MRGEDA Healthcare Committee
PHASE II Report, January 2019

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Made Possible through a Grant from
Presbyterian Healthcare Services

The Middle Rio Grande Economic Development Association (MRGEDA) represents a four-county rural region of New Mexico, including Catron, Sierra, Socorro, and Valencia counties. The mission of the HealthCare Committee (HCC) is to build a community-rooted behavioral health system that provides greater access for those in need by offering local services linked to regional hub providers. behavioral health care. The HCC is a broad, diverse network of that represents our communities, and includes:

- Advocates
- Behavioral Health Service Providers
- Community Health Councils (CHCs)
- Congressional Elected Officials and Staff
- Consumers
- County Government
- Courts
- Faith Community Representatives
- Hospitals
- Law Enforcement
- NM Public Health Department (PHD) Staff
- New Mexico State Legislators
- Nonprofit Organizations
- Primary and Urgent Care Providers
- Private Practice Therapists
- Schools
- State Nonprofit Intermediary Organizations
- Volunteers

Sharon Finarelli, Director of Resource Development at Sierra Vista Hospital, serves as the Chair of the HealthCare Committee, and the galvanizing force behind the development of the regional behavioral health network.

Anne Hays Egan is the consultant, working with the MRGEDA HealthCare Committee, and guiding the development of a rural, community-rooted healthcare system that includes traditional providers and services, as well as innovative approaches, and grassroots solutions.

Phase II of the planning work has been made possible by a generous grant from Presbyterian Healthcare Services. Presbyterian is not only involved as a funder, they are also integrally involved through their hospital, Socorro General, which plays a leadership role in the HCC.

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Overview

The Middle Rio Grande Economic Development Association (MRGEDA) HealthCare Committee (HCC) is developing a regional behavioral health initiative, working in the same geographic area covered by the economic development association. This provides an enhanced capacity for rural communities, by including a multi-county area that links very small communities with larger hubs.

The HCC is focused upon building a continuum of care "from the ground up," so that it is based on developing the community assets that currently exist, with crisis response and stabilization resources that can be more easily accessed at the local level. These services are then linked with the more intensive hospital and other services offered in larger communities within the region, and outside the region, in Albuquerque and Las Cruces. The HCC is also focused on supporting and developing partnerships with the four Community Health Councils, for mutual benefit and capacity building. HCC is also working closely with county governments, as the county government is an extremely important partner for all rural initiatives. The planning is both complex and straightforward: complex in some of the analysis and system development; straightforward in the way the HCC is creating system improvements in an incremental way by both type of service and goal area.

This report includes sections from the Phase I Report. It also includes a significant amount of new material about interagency collaboration throughout the region, data updates, information about the HealthCare Committee's work, and its goals moving forward.

The partners involved in the HCC are highly skilled, dedicated and committed people who are passionate about building community-rooted behavioral health services. It is a pleasure to work with all of you in this shared endeavor.

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I. The Region

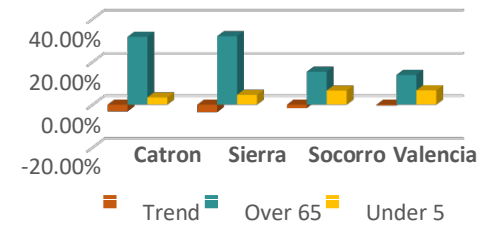
Middle Rio Grande Economic Development Association's (MRGEDA) Healthcare Committee represents a four-county rural part of New Mexico with significant population, behavioral health, economic, and workforce development needs and challenges. The MRGEDA four-county HealthCare Committee is focused on developing a regional behavioral health network that can build services, and address policy and funding issues in ways that impact the overall community's population and economic health. This means connecting the very important structural challenges of (1) economic development and job creation, (2) education, and (3) behavioral health to address the behavioral health risk factors and social determinants the four-county area shares with many other poor rural counties. These include social determinants and health risks with outmigration, and flight of jobs and capital. The federal Department of Labor sees the connection between communities with severe behavioral health needs and economic decline. What sets the MRGEDA region apart is (1) the deep, broad and passionate commitment of a large group of community leaders working both in the field and across sectors to address the issue systemically, from the ground up. This represents a community at work, beginning to develop traction that can take hold, with help from stakeholders, government bureaus, and funders, build the plan.

A. Population Trends

The population has grown more slowly over the decades than the state's overall population. In recent years, the region has actually lost population, with the largest population losses in Catron and Sierra Counties. Communities at highest risk of continued economic decline sustain population losses over time, and have large percentages of their population over age 65, with increasingly smaller percentages of the population under age 5. The region's economic and overall community health are at risk.

2010-2013	Population Trend	Elderly Over 65	Children Under 5
Catron	-3.20%	31.70%	3.40%
Sierra	-3.50%	32%	4.60%
Socorro	-1.60%	15.40%	6.60%
Valencia	-.4%	13.90%	6.70%

*nmhealthcouncils.org/2010-2013, most recent NMAHC data



Population losses (orange column) exist throughout the region. This represents a large rural geographical area in decline, which creates significant stresses to people, agencies and systems serving the region. Population loss makes economic development and job creation more challenging. Access to services is more difficult (1) as services begin to pull out of small towns, becoming increasingly centralized within hub communities inside and outside of the region, (2) people with transportation challenges find it more difficult to commute long distances, and (3) hiring and retention for many healthcare and other fields becomes more difficult.

B. Social Determinants of Health: Income, Poverty, Education, Race and Ethnicity

Many health challenges spring in large part from social determinants of health (SDOH), including poverty and low wages; and limited educational attainment. Areas with high proportions of Hispanic, Native American and Black families often face greater challenges. These social determinants shape individual, family and community health.

Regional earnings are lower than state averages, and poverty rates higher than state and national averages. The poverty rates have been trending down for the most rural areas of the region, however the median income has been improving for all four counties. [1] More current data, from NM DOH IBIS records for 2016 shows the following:

County	Poverty Rate	Median Household Income
Sierra	27%	$30,467
Socorro	25.4%	$33,239
Catron	23.2%	$34,868
Valencia	18.6%	$43,819
New Mexico	19.1%	$46,844
US/Nation	14%	$57,617

The region has more children aged 5 to 17 living at or below the poverty level than the state average, which is roughly 25%; with severe levels of need in the Quemado and Truth or Consequences school districts. The percentage of children that qualify for reduced or free school lunches run about 80% for the MRGEDA region. Catron County's school districts report approximately 70%-75% of children in need; whereas Sierra and Socorro County school districts report over 90% of the children qualify for reduced or free school lunches. This indicates that the vast majority of children in the school system have high levels of unmet need, which may also indicate behavioral health needs as well. Schools themselves are challenged, with some of the schools in the region rated at below average, and severely below average by the New Mexico Public Education Department. The need for schools to respond to this significant level of need, and receive strong community, county and state support for innovative approaches, is critically important, and has been identified as a priority by the HCC.[2]

Single parent heads of household often have lower incomes, longer work weeks with multiple jobs, and greater stresses. Although Sierra and Catron Counties have roughly the same average numbers of single mother headed households as the state rate (29.9% vs. 29.1%), almost half of Socorro County's households are headed by single parent mothers (45.4%). [3] Although most of the region has a teen birth rate which is at or below the state's average (33.6 per 100,000), Sierra County's teen birth rate is 61.4, almost double the state's rate. This adds stress to young mothers and their families.

