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APPROVED

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Region 13 – Cibola, Sandoval, Valencia

Regional Plan Proposal

June 2026

Acknowledgments

Cibola County thanks the many contributors to this report including our partners.

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Region Represented: 13

Counties, Pueblos, Tribes and Nations Represented Within Region: Cibola, Sandoval, & Valencia Counties; Santa Ana, Jemez, Acoma, San Felipe, Cochiti, Zia, Laguna, Santo Domingo, & Ramah Navajo Chapter

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I. PROGRAM OVERVIEW

Accountable Entity: 1) Identify the designated accountable entity responsible for fiscal, administrative, and operational oversight of the regional plan. Describe the accountable entity's roles and responsibilities, including governance, decision-making authority, and coordination with regional partners. 2) Explain how the accountable entity will ensure accountability, compliance, and effective implementation of the regional plan

Region 13 took time to identify its accountable entity given the responsibilities associated with the title. However, in the end, Cibola County was elected to be the Accountable Entity (AE) to oversee Behavioral Health Reform and Investment Act (BHRIA) activities, administration, and fiscal responsibility. In addition to providing fiscal responsibility and administrative support, Cibola County hired a contractor to provide outreach, community and stakeholder organization, planning, and implementation (Marcie Chavez). The Region 13 stakeholder committee has been robustly attended and consists of a consensus style discussion-based decision-making body that presents ideas and considerations for the local governments involved. Final votes come from the three-county manager across the region in terms of approving the budget, evaluation plan, and final regional plan. The regional plan will also need to be approved by all county commission bodies. Due to the fiscal component, Region 13 will monitor accountability, compliance, and effective implementation through efficient contracting with providers and projects interfacing with BHRIA funds. Additionally, Region 13 is dedicated to transparency and community engagement through implementation. Information will be shared with the community and stakeholders and will integrate feedback to support successful implementation.

Stakeholder Engagement: 1) Describe how stakeholders are meaningfully engaged in the development, implementation, and ongoing oversight of the regional plan. 2) Identify participating groups, including counties, Pueblos, Tribes, Nations, service systems, and individuals with lived experience. 3) Describe outreach methods, coordination mechanisms, and structured processes for gathering input, collaboration, feedback, and continuous improvements of the regional plan.

While it may have taken Region 13 some time to establish their AE, once Cibola County was established, they immediately began approaching stakeholders to establish projects and an early access proposal. During this process they began engaging community members, community-organizations and providers, local and regional agencies, and Tribal Partners. This

culminated in listening sessions, a very successful Enhanced Sequential Intercept Model (ESIM) event, and a well-attended weekly stakeholder committee meeting. Cibola County also puts out a monthly newsletter, hosted on a platform that allows users to review all past reports as well and can be found here: <https://region-13-bhria.beehiiv.com/>.

While there has been significant community involvement in the planning process, Region 13 has committed to continuing this open line of communication through implementation. During planning it was clear a disconnect existed between the intended implementation of programs and the community experience (e.g., thinking a specific service was not available or did not exist within the region when there are in fact providers in region offering the service). It will be imperative to continue to request utilizer input to make sure implementation is having the intended impact. This will be accomplished through community surveys and possible listening sessions. Additionally, the stakeholder committee will continue to act as an expert level panel for oversight of implementation to identify any unforeseen challenges and create solutions to problems when they arise. Consistent review of monthly outcomes from current projects will allow the AE to identify problems or challenges in real time and offer projects support to achieve success.

Regional Planning Structure: 1) Describe the governance and coordination structure used to guide development, implementation, and oversight of the regional plan. 2) Describe roles, coordination mechanisms, and processes for collaboration, accountability, and ongoing review and updating of the regional plan.

Cibola County will be utilizing their internal local government structure to oversee the implementation of the regional plan and BHRIA funds. County procurement procedures will need to be followed, and contracts will be made directly with the county to access BHRIA funds. Proposals will need to map on to one or more of the five priorities and identify implementation and measurable outcomes through a logic model, evaluation plan, and budget justification. If implementation exceeds one fiscal year, this will be identified in the initial contract. While Cibola County will be the main oversight for BHRIA activities they will also rely heavily on their local government partners, Tribal Partners, and Stakeholder Committee to address unforeseen challenges and to provide creative problem solving keeping the regional plan on a success trajectory. Contracts will require monthly data reporting to inform these decisional bodies on progress, direction, and possible enhancement to current process and procedures.

At this time there is still debate on how the Tribal set-aside will be handled. However, Region 13 is committed to continued collaboration and support of all Tribal partners within the region. This includes developing intergovernmental agreements (IGAs) between the Accountable Entity and Region 13 Tribal partners to access funding if that is the process agreed upon within the Behavioral Health Executive Committee (BHEC).

Priority Areas/Description of Services: 1) Describe priority areas and how it responds to regional needs and gaps identified through the regional needs assessment. 2) Identify the services and intended outcomes associated with each priority area. 3) Indicate whether proposed activities represent new services, expanded services, or enhancements to existing services, and describe how the plan build on current efforts where applicable.

Priority #1: Crisis Response, Mobile Services, and 988 Coordination

Voted as the top priority, the ESIM event and larger community listening sessions and Stakeholder Committee as well as Tribal Partners discussed the lack of Crisis Response Teams dedicated to behavioral health and Mobile Crisis Teams (MCTs) and difficulties with 988 coordination into crisis response systems.

Service	Intended Outcome	New, Enhanced, or Expanded
Expand Sandoval Regional Medical Center Crisis Mobile Team to expand coverage & includes technical assistance to the other two counties to support development of their crisis mobile programs	Increased regional access to mobile crisis services and reduced use of law enforcement and hospital ER	Expanded
Link EMS who deal with BH calls with MCTs for continuity of care	Increase regional access to crisis BH services	Enhanced
Consider implementing a program like Albuquerque Community Safety (ACS)	Greater resources for crisis calls to allow a continuum of crisis care	New
Coordination with 988 across region including Tribal partners	Greater coordination for crisis calls and identified level of care needed	Enhanced
Develop cross jurisdictional agreements (across each respective Tribe) related to crisis encounters (High Complexity)	Greater community impact across the region	Expanded/Enhanced
Santo Domingo to offer technical assistance to other Tribal partners for Tribal specific MCT implementation	MCT across all Tribal communities if needed	New/Expanded

Priority #2: Clinical Treatment, Recovery, and Service Capacity

Priority 2 aims to address the overall gaps within the behavioral health continuum of care within locally offered services; and to address the need for mental health and substance use disorders (SUD) to be addressed within the community rather than sending individuals to Albuquerque or out of state.

