profile of an individual on 7 domains, and then track progress on those domains. The data provides clinicians with specific indicators of progress or lack of progress on each of the 7 domains. Value Options has recently contracted with Inflexxions to provide a web-based ASI that consumers can take in the office. Scoring is immediate, and agencies can pull down scores for individual consumers as well as aggregate analysis of all consumers or any subset group (such as those in treatment for more than or less than a specific period of time; different demographic types based on age or sex; comparison of improvement rates based on different starting points, etc.).

Providers have just begun working with this resource, and some completed training only a few weeks ago. However, if Value Options and Inflexxions can continue to offer training and support, all providers should be able to use this data and analysis. In the future, clinicians should be able to see different trends among consumers and fine-tune their treatment planning to respond to different types of people and their specific needs. Studies conducted at Rice on the validity of internet ASI formats demonstrated that they were as reliable and valid as the interview format. (Brody et.al.)

The following is a schematic describing how the ASI is used as the primary outcome indicator demonstrating progress or lack of progress in treatment. Clinicians administer the ASI to determine the severity of substance abuse and the pervasiveness of its impact in someone’s life. A level of treatment is determined by the ASI score along with the clinician’s interview and any other assessments. A treatment plan is developed with goals, based on work needed in each of the ASI domains. Currently, Rio Arriba providers are using the ASI in the ways described in this section. Because the web-based program is new, we will gather outcome indicator data in individual meetings with providers looking at the web-based data, analysis and reports.



Clinicians now use the ASI to guide treatment planning and measure progress with individual consumers. For example, George starts treatment with generally moderate to low scores across most domains except for drug use and employment. The clinician works with George to develop strategies to maintain his sobriety, maintain and build on the strength of his employment, refrain from encounters with the law, and to build in other areas, especially building family and social support networks. Therapy involves reflecting on his life and behavior, what works and doesn't work, and how he can address problems and stressors. A retaking of the ASI shows some progress on the employment domain, but lower scores on social and psychiatric domains. The clinician uses this data to explore what is going on with the consumer, and finds that the consumer has stopped going to AA, is depressed, and has deteriorating relationships at home. This information can then guide some clinical interventions to help the consumer address depression (perhaps with medication), re-build a sobriety support system, and deal with challenges at home.

ASI information serve as indicators of progress, stagnation or lack of progress. The indicators are specific to the domains, and show clinicians how and in what ways consumers are changing. This allows the clinician to become ever more targeted in approach, addressing risks more quickly and specifically and strengths also more effectively. The consumer and clinician can move forward in therapy to address goals with greater assurance that they are taking steps more appropriate to the situation, steps that have a better chance of success.

Rio Arriba therapeutic providers use the ASI now, and have indicated that they use the tool much in the way it is described above. ASI data informs initial and subsequent treatment planning and therapeutic interventions.

However, most providers do not use the ASI data in a comprehensive way, looking at trends based on key factors such as: age, sex, race or culture, initial profile, types of supports for early sobriety, etc. This is partly because the web based program from Inflexxions is still new, especially with the 6.0 version of the ASI data. However, the consultant has been able to schedule visits with providers to review the data. An initial visit with the CMHC demonstrated that the provider was able to download general reports based on pre and post ASI 6.0 data, and to develop custom cross-tab reports, comparing the ASI alcohol and drug severity index scores with legal issues, employment, health and family. It was no surprise to find that those consumers that had high alcohol and drug scores were also compromised in other key areas of their lives. Those with lower alcohol and drug composite scores had better functioning in other areas of their lives. These cross tab studies can provide important analysis for clinicians and supervisors; as they work with different types of consumers, they can use these cross tab analyses to help guide treatment and track outcomes. The ASI data as reported by Inflexxions also provides demographic and composite score cross tab analysis, offering another window into consumer substance abuse severity, based primarily on age and gender. The CMHC and other providers should be able to run the general reports, and specialized reports, and use the data to guide clinical work. (See Appendix 7)

Data from the 6.0 web ASI and earlier data can be analyzed together for almost all queries. And LC1 should discuss these ASI outcomes issues in meetings. And, it would be helpful if VO could provide ongoing follow-up, just to make sure that providers understand the system, use the data reports, and find them helpful for clinical work.

If Inflexxions is able to provide regional and state aggregate analyzed data, along with agency specific aggregate and analyzed data for the provider, then providers can plan therapy based on the following types of information. Are there special treatment needs that youth or young adults have, that should be addressed? Do mothers with children have different needs and issues, particularly as relates to the social domain with family support? What are the key identifying factors of those that make the most progress – do they start with some strong areas/domains? Do they build strength in certain ways?

5. Analysis of funding, services funded, barriers and a plan for addressing barriers.

The LC1 behavioral health network of providers is a fragmented and fragile service delivery system which is less a network, and more a collection of a few core agencies. The most important barriers to improving outcomes are the following:

- The behavioral health system is fragmented and poorly organized, with limited ability to refer and follow consumers;
- LC1 has not developed an integrated outcome framework, demonstrating outcomes for different levels of care (Figs 9-10);
- A disproportionately high portion of care goes to RTC services, primarily RTC and TFC for youth outside of Rio Arriba County. As a consequence, less funding is available for other levels of care. The collaborative is therefore thin, poorly funded, with fragmented care and interagency competition.
- About 12% of all funds available to Rio Arriba providers is for case management (CCSS), which has the potential to help consumers find resources and stabilize their lives. Providers and consumers report that case management has been extremely helpful, and that more is needed.
- There is limited interagency collaboration, and mixed support for LC1. Some county providers have a history of independence which may be counterproductive to building the collaborative. And, leadership itself seems to be weak and in need of strengthening. There is no well defined leadership with strong support, but rather individuals and groups that take on leadership by turns.

It seems that all of the barriers can be summarized into three primary barriers, one internal, the other primarily external, and the third both internal and external:

- a. Competition, infighting and historical unwillingness to work together to build a network and create a mix of services. This will only change with a mix of strong incentives and disincentives, accountability, coaching and technical assistance, and creation of new resources that are a win-win for everyone.
- b. Providing services in a system that has limited services, service gaps and limited funding. These limited services draw only a portion of the consumers, services and dollars, or 25% of the billed amounts. Developing a network is difficult under these circumstances. Service fragmentation, and the lack of centralized intake, crisis response, important services for youth, and more case management create a system that is anemic. The funding for services and their allocation exacerbates the already existing historical dysfunction.
- c. Provider and LC1 service quality is mixed. Outcome reporting is spotty. Internal CQI was initially developed as part of R2BHP in the mid 1990s, but few agencies have maintained an internal CQI process without direction and support from the Managed Care Organization (MCO). There is little financial and service analysis. And, it is extremely difficult to track a consumer through the system, and ensure that person is not dropped. Much of the responsibility lies with LC1 providers and the network – to conduct outcomes training, to use the ASI data and analysis, to build frameworks based on the outlines developed in this report, and to conduct service and financial analysis. Part of the responsibility lies with VO, to share in the identification of outcomes and build a matrix, partner with outcome training, and provide financial and service data to each agency at least quarterly if not more often.

More information, with goals and strategies for reducing barriers are included in Section III, the Goals Section.

A thorough analysis of Value Options contract revenues, state and local funds, and foundation funds has been completed and is outlined in section B.1. with charts and graphs about the funding sources and levels. Value Options funding represents the vast majority of all funding for Rio Arriba providers, and is absolutely essential as core funding. The VO funding for care for county residents was \$8.8 million in FY 2006, 2007 and a few months of 2008. Approximately 25% of that funding is spent for a range of prevention, counseling/therapy, intensive outpatient, medication and residential treatment for adults. And 75% of the total is spent primarily for out of county residential and treatment foster care services for youth, and some therapeutic and hospital services for adults.

The greatest barriers to care for youth seem to be the lack of services for youth in Rio Arriba County. LC1 members and other stakeholders are extremely concerned about youth at risk in Rio Arriba County, and believe that having services closer to home would be more effective for youth and their families. They support the medical home and Children's Behavioral Health models that have as a principal value the providing of services close to home.

The providers are interested in building the capacity for a medical home for youth on the Su Vida model, and it should be possible to do so, if more capacity is developed in the system. Then the proportion of in to out of county services and related funding should shift closer to 50% to 50% or even 60% to 40%.

There are still services that are provided to Rio Arriba adults out of county, when there are in-county resources. For instance, there are a number of adults seen for counseling and therapy by providers in Santa Fe and Los Alamos. Providers in many counties provide psychosocial rehabilitation. And, hospitalization is provided in multiple counties. We have begun a project expansion to talk with executives of these agencies that serve Rio Arriba residents and with consumers to determine why people seek services further away from home, feedback about local resources, and a brief testing of local front-line responses. This information will help determine in a more specific way the perception of providers, which is very important to inform any plans to expand services in a pilot program for youth.