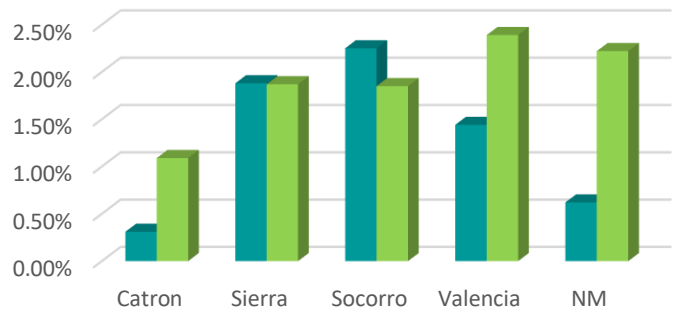
The state's incarceration rates and parent incarceration rates are some of the highest in the nation. National incarceration costs run $22,000 per month, compared to Medication Assisted Treatment which averages $4,000 per month.[4] A number of counties throughout the state are developing partnerships between law enforcement, the courts, and behavioral health providers to reduce arrests and recidivism through coordinated initiatives including alternative sentencing, jail diversion, behavioral health services in jail, and jail-to-community supports. A study of the first six months of the Santa Fe County LEAD program shows that it has reduced recidivism, even during its first six months of operation.[5]

C. The Economy and Jobs

The economic growth of New Mexico has lagged behind national economic growth trends for decades. The region has had overall slow economic growth for the long term, with the exception of Valencia County. However, in recent years, most of the region's economy has grown more quickly than the state's,

[1] Research by the New Mexico Association of Health Councils, documented in the *MRGEDA HCC Phase I Report*, had slightly better poverty rates using older, 2010-2014 data, which indicates that the trend continues to worsen for Catron, Sierra and Socorro Counties.
[2] NM DOH IBIS data, 2016; NM PED data.
[3] NM DOH IBIS data, 2011-2015, the most current year available.
[4] "Treating Drug Abuse and Addiction in the Criminal Justice System: Improving Public Health and Safety," by Chandler, Fletcher and Volkow, *Journal of the American Medical Association*, 2014.
[5] Data and reports from New Mexico Sentencing Commission.

with the exception of Catron County. The short-term growth trend could be a good sign for ongoing economic development for the region, especially in the area of healthcare, IT and other jobs deemed a priority by the NM Department of Workforce Solutions.



	Short Term 2010-2016	Long Term 1970-2016
Catron	0.31%	1.09%
Sierra	1.88%	1.87%
Socorro	2.25%	1.85%
Valencia	1.44%	2.39%
NM	0.62%	2.22%

Data from NM Rural Economic Analysis Project (NM REAP)

The Economic Innovation Group is a national research center that has conducted economic analyses of communities, regions, and the county by zip code, municipality, county and state. They indicate that one of the greatest divides in our country is now the rural-urban divide, and the population loss that is shaping challenges in most rural communities across the U.S. They have developed a Distressed Communities Index (DCI) for each region studied, to indicate the level of economic and population distress that communities face, based upon a mix of economic and social factors. They are similar to the Social Determinants of Health, but more heavily weighted toward economic issues such as regional population loss, job loss, as well as SDOH factors such as poverty and average family income.

DCI from 2012-2016	Catron	Sierra	Socorro	Valencia
Population	3,550	11,440	17,320	75,990
Minority Share	21.40%	33.70%	64.40%	65.80%
% Distressed Zip Codes	67.20%	66.30%	68.10%	29.30%
% Prosperous Zip Codes	0%	0%	0%	0%
DCI Score (Out of 100)	81.8	88.4	82.4	70.6
Change in DCI Score (from 2007-2011)	11	5	-13	-5.6

A DCI score of 25 would mean a very healthy community, whereas a score of 75 indicates significant levels of distress. Socorro and Valencia Counties have improved in their DCI ratings. Socorro still remains quite distressed, and Valencia is improving. Both Catron and Sierra Counties have high distress levels, with a trend toward greater distress and more challenges. It is interesting to note that, of the four counties, Valencia county has a larger population base, is closer to Albuquerque, the state's population hub, and has a lower DCI score.

The rural areas of the four-county region have significant economic challenges, along with some recent improvements in economic indicators. The MRGEDA HCC is focused on the broad framework of building healthcare in communities in ways that offer a locally accessible mix of services linked to hub specialty services in larger communities, using a hub and spoke model. This will improve population health outcomes, and build community economic health through the creation of more healthcare jobs.

D. Health and Behavioral Health Issues

Many areas within the four-county region are designated by the federal government as Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUA), because they are rural and frontier communities, with low population density. This means that health resources are stretched, and need to be

both leveraged and expanded in creative and innovative ways. The percentage of people with a primary care provider is lowest in the most rural part of the region: Catron, Sierra, and Socorro Counties.

	Have a Primary Care Provider	Unable to Access Healthcare Due to Cost
Catron	68.50%	12.30%
Sierra	70.50%	21.30%
Socorro	68.40%	16.60%
Valencia	72.60%	16.90%
NM	71.50%	13%
	2013-2017 NM DOH IBIS	*2012-2016 NM DOH IBIS (2016 only for NM)*

The four counties in the region share a number of common health challenges, as well as health issues unique to each county. Although some counties have a higher incidence of chronic diseases such as cancer, heart disease and stroke, these are not the most common factors shared throughout the region, nor are they the most significant health challenges. The most deeply troubling health challenges that have a lasting impact on the health of the communities are mental health and substance abuse issues. These behavioral health challenges are severe. Alcohol and drug related death rates are extremely high, compared to state and national averages. The rate of emergency department admissions for self-injury, are at or below state levels for two of the four counties, but extremely high for two others.[1]

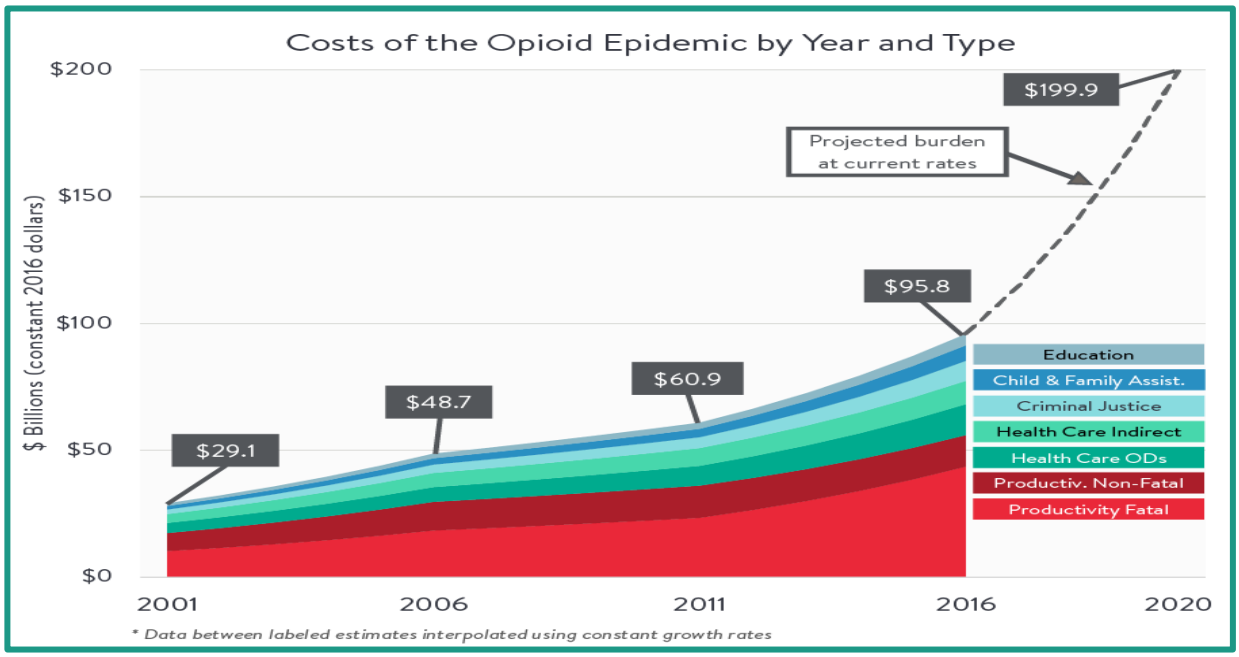
The region has a higher than state average incidence of behavioral health problems with alcohol, drugs, and self-injury. New Mexico has a more significant level of behavioral health challenges than we see nationally.