Service	Intended Outcome	New, Enhanced, or Expanded
Increase day programming for psychosocial rehabilitation	Increased regional access to appropriate levels of care	Expanded
Increase community access to Narcan and overdose training	Increased access to lifesaving means	New
Develop peer run services such as funding Certified Peer Support Workers in all Emergency Departments and peer run drop-in centers	Access to greater support services at the time of care	New
Expand CCBHC services across region	Greater access to services	New/Expanded
Build behavioral health capacity within the new Valencia Hospital	Greater access to services	New/Expanded
Utilize the UNM FOCUS model for whole family medication assisted treatment (MAT) services	Greater access to services	New/Expanded
Increase access to MAT services within jails and detention centers	Greater access to services	Expanded
Increase access to forensic assertive community treatment (FACT) team	Greater access to community focused care	New
Increase mobile based services like detox, immunizations, and screenings	Greater access to services	New
Create Tribal-based prevention curriculum that can be used Pueblo, Tribe, or Nationwide that can be tested across time and supported as an evidence-based model	Greater access to community focused services	New

Develop peer run drop-in centers (e.g., living room model)	Greater access to community support services	New
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Priority #3: Care Coordination, Navigation, and Continuity of Care

Service	Intended Outcome	New, Enhanced, or Expanded
Hire region wide service coordinator to monitor and assist with continuity of care through support of a closed loop referral system and other service data base systems and sharing information/success/opportunities across the region	Increase regional service coordination	New
Increased coordination between Children, Youth, and Families Division and behavioral health services to promote greater family cohesion, support and child safety	Improve coordination and family outcomes	Enhanced
Increase number of Tribal Liaisons/Cultural Brokers within clinical services	Greater cultural responsiveness across behavioral health services	New
Increase behavioral health services and reentry coordination within detention centers	Greater coordination and access to services for justice involved individuals	New/Enhanced
Increase access to insurance for adults and increase awareness of MCO offered services	Greater access to services	New
Increase telehealth services and decrease need for transportation	Greater access to timely services	New/Expanded
Hire navigators to increase awareness and access to available services	Greater connection and referral to relevant services	New
Place CPSWs and CHWs in community spaces like libraries to assist individuals seeking assistance	Greater connection to community-based services	New
Develop community hubs or drop-in centers where patients can connect with providers, CHWs, and CPSWs	Greater access to community-based services	New

Priority #4: Housing, Transportation, and Basic Needs

Service	Intended Outcome	New, Enhanced, or Expanded
Expand transportation services regionally	Increased regional connections	Expanded/Enhanced
Increase access to transportation options upon release from detention or hospitalization	Increase regional connection	New
Advocate for improvements with local bus companies to address transportation issues in rural areas	Greater connection to resources	New/Expanded
Increase transportation options for families to visit relatives in detention centers or who may be hospitalized	Support local support systems	New
Advocate for dedicated walk/bike paths along roads	Greater community movement	New/Expanded
Increase second chance housing options	Greater community stability	New
Expand transitional living and group homes for youth	Greater access to community safety and stability	New/Expanded
Advocate for refurbishing existing spaces for housing options	Greater community safety and stability	New
Provide youth/adult emergency shelters in each community	Greater community safety	New
Advocate for housing options for providers willing to relocate to rural communities.	Access to providers	New
Offer shower and laundry vouchers at local aquatic centers and other locations	Greater access to basic needs and positive health outcomes	New
Increase transportation options (e.g., mileage reimbursement, use of county/program vehicle, etc.) for providers to reach more rural areas and communities.	Greater access to rural behavioral health care needs	New

Priority #5: Workforce Development, Training, and Provider Support

Service	Intended Outcome	New, Enhanced, or Expanded
Establish provider and staff incentives to work in rural and underserved areas	Increase workforce, less job vacancies, decrease wait times	Expanded
Increase awareness of current student loan forgiveness programs	Increase workforce, less job vacancies, decrease wait times	Enhanced/Expanded
Advocate for increased CPSW certification training opportunities in the community and ongoing required training.	Increase workforce, decrease wait times	New/Expanded
Competitive salaries for licensed providers working in rural and Tribal communities	Increase workforce, less job vacancies, decrease wait times	Enhanced/Expanded
Increase access to supervision towards licensure for BH providers in rural areas	Greater retention of early career workforce	Expanded/Enhanced
Develop an education pipeline for middle and high school students geared towards justice system, law enforcement, and behavioral health career opportunities	Increased local workforce	New
Create partnerships with colleges, universities, and trade schools for internships and other training opportunities	Increased local workforce	New
Increased education and training opportunities for workforce	Increase work benefits	New

Longevity of Care:

- 1) Describe the model for sustaining access to behavioral health services over time.
- 2) Explain how services will be coordinated to ensure continuity across the lifespan.
- 3) Address long-term considerations for maintaining services beyond initial implementation.

Region 13 is aware of the limitation of BHRIA funding to the end of Fiscal Year 2029 (FY29). Therefore, projects that require one time funding to build capacity or infrastructure will be prioritized. Programs/projects that will need increased funding past the three-year BHRIA funding period will be addressed through federal and state grant opportunities, state funding opportunities through the rural health care fund, workforce solutions, housing department, and other state agencies aligned with regional priorities. Finally, Region 13 is committed to leveraging Medicaid to the best of their abilities while understanding that not all behavioral health services are billable services.

Region 13 priorities address behavioral health across the lifespan; however, specific attention will be paid to the transitional periods (e.g., youth to adult health care system, working to retired health care system), as well as reentry from the justice system and return from hospitalization or residential treatment programs.

Access to care continues to be a deep discussion within Region 13. The region itself covers a large geographic footprint of largely rural areas. Transportation and services located within the region are identified challenges to this plan. However, increasing capacity of current services and finding creative solutions to expansion within the region will allow greater access to regionally based services that can provide all behavioral health basic needs with referral to larger regions for specialty programs.

II. CONTINUITY OF CARE

Applicants must describe how the regional plan ensures coordinated, continuous access to behavioral health services across providers, service levels, and populations. Explain how individuals will be connected to behavioral health resources across the continuum of care and how services will be coordinated among providers, systems, and levels of service within the region.

- a. Strategies to support continuity of care
- b. How it will be maintained over time

Region 13 stakeholders have been extremely active across the planning process. This has allowed consistent discussion and communication related to continuity of care and sustainability (more than financial but across access and service provision). Region 13 stakeholders have committed to continued collaboration and oversight of the BHRIA process. This will allow partners to communicate in real time, address unforeseen hurdles, and address communication breakdowns as they occur. This real time action of addressing challenges will allow Region 13 to adjust the phased implementation as needed, making sure there is enough support for projects and that services are rolled out in a timely and consistent manner. The

stakeholder committee has already demonstrated their commitment to BHRIA activities to address the total regional population with specific focus on vulnerable and disproportionately impacted populations.

This oversight and support process will last through the BHRIA funding period; however, the goal would be that this process creates a different level of behavioral health system support, regionally and with tribal partners. Use of EHRs, closed loop referral systems, and data sharing agreements will assist in the oversight process and provide valuable information regarding utilization, referral sources, and possible access bottlenecks that can be addressed. Taking a data driven approach to system upgrades and maintenance.

III. DEMONSTRATION OF NEED

Applicants must clearly demonstrate the behavioral health needs within the region that the proposed priorities are intended to address. This section must be supported by relevant data and regional context. Support descriptions with relevant quantitative/qualitative data. At a minimum, applicants must address the following:

Population Needs: Describe the population(s) to be served and their specific behavioral health needs. Include key demographic characteristics and the estimated size of the primary population. Describe disproportionately impacted communities (e.g., rural/frontier populations, race/ethnicity, housing status, immigration status, insurance coverage) and how the plan will address barriers to reduce disparities. Applicants should clearly describe how identified behavioral health needs and service gaps affect rural and frontier populations within the region, including barriers related to geography, access, workforce availability, and service delivery, and how proposed priorities address these barriers in addition to population centers.

Region 13 is made up of Cibola, Sandoval, and Valencia Counties and nine tribal partners; Santa Ana, San Felipe, Cochiti, Jemez, Acoma, Laguna, Zia, and Santo Domingo Pueblos; and Ramah Navajo Chapter.

Cibola County, acting as the Accountable Entity, has roughly 26,845 residents covering 4,540 square miles with a median age of 40 years old. Fifty percent of the population is female, 43% identifies as Native American, 33% identify as Hispanic, 19% identify as White, 2% identify as Black, and 1% identify as Asian. The median household income is roughly \$50,700 with 50% of the population making under the median income. Children under 18 years of age make up 42% of the poverty level and seniors 65 years or older make up 19% of the poverty level.¹ Cibola County was ranked as one of the top counties needing senior housing/age in place services.