Plans for addressing service delivery issues include:

- a. Addressing key issues outlined in this report and plan, including problems with collaborating, lack of a system and sense of shared goals, competition, and undercutting. Activities to address these would include an identification of shared goals as part of the planning process, and writing a shared goals statement and agreement. Developing MOUs for collaboration and agreements about collaboration and competition. Agreement to create a mutually supportive environment and to refrain from backbiting. Agreement to set minimum standards for performance related to services provided, funds expended and outcomes.
- b. Gathering feedback from consumers and providers out of county to paint a profile of Rio Arriba providers, with recommendations for addressing perceptions, especially those for individual providers;
- c. Working together on a joint pilot project for centralized intake, to provide a more integrated system. Work in partnership with the CARE Connection.
- d. Identifying other areas where increased funding for collaborative work is possible. Provide financial rewards to agencies that provide quality services meeting standards and that work in a collaborative framework.

Providers have a number of barriers to developing funding for services, and these are both internal and systemic. They include loss of funding from prior years, inability to draw down funding in current and prior years, and limited funding from outside sources.

- a. Some agencies have received either changes in the way funds are allocated or reduction in funds because a program was shut down, reassigned or cut back. These funding shortfalls create considerable stress for agencies, even when they are considered to appropriate actions.
- b. In some cases, agencies have not fully drawn down funds to which they are entitled; during FY 2008, it appears that there could be up to \$500,000 not yet expended by two of the primary agencies in the county. This funding needs to be either expended or reallocated, or it will be lost. Providers need to be able to track expenditures on a quarterly basis, and make appropriate changes to ensure that funds are either spent by them or by another agency, so that they do not go back to VO or the general fund.
- c. Some agencies have received significant funding from other state agencies or programs, and from private foundations. These are usually larger agencies, and agencies that work with prevention and youth, or with special initiatives. In 2003, there were 11 different grants and contracts given to R2BHP agencies; in 2007, there were just 5 grants or contracts. One wonders why there has been a more than 50% drop in additional funding support. Part of the reason could be the differences in funding streams between the old R2BHP and LC1; or there could be changes in state contracts; reduction in foundation funding; short-term grants not eligible for renewal; or the different funders could be less supportive of initiatives they funded previously. It is important for providers to contact previous funders to determine why something did not receive additional funding.

Many agencies feel they do not have the time or skills to be involved in serious fund raising. However, many also find time to apply for specific grants related to their programs, primarily from state and local government. Some agencies, usually larger ones, have been able to obtain foundation funding as well. It will take continued hard work on the part of executives, and support from peers to build the grantwriting capacity. Some programs can do additional fund raising, particularly if the work with children or special initiatives. However, in general, the public does not normally rush to support community behavioral health programs.

Another barrier to bring in more outside resources lies with the LC1. Currently, in Rio Arriba, the LC1 has not developed a strong collaborative structure or feeling. Therefore, if there were to be a new pilot initiative for youth, it could be difficult for providers to come together around such an opportunity and work together to build effective services that would generate additional funding. However, if there is strong leadership, and a core of strong, well respected agencies driving the pilot, the work might actually serve to build momentum for collaboration. In the future, there could be additional funding for a federal or state initiative that comes from the Governor's Office on Faith Based and Community Initiatives. It would be important for the providers to come together around such an opportunity, and to be building a track record of successful collaboration, community outreach and engagement, and articulation of outcomes or results.

A final barrier to getting more funds lies in the funding ratios for Rio Arriba. As long the region does not have youth services or other specialized services, then it will receive only a portion of the funds allocated to residents, since residents seek services elsewhere. Therefore, working to build greater quality and capacity among individual providers and the LC1 is a top priority. Another top priority is to bring on board those services not currently present, and most in demand by residents. These would be building centralized intake, youth services, and crisis response according to feedback from a broad base of stakeholders.

Individual providers can continue to augment core funding with funding for special projects from state and county contracts and foundations. The local collaborative can seek special funding for building a culturally appropriate mix of services, especially those with an outreach to youth and young adults, and to those recently incarcerated. Any coordinated services to youth should be able to generate additional government and foundation support.

The county itself should be asked to provide some of the funding needed to expand services, acting as a leverage for additional funding from Value Options and others. If the county makes a significant investment in youth services during the pilot period, it will be much easier to develop the sort of diversified funding required for long term success.

There are a few steps that need to take place to ensure that a mix of youth services on the children's medical home model can succeed (involve Su Vida and VO staff in the planning and identification of services). The resources will need to be seen by the youth as safe and cool. Youth providers that have already developed trusting relationships with youth in Espanola, Chimayo and Chama should provide critically needed leadership in how services should be structured, how youth should be involved along with adults in developing the resources, and strategies for reaching and engaging youth.

- Preliminary identification of the service mix and providers to offer services (school based prevention, school based counseling and case management, drop-in services at key locations, crisis response services, community case management and counseling for youth and families, intensive outpatient and perhaps limited residential).
- Investigate the mix of services needed and funding available (\$ 65,000 for TCA pilot).
- Develop publicity and outreach to schools, faith communities, youth organizations and other places where youth congregate. If youth have been involved in the plans, they can provide some of the best outreach.
- Provide services, working with Su Vida and VO as resources. Track progress with assessments, clinical feedback and feedback from consumers and other youth.
- Expand and develop as appropriate.

There are other barriers for funding services that can be addressed to bring more money into the service delivery system, thereby building the potential to expand and fund services. Most of the consumers of services are working poor, many covered by Medicaid, with funding covered by the Medicaid stream of income from Value Options. However, there are many working poor who do not qualify for Medicaid, who would qualify for the State Coverage Initiative of Insure NM! Helping those consumers get coverage through SCI would bring more resources into the system.

Finally, there are some providers that might be able to reach out to the insured population of Espanola, many of which are employed by the State of New Mexico or Los Alamos National Labs. If some providers were able to add 2% to 5% of insured consumers to the budget, this could make a substantial, perhaps critical difference for those providers. The providers most able to attract consumers with insurance would be those larger, more well organized organizations and organizations providing an easily accessible niche service.

6. What will be done differently?

An analysis of the Rio Arriba provider network has provided us with important information about what works, what doesn't, and what needs to be done differently. This includes data analysis, a survey of providers, interviews with providers and consumers, and community meetings. This section provides an analysis of the situation, and a description of what should or could be done differently. A Matrix of Agencies and their Services is provided as Appendix 5.

Feedback came from a variety of stakeholders, holding many different views. They are summarized below:

Strengths of the Rio Arriba provide network include:

- A mix of deeply committed agencies and talented professionals;
- Agencies rooted in the community and committed to Rio Arriba;
- Agency progress with many behavioral health requirements;
- A commitment to the planning process;
- A strong system of prevention services;
- A desire to build a stronger network.

Weaknesses of the network include:

- Limited number and scope of services available locally;
- Service fragmentation;
- A lack of knowledge and understanding about prevention services;
- Interagency infighting, which often results in a lack of referrals and interagency coordination;
- Lack of centralized intake and referral for new consumers and those coming back from RTC;
- Outcomes and quality standards that are not fully outlined, nor integrated for the network;
- Financial analysis and service analysis and projections;

In studying the service delivery system and its funding, the following represent important areas that require change:

- The service mix needs to be reviewed and shifted so that more services are provided in Rio Arriba County, including an array of outpatient and intensive outpatient services for youth and adults, and perhaps limited residential services for youth.
- The services in Rio Arriba County need to be more effectively coordinated. Currently, people enter the system either through one of the agencies in the county, through an outpatient service outside of the county, or an inpatient treatment facility outside of the county. Intake and referral needs better coordination and follow-up; residential stays should have follow-up with a local provider (with permissions); and local providers should follow up with consumers that have completed or terminated. The CARE Connection is one model discussed for coordinated intake and service referrals.
- Key executives who have not been able to work together need to find a way past differences, and work more collaboratively. There has been some initial discussion among some key executives and Value Options, to look at ways that Rio Arriba providers can collaborate more effectively.
- Serious interagency collaboration should be supported and rewarded. There is a long history of infighting in the county which remains to this day. It is well rooted, and not easily changed. Even though many providers would like to see less infighting and undercutting, it will not shift by statements and plans. There need to be some specific agreements, interagency MOUs, technical

assistance through coaching, and (if possible) financial incentives. When collaboration becomes more professionally, socially and financially beneficial, the behavior will change.

- Financial information needs to be used more for planning and analysis. Agencies have not used service and finance statistics and statistical analysis for analysis and planning. To move forward, Value Options will need to provide monthly financial reports online with preliminary financial and statistical analysis. Then, agencies will need to use that data for further analysis and service planning. The provider group might also benefit from some financial training and data analysis.
- Some providers have shared concerns about CCSS. Case management requirements do not seem to be feasible in terms of service delivery and financing. Currently, they find it is difficult to maintain requirements (especially no funding for travel) and to adequately fund a case management position without drawing from other cash reserves. Most agencies do not have cash reserves. Agencies have expressed concern about this issue, and worry that this case management system is not sustainable. VO has reported that in some locations, agencies have used CCSS to support other services. It seems that a meeting is in order to allow agencies to share concerns and VO to provide information and training on how to maximize CCSS as a revenue center.
- The LC1, Rio Arriba County needs to investigate some of the negative perceptions about the agencies. Consumers report difficulties with a number of agencies, and agencies have negative things to report about one another. Changes in operations and perception are needed.

So, what should be done differently, starting immediately?