Region	**Alcohol-related Injury Death Rate ***		**Drug Overdose Death Rate ***		**ED Admissions for Self-Injury ***	
	2010-2014	**2013-2017**	**2010-2014**	**2013-2017**	**2010-2014**	**2013-2017**
Sierra	**35.7**	**38.9**	**33.6**	**29.5**	**215.3**	**NA**
Socorro	**36.14**	**36.8**	**20.4**	**19.6**	**218.1**	**NA**
Catron	**60.2**	**41.9**	**55.0**	**29.5**	**128.4**	**NA**
Valencia	**28.6**	**30.5**	**22.2**	**27.1**	**169.8**	**NA**
New Mexico	**28.7**	**29.3**	**24.6**	**24.6**	**163.2**	**NA**
US/Nation	**18.5**	**NA**	**16.3**	**16.3**	**NA**	**NA**

Data NM DOH IBIS, US Census, and MRGEDA CAHF (* per 100,000) NA means "not available."

The opioid epidemic has had a devastating impact upon our people, jobs, the workforce, the economy, economic development, and overall community health. A comprehensive analysis by Altarum Research indicates full health, social, workplace, law enforcement, economic, and years of life lost costs to communities runs at $800,000 per opioid-related death. By 2020, annual opioid related costs to the US are projected to run $199,000,000, with the cumulative cost topping $1 trillion dollars.[6]

[6] "Economic Toll of Opioid Crisis in U.S. Exceeded $1 Trillion Since 2001," Altarum Group. https://altarum.org/about/news-and-events/economic-toll-of-opioid-crisis.



Comprehensive analysis such as Altarum's looks at the broad systems, and how the many parts of community, state and national life are impacted by this opioid epidemic. Almost half of projected costs are "soft costs" related to years of life lost and earnings lost. Currently, the estimates of projected costs to communities and states varies significantly based upon a range of assumptions, factors, multivariant analytical tools used and their weighting, and the analysis. More research needs to be completed, with state-by-state analyses with clearly identified assumptions, factors, analytical tools, and weighting, so that similar research systems can be utilized and compared at state and local levels.

Clients with substance use disorder (SUD) often have co-occurring disorders and may be poly-addicted. Opioid related drug overdoses have become an epidemic in New Mexico. Cutting-edge behavioral health community-based systems are building in naloxone distribution and training, with a wide array of partner agencies located throughout communities; they are offering medication assisted treatment (MAT); and many provide peer support and/or case management and navigation to help people move forward with recovery.

This four-county area also has major economic challenges related to the loss of population, jobs and capital over a number of decades. This has impacted every area of community health, as the small communities in the region deal with the ripple effects of this trend, in education, law enforcement, government, and the nonprofit sector. In addition to behavioral health providers, the MRGEDA HealthCare Committee includes county government representatives, law enforcement, school officials, faith community leaders, and economic development. This broad-based approach reflects the mix of community stakeholders that need to be involved to address the complex mix of behavioral health and economic challenges facing the region. The HealthCare Committee is also deeply committed to building upon community assets, calling out and supporting the effective collaboration that is already building.

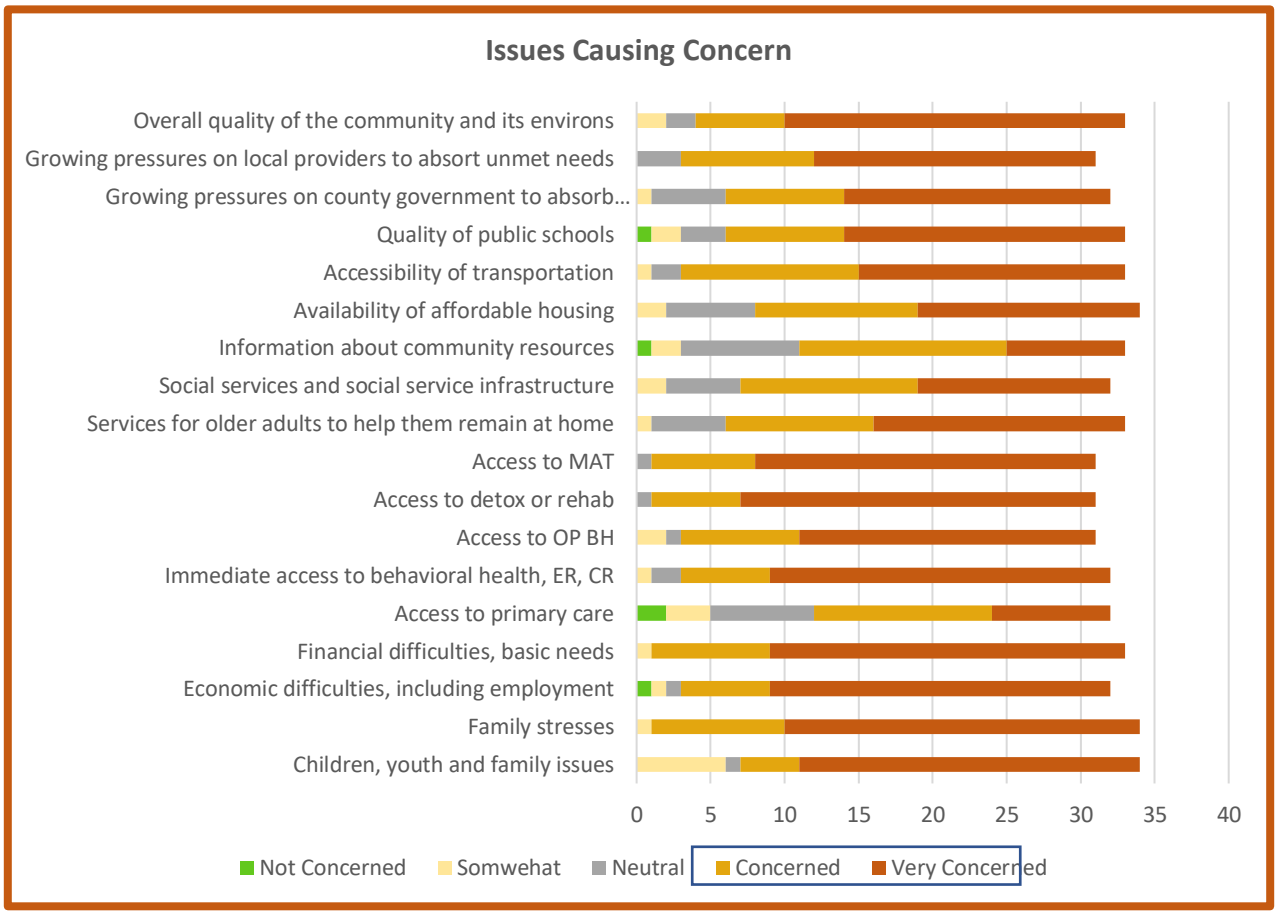
II. Needs, Services & Gaps

Overview

Many in this region face challenges with access to care, and often need to travel 50 to 100 miles for services. Those services that do exist are fragmented and stretched thin. The MRGEDA HealthCare Committee has identified the following as key behavioral health and community issues that impact behavioral health. In Phase I, the HCC conducted a survey to determine the services and gaps.