¹ <https://censusreporter.org/profiles/05000US35006-cibola-county-nm/>

Further, Cibola County was evaluated to need 156 total housing units (rentals and ownership) to address all Average Median Income (AMI) needs by 2035.²

Sandoval County has roughly 160,000 residents and covers roughly 3,714 square miles. On average 59% of the population falls within the age range of 18-64 and those 65 years and older represent 21% of the population.³ The median age is 41.8 years old and 50% of the population is female. Sandoval County's population is made up of 41% identifying as Hispanic, 39% identifying as White, 11% identifying as Native American, 3% identifying as Black, and 2% identifying as Asian. The median household income is recorded as \$91,660 with 23% of the population making under \$50,000 and 9.2% of the population falls under the poverty line.⁴ Sandoval County participated in the joint Albuquerque and balance of state point in time (PIT) count for homelessness. The balance of state counts suggests that 63.8% of survey respondents were chronically homeless, Sandoval had 24 survey responses.⁵

Valencia County consists of roughly 80,813 residents covering 1,066.7 square miles. The median population age is 39.8 years old. Fifty percent of the population identifies as female, 61% identify as Hispanic, 29% identify as White, 3% identify as Native American, and 1% identify as Asian. The median income is reported as \$71,216 and 36% of the population falls under \$50,000, 15.4% of the population falls below the poverty line.⁶ It does not appear that there is a specific homeless population count for Valencia County; however, in review of services it appears Valencia County has limited homeless shelter options and rely heavily on neighboring counties to support this crisis population.

Region 13 Tribal Partners are participating in the Tribal Addendum Plan and will be describing their populations within those attachments. It is important to note that Region 13 has the largest Tribal partnership across all regions with 9 Pueblos, Tribes, and Nations represented. It is known that there are more Tribal partners with land within Region 13 but due to the breakout of regions and Tribal assignments, only the Tribes designated to Region 13 are represented in this plan.

Region 13 largely consists of rural/frontier communities with significant geographic distances between communities and services. Many communities utilize services in Albuquerque (Region 2). Cibola County is considered mostly rural; however has the designation of "mixed urban/rural" with only two major urban centers (Grants and Milan).⁷ Valencia county is largely

² https://housingnm.org/uploads/documents/Homlessness_and_Special_Needs_Housing_Research_Brief.pdf

³ <https://www.sandovalcountynm.gov/about/sandoval-county-history/>

⁴ <https://censusreporter.org/profiles/05000US35043-sandoval-county-nm/>

⁵ [https://568ac5c8-a616-4ffa-987e-](https://568ac5c8-a616-4ffa-987e-7f77d5d1e6aa.filesusr.com/ugd/ad7ad8_0b3a57c7ce914d7f9bc94b6ea37be15c.pdf)

[7f77d5d1e6aa.filesusr.com/ugd/ad7ad8_0b3a57c7ce914d7f9bc94b6ea37be15c.pdf](https://568ac5c8-a616-4ffa-987e-7f77d5d1e6aa.filesusr.com/ugd/ad7ad8_0b3a57c7ce914d7f9bc94b6ea37be15c.pdf)

⁶ <https://censusreporter.org/profiles/05000US35061-valencia-county-nm/>

⁷ <https://www.nmcounties.org/counties/cibola-county/>

considered a rural county; however, it follows the Albuquerque metropolitan corridor and thus 70% of residents are considered to live in an urban area.⁸ Finally, Sandoval County is classified as a metropolitan county rather than strictly rural primarily due to the heavily populated Rio Rancho area and its integration through the Albuquerque metropolitan corridor.⁹

The University of New Mexico – Technical Assistance Center (UNM-TAC) produced Medicaid Utilization data related to Region 13 within their Enhanced Sequential Intercept Model (ESIM) Report.¹⁰ The top 10 behavioral health disorders for individuals under 18 years of age in order from most prevalent to least were:

1. Anxiety Disorders
2. Attention Deficit Disorders
3. Mood Disorders
4. Developmental Disorders
5. Conduct Disorders
6. Intentional Self-Harm & Suicidal Ideation
7. Cannabis Use Disorder
8. Emotional Disorders Childhood Onset
9. Psychotic Disorders
10. Impulse Disorders

The top 10 behavioral health disorders for adults 18 years of age or older in order of severity include:

1. Anxiety Disorders
2. Mood Disorders
3. Alcohol Use Disorders
4. Opioid Use Disorder
5. Stimulant Use Disorder
6. Cannabis Use Disorder
7. Psychotic Disorder
8. Attention Deficit Disorder
9. Intentional Self Harm & Suicidal Ideation
10. Hallucinogen and other substance use disorders

⁸<https://www.nmlegis.gov/handouts/LHHS%20092519%20Item%202%20New%20Mexico%20Rural%20Health%20Plan.pdf>

⁹<https://www.nmlegis.gov/handouts/LHHS%20092519%20Item%202%20New%20Mexico%20Rural%20Health%20Plan.pdf>

¹⁰ https://hsc.unm.edu/medicine/departments/psychiatry/bhtac/_media/e-sim-and-prioritization-report-bhr-13.pdf

The top behavioral health service types utilized in Region 13 per the ESIM report were 87.2% behavioral health outpatient services, 20.55% crisis services, 12.94% recovery services, 6.81% intensive outpatient services, and 3.41% residential and inpatient services. A further breakdown of outpatient services, the most utilized service, includes 34.38% Primary Care Clinicians, 12.32% behavioral health prescribers, 3.58% independently & non-independently licensed psychotherapy practitioners, and 0.66% dedicated substance use practitioners. Hospitals and behavioral health agencies were the largest infrastructures providing utilized behavioral health services. In general, region 13 demonstrated lower crisis calls than the overall state average and a little less utilization of emergency departments than that of the average state report.

Santo Domingo Pueblo completed a health survey and recently received the results. The survey indicated substance abuse as the largest community concern and problem. Echoes of this across all tribal partners was heard and discussions related to the need for treatment and detox facilities are ongoing.

Service Gaps & ESIM: Identify existing gaps in behavioral health services within the region and explain how proposed priorities are tailored to address identified gaps. Summarize critical needs identified through enhanced sequential intercept mapping (ESIM) and prioritize workshop process: Youth and adolescent behavioral health access, etc. provide documentation that the ESIM and prioritization was completed in partnership with UNMHSC and AOC.

The ESIM report indicated gaps across the 7 identified intercepts, pre-intercept prevention; Intercept 0 community treatment, schools, and crisis services; Intercept 1 law enforcement (initial contact with CYFD or school police); Intercept 2 initial court hearing or detention (juvenile justice intake or diversion); Intercept 3 jails, prisons, courts (judicial processing); Intercept 4 community reentry services; Intercept 5 community corrections and support (juvenile community corrections and support). These gaps included

Pre-intercept

Discussion and identified gaps revolved around the need for social activities for adults 18+ that were prosocial and did not include alcohol consumption. Additionally, discussion included the challenge to attract, hire, and retain licensed professionals creating waitlists and administrative burdens on the current local providers system. A large piece was targeted at the culturally different approaches to behavioral health between Western, Hispanic, and Native American approaches. Further challenges include the stigma, shame, and cultural barriers around seeking behavioral health services. Region 13 being a large geographic region discussed the challenges in transportation as well as the lack of a true bus system with identified route stops and schedules. In addition to transportation, internet and data services were described as barriers to the more frontier communities and creates isolation for those individuals. This large area also

makes it challenging to disseminate information to everyone and to plan/coordinate overlapping events. Additionally, the communities feel there are many abandoned or unusable buildings that creates frustration when there is also a lack of funding to build, convert, or restore these structures. Language/translation services were identified as a gap and that youth are often used to translate in the home and at appointments with elders.