- Planning meetings to set up the pilot centralized intake, including provider that might offer space and phones, TA consult with , process for hiring or choosing a part time pilot staff person, plans for outreach and marketing, and next steps for further identification of services and levels available.
- Identification of different services available and important referrals for treatment. And identification of how prevention services relate to the overall continuum of care.
- The co-chairs of the LC1 providers network should send out an anonymous survey to providers asking them to share about what they need to become engaged with and involved in the LC1 network. The survey should also ask executives for feedback about the LC1, how it operates, its priorities, leadership, accomplishments, etc. Currently, only about half of the providers are actively and regularly engaged. A number have reported some level of concern to the consultant. LC1 needs to address this, and find a way to both strengthen leadership and involve more of the providers.
- The LC1 meetings should include on the agenda the plan goals, interagency collaborative activities and progress being made toward goals. They group should also discuss outcomes, and ASI data for outcome indicators, CCSS and financial data. This is especially important if agencies are to be working together on a youth services pilot.
- Value Options can provide training on financial data, ASI outcome indicators and CCSS as part of, or adjacent to LC1 regular meetings.
- LC1 providers should work with Inflexxions and Value Options to get training and technical assistance on how to download and use the ASI data and analysis for outcome indicators. The LC1 providers should develop individual outcome indicators to show consumer progress in key domains over time, and demonstrate how particular therapeutic interventions affect specific populations as shown on ASI and other measures.

- The LC1 should develop a small, confidential group that handles consumer complaints, if not already in place. The group should include consumers and family members and perhaps a representative from the state or VO. Complaints about specific agency practices should go to this group for resolution. Feedback gathered by the consultant from consumers should be shared with this group as well, and a summary shared with the LC1.
- Providers should work with VO finance staff to track their service utilization and funding. Those providers that have excess revenue should develop plans to expend and/or transfer funds within the next 90 days, to ensure that funds remain spent or encumbered.
- Youth providers and providers working in partnership with Su Vida or other youth groups should begin working together to develop a plan for a mix of youth services for a pilot program to start in April, running for 3-4 months until the end of the fiscal year. The program should include expanded prevention and outreach for youth, school based counseling and case management, centralized intake and crisis response for youth and their families. It should also include individual, group and family counseling, intensive services as needed, and short term shelter as needed. Shelter programs require significant levels of funding, site approval and other certifications that might delay a pilot for 6 to 12 months. Therefore, the pilot might want to start with a mix of services other than residential and add those later as need, development, funding and certification allow.

7. Address length of stay issues and re-admissions.

Re-admissions occur all too frequently in behavioral health services, and are due to many factors. Frequent re-admissions increase the cost of delivering care. Length of stay issues create problems when agencies and the system do not manage level of care and length of stay issues, thus adding to the cost of treatment.

The biggest length of stay challenge lies in the RTC and TFC long lengths of stay, primarily for youth but also for some adults. The youth that are sent outside of Rio Arriba County for treatment often have long lengths of stay, with limited follow up, which can lead to additional coping problems later on, and re-admissions. These length of stay issues need to be addressed between these agencies and Value Options. At the current time, LC1 has little or no involvement in these RTC ALOS issues, especially for RTC and shelter care outside of the county.

Many providers have indicated that they don't have or don't know how to get and interpret statistics. With the web based ASI data from Inflexxions, agencies should be able to gather critically needed information about ASIs for individual consumers, as well as groups. This data should help clinicians refine their care, and more effectively track a consumer's progress on goals and growing resilience.

Individual providers need additional service utilization data on consumers (by unique identifier code) from Value Options so that they can track a consumer's involvement. Each agency should be able to analyze its ALOS on a monthly basis, along with trends with ALOS. This should be a requirement of funding, with each agency tracking length of stay on a monthly basis. The LC1 should discuss ALOS at least quarterly, if not monthly, and look at how interagency referrals could provide maximum support and care for consumers, with more effective and cost effective lengths of stay. Again, LC1 would need even summarized data regarding LOS in different parts of the system. Currently, that data is not easily available, even in an anonymous format.

Some entity such as VO needs to track and analyze the movement of consumers by unique identifier, defining a consumer's movement between agencies and treatment types. It would analyze service patterns by agency, type of service or consumer demographic. For example, one very well respected youth provider agency explained that many of the youth go through a range of services in Albuquerque, Santa Fe and other locations. There is a "circuit" where youth who have left home or are adjudicated travel to maintain shelter and support, with each providing a stay of up to 30 days or longer. Schools back home are supposed to send lesson plans but this is seldom the case. This "circuit riding" has a significant impact on how services are delivered, funds expended and progress made. With a youth services "circuit," one finds many readmissions, and a re-working of the therapeutic process from one site to another. The kids are very savvy, and know how to use the system. More local services with the medical home medical could make a positive difference.

Another issue that strongly affects re-admissions and, to a lesser extent, ALOS is the silo effect that occurs between service providers when a youth is sent away for residential or shelter treatment. A teen can be sent to the Peak in Las Cruces for 30, 60 or 90 days. Family is often involved only tangentially, and few families can afford to travel to Las Cruces for family therapy or family week-ends. The youth makes progress in the RTC or shelter in an environment that is removed from community. They return, and providers in Rio Arriba state that seldom are they made aware of a return or involved in a transition. Part of this could be HIPPA requirements, but it certainly seems reasonable that an intensive care provider away from home could, with youth and family approval, work with agencies back home to facilitate transitions. A number of agencies have provided anecdotal information about youth who return, reconnect with their old high risk friends and behaviors, run into problems again with family, and quickly undo much of the good done in the RTC or shelter. Without careful transition partnering between agencies, there will continue to be high rates of recidivism and readmissions. There is no data available to the consultant about re-admissions, however, this should be data mined and made available to the LCs.

There is another silo affect that happens when Rio Arriba adjudicated youth go to a shelter or RTC. In at least one case, a well respected agency reported that, with adjudicated youth (the case with many from Rio Arriba County), CYFD is supposed to follow up with youth transitioning from RTC or shelter back to the community. Collaboration and ensuring youth follow-up by all parties involved should be a requirement of service. Therefore, the partner finishing work, CYFD caseworker and the agencies at home receiving the consumer should all be connected during transition to ensure the quality of transition needed by the consumer. If the transition is not carefully orchestrated and documented, it is too easy for something to go amiss, and the youth is back at home, without supports and under much greater stress.

Length of stay issues are very important for all levels of treatment, and each organization should have policies in place that allow staff to maximize effective treatment and length of stay, moving the consumer to lower levels of care when this is warranted. Length of stays for inpatient or residential treatment services are the most important, because the RTC is the most expensive level of care.

Length of stay of youth in out of county RTCs is long, and the cost of over \$3 million for that care is the biggest budget expense, and area of concern. If some of the youth could be served by a mix of intensive outpatient, counseling, skills development and case management from a youth medical home perspective (Su Vida) this would significantly impact length of stay, and should improve re-entry into the community. Adult RTC length of stay vary from 30 or 60 days to longer stays; the adult RTC should continue to track its treatment planning and adjust LOS as needed, providing a segue to intensive outpatient as soon as possible.

The CMHC, which handles most of the outpatient treatment in the county, has been through tremendous upheaval, losing its methadone clinic and struggling with high staff turnover. It needs to continue to build a strong treatment framework that will address length of stay issues more aggressively, and to partner with agencies that are sending youth and adults back into the community. Equally, the CMHC needs to partner with agencies when it is making a referral out for more intensive treatment. Partnerships with MOUs are being developed with a number of agencies.

Providers are hard pressed to track readmissions except in their own facilities because of HIPPA regulations. This will remain true unless there are policies that strongly encourage agencies to share information during a transition in a way that meets all HIPPA guidelines, with youth and family approval. The Value Options statistical and quality management staff should track the readmissions within county and out of county by unique identifier and conduct analysis on the readmission rates by provider, type of service and consumer demographics if possible. Because there are facilities throughout the state, re-admissions can only be tracked effectively statewide, by unique identifier, with data funneled back to the LC and appropriate providers in the county of residence.

Finally, in future years, when greater statistical capability is the norm, it might be helpful to flag and cross tab both length of stay and readmissions issues, related to the types of service, service provider, ASI and other treatment data, and demographic information.

8. Address engagement and outreach

Many consumers and community members have mentioned that some agencies are not well known, and some are not easily accessible. Agencies are interested in engagement and outreach, but little has been planned or implemented, partly because agencies become overwhelmed with the day-to-day program operations, and find social marketing to be confusing and difficult.

However, the LC1 needs to broaden the prevention efforts to include community outreach strategies so that a wider spectrum of the community knows about resources. This social marketing would be partly community substance abuse education and partly marketing agency services. Ideally, such a social marketing effort would be conducted as a collaborative effort between LC1, DWI Task Force, judicial system, schools, churches and the business community. This would ensure that multiple stakeholders share in education, shaping of the message, and disseminating information. This broad based working group would develop the messages, and provide resources for getting the word out to their constituencies. The LC1 could serve as the umbrella, and call together a diverse working group tasked with the responsibility of developing outreach strategies and materials, and for building a community base of stakeholders committed to sharing information. (See the Appendices for information about a national United Way of America Success by Six Social Marketing strategy and New York You Can Read Social Marketing)

Social marketing would develop core strategies for priority target populations, developing a focused or targeted approach. Strategies for youth might be shaped primarily by youth themselves and youth serving providers, along with leaders from schools, other youth serving agencies, families, churches and others. Strategies for incarcerated people would be shaped by consumers who have been incarcerated, providers in corrections, working with the DWI Task Force and judicial system. Strategies for women would involve women and community stakeholders serving women.