A. Needs & Gaps

The issues that cause the greatest concern include the lack of access to detox, rehab, and medically assisted treatment (MAT). People express serious concerns about family stresses, financial difficulties, and lack of employment. There are also concerns about the overall quality of community life, growing pressures on local providers and county governments to absorb unmet needs, quality of schools, transportation, and housing. There is slightly less severe concern about access to outpatient behavioral health services, but the issue is still a serious concern. This indicates that the primary social determinants of health are all significantly involved in community problems, and joint solutions. Looking at the list of issues and the level of concern graphed in colored bars on the right, it is easy to see that all of the issues are of concern to the Healthcare Committee members. Most of the issues are of grave concern (indicated by the amount of red and orange in the bars).



Providers indicated there are many community needs that impact behavioral health. These include: poverty and lack of employment opportunities; lack of access to care, especially in crisis situations; and lack of affordable housing and transportation. Healthcare Committee members are deeply concerned about the lack of access to needed behavioral health resources, and indicate that there is much better access to primary care and emergency care.

In discussing and prioritizing the needs and gaps, the HCC has identified the following as key areas of concern for service development. These will be further prioritized as the HCC moves into Phase III with the development of specific strategies to address some of these areas.

	Summary of Needs and Gaps
1	Lack of access to care;
2	Lack of access to help for many in crisis situations;
3	Too few service providers and resources;
4	High rates of substance abuse, with high overdose rates;
5	Hospital Emergency Room (ER) overuse;
6	Children and families at high risk;
7	Too many people with behavioral health needs in jail;
8	Limited job opportunities, poor job readiness, and high poverty.

B. Services

People with drug related behavioral health challenges need: (1) easy and multi-pronged access to prevention, harm-reduction, and recovery care; (2) accessible crisis stabilization and support; (3) medication assisted treatment (MAT); (4) local outpatient services (within a reasonable length of time); (5) consistent access to reliable transportation; (6) navigation and advocacy to access needed services.

Currently, there are limited services for those with behavioral health needs, especially the severely mentally ill, dually diagnosed (mental illness and substance abuse disorder), poly-addicted, and those with opioid use disorder. Hospitals in rural communities, like PHS and SVH, often serve as local and regional health hubs. Hospital Emergency Departments (EDs) become the access point for many people in crisis, and rural hospitals often lead rural health system development by creating partnerships with other providers for better integrated services. Effective behavioral healthcare requires a spectrum of services from crisis response and stabilization to treatment, through a mix of different levels of providers. Currently, the services that exist in the region are fragmented. There are many prevention programs that are not necessarily linked to either one another or to related treatment, except through some Community Health Council and Sierra County Opioid Partnership activities. There is no coordinated intake, screening and referral; the crisis response and screening work is done by each behavioral health provider. Treatment options are scattered, with much of the needed therapy available only in larger population hubs. Expanded MAT treatment has been developed by Sierra Vista Hospital (SVH), and SVH is working to develop peer counseling and/or community health worker (CHW) resources in the Emergency Department, to help clients with a transition to community services and a medical home.

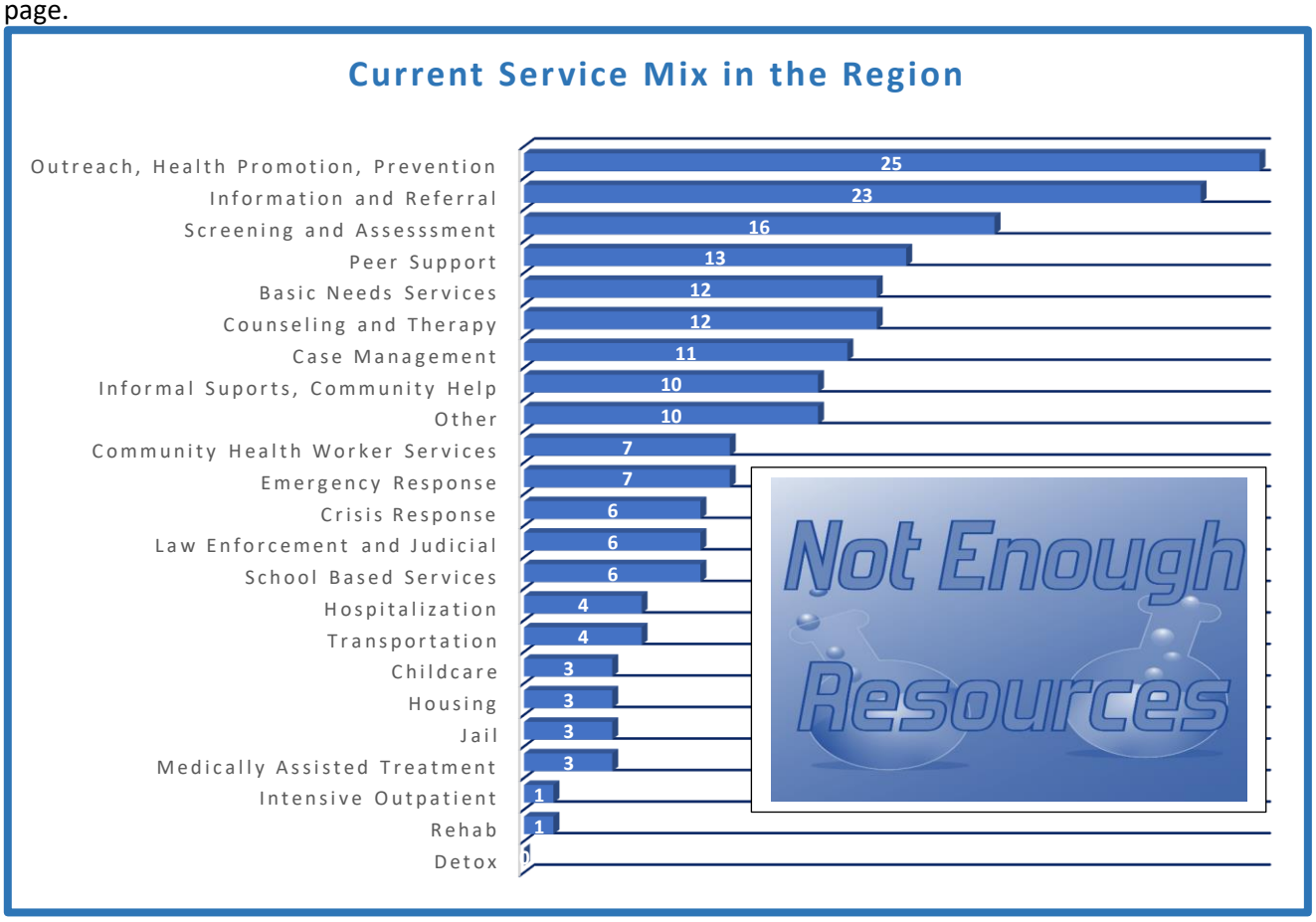
Community Health Council Coordinators provided feedback about services, which was used for HCC discussions during Phase II. The group discussed the following issues.

1. Outreach and Prevention: many different programs exist, focused upon different age groups and interest areas, offered by a range of providers. Most aren't well-linked to other services.