Intercept 0

Crisis response capacity, training, or complete lack of service (e.g., mobile crisis in Valencia, Cibola, and many Tribal lands), and limited hours of availability of crisis services. Jurisdictional issues exist regarding crisis services between county, city, and Tribal partners for response and transport, and the distance across the region makes response times lag and programs are difficult to staff. Behavioral health workforce shortages are experienced across the entire region. Barriers to hiring include lack of housing for professionals, lack of competitive salaries, and challenges in geographic and cultural barriers. This workforce shortage impacts the ability to expand or enhance services such as developing assertive community treatment teams, building services around certified peer support workers (CPSW) or community health workers (CHWs). Limited recovery-oriented services across the behavioral health spectrum from individual and group therapy to detox centers and sober living homes. Challenges for providers and clients to enroll with Managed Care Organizations (MCOs), licensing and certification burdens/barriers, and lack of affordable services and continuing education and training opportunities. Finally, challenges in coordination and communication across entire behavioral health continuum of care limiting data sharing and other support services.

Intercept 1

Criminalization of behavioral health disorders, or the utilization of the criminal justice system to receive behavioral health services. A lack of diversion programs such as Law Enforcement Assisted Diversion (LEAD) and insufficient staffing sustain functional crisis intervention teams. Behavioral health system professionals (law enforcement, therapists, doctors, etc.) burnout. Lack of staff across the system creates challenges to allow staff to take time off for trainings, etc. The overall complexity of jurisdictional issues across Tribal communities and their ability to detain, assess, divert, and transport individuals with behavioral health needs. Overall lack of training for law enforcement related to behavioral health issues and how to handle these in the field.

Intercept 2

A lack of providers for competency evaluations and restoration that create long wait times and delay court proceedings. There is no district attorney's office located in Region 13 requiring contracts with attorneys from Albuquerque which can often delay cases. Tribal courts lacking

specialty court services, diversion options, pretrial services, and access to clinicians to conduct behavioral health assessments. Gap in law enforcement accessing behavioral health assessments. Challenges establishing guardianship within tribal communities and a lack of services offered to individuals found not competent and have their charges dismissed. Accessing higher levels of care such as civil commitment or mental health holds for stabilization. An overall lack of transportation to and from court services.

Intercept 3

Workforce shortages within court staff to support the judicial continuum including specialty courts, pretrial services, jails, probation, and diversion programs. Lack of consistent providers specifically in Sandoval County. Lack of residential treatment centers for Tribal judges to send individuals to and jurisdiction issues when individuals move between courts. Court programs and evaluations feel overly complex, making participation limited. Grant funded court programs lack sustainability and there is constant concern of programs ending. Detention facilities are often long distances, and family visits are challenging as well as a lack of detention centers on Tribal lands; these facilities often have little to no behavioral health services. In addition to the lack of behavioral health services there is also limited medication assisted treatment (MAT) within detention centers making withdrawal and sobriety dangerous and difficult. There is no reentry independence through sustainable efforts (RISE) program offered in Region 13 an evidence-based program improving reentry and lowering recidivism rates. There are difficulties with managed care organizations (MCOs) entering the detention centers and getting individuals registered with Medicaid and ready for reentry slowing the process upon release to access services. There are also barriers to family support during the court process and often limited mental health literacy for those going through the justice system.

Intercept 4

A lack of transitional housing, reentry centers, and family-focused services across the region. This increases wait times and contributes to limited bed spaces. Housing includes landlord stigma and limited allowability for renting to those with mental health or felony charges. Some Tribes will restrict reentry onto Tribal land after sentencing causing housing challenges and limited community supports upon reentry. In addition, there is poor communication between detention facilities and Tribes related to reentry plans. There is limited training for probation and parole officers related to behavioral health, substance use disorders (SUDs), developmental disabilities (DD), and cognitive disabilities making working with these individuals challenging and resulting in additional violations. Limited use of peer support in detention centers and continued stigma and lack of behavioral health education within communities. Employment barriers for justice-involved individuals limiting their ability to financially support themselves in the community. No forensic assertive community treatment (FACT) teams or ACT teams.

Intercept 5

High probation/parole caseloads, and limited probation/parole services within Tribal lands.

Youth System Gaps

Limited school-based health centers across the region as well as early screening and intervention programs. School counseling often prioritizes academics over behavioral health and can feel punitive or unsafe due to parental participation/communication. Bullying and school climate concerns as well as a lack of individual education plan (IEP)/504 plans following students as they transfer schools. Turnover impairs long-term school supports. Absence of teen parenting supports and CYFD mentoring programs and overall parenting education. The youth system, similarly, to the adult system experiences long waitlists for all services along with gaps within these services such as specific SUD treatment, intensive outpatient treatment, residential treatment centers, and specialized trauma approaches such as dialectical behavior therapy (DBT), trauma focused cognitive behavioral therapy (TF-CBT), and multisystemic family therapy (MST). Transportation for all ages is a complication as youth typically rely on parents and family members for rides. Youth outreach needs to be in a format that is effective for youth. Overall, there seems to be limited youth buy-in or participation in current services and these programs usually are deficit focused rather than strengths based. There is a lot more bureaucracy involved in developing and deploying youth programming that often does not align with the actual community need it was meant to address. There are significant wait times for 988 responses in rural areas.

How Needs are Identified: Describe the unmet or underserved behavioral health needs within the region, including contributing factors or barriers such as access to care, coverage gaps, workforce shortages, or other systemic challenges. Explain how these needs were identified, including information beyond regional workshops and ESIM, such as data analysis, community input, and other relevant research or assessments.

Once the five priorities were voted on, additional discussion was had around implementation and sustainability issues.

Priority 1: Crisis Response, Mobile Services and 988 Coordination

<i>Implementation Issues</i>	<i>Sustainability Issues</i>
Large rural geography requires multiple teams, a hub and spoke model, reliable transportation, and on-call/after-hours staffing. Addressing limited or inconsistent cellular service and broadband issues. Addressing governance, jurisdiction, and	Funding plans must extend beyond initial grant period. Behavioral health is often the first service that is cut in law enforcement during budget cuts even though it has a high rate of return on county and city savings with lower visits to the ER, less aggressive

<p>coordination because crisis occurs across tribal, county, and state jurisdictions. Consistent language and agreements on responsible parties including certificates for evaluation (C4E) and must be co-designed with law enforcement and behavioral health experts. There are workforce and training restraints (certified supervisors, licensed clinicians, crisis intervention training for Law enforcement officers, and address high risk of burnout dealing with high level behavioral health crisis calls. Data systems and standards must be addressed, and community engagement and equity must be considered.</p>	<p>confrontations in the community, and appropriate care provided over time. Workforce retention and wellbeing must be forefront of budget strategy. Training and systems continuity for long term consistent training for law enforcement as well as educational opportunities for the communities. Crisis response model and MOUs should be updated regularly, and regional collaboration must continue to share lessons learned and coordinate trainings to reduce duplication of services.</p>
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Priority 2: Clinical Treatment, Recovery and Service Capacity

<i>Implementation Issues</i>	<i>Sustainability Issues</i>
<p>Workforce and capacity, lack of and high turnover rates for licensed professionals across the region. Training quality and consistency to meet and evaluate standards of care practices. Systems coordination across transportation services, courts and behavioral health system, and services across counties and Tribal partners. Finally, infrastructure, appropriate buildings and spaces to host activities and programs; and data systems and standards across behavioral health continuum of care.</p>	<p>Long-term funding stability due to reliance on short term grants and possible lack of Medicaid billable services. The Counties face budget constraints requiring cost sharing, state advocacy, and blended funding strategies. Limited billing codes for CPSW and credentialing bottlenecks as well as clarification needed for CCBHCs. Weakened workforce pipelines (recruitment and retention). Data outcomes and accountability is inconsistent across programs. Program durability and lasting potential.</p>