Centralized intake would help providers to track how consumers enter the system, referrals, and the effectiveness of treatment (if the CI conducts surveys). A broadly advertised SPOE could increase the community awareness of services and resources, and the SPOE could help ensure consumers receive appropriate and timely treatment.

The LC1 might decide to spend some of the TCA funds on social marketing. However, social marketing is often a high time investment and low budget activity that can be built with a project like centralized intake. Slogans, appeals and stories can be developed by the working group, hopefully with a marketing person or two as volunteers. Materials can be printed by member agencies and distributed by members of the working group. As the group builds success, additional more costly strategies can be developed, such as advertising, more expensive printing, and other strategies. The LC1 can begin this activity at any time, especially if there are some LC1 core members who are well respected willing to take leadership. This activity should not detract from a youth pilot initiative, and the people working in each area should primarily be different people, except for youth and youth providers involved in shaping the marketing message.

An outline or blueprint for social marketing can be found in the Appendices.

10. Implementation

The implementation plan follows as Section III. It is developed in the format of a traditional strategic plan, with goals for programs and service, collaborative, community outreach, budget, funding and technical assistance.

III. IMPLEMENTATION PLAN: GOALS AND STRATEGIES

This section of the plan contains the implementation plan for goals and strategies for the work of the Rio Arriba LC1. It includes a mission and values, program goals and strategies, community outreach goals and strategies, and funding sources. Where appropriate and known, timeframes are provided. The plan also includes goals and strategies for capacity building, including technical assistance.

The section starts with (A) a short summary of Rio Arriba County needs and priorities, (B) goals for pilot work with the TCA grant, (C) ongoing LC1 goals and priorities, (D) technical assistance goals, (E) budget and (F) fund raising goals.

A. Summary of Rio Arriba County Needs and Priorities

Stakeholders in Rio Arriba County are deeply concerned about the demographic profile of the county, and what that means to residents on a day to day basis. Too many youth and adults at risk of substance abuse problems, drunk driving, behavioral problems and suicide – with too few resources in the county. Resources are especially thin for youth; they and their families must seek specialized and residential treatment elsewhere, as far away as Las Cruces. When youth return, there is no real connection made with local providers to help create a supported transition. As a consequence, many youth find themselves struggling at home, alienated at school, adrift in the community, and using substances because they are easy and popular. If local, community based resources are not available to help youth break the cycle of substance and build from an asset-based framework with activities and experiences that engage and excite, then many youth find themselves in the juvenile justice system. In fact, many youth from Rio Arriba seen by at least one outside agency are already adjudicated. Having a mix of youth services built upon the children's medical home model will provide youth in Rio Arriba County with real alternatives, many for the first time. The Search Institute has demonstrated through its landmark national research that only by helping youth substitute positive behaviors and success can the risks of substance abuse, DWI, teenage pregnancy and suicide be significantly reduced. This means creating a mix of services that partners with other youth serving nonprofits, the school system, employers, faith communities and other community organizations to create an environment that helps youth build assets. Some of the prevention programs in the county, such as Chimayo Youth Conservation Core and North Central Community Based Services have significant experience working with asset-based youth development. And, Las Cumbres has expanded its children's programs. Together with the other behavioral health providers, there should be a strong base for building a pilot for a mix of services for youth.

Residents of the county are frustrated and concerned that adults who are trying to move from an institution to the community find it very tough going. Missing is any structured, coordinated effort to engage the buy-in of the provider network, community leaders, law enforcement, housing officials and employers in an effort to provide comprehensive services to the ex-offender population transitioning back into the community. Consequently, many landlords do not want to rent to someone with substance abuse problems, or a history of incarceration. Finding really low cost housing within commuting distance of town or work is also hard. Finding a job is difficult both because employers are wary, and also because re-entry is difficult and job and social skills are needed. What often happens is case managers work many hours with consumers trying to find housing, and trying to find employment. If there were some type of county-wide and community-wide re-entry initiative to encourage landlords, employers, community leaders and law enforcement to partner in reintegration [recovery] as a win-win, that could help immensely. Case managers have said that oftentimes, employers don't realize that it is a real bargain for them to hire someone in transition, with tax abatements and federal bonding and other benefits that are provided. LC1 and other county partners can make strong inroads in this area by first involving all of the key community stakeholders in the development of a re-entry plan assisting ex-offenders in community reintegration to reduce recidivism and increase public safety. This could be part of the community outreach and social marketing work

LC1 stakeholders are concerned that there is not a more effective, better functioning network of services for youth, adults and families. There is little coordination – in intake, referral or service coordination. And, community members often don't know about the resources that are available. Providing more accessible, better quality services is one top priority for the LC1.

Crisis response can be started in Rio Arriba County as part of the youth initiative, where crisis response is a central part of the children's medical home model, and developed as a core part of the mix of services to youth. As this grows and develops, and additional community stakeholders become involved and supportive, then the crisis response can be expanded to include the entire community. Santa Fe Crisis Response can probably be a helpful resource, so that Rio Arriba County can develop its system based upon what works elsewhere. In addition, there are crisis response and United Way 211 information programs throughout the U.S., and there would be helpful lessons learned from other rural communities that could be applied to Rio Arriba County.

B. Pilot Goals

TCA Pilot Project – Centralized Intake

LC1 RA providers will develop a centralized intake pilot, working with the CARE Connection to leverage resources for maximum benefit of consumers and participating agencies. Then, they plan to institutionalize centralized intake, based on a successful pilot. They will

a. Develop a model based on and working with the CARE Connection

Conduct preliminary meetings with CARE Connection to discuss their model, how it might be adapted to Rio Arriba for a pilot (without vouchers or with limited vouchers). This would include identifying the strategies for handling intake, initial assessment using the ASI and other tools as needed, initial interview/s, information and referrals, data collection and analysis, and follow-up. That mix of services allows for more integrated outreach to the community, more standardized assessment using professionals highly proficient in assessment and conducting assessment on a very frequent basis. Referrals increase the level of consumer education and choice relative to different provider options. And, ASI and other data, including follow-up contacts are handled in a centralized unit that provides frequent reports to providers and to LC1.

Conduct meetings with LC1 and other county stakeholders to discuss the development of centralized intake, and the need for ongoing collaboration with these stakeholders. Most important to the planning and collaboration would be the judicial system, faith communities, hospital, and other nonprofits. When youth programs are added, the schools represent a critically important partner.

This model has been highly effective in Santa Fe County, and a significant number of consumers from Rio Arriba County have entered the system through the CARE Connection, so that organization already knows something about the county consumers and their needs, as well as the resources available.

The joint planning would ensure that Rio Arriba County and CARE Connection's needs and priorities are met in the development of the pilot. Agreements would be made concerning the roles and responsibilities of the CARE Connection, providers, the county and LC1.

b. Develop the pilot, using the balance of the TCA funding.

1. Overview

The budget for the Rio Arriba centralized intake would run between \$65,000 and \$70,000, based on the amount left in the original TCA planning grant. The following represent some of the core costs for developing the pilot, working with the CARE Connection.

2. Staffing levels and costs

Initial staffing for 5 to 8 hours a day, 5 days a week at a centralized location. Based on the CARE Connection's own pilot staffing levels, adjusting for community size, it is expected that the pilot might start with a part time to full time therapist on contract (prorated at \$ 9,000 to \$15,000 for 3 to 3 ½ months). A part time case manager would run \$7,000 to \$10,000 for 3 to 3 ½ months. And, an office administrator, working all hours that the office is open, might run \$5,000 to \$8,000 for the pilot period.

Total staffing costs for the pilot should run between \$21,000 and \$33,000. There would also be a portion of the CARE Connection Director's salary focused on the pilot, to be offset in whole or in part, which could run from .15 FTE to .2 FTE for the 3 to 3 ½ months, or roughly \$4,000 to \$5,000.

Much of the staffing costs for the pilot period would be covered by the TCA grant. However, some costs for services like assessment might be billed to VO. This would allow the pilot to stretch its resources.

3. Services

The centralized intake would include the following core services:

- Community outreach, CI staff working with LC1 and Rio Arriba providers;
- 800 number for intake, covering the county (since calling across the county is not local, and some isolated areas must call long distance which is a barrier to care);
- Screening and assessment;
- Limited counseling/therapy if required to stabilize prior to referral;
- Consumer education about process and choices available;
- Referral to provider of consumer's choice;
- Follow up with consumer regarding the referral and treatment experiences;
- Follow up with provider regarding referral;
- Data analysis and reports to providers;
- Analysis of ongoing consumer needs, referrals and feedback;
- Service, resources and gap analysis.

The centralized intake would work closely with LC1, providing reports, updates and helpful information. It would also work collaboratively with LC1, the county and other providers in planning and reviewing community needs, service availability, service gaps and priorities for development of services.

Prevention services are critically important to this and all other initiatives. Therefore, the network plans to expend 20% of the pilot funding on prevention activities as they relate to community awareness of substance abuse and resources to combat substance abuse. Prevention

providers will be best equipped to identify specific related community outreach strategies. (Approximate cost \$6,500.)