2. Medication Assisted Treatment (MAT): Medication Assisted Treatment is available in Sierra County at Sierra Vista Clinic, at public health offices in all four counties and at First Choice Clinic in Belen.
3. Crisis Response and Stabilization: varies greatly among counties, with some counties reporting that the state crisis lines are well publicized and used, to others that report limited knowledge and access. Naloxone is available from First Responders. However, first responders report that normally EMS is responsible to administer Naloxone because they evaluate whether another medical issue besides Overdose may be present.
4. Law Enforcement and Judicial: law enforcement and jails report most detainees have behavioral health needs, which costs counties an unsustainable 40% to 50% of their budgets. Unfortunately, resources to meet the behavioral health needs of detainees are often not currently available. The Health Care Committee is exploring successful models of jail diversion, alternative sentencing, mental health courts and other intercepts which can address the crisis (In NM about 110,000 bookings are made to roughly 7,000 people).
5. Emergency Response: is active in all counties, coordinating with law enforcement, hospitals and selected behavioral health providers; involved with Naloxone training and distribution.
6. Information & Referral: varies by county, with more resources in larger communities within the counties. Share NM is a statewide resource that is available; however, since smaller counties are not aware that they of the resource or of their responsibility to update, it is not as useful as it could bee to provide information & referral resource in rural areas.
7. Basic Needs Services: varies by community, with many providing some help for food, clothing and shelter; resources are not enough to meet needs, and are fragmented, with help often on a one-time basis. Access to these resources is often limited because there is no central repository of information regarding location and how to access the resource in more rural areas.
8. Transportation: represents a significant regional challenge, especially for the poor.
9. Housing: options for affordable and rental housing have become increasingly more limited over the years, with much of the housing stock in communities already occupied by long-time residents. Transitional/Supportive housing is also is not available in the region.
10. Child Care: of any time is more limited in rural communities, other than that provided through friends and families; affordable child care resources are almost non-existent.
11. Intake, Assessment & Referral: is provided as a part of behavioral health services, from agencies and private practitioners; however, there is no system-wide intake, assessment and referral. As a result, the same information is requested from multiple agencies which delays access to care and frustrates patients.
12. Outpatient: Limited outpatient services are available through behavioral health providers and private practitioners; many have long waiting lists, which varies, and can often run up to 6 weeks.
13. Intensive Outpatient: does not exist in most areas; providers need to arrange for this with hub agencies, at some distance, with waiting times. In Sierra County, Intensive Outpatient services are available by referral only as a part of the Drug County Program.
14. Inpatient Detox: is not available in the region and poses a significant challenge with referrals to providers outside of the region, creating wait times and long distances for client and family travel.
15. Inpatient Rehab: is not available in the region, and poses challenges similar to detox; however, additional challenges are created when people return home without a “warm handoff” to local providers to help with re-entry.

16. Hospital: services are available in Socorro and Sierra Counties; a new facility is currently under construction in Sierra County.

A survey conducted during Phase I among HCC members provided additional information about the services in these 18 areas that exist, with most services very limited and fragmented. Those services that do exist for many areas are stretched and not able to handle the need. This systemic problem creates a situation where people in crisis move deeper into crisis, often act out, and find themselves in the hospital ER/ED or in custody, which further exacerbates the problem, family distress, and adds to health system and county costs. The services reported by a small group of 24 responders, primarily healthcare professionals, is shown on the next page.



C. HCC Discussions About Services and Service Priorities

The discussions at the MRGEDA HCC meetings during the Phase II period, from October through January, included presentations from law enforcement, schools, county management, health councils, hospitals, the core service agency, a state legislator, and specialty care services. As a result of presentations by these experts, the HCC discussed the service mix and highlighted the following needs and gaps that should be addressed by a more targeted mix of services, offered by licensed clinicians, peer support workers and community health workers. These include the following, which are also outlined on the Continuum of Care chart on the next page.

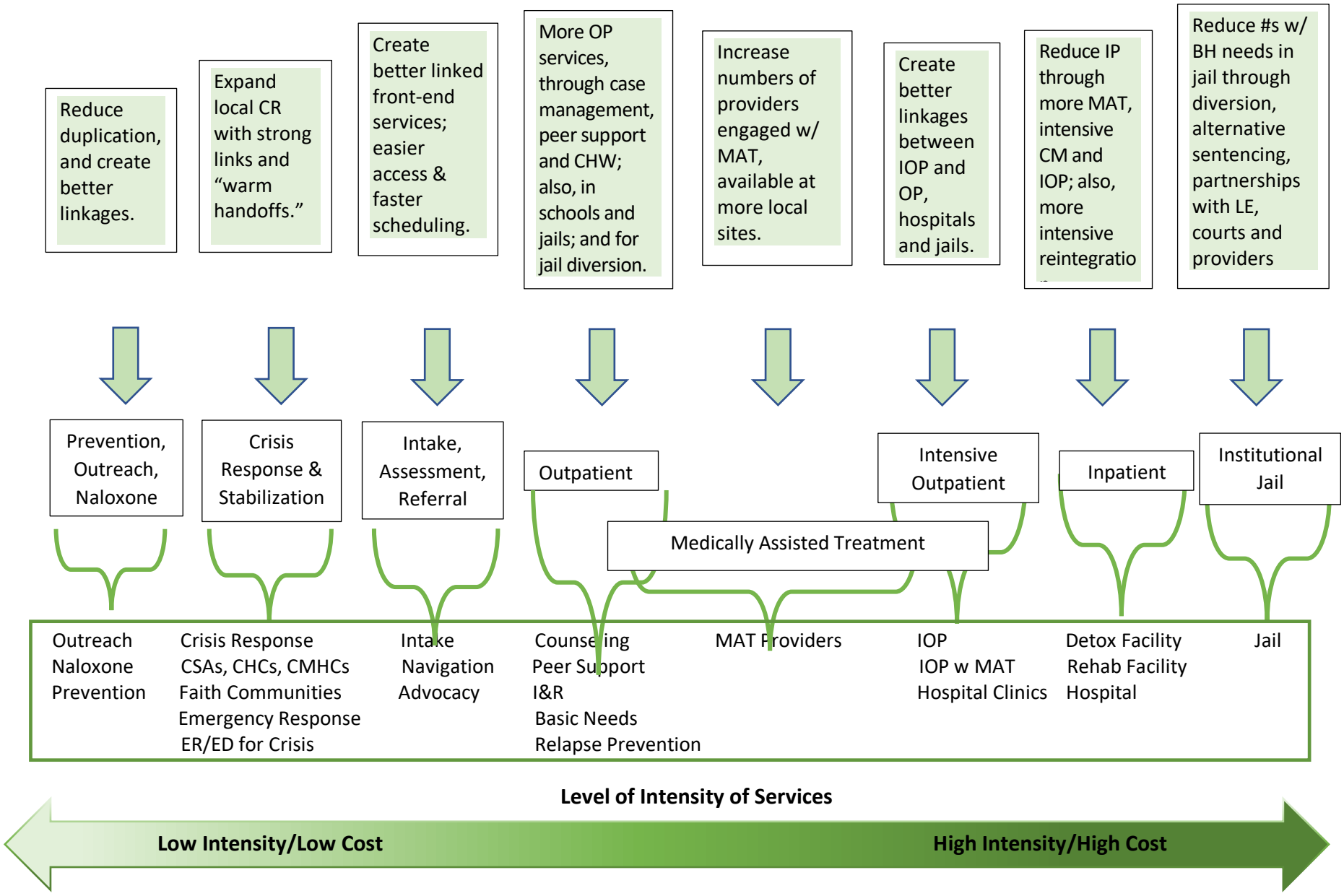
- Better Access to Local Resources
- Crisis Response & Stabilization
- Better Networked Care, with “Warm Handoffs” between Providers
- Medication Assisted Treatment for Substance Abuse and Opioid Use Disorder

- Appropriate Hospital Emergency Room Utilization through Partnerships with Local Providers
- School Based Training, Peer Support and Counseling for Students and Families
- Jail Diversion to Reduce the High Cost of Jail-Based Care to Families and Counties

The group discussed the fact that developing jobs in these areas would help with building health-care related job development. This could help the economy in the region, in a slow and incremental way.