Priority 3: Care Coordination, Navigation, and Continuity of Care

<i>Implementation Issues</i>	<i>Sustainability Issues</i>
<p>Governance, ownership, and structure clarity and responsibilities defined. Legal, policy, and compliance barriers to service provision, data sharing, and making agreements across governing bodies. Operational challenges through lack of shared language across system (e.g., definition of services etc.), challenges in keeping resource lists updated, navigators' physical location in a largely rural</p>	<p>Funding and finance Workforce sustainability System tools such as resource directories, funding positions to monitor and address communication and coordination of directory services and the utilization of data to make systems level decisions. Regional collaboration must be sustained through formalized MOUs, shared data</p>

region, and a need for regional training for standardization across parole, probation, and justice partners on care coordination roles an expectation. Finally, care coordination must be culturally responsive and are provided equitably across the population.	dashboards reducing individual relationships and creating greater connections.
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Priority 4: Housing, Transportation, and Basic Needs

<i>Implementation Issues</i>	<i>Sustainability Issues</i>
<p>Transportation barriers and logistics leaving large gaps within tribal communities and the more frontier lands. The long distances, rising fuel costs, and the need for vehicles, certification, insurance, and licensure.</p> <p>Housing development and systems barriers such as zoning laws, landlord stigma, permanent supportive housing requirements (e.g., HUDs 1 year homelessness rule), insufficient shelters in many communities they do not exist, staffing, property maintenance, and operational capacity needed for any expansion, and need for skill building for those who are chronically homeless.</p> <p>Infrastructure and access challenges such as limited broadband availability, transportation, reentry services, vulnerable populations such as youth and seniors.</p>	<p>Long-term funding and cost management such as lack of consistent funding streams.</p> <p>Workforce capacity</p> <p>System integration and policy alignment across regional agencies.</p> <p>Housing and transportation solutions must support long-term stability not just crisis response and short-term solutions.</p>

Priority 5: Workforce Development, Training, and Provider Support

<i>Implementation Issues</i>	<i>Sustainability Issues</i>
<p>Recruitment, Attraction, and Retention</p> <p>Workforce pipeline and training barriers such as current vacancies within the system create the need to bolster the current system before addressing expansion. Limited access to training programs forces individuals to leave the region for education without a way back for work experience (e.g., clinical rotations, practicums, or internship experiences).</p> <p>Training logistics and coordination required</p>	<p>Long-term funding stability</p> <p>Retention and workforce continuity</p> <p>Training system durability to last over time and changes in requirements</p> <p>System integration at onboarding</p>

dedicated staff time, space, trainers, and funding for local and national experts. Staffing shortages prohibits many from participating. Infrastructure and coordination such as a central training platform or portal is needed for onboarding new staff to reduce duplication. Workforce housing, transportation, and travel logistics must be addressed.	
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Region 13 hosted listening sessions and within these sessions workforce and service gaps were identified as the largest issues within the system. As presented above, it is clear that workforce development and fiscal sustainability are concerns across all five priorities and have been the bulk of the conversation across leadership, stakeholders, Tribal partners, and community participants.

Anticipated Impact: Describe the anticipated outcomes or benefits for the targeted population because of addressing the identified needs. Explain how proposed priorities are expected to improve access, quality, or outcomes.

Region 13 participants in the ESIM event were incredibly thoughtful about how these priorities would enhance the current behavioral health system of care in place. They identified areas that would support a decrease in emergency room visits for behavioral health crisis by prioritizing crisis services (e.g., mobile crisis teams, and 988 coordination). This prioritization also has the intended impact of decreasing individuals' justice system involvement from minor crimes such as trespassing, shop lifting, etc. and assisting individuals in receiving the community supports they need.

By addressing clinical treatment, recovery, and service capacity as well as care coordination, navigation, and continuity of care aim to increase access to the appropriate level of care an individual may require in a specific point in time. These activities assist in a reduction in recidivism upon reentry from the justice system and assistance in reentry to the community from higher levels of care (e.g., hospitalization, inpatient treatment programs, etc.). These services also aim to assist youth and families to receive the support necessary to address behavioral problems, decreasing school absences and increasing graduation rates. These two priorities also open the workforce through the utilization of certified peer support workers and certified health workers increasing the behavioral health workforce.

Housing, transportation and basic needs seek to address the bones of developing positive mental health and community stability. Addressing these issues decreases involvement with law

enforcement and the justice system, decreases visits to the emergency department, increases workforce development, and decreases recidivism.

Finally, workforce development is a key factor

Local Resources and Partnerships: Identify existing local resources, providers, or partnerships that support or complement the proposed priorities. Describe how these resources may help offset costs, enhance implementation, or strengthen sustainability.

Region 13 has robust partnerships with leadership across the three counties, Tribal partners, the larger local behavioral health agencies and providers, law enforcement, and the judicial system. Throughout the process of the stakeholder committee meetings collaborations have been identified with current or soon to implement projects that coincide with the five priorities that were identified in the regional plan. It is the Stakeholder Committees opinion that these projects should be outlined and shared to either reduce duplication and/or to support projects that may need additional help past the current grant process to meet project goals. With collaboration like this, Region 13 can identify where funding can be braided, where projects are already happening and put funding towards other projects and how to identify additional state and federal grants to assist in supporting larger projects.

IV. IMPLEMENTATION

Applicants must describe how selected regional priorities will be implemented through a feasible, phased, and coordinated approach. This section should focus on execution readiness, operational capacity, and administrative processes. At a minimum, this section must address the following:

Organizational Readiness: Describe organizational readiness to implement proposed priorities, including staffing plans, hiring needs, onboarding processes, and workforce capacity. Describe available infrastructure, including physical space, equipment, technology, and systems needed to support implementation.

Cibola County has contracted with Marcie Chavez to assist with planning and hopes to retain her for the initial phase of implementation for ongoing consistency, outreach, and facilitation. Region 13 is made up of three counties and plans to leverage the three counties staffing system to support BHRIA implementation processes. Sandoval and Valencia County Managers are supportive of this process and are willing to assist Cibola County through implementation. Cibola County is looking for ways to address the massive data reporting responsibilities across all BHRIA projects and addressing this in the most effective and efficient way. Cibola County will also be utilizing a portion of the 15% administrative cost to address these systemic needs.

Implementation Approach & Phasing: Describe the phased implementation approach for proposed priorities, including sequencing of activities, timelines, and responsible entities. Describe how implementation activities will be coordinated across partners and align with available capacity.

As stated previously, projects will be reviewed for readiness and capacity.

Phase one will include a solicitation for proposals from community providers across the region. These proposals will include BHRIA requirements such as logic models, evaluation plans, and budget justifications. They will also require the provider to identify how they are currently meeting the behavioral health standards as outlined by the Health Care Authority (HCA) and if they do not meet those standards, their plan to meet those standards within the timeframe of their contract.

Phase two will be contracting and initial implementation. Monthly data reports will be required for all accepted participants, and the Accountable Entity will then synthesize these reports into one monthly regional report that the Stakeholder Committee will review. The Stakeholder Committee will be utilized as an overall expert panel to identify challenges early and provide recommendations for projects to remain successful.

Phase three the Stakeholder Committee and the Accountable Entity in conjunction with Sandoval and Valencia County leadership will review the first-year projects, identify projects that will have reached their goal and will not be funded in year two and those that will require continued funding that may have been unforeseen when the proposal was originally written. This will be taken into consideration in year two solicitation for new proposals. Further, new fiscal year grants and funding will be taken into consideration across the region when looking at braiding funding and stretching funding for maximum outputs.