The costs for additional community outreach, 800 number, office rent, phones and computer equipment could run approximately \$4,000 to \$6,000 for the pilot period, depending upon the office location and rental. The CARE Connection has a website, ATR database, and is developing another database to be used with non-voucher programs.

In meetings with providers, consumers and community members, people frequently mentioned the need to have centralized intake which would ensure an easier entry into and movement through the system. Centralized intake might facilitate a transition to having more people choose local resources as their preferred option, and would facilitate people moving from an out of county residential placement back home. The Rio Arriba LC1 would like to have an in-county centralized intake based in Rio Arriba County, working in partnership with the CARE Connection to leverage their specialized skills and track record, reduce start-up time and challenges.

B1. FY 2009 Development Goals

B1. Strengthen Network, Build Readiness for Expansion for Youth and Other Services

Develop the core centralized intake services, gathering additional information about consumer needs based on calls, referrals and services needed. Identify youth services available and those needed to be developed in county.

B2. Expansion and Development of Youth Services

1. LC1 develops a preliminary identification of the service mix and providers to offer services (community and school based prevention, school based counseling and case management, drop-in services at key locations, crisis response services, case management, counseling for youth and families, intensive outpatient and perhaps limited residential).
2. LC1 creates a youth committee to develop services. It would be comprised of providers listed above, other interested providers that offer counseling, and youth. The committee would also include representatives from schools, juvenile justice, DWI task force, youth serving nonprofits, faith communities,
3. The youth committee would identify lead agencies for the mix of youth services, ideally those currently successful with youth prevention services (at least three in the county), those agencies providing counseling to youth at school, and any agencies involved with the community medical home model developed by Su Vida.
4. The youth committee completes a detailed plan for services to be delivered and by which agencies, along with a description of costs. (TCA budget is \$65,000, and there may be additional funds from agencies underutilizing some funds allocated by VO).
5. The youth committee would develop publicity and outreach to schools, faith communities, youth organizations and other places where youth congregate. If youth have been involved in the plans, they can provide some of the best outreach. The committee would use principles of social marketing.

6. Agencies would begin to provide services, working with Su Vida and VO as resources. Agencies and the youth committee would track progress with assessments, clinical feedback and feedback from consumers and other youth.
7. The youth committee would recommend that the services be expanded, provided they have been well received and utilized, and have strong positive feedback. A budget for ongoing services would be developed by the committee. It is expected that the majority of costs would be covered by billings for services, and that VO might provide additional funding for outreach, network development relatively proportionate to the cost savings moving youth services closer to home in a range of services less intense than the current RTC ratio of services.

C. Other Programmatic Goals

There are a number of programmatic goals that LC1 wants and needs to develop during 2009 and 2010. The most important of these include developing a capacity for crisis response, and expanding case management. Some of these goals are priorities for all stakeholders, including consumers, community members and providers, whereas others are primarily goals for providers. Those goals that have the strongest level of support are listed first.

1. Crisis Response – LC1 will work with the community to build crisis response, leveraging resources already developed with centralized intake, and models being developed for integrated crisis response with youth services.
 - a. Develop an LC1 committee tasked with investigating and designing a crisis response framework for Rio Arriba County. This committee would include providers, consumers and interested community members.
 - b. The committee would identify the key populations in at risk and in need, who would utilize crisis response, using the target population study provided in this plan. The priority populations would include youth at risk, young adults, males, people stopped for DWI and others as identified.
 - c. The committee will investigate options for designing crisis response, including but not limited to, a local service, subcontract with Santa Fe Crisis Response, or develop a local service in consultation with Crisis Response.
 - d. The committee will recommend a crisis response framework and budget. Ideally, the crisis response service should be funded by a mix of funders, with VO and the county playing key roles.
 - e. Crisis response will be implemented, working with Santa Fe Crisis Response (directly or through consultation). CR would be focused on areas of community need and priority populations. Track utilization levels over 6 months and effectiveness of referrals (follow up with agencies).
 - f. Maintain crisis response as needs and utilization levels indicate.

Community members, consumers and providers all have spoken in meetings about the need for Rio Arriba to have a crisis response. Key arguments made in support of crisis response include a concern that there are so many high risk youth and adults in the county, who need more accessible and responsive support. Other believe that by having crisis response, people can be seen more quickly and more effectively.

2. Case Management – LC1 will work with the community to expand case management.
 - a. Identify unmet needs in case management, specifically those at high risk that need CCSS services.
 - b. Provide training to CCSS providers in how comparable agencies have been able to develop case management as a profit center.
 - c. Involve community stakeholders in supporting CCSS consumers in successful transition. Develop a CCSS or “Transitions” committee comprised of CCSS providers, employers, landlords, faith communities, justice officials and others as appropriate. Employers could be extremely supportive by working as a group committed to successful transitions, and involved employers receive tax breaks. Landlords have a role similar to employers. Faith communities can provide a spiritual base, resources for basic needs, and an important spiritual, social and resource network. It is this committee that can help spread the word about the positive community benefits of hiring, housing and supporting newly sober people with successful transitions.
 - d. Develop an outcomes framework for case management that incorporates the ASI and progress on key domains related to areas of the ASI (sobriety, employment, legal, social). Provide ASI and CCSS log data to provide indicators that show movement, and hopefully successful transitions.
 - e. Offer incentives for people leaving CCSS to remain in contact for program evaluation. Involve some CCSS graduates on the committee.
 - f. Find a graduate student from UNM or Highlands who would handle program evaluation, re-contacting people who were served one year, two years and even three years previously. Use data and consumer feedback to improve program services and quality, and to make a case statement for ongoing and increased support as needed.

Consumers, community members and providers have each, from their own perspective, discussed the importance of having case management available to people at risk who are making difficult transitions from institutional life back to the community. Consumers indicated that case management was unbelievably important. They said they probably would not have made a successful transition without the support of their case manager. Consumers mentioned that it was very hard to find AA and other social supports, a job, a place to live and transportation. Case managers mentioned they find people with many needs, and resources hard to put together in the right timeframe. A number of people do not make a successful transition, even with the supports of case management; often they are those that are isolated, not active with AA or other social supports, and those who encounter many barriers. However, it is case management that provides a platform for possible success.

3. Interagency Collaboration – LC1 providers will collaborate more intentionally with one another and other community providers. Providers will:
 - a. Update a map of services by provider and service category using the charts and preliminary map provided in the report section of the plan.
 - b. Sign and support plan goals. Be involved in helping to build a stronger network of services, including centralized intake, crisis intervention, more case management and more in county services for youth.
 - c. Identify selected areas where multiple agencies can collaborate (i.e. school based programs, corrections, and others).
 - d. Develop MOUs for areas of collaboration, such as interagency referrals and interagency collaboration in specialized areas such as serving youth, corrections and other groups.
 - e. Provide incentives for agencies to attend at least 80% of core meetings (and consider disincentives for those that do not participate).
 - f. Share positive information about agencies and their accomplishments.
 - g. Encourage agency leaders to refrain from negative comments about other agencies. Serious concerns should be discussed by one agency with the agency in question. Ongoing concerns should be discussed with the LC1.

Providers discussed interagency collaboration at a number of meetings, primarily with other agencies and Value Options. Commitments have already been made for enhanced interagency collaboration, and providers have discussed strategies.

4. Continuum of Care – Providers will strengthen the continuum of services by providing a greater mix of services locally to county residents.
 - a. Strengthen the current base of programs in the county to ensure an effective base from which to build the continuum of care.
 - b. Develop a plan for developing a mix of services for youth targeting the population that has less intense issues (would require a summary analysis of assessments from RTCs).
 - c. Create a mix of services for youth, on the Su Vida and Youth Shelters models, to provide counseling, skill development, after school services and space for youth.
 - d. Increase the amount of case management available, through the designated agencies.

Provider agencies have spent a considerable amount of time discussing the problems with the continuum of care, areas where services need to be added or modified. Because youth services and other specialty care is not available in Rio Arriba County, consumers travel outside the county for care, and 75% of all VO funds are billed from out of Rio Arriba County, the network is, by definition, weak and fragmented. Since 50% of funds are spent on residential treatment (primarily for youth), that level of care should be examined to see if more mid-level resources would be appropriate if developed on the medical home model. Providers, consumers and community members all would like to see more youth treated closer to home, and would like closer integration between elements of service. Currently, youth are released from RTC back home, and there is not necessarily any follow-up or hand-off to local agencies. To determine the potential base of consumers, Rio Arriba providers would need to have Value Options analyze data from RTCs to determine the percentage of past patients from Rio Arriba County who might be served as well or better through a mix of resources at home. Providers, consumers and community members all mentioned how important and successful are current case management services, as well as the critical need to help more consumers access more needed resources, helping with areas like skill development, support systems, job searching and coaching, housing and transportation.

5. Evidence Based Practices and Outcomes – Providers will develop their own agency outcomes, and the LC1 will build and sustain an outcome based system.

Create an outcome-focused network of behavioral health services that can demonstrate outcomes for different types of services in consumer-focused language.