Reframing and Improving the Behavioral Health Continuum of Care for Better Access, Service Quality & Cost Savings

The continuum of care needs to be restructured, with some services better networked, others reduced or changed, and some added and enhanced. The suggestions are in colored boxes with arrows to the type of care.



The MRGEDA Healthcare Committee's work with New Ventures has enabled it to begin the preliminary steps for building community-rooted behavioral healthcare. This work needs to be developed in context of the community and its issues, and how Social Determinants of Health and behavioral risk factors are impacting families. When asked about their primary concerns about community healthcare and quality of life issues, they responded by indicating a very high level of concern about: (1) children, youth and family issues and family stresses, and their impact on families and on children at school; (2) economic difficulties and families with financial difficulties and basic needs crises; (3) access to crisis response and stabilization; (4) access to outpatient behavioral health services; (5) access to Medication Assisted Treatment; and (6) access to detox or rehabilitation. They also expressed concerns about the loss of jobs and capital from the region, and the fact that an increasing number of healthcare, law enforcement, and other professionals are living in hub communities like Albuquerque and Las Cruces, and commuting into the region to work, to enable their spouse to find work and children to attend better schools.

The social determinants and behavioral risk factors are critically important issues, within the larger frame of the community economy, with the need for job creation and workforce development. The HCC is addressing these issues, with specific goals that are beginning to emerge to guide the work. These goals have been developed, and are included in the following section as a draft menu of options, which the HCC can continue to develop during Phase III. The HCC may choose to create specific working groups around goals and strategies.

III. HealthCare Committee (HCC) Solutions

A. Building the Network of the HCC

The work of the HCC needs to not only address the serious behavioral health needs in the region, it also needs to develop strategies that are meaningful to the different stakeholder groups involved - - from advocates and behavioral health providers to law enforcement, government, schools, faith communities, and health councils. Having a clear focus, with benchmarks to track progress, and celebrating achievements will go a long way to keep people involved and engaged. Because the people in the HCC are deeply committed to community building, they will remain involved if the HCC can tie this passion for the common good to actual practical strategies and accomplishments.

Although there has been some funding to support some of the consultation, and the involvement of the Community Health Councils, that funding has been extremely limited. More funding will be needed for planning, goal and strategy development, system development, and ongoing system and community building. There are a number of federal and state grant opportunities that the HCC Chair and MRGEDA ED are currently working to develop, which are crucial for ongoing system development and success.

Monthly meetings of the large group may serve as an excellent format for moving forward. However, it may be equally or more effective for the HCC to meet quarterly, with subgroups working online or in person on goals and strategies during the other months. The subgroups could focus on building strategies for each of the goal areas that address needs, listed below.

	Needs and Gaps	Solutions
1	Lack of access to care;	Outreach, Medicaid enrollment, service expansion;
2	Lack of access to help for many in crisis situations;	Crisis response & stabilization available locally;
3	Too few service providers and resources;	More types of services and providers (CHWs, peers);
4	High rates of substance abuse, with high overdose rates;	Medication assisted treatment (MAT);
5	Hospital Emergency Room (ER) overuse;	Recovery and relapse prevention services partnerships with providers;
6	Children and families at high risk;	School based training, supports and services;
7	Too many people with behavioral health needs in jail;	Jail diversion, alternative sentencing and case management;
8	Limited job opportunities, job readiness, and high poverty.	Healthcare workforce development partnership with schools.

B. HCC Goals

The HealthCare Committee Chair, who serves as the Director for Resource Development for Sierra Vista Hospital, completed a HRSA grant application for Rural Behavioral Health Planning. The focus is initially on in-depth planning for Sierra County with the hospital as the lead, coordinated with a four-county Behavioral Health Plan by and with the MRGEDA HCC. This is a highly competitive grant. If this, or other grant funding is available, the HCC will be able to develop a full and integrated strategic and business plan with goals, strategies, workflows, benchmarks, and service and system outcomes. Meanwhile, the HCC can make incremental progress on what it considers to be the highest priorities in the eight goals that are being drafted for consideration from the eight solution areas listed above.

In its discussion at the November and January meetings, the HCC expressed strong interest in focusing on work to build out some of the practical strategies in two ways:

1. At the county level, working with Community Health Councils, County Governments and leading behavioral health service providers; and
2. At the regional level, working on the priority goal areas, which are described below, along with the key strategies for addressing critical community needs.

The HRSA proposal, as amended by HCC discussion, identified (1) three primary goal areas for the HCC's work regionally and in each county, well as (2) key service priorities for behavioral health, and (c) a strong focus on workforce development. These were initially shaped by the HCC during its early work in Phase I (June through September), and again through group discussions and priority-setting during Phase II (October through January). The discussions at the January 4th meeting helped to provide additional shaping to these goals and service priorities as the HCC moves into Phase III. Because of the rural provider requirements of the HRSA grant as well as limited staffing resources for grantwriting only available through Sierra Vista Hospital, this HRSA proposal was developed with Sierra Vista Hospital as the lead agency, and Sierra County as the primary region; with MRGEDA's HCC and the four-county region significant involvement for network development. The goals below are modified and expanded to focus more on the HCC than Sierra County alone. If funded, Sierra Vista will expand its hospital and community hub work with a mix of healthcare services.

Goal 1. Achieve Efficiencies by Developing/Strengthening the Rural Behavioral Health Network

Continue to map the network and resources, expanding the work that has been done by the HCC in Phase I and Phase II. Include a broad mix of providers and agencies, local and county government, elected officials, law enforcement, basic needs agencies and groups, schools, faith communities, associations, civic groups and advocates. Focus on: (1) developing professional behavioral health services to address unmet community needs and gaps; (2) creating formal and informal help for people in communities through identified gatekeeper agencies; (3) linking the network of concerned people and agencies together, building upon community assets.

Goal 2. Identify needs in the community and create a plan to address most critical needs.

The key strategies and service priorities for this goal area are as follows:

1. Conduct a Community Health Needs Assessment (CHNA).
2. Develop a Strategic Plan for Network Systems of Care that develop services, benchmarks, workflows, and outcomes that relate to the priority solutions and goals that are listed in the Network Service Draft Goals Matrix on the following page.