Phase I (FY27)	Phase II (FY28)	Phase III (FY29)
Procurement and contracting Baseline data collection Launch pilot projects Execute MOUs/IGAs Develop shared metrics	Expand successful pilots Implement closed-loop referrals Expand MCT coverage Launch workforce initiatives	Institutionalize services Transition to braided funding Evaluate outcomes Sustainability planning

Administrative and Operational Processes: Describe administrative processes for implementing services, including procurement processes and anticipated barriers. Identify agencies or organizations responsible for administering funds and overseeing implementation.

Region 13 County Attorney reviewed the procurement and process and the BHRIA statutory language and identified that BHRIA funds qualify under exemptions within the procurement

code. Therefore, Region 13 will proceed with a solicitation for proposals and bypassing the formal request for proposal (RFP) process. This will allow the Accountable Entity to approve proposals and fund projects in a more expeditious manner.

V. HOW NEED IS MET

Applicants must describe how proposed priorities will directly address the identified regional needs and service gaps. This section should focus on service design, alignment with identified needs, and equitable access. At a minimum, this section must address the following:

Service Alignment: Explain how proposed priorities and services directly address identified regional needs and service gaps. Describe how services are aligned with populations identified in the Demonstration of Need.

Region 13's ESIM event was a perfect demonstration of the dedication to the regions' populations of need and the overall system gaps and needs. Region 13 identified immediate action items within each priority that address the gaps and needs.

Priority	Immediate Actionable Steps
1	<ul style="list-style-type: none"> • Expand mobile crisis response capacity across region • Strengthen 988 and 911 integration • Formalize cross-jurisdictional collaboration • Build workforce and training for crisis response
2	<ul style="list-style-type: none"> • Expand access to the ore clinical and crisis services (UNM expansion, CCBHC development, increase detox options, reduce delays in BH evaluations) • Strengthen recovery-oriented and peer-led services • Create accessible "one-stop" service hubs • Center all services around culture, equity, and community
3	<ul style="list-style-type: none"> • Regional care coordination infrastructure • Dedicated care coordination and navigation roles • Continuity of care across the justice and health care systems • Shared information, transparency, and visibility
4	<ul style="list-style-type: none"> • Expand and coordinate transportation options region wide • Increase access to housing across the housing continuum • Address immediate basic needs
5	<ul style="list-style-type: none"> • Build and maintain a local BH workforce ("grow our own") • Improve recruitment and compensation • Expand and coordinate training

BH Service Standards: Describe how proposed services adhere to New Mexico Behavioral Health Service Standards. Identify required practices, quality benchmarks, and compliance expectations.

Region 13 is dedicated to meeting the behavioral health service standards set by the Health Care Authority. These standards will be a requirement for all participating in BHRIA funding. However, Region 13 is also dedicated in assisting those who are currently struggling to meet those standards and raise their capacity towards compliance. This will be provided through contracting, training, and additional connections to support materials through the region and the state.

Provider Network Capacity: Describe the network of providers involved in delivering services, their capacity to meet anticipated service demand, and plans to expand or strengthen capacity as needed.

As described throughout this plan, workforce has been and continues to be a regional challenge. While there are some more populated areas within Sandoval (Rio Rancho) the region itself is largely rural and frontier land with significant recruitment and retention issues. Most agencies currently have open vacancies that would need to be filled to meet the expected outcomes of the agency. Expansion of services would require these positions to be filled first and then a push for service expansion. However, when these current vacancies are filled the community will experience greater access, shorter wait times, and providers may be more available for training addressing some of the items within the gaps and needs assessed.

Cultural Humility: Describe how services will be tailored to meet the cultural needs of diverse populations. Explain how service design reflects the needs of communities served, including Nations, Pueblos, Tribes, and disproportionately impacted populations.

Region 13 may be one of the most culturally diverse regions in the state with 12 Pueblos, Tribes, and Nations represented and a large Hispanic population. Therefore, cultural responsiveness, sensitivity, training, and humility have been a key component across all BHRIA planning discussions. From traditional healing approaches, need for cultural humility training within leadership, down to language access and appreciation.

Access to care: Outline how barriers to care will be identified and reduced. Describe strategies to improve access to services, including measurable access goals where applicable.

Region 13s ESIM report identifies many barriers to accessing the behavioral health system from complete lack of a specific service (e.g., detox centers), transportation limitations, broadband and connectivity issues across the region, and workforce to provide the services themselves. These are all items that have been included within the top priorities as areas to address when considering project implementation. For example, by focusing on a priority like workforce development the region will have a deeper understanding after the first year of implementation regarding the realistic barriers and will be able to apply this knowledge to strategies in years

two and three. This deeper understanding of realistic barriers is anticipated across all identified priorities.

Language Access: Describe how translation and interpretation services will be provided to ensure equitable access to services, including plans for multigenerational outreach and accessible formats for program materials.

Again, the cultural and language representation across the region is large. During Tribal partner meetings it has been discussed regarding how to get more materials in native languages, and this will be an ongoing discussion. However, language access remains a top priority to care and will be reviewed in terms of printed materials and translation opportunities that remove the reliance on younger family members. For example, training is a large component across priorities, and this will come with language access requirements for all participants both in written materials and translation services.

VI. FUNDING STABILITY

Applicants must describe how proposed priorities and services will be financially supported during the funding period and sustained beyond BHRIA funding. This section should demonstrate responsible use of funds, coordination with Medicaid and other funding sources, and long-term sustainability planning. At a minimum, this section must address the following:

Use of funds: Explain how requested funds will be utilized to appropriately and effectively meet the needs of the identified priority areas. Describe how proposed expenditures are necessary, reasonable, and aligned with project goals and deliverables. And demonstrate how funding supports implementation of identified priorities.

At this time, the region is dedicated to funding projects that align with the five identified priorities. Further, these projects must be identified as one time funding initiatives (e.g., capital projects) or identify a clear path towards sustainability (e.g., leverage Medicaid billable services, identify ongoing grant funding opportunities that align with the project that can be braided within the BHRIA fiscal period. Expenditures will be deemed necessary if they meet the needs outlined within the regional plan addressing one or more of the five priorities of the region. Finally, all contracts distributed will outline the deliverables, timelines, and data requirements for participation and how the Accountable Entity will monitor project implementation and contract compliance. However, Region 13 also appreciates the unforeseen and has committed to the value of success, leveraging the Stakeholder Committee as an expert oversight body providing recommendations for possible unforeseen barriers to implementation.

Sustainability Plan: Identify strategies for long-term financial viability, including anticipated revenue sources or system integration. Describe the plan to sustain services beyond BHRIA funding.

Region 13 is committed to identifying additional funding sources to braid into BHRIA activities. Current providers have already commented on pending grant initiatives that may pay a portion of a project where BHRIA funds could be used to complete the project in a more expeditious manner. For example, some entities have submitted proposals to the rural health care fund that would partner with BHRIA identified activities. Additionally, there has been funding distributed by the Department of Justice (DOJ) that could also be braided together with BHRIA fund for greater community impact. Sustainability becomes a challenge when workforce is discussed as often salaries are not fully covered by Medicaid billable services. For example, while Mobile Crisis Teams (MCTs) have a large Medicaid billable component, it does not account for the entirety of the operation. You can only bill Medicaid for enrolled individuals, Medicaid covers licensed clinicians and peer support but does not cover dispatchers, vehicles (insurance, gas, maintenance), and there is an on-call funding gap because Medicaid does not cover stand-by, unutilized, or “on-call” time only face to face encounters. Therefore, it will be necessary for Region 13 to identify the greatest impact BHRIA funds can have and then identify how these positions will be maintained financially like increased law enforcement budgets. These billing gaps in Medicaid will need to be addressed across the continuum of Medicaid does not pay for administrative time or capacity.

Medicaid Coordination: Describe how proposed services will coordinate with New Mexico Medicaid; explain how services will optimize, leverage, or align with Medicaid or other regional systems; and identify any billing, reimbursement, or system coordination considerations.