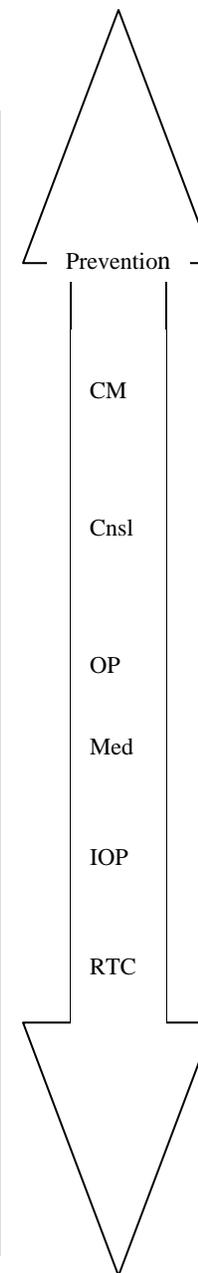
- a. Provide support to enable each agency to build its own outcome framework that incorporates BHC and VO standards and requirements as well as effective practices from the field (ASI, ASAM, CFARS, Matrix Model, CRA, Multisystemic therapies, FFT, etc.).
- b. Conduct training on outcome evaluation to LC1 RA providers for executives, managers and program staff.
- c. Each provider completes their outcomes and measures and submits them to LC1 to maintain an outcome framework for the network.
- d. VO will provide data and basic data analysis through Inflexxion for ASI data and directly for service and finance data on a monthly basis to each provider to give them the data. Providers are responsible for reviewing data and analysis, and using these as outcome indicators.
- e. Providers will share progress with outcomes, using VO's data to demonstrate progress with key indicators, using the LC1 providers group as a resource for discussing individual and network outcomes, indicators and progress made. (All data will be summarized and aggregated, to ensure consumer confidentiality.)
- f. Submit outcomes with key indicators and measures to the LC1 and VO for discussion and network planning at least twice a year.
- g. Provide annual outcomes training for new staff and refresher training for continuing staff.

This network has a number of important consumer successes, which could be demonstrated more explicitly as outcomes. There are weak areas both in terms of gaps in service (access) and quality. When each agency develops a strong outcome framework and outcomes are shared, then individual agencies and the network can identify the successful outcomes and develop quality practices that reinforce the activities that lead to successful outcomes. Weak outcome indicators can also be identified, and agencies and the network can look at the internal and external factors that relate to those outcomes, and work to improve services, interagency referrals, and community supports.

LCI Provider Integrated Outcomes Framework – Key Clusters - Logic Model

Fig. 13

Initial Outcomes	Intermediate Outcomes	Long Term Outcomes
<p>Students and community members are introduced to information about substance abuse.</p> <p>Consumer enters system. Screening and assessment provide a picture of consumer’s needs, issues and strengths.</p> <p>Consumer develops treatment plan with counselor.</p> <p>Consumer creates goals for sobriety, social supports, employment, housing and transportation.</p> <p>(Consumer receives medication to help stabilize if needed.)</p> <p>Consumer is stabilized through appropriate mix of case management, outpatient, or IOP or RTC. <i>(For some consumers, this means OP therapy; others, IOP or RTC.)</i></p>	<p>Students and community members learn basic warning signs and how to seek help.</p> <p>Consumer implements treatment plan goals.</p> <p>Consumer makes progress in areas of sobriety, social supports, employment, housing and transportation.</p> <p>Consumer tracks progress and reports to case manager and/or counselor.</p> <p>Consumer builds skills.</p> <p>Consumer builds base of support..</p> <p>(Medication is maintained, monitored, and reported helpful w/ stabilizing consumer)</p> <p>Consumer works to build sobriety, with or without lapses.</p>	<p>Students and community members can report ability to access more positive outlets and fewer harmful ones.</p> <p>Consumer achieves most or all goals.</p> <p>Consumer reports that life is working better, and is more stable.</p> <p>Consumer regularly uses support systems to maintain sobriety and quality of life.</p> <p>Consumer continues to build and use sober skills.</p> <p>(Medication is maintained, monitored, and reported helpful w/ stabilizing consumer.)</p> <p>Consumer maintains sobriety, with a lower level of therapeutic maintenance resources.</p>



- D. LC1 System Development – LC1 will support the development of a behavioral health system, and ensure the system delivers culturally appropriate, effective services.
1. Use the SPOE pilot and roll-out as an opportunity to gather consumer
 2. Share information with VO and BHC about where the system is working and not working.
 3. Provide input into changing decisions about levels of care, requirements for providing care and other core issues.
 4. Ensure that case management requirements are working in the field, and make adjustments as necessary (transportation; en-situ); provide training to LC1 on how case management has provided revenue over expenses for other providers.
 5. Promote a Community Reinforcement Approach (CRA) and support the network’s capacity to reach out to consumers and family members, involving them more heavily in both the consumer’s committee as well as other areas such as planning and outreach.
 6. Involve community members and other stakeholders (businesses, churches, schools, etc.) as partners, and have them help with interagency collaboration and community outreach.
 7. Conduct and maintain an annual financial audit for each agency focused on service statistical analysis and financial analysis.
 8. Hire a manager to coordinate the system, provide training and TA, promote service quality, and guide collaborative initiatives.
- E. Finance and Budget Planning – LC1 will support provider budgeting and budgets for collaborative initiatives.
1. Develop a pilot for centralized intake for March – June of 2008. (\$65,000) If the pilot goes well, develop centralized intake as part of the service mix for FY 2009. (Annual cost for centralized intake, approximately \$85,000 to \$125,000 depending upon staffing.)
 2. Develop initial mix of youth therapeutic services. Much of the budget would be covered by cost shifting, billing resources locally rather than outside of the county. However, there would probably be start-up costs, and additional costs for building the mix of youth services, for approximately \$150,000 per year, depending upon the mix of services, from prevention to therapeutic and follow-up. Maintain a base budget of \$3 - \$3.5 million per year for basic services by FY 2010, growing approximately 5%-10% per year as the youth services build a stronger base, and fewer out-of-county RTC services are needed. Set as a goal \$4.5 for an overall expenditure of services in Rio Arriba County by 2012 (represents just over half of the current behavioral health expenditures).
 3. By FY 2009, begin shifting funds from high intensity RTC to a mix of local youth services. Shift would be \$500,000 FY 2009 and another \$500,000 to \$750,000 in FY 2010. Shifting in funds should cover most if not all of the cost of services.
 4. Develop crisis response for the county, expanding youth services crisis response to the larger population. (\$75,000 - 100,000 for pilot). Connect or link w/ centralized intake.
 5. Fund a part time staff manager position or contract for the LC1 to guide building network, service mix development, outcomes and technical assistance (\$15,000 to \$50,000 depending upon tasks and time requirement).
 6. Expand case management for a cost of \$50,000; some of this responds to stakeholder discussions about the need to provide case management (CCSS) to more people, as well as an anticipation of more CCSS that could come from centralized intake and crisis response.
 7. Increase grant income by at least \$100,000 in FY 09 for providers in the system, and \$200,000 a year thereafter.
 8. Develop income from insured consumers, adding 2% to 5% of participating provider budgets, or approximately \$50,000 in FY 09 and up to \$120,000 a year thereafter. These funds would add to the participating agency budgets.

The LC1 has a small collaborative or system budget which should increase a bit. We recommend that the LC1 develop an aggregated budget based on the budgets of cooperating providers and LC1. And the LC1 should then connect services to expenditures, analyze trends and develop services and funding estimates for the future.

E. Funding Goals – LC1 seeks to develop new sources of funding for interagency initiatives, provider work and the work of the LC1.

1. Develop new sources of funding for some individual providers from more state grants from key departments, such as DOH and CYFD. Examples of these include CYFD other funding for children, such as the Children's Trust Fund, early intervention grants, treatment foster care (perhaps only through VO) and more. DOH other funding includes funding for health councils, tobacco cessation, substance abuse training and other areas.
2. Develop new sources of funding from grants (these require research, as requirements change): Casey Foundation, Con Alma Foundation, Daniels Fund, Frost Foundation, Kellogg-NM Youth Initiative, Readers Digest, Human Development and others).
3. Research grant opportunities from other state sources, such as Economic Development and the Department of Labor.
4. Seek grants from federal opportunities, such as through the Governor's Office for Faith Based and Community Grants and other sources.
5. Work selectively with an experienced grantwriter to identify new funding opportunities.
6. Build income through maximizing the number of consumers signed up with SCI. Track progress and set annual targets starting in FY 2009.
7. Conduct outreach to insured consumers (primarily State of New Mexico and Los Alamos Lab employees). Increase the number of insured consumers to 2% to 5% of the population. Start in FY 2009, track progress and set targets for subsequent years.
8. Investigate the potential of \$500,000 to \$1 million in new funds from multiple government and foundation sources to support new initiatives.

F. Technical Assistance Goals – Provide technical assistance to LC1 and the provider agencies to help build capacity.

1. Provide training and technical assistance to LC1 on outcome evaluation, using LC1 providers, VO staff and resources from Inflexxions.
2. Provide financial and service data technical assistance. TA would come from a team comprised of: LC1 leadership, a financial consultant, the agency executive, auditor and the quality management staff from VO. The LC1 staff person and agency executive would guide the process. The VO staff person would ensure that service and financial data was current and analyzed properly. The consultant would provide guidance and analysis as need, and recommend steps for capacity building based on the findings. The auditor would be doing their normal, with some additional input and guidance. This would ensure that costs would stay low, since the process would piggy-back on the audit.