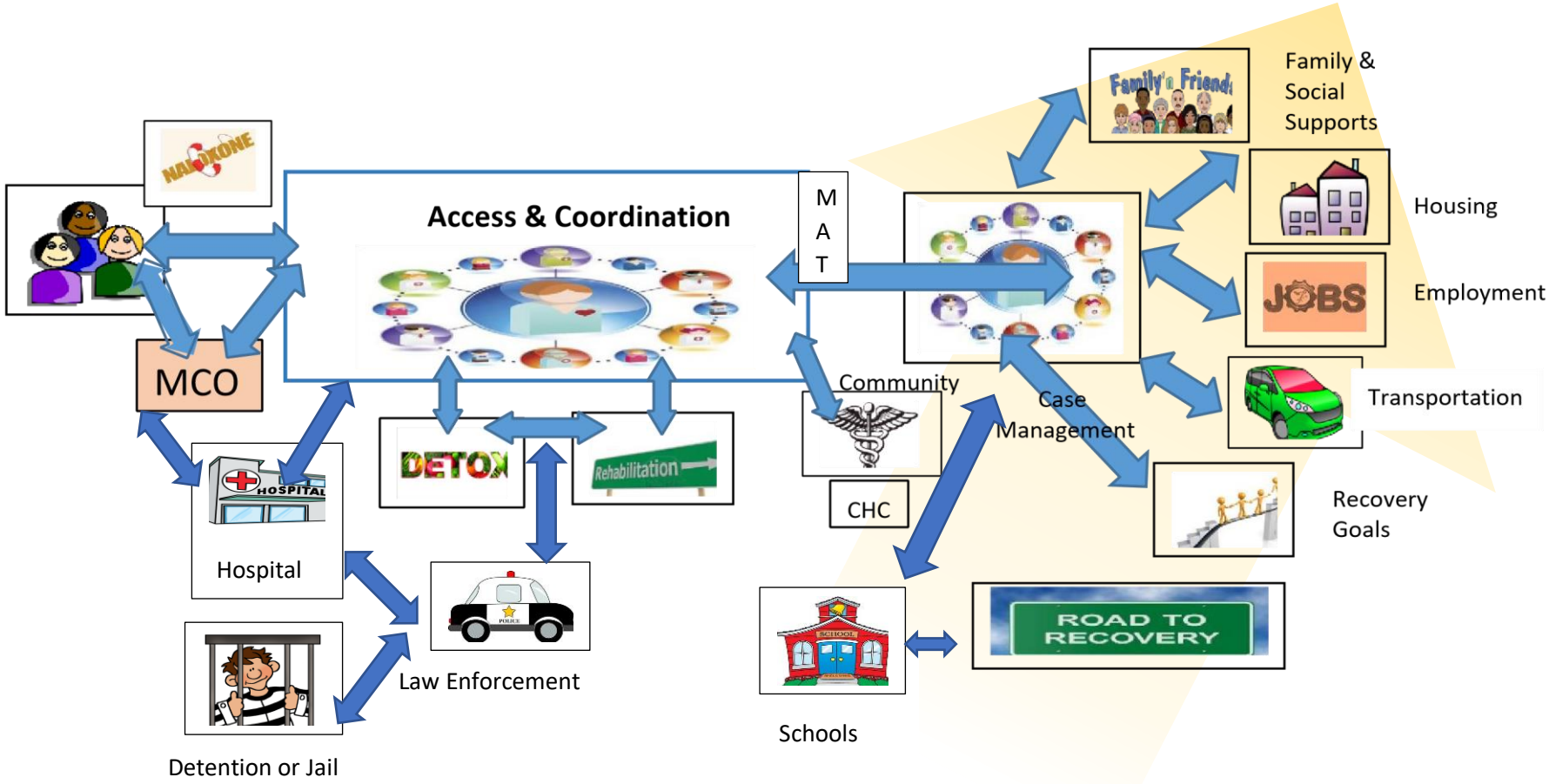
Goal 3. Plan for Network Sustainability

The Sustainability Plan will provide strategies to build ongoing recurring revenue from multiple sources by focusing upon the core of sustainability: to do work that is valued by the community. Our network will also bring value to members through cost/benefit projections for recommended service innovations. We can reduce costs and garner additional funding to sustain the network to provide needed community-rooted services. This plan is based on a similar HRSA project in Rio Arriba County, and other successful behavioral health models in NM and elsewhere.

HCC Network Service Draft Goals Matrix

	Needs and Gaps	Solutions	Draft Goals
1	Lack of access to care.	Outreach, Medicaid enrollment, service expansion.	a. Expand information about resources through more integrated and coordinated outreach. b. Increase presumptive Medicaid enrollment and other Medicaid enrollment activity. c. Track and report service gaps, long wait times, etc.
2	Lack of access to help for many in crisis situations.	Crisis response & stabilization available locally.	a. Create and publicize "mini-hub" CR access points in each community (i.e. PHS & PMS in Socorro; SVH in TorC; PMS in Catron County; CSA and PHD in Valencia. b. Develop and maintain strong relationships with law enforcement (LE), hospitals and first responders. c. Build upon partnerships such as the PHS-PMS partnership in Socorro and the Opioid Partnership in Sierra County. .
3	Too few service providers and resources.	More types of services and providers (CHWs, peers).	a. Expand services available by providing training and credentialing for CHWs and Peer Support Workers (SVH, PHS and PMS). b. Share information about expanded Medicaid funding for CHWs and Peer Support Workers. c. Continue to invite providers, including therapists in private practice, to join the HCC, and build the listing of available services, through the CHCs.
4	High rates of substance abuse, with high overdose rates.	Narcan Distribution and Medication assisted treatment (MAT).	a. Expand the network of first responders, LE and others involved in training and distribution of Naloxone/Narcan in partnership with PHS, PMS and SVH. b. Develop and expand the group of providers involved with MAT in each of the four counties.
5	Hospital Emergency Room (ER/ED) overuse.	Relapse and recovery services, partnerships with providers.	a. Create partnerships between hospitals and local providers to provide for an relapse prevention and recovery services, with lower system costs. b. Hire paraprofessional CHWs/Peer Support Workers to provide case management services for those in crisis and in transition, for wrap-around care at lower cost.
6	Children and families at high risk.	School based training, supports and services.	a. Working collaboratively with CHCs and behavioral health providers, offer training and support in designated schools in the region. b. Adopt some elements of the PMS School Based Health program in Catron County and Ben Archer's School Based services in Sierra county, in the other two counties. c. Increase behavioral health services in the schools, as resources allow.
7	Too many people with behavioral health needs in jail.	Jail diversion, alternative sentencing and other services.	a. Expand opportunities for jail diversion, alternative sentencing, mental health courts, using the LEAD and Stepping Up models and intercept points, working with an expert cross-agency team. b. Implement strategies in each county that fit best with county government, law enforcement, jail and behavioral health provider priorities and capacities.
8	Limited job opportunities, job readiness, and high poverty.	Healthcare workforce development.	a. Involve the local DWS office to provide free training and support to employers who hire those at risk that fit within the DWS target population profiles. b. Partner with High Schools for technical training certification programs.

Client Flow Chart – Community Based Behavioral Health Care – MRGEDA HealthCare Committee



This Workflow Chart graphically depicts the community-rooted behavioral health care system the consultant has developed with the MRGEDA HealthCare Committee. It is based upon and adapted from a similar workflow the consultant developed for the Rio Arriba County Behavioral Health Investment Zone in 2016-2017. The workflow shows coordinated services, and access to key types of services that address the most significant life challenges, and help people maintain sobriety and build on recovery goals. The Road to Recovery is marked with a yellow arrow, with specific recovery goals listed. The system requires collaboration between Medicaid Managed Care Organizations, emergency responders, law enforcement, hospitals, behavioral health providers, schools, jails, courts, county government, and other community agencies. Anne Hays Egan, New Ventures Consulting, 1/28/2019.

C. Community Health Councils in the Four Counties

Historically, the network of Community Health Councils has played a critically important role in community health. Designated as the key community health planning body, by state statute, the mission of the CHCs is to convene diverse stakeholders in every county and tribal area to address health and healthcare in their regions. Their work is to conduct research on health needs, provide community health profiles and reports, and convene diverse stakeholders around issues of import. Community Health Councils work collaboratively at the state level to address state health issues, policy concerns, and funding. When the CHC network was fully funded, prior to 2010, the CHC network had part-time to fulltime staff, with significant capacity. In 2004-2006, consultants Anne Hays Egan and Ron Hale worked on a state CHC capacity building project. As part of the project, the consultants researched the impact that CHCs have in communities, to discover that, when properly funded, CHCs are able to leverage new funding resources at a ratio of 4:1. However, like the behavioral health network, CHCs need to be funded. The CHCs participating in the MRGEDA HCC represent a wide range of capacities. The larger communities that have funding in addition to the small amount provided by the Department of Health (like Valencia and Socorro), have the potential and capacity to engage in more community building work. If CHCs are funded in the 2019 legislative session, the potential for them to serve as a strong partner, convening community stakeholders around shared goals, will be increased substantially.