Medicaid will be a significant player in making the Region 13 behavioral health continuum of care sustainable. Efforts to leverage Medicaid billing through additional trainings and support for providers to appropriately and efficiently bill Medicaid will be implemented. Identifying ways in which providers are having difficulty billing Medicaid (e.g., billable services and reimbursement for CHWs/CPSWs) and bringing these considerations forward through the Health Care Authority’s implementation support team to address additional barriers to sustainability and systems gaps and needs that can only be addressed at the state level.

Other (non-Medicaid) Sources of Funding: Identify additional non-Medicaid funding sources that will support the proposed priorities; describe how braided or blended funding will be used to support implementation and sustainability; and explain how these funding sources compliment BHRIA funding.

The state of New Mexico has been focused on housing and workforce development for years. These programs will be followed for grant funding opportunities as well as projects that may be happening within the region and the ability to partner with these projects in meaningful ways. Currently, workforce solutions department has a working group for behavioral health workforce development, a specific priority in Region 13's plan. Federal grants fund many projects within the region and the lack of clarity around the stability of these grants in the foreseeable future is causing many programs to seek more stable funding opportunities. However, federal agencies such as Substance Abuse and Mental Health Services Administration (SAMHSA), the Department of Justice (DOJ), and Housing and Urban Development (HUD) will continue to be utilized for program funding.

VII. RISK & MITIGATION STRATEGY

Applicants must identify potential risks or challenges that could affect successful implementation of the regional plan and describe strategies to mitigate those risks. This section should demonstrate awareness of barriers and proactive planning to minimize disruption. At a minimum, this section must address the following:

Risk Identification: Identify key risks or challenges that could affect the regional plan, including barriers to successful implementation, service delivery, staffing, infrastructure, partnerships, funding, or system coordination, and describe their nature and potential impact.

Workforce development is a large concern for Region 13. Without the ability to recruit, attract, retain, and support local workforce expansion of behavioral health services is virtually impossible. While the expansion of telehealth services is possible, telehealth does not account for everything needed within a behavioral health continuum of care.

Funding stability is an additional risk. Region 13 counties are limited in their ability to offer large long-term funding solutions. Therefore, the need to identify and leverage federal and state grants and other funding opportunities will be necessary. Due to the cyclical nature of applying for grants and waiting to know if funding will be available makes overall, long-term budgeting challenging.

The lack of post-secondary education programs also creates a challenge in a workforce pipeline project without being able to offer clinical supervision towards certification or licensure. Attempting to bring back the younger generations after college requires incentives and opportunities.

Housing is also a larger concern not only for transitional living towards more sustainable housing options but also general housing availability for the hopeful incoming workforce.

Mitigation Strategies: Describe specific mitigation strategies for each identified risk, explain how they will reduce risk, maintain service fidelity, and support continuity of implementation, and identify responsible parties where applicable.

Region 13 is committed to addressing workforce development within the region. This will require Region 13 to partner with all state and local agencies working towards this same goal to create a robust recruitment and retention strategy.

Funding stability is sought across all regional activities. This will continue through BHRIA activities as well as identification and deeper understanding of the areas within Medicaid billing that does not cover necessary services within the behavioral health continuum of care. This will allow a greater appreciation of county, city, and agency budgeting strategies.

A “build your own workforce” development approach that will need additional supports such as making rural life more appealing to younger individuals. While the average age across the region is 40 years old there are difficulties attracting younger professionals to move to more rural areas that may not offer the same social stimulation that larger communities may offer. Ideas around this include prosocial activities for adults such as softball teams, kick ball teams, bingo nights, etc. providing young people with opportunities for socialization within their communities.

Finally, housing will be a challenging item to address; however, housing has been an item on all three counties list of barriers and will continue to be supported for all levels of housing needed.

VIII. MEASURING SUCCESS

Applicants must describe how progress and outcomes will be measured, evaluated, and used to inform continuous improvement of the regional plan. This section should demonstrate alignment between priorities, activities, outputs, and intended outcomes. At a minimum, this section must address the following:

Performance Metrics: Identify performance metrics that will be used to measure progress and success, including indicators, benchmarks, and reporting tools. Describe how data will be collected, monitored, and used to assess progress towards stated goals.

Overall, the region is looking for a decrease in job vacancies within the behavioral health system, a decrease in emergency department utilization for behavioral health issues, an increase in behavioral health programs, a decrease in wait times for behavioral health services, a decrease in recidivism after reentry from the justice system, a decrease of justice system involvement, and an increase in community prosocial activities. The entire system will be recruited to participate in data gathering and reporting. Data collected during implementation will be utilized to make informed decisions about next steps, continued funding, and possible blind spots and needed adjustments to the overall system approach.

Evaluation Plan:

Priority	Target Population	Sampling	Evaluation Approach/Method	Data Collection	Implementation Timeline
1	Community members in crisis & Crisis team members	Full community service	Demographics Crisis outcome – resolution, transportation, detainment Number served Number resolved through 988, number transferred to 911, Officers and staff training completion	Officers/team members will need to enter data into their current system when dispatched, 988 records review	Focus on this priority in year 1 with workforce development, appropriate training and 988/911 interoperability. Continued support for these projects in years 2 and 3
2	All community members	Full community services with possible specialty services established (e.g., youth specific services)	Program evaluation will be dependent on the type of program/project and will be established within the contract created with the AE if proposal is approved.	Demographics, number served, diagnosis, referral connections, missed appointments, continued barriers to services identified	While a smaller financial focus will be given to this priority in year 1, it will be highly funded in years 2&3. However, this system needs significant workforce development and so will benefit from other priority focus
3	All community members	Community members who have had an encounter within the behavioral health, medical, crisis, or	Program evaluation will be identified within the contracting period of accepted proposals.	Demographics, number of follow up encounters, number of successful referrals, appointment follow through, services	Coordination and navigation assist the entire system and therefore will be funded consistently across all three years in hopes of developing a robust system

		justice systems		ranked by utilization	that may require data systems upgrades etc. for shared data and referrals
4	Individuals in need of housing options	Homeless and those seeking to re-locate to the community and those reentering the community from corrections or treatment	Program evaluation will be dependent on the type of program funded and will be identified in the contract once proposal is approved.	Housing type, population served, number of beds, capacity over time, units sold/rented	Dependent on type of project presented and resources needed for the project.
5	Regional	Behavioral health specific workforce	This depends on the project proposed and will be clarified within contract with Accountable Entity	Data collection will also depend on project, but broad understanding of positions filled and vacancies that still exist.	Workforce will be addressed consistently across all three years.

Logic Model: See attachment

Feasibility Analysis: Describe the practical capacity to carry out proposed activities, including staffing, timelines, infrastructure, and resources. Explain how feasibility considerations support successful implementation and sustainability of the regional plan.

As a portion of proposal review, the AE will be reviewing the proposer's capacity to carry out the proposed project within the timelines and funding limitations. There may be times when taking a larger risk to gain greater rewards is necessary and these projects may require additional support or greater funding resources. The AE will need to take this into consideration and work with these projects to make sure they are clear on the requirements necessary for BHRIA

activities. Projects with braided funding will need to have the capacity to meet the needs of all funders in terms of outputs and reporting. These considerations will be made during proposal review and approval.