APPENDICES

1. Funding Tables – Showing detail of funding types and levels for 11 Rio Arriba agencies from 2003 – 2007
2. Social Marketing – United Way of America Success by Six and New York You Can Read
3. Prevention Outcomes for Northern New Mexico
4. Funding Resources
5. Service Matrix
6. ASI Report
7. Children’s Behavioral Health Collaborative Priorities and Continuum of Care

Funding Tables

1. Funding Tables

These tables describe funding sources and levels for 11 Rio Arriba VO providers between 2003 and 2007. The number is small, therefore data can be skewed. However, this represents the experiences of the core group of RA providers.

2007		Less than \$50,000	\$50,000 to \$99,000	\$100,000 to \$249,000	\$250,000 to \$499,000	\$500,000 to \$999,000	Over 1 million
Options - BHC	Value	0.0% (0)	0.0% (0)	50.0% (3)	0.0% (0)	16.7% (1)	16.7% (1)
Options - CYFD	Value	0.0% (0)	40.0% (2)	20.0% (1)	0.0% (0)	0.0% (0)	0.0% (0)
Options - ATR	Value	0.0% (0)	0.0% (0)	50.0% (1)	0.0% (0)	0.0% (0)	0.0% (0)
Options - Medicaid	Value	16.7% (1)	33.3% (2)	16.7% (1)	0.0% (0)	0.0% (0)	0.0% (0)
government funding	Local	0.0% (0)	0.0% (0)	60.0% (3)	0.0% (0)	0.0% (0)	0.0% (0)
government funding	Other state	0.0% (0)	0.0% (0)	20.0% (1)	20.0% (1)	40.0% (2)	0.0% (0)
foundation funding	State/Local	50.0% (2)	25.0% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
foundation funding	National	0.0% (0)	33.3% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)

2006		Less than \$50,000	\$50,000 to \$99,000	\$100,000 to \$249,000	\$250,000 to \$499,000	\$500,000 to \$999,000	Over 1 million
Options - BHSD	Value	0.0% (0)	0.0% (0)	16.7% (1)	16.7% (1)	16.7% (1)	16.7% (1)
Options - CYFD	Value	0.0% (0)	25.0% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
Options - ATR	Value	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
Options - Medicaid	Value	33.3% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
government funding	Local	16.7% (1)	16.7% (1)	33.3% (2)	0.0% (0)	0.0% (0)	0.0% (0)
government funding	Other state	0.0% (0)	0.0% (0)	16.7% (1)	16.7% (1)	33.3% (2)	16.7% (1)
Federal funding	Other	0.0% (0)	20.0% (1)	40.0% (2)	0.0% (0)	0.0% (0)	20.0% (1)
foundation funding	State/Local	25.0% (1)	25.0% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
foundation funding	National	40.0% (2)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)

2005		Less than \$50,000	\$50,000 to \$99,000	\$100,000 to \$249,000	\$250,000 to \$499,000	\$500,000 to \$999,000	Over 1 million
Options - BHSD	Value	0.0% (0)	14.3% (1)	14.3% (1)	14.3% (1)	14.3% (1)	14.3% (1)
Options - CYFD	Value	0.0% (0)	25.0% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
Options - ATR	Value	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
Options - Medicaid	Value	33.3% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
government funding	Local	16.7% (1)	16.7% (1)	33.3% (2)	0.0% (0)	0.0% (0)	0.0% (0)
funding	Other state	0.0% (0)	0.0% (0)	16.7% (1)	16.7% (1)	33.3% (2)	16.7% (1)
Federal funding	Other	0.0% (0)	20.0% (1)	40.0% (2)	0.0% (0)	0.0% (0)	20.0% (1)
foundation funding	State/Local	25.0% (1)	50.0% (2)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
foundation funding	National	33.3% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)

2004		Less than \$50,000	\$50,000 to \$99,000	\$100,000 to \$249,000	\$250,000 to \$499,000	\$500,000 to \$999,000	Over 1 million
Options - BHSD	Value	14.3% (1)	0.0% (0)	28.6% (2)	0.0% (0)	14.3% (1)	14.3% (1)
Options - CYFD	Value	0.0% (0)	25.0% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
Options - ATR	Value	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
Options - Medicaid	Value	33.3% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
government funding	Local	16.7% (1)	16.7% (1)	33.3% (2)	0.0% (0)	0.0% (0)	0.0% (0)
funding	Other state	0.0% (0)	0.0% (0)	16.7% (1)	16.7% (1)	33.3% (2)	16.7% (1)
Federal funding	Other	0.0% (0)	25.0% (1)	25.0% (1)	0.0% (0)	0.0% (0)	25.0% (1)
foundation funding	State/Local	25.0% (1)	50.0% (2)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
foundation funding	National	25.0% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)

2003		Less than \$50,000	\$50,000 to \$99,000	\$100,000 to \$249,000	\$250,000 to \$499,000	\$500,000 to \$999,000	Over 1 million
Options - BHSD	Value	16.7% (1)	0.0% (0)	16.7% (1)	0.0% (0)	16.7% (1)	16.7% (1)
Options - CYFD	Value	0.0% (0)	33.3% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
Options - ATR	Value	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
Options - Medicaid	Value	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)

government funding	Local	20.0% (1)	20.0% (1)	40.0% (2)	0.0% (0)	0.0% (0)	0.0% (0)
funding	Other state	0.0% (0)	0.0% (0)	0.0% (0)	25.0% (1)	50.0% (2)	25.0% (1)
Federal funding	Other	0.0% (0)	0.0% (0)	33.3% (1)	0.0% (0)	0.0% (0)	66.7% (2)
foundation funding	State/Local	100.0% (3)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
foundation funding	National	33.3% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)

Social Marketing

2. United Way of America Success by Six

This national initiative involved local United Ways as community leaders in mobilizing community members to create new resources and services for children in need. United Ways developed community committees comprised of stakeholder groups across the community concerned about children and interested in developing new resources (United Way, children's providers, faith communities, preschools and kindergartens, local businesses, banks, government entities, funders and others). Groups develop goals for work, and subgroups develop specific goal areas. The committee develops social marketing to involve the rest of the community in supporting the initiative. Some examples of social marketing with UWA Sby6 programs include:

- a. Involving local grocery stores to promote child-friendly stores by providing children's corners staffed with early childhood volunteers who read stories and play games;
- b. Grocery stores that print messages about Sby6 on grocery bags and/or inserts;
- c. Local utility company provides information about children's resources as inserts in utility bills;
- d. Announcements about children's issues and resources, made in faith communities at services;
- e. Information and resources about child development in local libraries, along with information about local activities and events;
- f. Flyers in stores and offices share information about resources for children;
- g. Human resources offices share information about child development and children's resources through employer information channels;
- h. Sby6 shares information and resources at community events and fairs.

3. New York You Can Read

- a. The NY You Can Read Campaign focused on teaching social marketing skills to literacy program staff and volunteers. Literacy programs were encouraged to think "outside of the box" when developing social marketing strategies. Literacy programs identified a number of strategies including:
 - b. Develop simple flyers and distribute them in places where family members of people needing literacy services can see;
 - c. Create slogans for radio and TV;
 - d. Get respected leaders in different fields (government, radio and TV, automotive, etc) to make short announcements supporting literacy;
 - e. Meet potential consumers where they go: Wal-Mart, laundromats, theaters, malls, etc.

NNM Prevention Outcomes

4. Prevention Outcomes, NNM (DOH Prevention Services Bureau, Outcomes 2007 Report

Program	Location	Programs implemented	Outcomes
Hands Across Cultures	Greater Espanola Valley, Rio Arriba County & Northern Santa Fe County	Coalition Development Project Success in Espanola and Pojoaque Valley schools	<ul style="list-style-type: none"> • Community needs assessment was developed • Coalition efforts have finally culminated in the passage of an excise tax increase for the County of Santa Fe • Coalition succeeded at involving youth in the coalition process in a meaningful way • Smoking Ban in Espanola due to environmental strategies for the past 4 years • Spanapalooza for Youth Involvement • Coalition formally came together and resisted a new alcohol outlet in Abiquiu • Redistribution of alcohol tax dollars to a specific fund for prevention • SYNAR activities – 100% compliance in non sales • Significant findings for the group included decreases in the % of youth reporting use of alcohol, cigars, speed, downers, ecstasy, and inhalants • Male youth reported decrease in behavioral symptom checklist representing a positive trend • Tobacco use remained level from pretest to posttest • Service population reported 0 heroin, crack or steroid use at either pretest or posttest • Program served twice as many students as contracted
RAFCN	Espanola Valley	SPF program	Not included in this report
La Clinica del Pueblo de Rio Arriba	Rio Arriba County	Dare To Be You	<ul style="list-style-type: none"> • Statistically significant positive increase in family interaction • Parents reported significant increase in positive parental attitude • Parents learned positive discipline methods
North Central Community Based Services	Northern Rio Arriba County	Botvin Life Skills Across Ages Dare To Be You Across Ages mentoring Too Good for Drugs Drug free Communities SYNAR SPF	<ul style="list-style-type: none"> • Parent communication increased • Tobacco use decreased • Perceived harm increased • Parent communication increased • Tobacco use decreased for boys • Perceived harm increased for boys and girls • Group as a whole had a decrease in disruptive behaviors • Increased attitude toward ATOD use, perceived harm from ATOD use in group overall • Decreased marijuana and illicit drug use for group overall • Family bonding increased for boys • Statistically significant increase in perceived harm from ATOD for boys • Girls reported no marijuana or tobacco use, boys reported decreased illicit drug use, marijuana use at zero • Girls reported that their grades increased slightly • Both boys and girls showed healthy connection to their parents • Parents reported decrease in psychosomatic problems <p>This report does not include the outcomes for the work we did with the SYNAR program and through the SPF program</p>

5. Funding Resources

The following represent examples of funding that might be available for individual agencies in the LC1 or for LC1 collaborative activity. They are not an extensive list, but rather illustrative of what is available. A good grantwriter could conduct grant research to identify more possibilities.