The following represents a summary of Community Health Council (CHC) work planned for 2019 in each of the HCC priority areas, as shown on a matrix. The work was developed by New Mexico Alliance of Health Councils staff manager Chris DeBolt, with the Coordinator of each of the four CHCs.

CHCs in the Four Counties at Work in Partnership with Others

	Goal Area	Catron	Sierra	Socorro	Valencia
1	Access to Care	CHC provided leadership to obtain dental care and imaging services. Health Fair on emergency preparedness.	Member Sierra County Opioid Partnership to increase access to care.	Working to get more BH and basic needs resources in place. CHC donates items for new parents; coordinates with First Born for outreach.	Working to get a hospital in the county. BH providers are forming a collaborative focused on children at risk.
2	Crisis Response & Stabilization	PMS provides a range of CR services, which the CHC publicizes.	CHC involved in grant funded Self Harm & Suicide Prevention work; Opioid Partnership promoting Warm Line	EMS transports to PHS and Albuquerque. PHS and PMS are partnering for provider coordination and "warm handoffs."	Partnering with Assertive Community TX community partnerships through SAMHSA grant;
3	Too few providers	This is an issue, as resources are severely limited.	Provides a forum for providers to promote training opportunities and services availability.	This is an issue, especially with the poverty and small county budget.	Services and resources are greater in this region; however, a hospital is needed.
4	Medication Assisted Treatment (MAT)	MAT not yet available Naloxone is available from EMS.	MAT offered at Sierra Vista Clinic. CHC will continue to identify needs.	Naloxone is carried by EMS, LE and other first responders. MAT is available.	MAT offered by First Choice; methadone clinic in Belen; Naloxone is widely distributed
5	Reducing ER Use with Linked Services	PMS handles most emergencies and transport to hospitals.	CHC provides the opportunity to promote community services	PHS and PMS are partnering to create strong hospital-community linkages.	People use nearby hospitals and clinics for emergencies; more linkages and hospital are needed.
6	Jail Diversion & Alternative Sentencing	Suicide Prevention training for inmates. DWI, LE and courts provide informal diversion.	Sponsors Mental Health First Aid and CPSW training.	Socorro Alternatives Program through Court System; DWI and JJAB are active; CHC supports these.	Mental Health First Aid is available; local judges are interested in diversion and alternative sentencing.
7	Partnerships with Schools	PMS School Based Health offers services in schools.	Ben Archer School Based Health offers services in schools.	Partnering to provide Breaking the Silence training in middle and high school.	Part of the BH coalition's focus on children at risk.
8	Healthcare Workforce Development	More rural providers are needed. PMS has this as a priority.	T or C Schools is working in partnership with SVH to develop technical certification programs for healthcare workers.	CHC sees need for more specialists.	Proximity to Albuquerque helps w/ recruitment and retention.

D. Making the Case for Support

There are many ways the HCC can and should make its case for support. New Ventures Consulting is providing technical assistance for MRGEDA capacity building. As part of that work, we will be offering some limited consultation on capacity building to the HCC. The HCC Chair has been, and will continue to make the case for funding the HCC's work.

Why Should Funders Support the HCC?

The focus of the HCC's work to create rural, community-rooted behavioral health services that more adequately meet the needs of communities in the region, within a framework of economic development. This makes the HCC's work very unique, and represents a cutting-edge approach that is gaining traction at national and state levels. People need to have hope as a key element of recovery, and having a potential job is one of the best public health strategies available. The HCC is building its framework based upon leveraging current community assets in cost effective ways, rather than trying to bring "the big box store" to the small town. Building the system incrementally, from the ground up, leveraging already-existing resources and community assets makes for a much more sustainable system. The framework is based upon building services in ways that are practical and workable for those most at risk, addressing the social determinants. From the outset, there are a diverse group of stakeholders involved, representing the leadership of communities, which is critical for long-term success.

What Will the HCC Accomplish?

The HCC can serve as a rural model for behavioral health, mixing evidence-based practices and professional standards with creative, community-rooted approaches in a hybrid, cost-effective model. This type of rural hybrid is beginning to gain traction nationally, and can provide the HCC with an opportunity to serve as a leader in New Mexico.

What Will Funders See as a Result?

With adequate levels of funding to support the planning, service development, benchmarks, outcomes, integration, system development, and evaluation, the HCC may be able to provide the following benefits to families, communities, counties, the region, the state, funders, and policymakers. The potential collective impact is enormous, and the possibility of the HCC to serve as a multi-county rural model is excellent, if the work can continue during the coming months, and funding is obtained to support the ongoing activity.

The HCC Benefits Matrix on the next page lists a few examples of benefits; there are many more which can be developed.

Benefits Matrix for HCC Stakeholders

	Outcome and its Benefit	Stakeholders	Timeframe
1	Fewer people in crisis, able to function more effectively. Incremental improvements with behavioral health services in the goal areas, to provide more and better integrated services, at the local level, creating cost savings.	Individuals & Families Communities Service Providers Counties, Budgets Medicaid	Ongoing Small outcomes starting in 2019, that create a collective impact proportionate to the investment, over time.
2	Fewer people in jails, with improvements in recovery and recidivism rates. Incremental improvements through intercept points, reducing the loads on law enforcement and courts, improving wrap-around services and supports.	Individuals & Families Communities Service Providers Law Enforcement Courts Counties, Budgets Medicaid	Ongoing Starting with targeted responses at key intercept points. Over time, these create a collective impact and cost savings.
3	Supports for children at risk and in trouble in school, with training, behavior modification and support services. The work helps improve student and teacher functioning, improving schools.	Individuals & Families Communities Providers & Teachers Schools	Targeted approaches with different schools, in partnership with CHCs and BH providers. Creates collective impact.
4	Peer Support, CHW, therapist and other behavioral health and related jobs are created as part of the process.	All of the Above Economic Development	Targeted approaches with small numbers of healthcare jobs developed.
5	Sustainable income streams created for the HCC, behavioral health services, job development and other economic development and county priorities based upon cost savings created, especially with jail diversion/alternative sentencing.	All of the Above	Targeted, incremental approaches based upon each county's priorities and needs; cost savings tracked. Revenues reinvested.

E. Next Steps

What is probably most important for the MRGEDA HCC is to continue to build upon the momentum it has developed thus far. There are exciting developments created by you, the experts in the field who are passionate about building your communities. Keep working at it. Expand the base of stakeholder involved so that faith communities, small businesses, additional county staffers, funders, legislators, and other participate in the process.

Prioritize the list and focus now on a few of those areas you consider to be most important. This might include some or all of the following: (1) build upon the collaborative relationships like PHS-PMS in Socorro (hospital/behavioral health provider), to strengthen the continuum of services and "warm handoffs" to clients; (2) develop some crisis "hot spots" that people know are safe go-to spaces; (3) expand the MAT incrementally; (4) provide some additional resources to schools; and (5) develop targeted jail diversion and alternative sentencing initiatives. Addressing the jail issue with diversion, alternative sentencing and other behavioral health supports has the potential to create probably the greatest cost savings for counties.

Celebrate who you are and what you're doing to make our communities healthier. If at every meeting, people can share some stories about what's working, that will energize you and give you power for the journey.