A. Federal Funding

1. Federal initiatives related to youth at risk and community collaborative initiatives;
2. NM Office of Community and Faith Based Initiatives, Compassion Capital and other grants; the office sends out regular emails on many different government funding possibilities and provides some TA and support for groups interested in applying for federal and state grants.

B. State Funding

1. CYFD – grants and contracts for early childhood treatment foster care (perhaps only through VO) and more.
2. Children’s Trust Fund – part of CYFD, small grants for special projects.
3. DOH – grants and contracts for health councils (which applies for Rio Arriba County in its development of a new health council); tobacco cessation programs and substance abuse training (special RFP).
4. NM Community Development Block Grants, including Empowerment Communities (partnering w/ Rio Arriba County, as part of a broad community development approach)

C. Private Foundations (local and national)

1. Annie Casey Foundation
2. Catholic Human Development Fund
3. Con Alma Foundation
4. Cummings
5. Daniels Fund
6. Ford
7. Frost Foundation
8. Hearst
9. LANL Foundation
10. McCune Charitable Trust
11. PepsiCo
12. Kellogg – New Mexico Youth Initiative (NMCF and NM Forum for Youth & Community)
13. Reader’s Digest
14. Robert Wood Johnson Foundation
15. Rockefeller
16. Santa Fe Community Foundation
17. United Way of Los Alamos County

6. Service Matrix

This service matrix identifies which types of services are offered by providers based in Rio Arriba County. The LC1 might decide to further subdivide categories, and add providers that are outside of the county. Providers should send any corrections to Anne Hays Egan (aegan@cybermesa.com) before March 7th, and to Lauren Reichelt (LMReichelt@rio-arriba.org) after March 7th.

	Prev	Assm & Tstng	CCSS	Couns A, C, Y Fam/Gp	Respite	Couns Correct	Skill Develop	Psycho Soc Rehab	IOP	TFC	RTC Youth	RTC Adult	Meds
Ayudantes		✓	✓	✓			✓	✓	✓				✓
Chimayo Youth Conservation Corps	✓						✓						
Clinica del Pueblo		✓		✓									✓
El Centro		✓	✓	✓									
Human Res Dev		✓				✓	✓						
Hands Acr Cultures	✓												
Hoy									✓			✓	
Las Cumbres		✓		✓	✓		✓	✓					
North Central	✓												
RA County			✓										
SF Recovery Center		✓							✓				
Teambuilders		✓		✓									
Una Ala													✓

7. CMHC ASI Summary Data Analysis

Provides an example of how data can be used in special reports w/ cross tab analysis.

These tables represent cross tab analysis conducted by the CMHC, looking at correlations between high alcohol and drug use, and high levels of difficulty in other areas of life, such as employment and legal. Other correlations between alcohol and drug high ASI scores and family difficulties were also reviewed, but are not included in this example.

These cross tab analyses, which are developed using the special reports option, provide the clinical staff with important pictures showing the impact of high levels of substance abuse severity with diminished capacity and serious difficulties in other areas of life.

Composite score for family section	Drug Composite Score	Totals	Percent
0 - 0.249	None	228	52.78
0 - 0.249	Low (0.001 - 0.109)	142	32.87
0 - 0.249	Medium (0.110 - 0.209)	43	9.95
0 - 0.249	High (0.210 - 1.0)	17	3.94
0.25 - 0.499	None	65	42.21
0.25 - 0.499	Low (0.001 - 0.109)	52	33.77
0.25 - 0.499	Medium (0.110 - 0.209)	19	12.34
0.25 - 0.499	High (0.210 - 1.0)	16	10.39
0.5 - 0.749	None	20	32.79
0.5 - 0.749	Low (0.001 - 0.109)	14	22.95
0.5 - 0.749	Medium (0.110 - 0.209)	10	16.39
0.5 - 0.749	High (0.210 - 1.0)	17	27.87
0.75 - 1	None	3	60
0.75 - 1	Low (0.001 - 0.109)	0	0
0.75 - 1	Medium (0.110 - 0.209)	0	0
0.75 - 1	High (0.210 - 1.0)	2	40

Legal Composite Score	Drug Composite Score	Totals	Percent
0 - 0.249	None	280	53.54
0 - 0.249	Low (0.001 - 0.109)	159	30.4
0 - 0.249	Medium (0.110 - 0.209)	50	9.56
0 - 0.249	High (0.210 - 1.0)	33	6.31
0.25 - 0.499	None	27	29.35
0.25 - 0.499	Low (0.001 - 0.109)	34	36.96
0.25 - 0.499	Medium (0.110 - 0.209)	18	19.57
0.25 - 0.499	High (0.210 - 1.0)	11	11.96
0.5 - 0.749	None	6	23.08
0.5 - 0.749	Low (0.001 - 0.109)	13	50
0.5 - 0.749	Medium (0.110 - 0.209)	2	7.69
0.5 - 0.749	High (0.210 - 1.0)	5	19.23
0.75 - 1	None	4	57.14
0.75 - 1	Low (0.001 - 0.109)	0	0
0.75 - 1	Medium (0.110 - 0.209)	0	0
0.75 - 1	High (0.210 - 1.0)	3	42.86

Employment Composite Score	Drug Composite Score	Totals	Percent
0 - 0.249	None	101	60.48
0 - 0.249	Low (0.001 - 0.109)	40	23.95
0 - 0.249	Medium (0.110 - 0.209)	17	10.18
0 - 0.249	High (0.210 - 1.0)	7	4.19
0.25 - 0.499	None	14	43.75
0.25 - 0.499	Low (0.001 - 0.109)	8	25
0.25 - 0.499	Medium (0.110 - 0.209)	4	12.5
0.25 - 0.499	High (0.210 - 1.0)	5	15.62
0.5 - 0.749	None	95	44.81
0.5 - 0.749	Low (0.001 - 0.109)	75	35.38
0.5 - 0.749	Medium (0.110 - 0.209)	22	10.38
0.5 - 0.749	High (0.210 - 1.0)	20	9.43
0.75 - 1	None	110	43.48
0.75 - 1	Low (0.001 - 0.109)	90	35.57
0.75 - 1	Medium (0.110 - 0.209)	31	12.25
0.75 - 1	High (0.210 - 1.0)	21	8.3

Employment Composite Score	Alcohol Composite Score	Totals	Percent
0 - 0.249	None	93	55.69
0 - 0.249	Low (0.001 - 0.339)	65	38.92
0 - 0.249	Medium (0.340 - 0.679)	4	2.4
0 - 0.249	High (0.680 - 1.0)	5	2.99
0.25 - 0.499	None	16	50
0.25 - 0.499	Low (0.001 - 0.339)	14	43.75
0.25 - 0.499	Medium (0.340 - 0.679)	1	3.12
0.25 - 0.499	High (0.680 - 1.0)	0	0
0.5 - 0.749	None	124	58.49
0.5 - 0.749	Low (0.001 - 0.339)	66	31.13
0.5 - 0.749	Medium (0.340 - 0.679)	17	8.02
0.5 - 0.749	High (0.680 - 1.0)	3	1.42
0.75 - 1	None	155	61.26
0.75 - 1	Low (0.001 - 0.339)	79	31.23
0.75 - 1	Medium (0.340 - 0.679)	11	4.35
0.75 - 1	High (0.680 - 1.0)	6	2.37

Legal Composite Score	Alcohol Composite Score	Totals	Percent
0 - 0.249	None	328	62.72
0 - 0.249	Low (0.001 - 0.339)	169	32.31
0 - 0.249	Medium (0.340 - 0.679)	15	2.87
0 - 0.249	High (0.680 - 1.0)	9	1.72
0.25 - 0.499	None	39	42.39
0.25 - 0.499	Low (0.001 - 0.339)	35	38.04
0.25 - 0.499	Medium (0.340 - 0.679)	13	14.13
0.25 - 0.499	High (0.680 - 1.0)	3	3.26
0.5 - 0.749	None	4	15.38
0.5 - 0.749	Low (0.001 - 0.339)	17	65.38
0.5 - 0.749	Medium (0.340 - 0.679)	4	15.38
0.5 - 0.749	High (0.680 - 1.0)	1	3.85
0.75 - 1	None	6	85.71
0.75 - 1	Low (0.001 - 0.339)	0	0
0.75 - 1	Medium (0.340 - 0.679)	0	0
0.75 - 1	High (0.680 - 1.0)	1	14.29