Additional Documents Attached in Appendix

- MOUs/IGAs
- Letters of support
- BH Provider List

**** NOTE: Due to the unknown aspects of regional planning this plan is subject to change to meet the needs of Region 13 planning and implementation. Any changes to this document will be submitted to the BHRIA Executive Committee. This includes changes to the budget as well as logic models. Changes will only enhance specificity and clarity.**

Regional Plan: Tribal Component

Region 13 has been working closely with its Tribal partners: Pueblo of Laguna, Santo Domingo, Cochiti, Jemez, Santa Ana, San Felipe, Zia, Acoma, and Ramah Navajo Chapter. Attached you will find letters of support from Tribal Partners. Currently the Pueblo of Laguna, and Santo Domingo are the only Tribal Partners with a completed and approved plan from their Tribal Council. It is attached in the appendix. All subsequent plans will be attached to this regional plan as addendums. We expect to receive completed plans from San Felipe, Pueblo of Acoma, and Pueblo of Zia.

Tribal leadership and requirements vary across entities and therefore, the process for approval varies in time. Region 13 will continue to support all Tribal Partners in completing Tribal plans as well as collaborating with all Tribal Partners on the larger regional plan accepting proposals from any Tribal Partner for additional funding through the regional plan funding in addition to their Tribal set-aside.

*** This Space Left Blank for Tribal Priorities***

Regional Plan: Judicial Component

Judiciary Allocation: The Administrative Offices of the Courts received a BHRIA allocation specific to the courts, \$167,000 per year for FY27 and FY28. The 13th Judicial District Court will receive separate funds to be used towards the court's behavioral health projects (e.g., specialty courts, navigators, etc.) These funding allocations will be disbursed directly from the Administrative Offices of the Court to the Judicial District.

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Budget Justification Total Allocation FY27-FY29 \$9,721,392.5

Year 1 – FY27 \$3,240,464			
Priority	% of Total Annual Funding	Total \$ Amount	Justification
Crisis response, mobile services, and 988 coordination	30%	\$972,139.25	Crisis response was the number one priority voted on. Therefore, more significant portion of year 1 funding will be allotted in this area to address 988/911 interoperability and coordination and mobile crisis response.
Clinical treatment, recovery, and service capacity	10%	\$324,046.40	While clinical treatment is a large area, this is one that currently has workforce vacancies. The smaller allotment is meant for those programs ready to expand or enhance while greater focus will be on getting to staff at full capacity.
Care coordination, navigation, and continuity of care	15%	\$486,069.60	Care coordination and navigation was also discussed across all gaps and needs within the BH continuum to assist in continuity, service provision, and appropriate services referred. Therefore, this priority will also be consistently funding across all three years.
Housing, transportation, basic needs	15%	\$486,069.60	Housing and transportation are ultimately very expensive projects, that even if full funding were dedicated to this are there would not be enough to complete a project. However, with braided funding and some ability to apply these dollars to capitol purchases there is an opportunity to make a difference across housing, transportation and basic needs. Therefore, funding in this area will remain the same all three years.
Workforce Development, training, and provider support	30%	\$972,139.25	Workforce development is one of the largest necessities to see the other priorities succeed. Therefore, funding towards workforce development solutions will remain a top funded priority across all three years likely with different focus across the years. <i>Year one focus on filling current vacancies across system to strengthen current service provision.</i>

Year 2 – FY28 \$3,240,464			
Priority	% of Total Annual Funding	Total \$ Amount	Justification
Crisis response, mobile services, and 988 coordination	10%	\$324,046.40	After one full year of larger funding focus it is likely crisis response will need less funding to sustain projects. Therefore, the funding is reduced in this area for the final two years to place greater funding support towards clinical treatment and recovery services and service capacity.
Clinical treatment, recovery, and service capacity	30%	\$972,139.25	Clinical treatment and recovery services and service capacity was the second most important priority and address the significant wait times and the lack of services within the BH continuum. Therefore, greater funding will be placed towards these initiatives in years two and three.
Care coordination, navigation, and continuity of care	15%	\$486,069.60	Care coordination and navigation was also discussed across all gaps and needs within the BH continuum to assist in continuity, service provision, and appropriate services referred. Therefore, this priority will also be consistently funding across all three years.
Housing, transportation, basic needs	15%	\$486,069.60	Housing and transportation are ultimately very expensive projects, that even if full funding were dedicated to this are there would not be enough to complete a project. However, with braided funding and some ability to apply these dollars to capitol purchases there is an opportunity to make a difference across housing, transportation and basic needs. Therefore, funding in this area will remain the same all three years.
Workforce Development, training, and provider support	30%	\$972,139.25	Workforce development is one of the largest necessities to see the other priorities succeed. Therefore, funding towards workforce development solutions will remain a top funded priority across all three years likely with different focus across the years. <i>Year 2 focus on programs ready for workforce expansion.</i>

Year 3 – FY29 \$3,240,464			
Priority	% of Total Annual Funding	Total \$ Amount	Justification
Crisis response, mobile services, and 988 coordination	10%	\$324,046.40	After one full year of larger funding focus it is likely crisis response will need less funding to sustain projects. Therefore, the funding is reduced in this area for the final two years to place greater funding support towards clinical treatment and recovery services and service capacity.
Clinical treatment, recovery, and service capacity	30%	\$972,139.25	Clinical treatment and recovery services and service capacity was the second most important priority and address the significant wait times and the lack of services within the BH continuum. Therefore, greater funding will be placed towards these initiatives in years two and three.
Care coordination, navigation, and continuity of care	15%	\$486,069.60	Care coordination and navigation was also discussed across all gaps and needs within the BH continuum to assist in continuity, service provision, and appropriate services referred. Therefore, this priority will also be consistently funding across all three years.
Housing, transportation, basic needs	15%	\$486,069.60	Housing and transportation are ultimately very expensive projects, that even if full funding were dedicated to this are there would not be enough to complete a project. However, with braided funding and some ability to apply these dollars to capitol purchases there is an opportunity to make a difference across housing, transportation and basic needs. Therefore, funding in this area will remain the same all three years.
Workforce Development, training, and provider support	30%	\$972,139.25	Workforce development is one of the largest necessities to see the other priorities succeed. Therefore, funding towards workforce development solutions will remain a top funded priority across all three years likely with different focus across the years. <i>Year 3 focus on training and provider supports for long term sustainability.</i>

PRIORITY	INPUTS / RESOURCES	ACTORS	ACTIVITIES	OUTPUTS	SHORT-TERM OUTCOMES (1–2 years)	LONG-TERM OUTCOMES (3–4 years)
PRIORITY 1 <i>Crisis Response, Mobile Services & 988 Coordination</i>	Region to identify most effective way to address crisis response and mobile crisis services for the entire region including Tribal lands. This also includes working with 988 and 911 to identify ways to better integrate dispatch services	Cibola County (AE), Sandoval Regional Medical Center, 988 providers, Local EMS agencies, Tribal governments, Law enforcement agencies, Mobile Crisis Providers	<p>Identify prioritized list of policies to review and make recommendations. This includes cross jurisdictional components</p> <p>Expand technical assistance for communities starting MCTs</p> <p>Create policy guidelines and agreements</p> <p>Identify most effective mobile crisis model for region (possible hub and spoke model)</p> <p>Identify training requirements for law enforcement and mobile crisis units</p>	<ul style="list-style-type: none"> • # of MCT services or units operating in the region • # of crisis calls responded to • # of responders trained • # of MOUs/agreements executed • # of training programs available for crisis responders 	<ul style="list-style-type: none"> • Increased access to mobile crisis services • Improved 988/911 coordination • Increased diversion from Eds and detention centers • Faster connection to behavioral healthcare 	<ul style="list-style-type: none"> • Reduced behavioral health ED utilization • Reduced justice involvement • Increased regional crisis system capacity • Improved continuity of care across jurisdictions
PRIORITY 2 <i>Clinical Treatment, Recovery & Service Capacity</i>	<p>Increase access to community based behavioral health services including SUD recovery services</p> <p>Expansion of current services</p> <p>Addition of new services missing from BH continuum</p> <p>Utilization of closed loop referral system and EHR integration for greater data collection and follow through with service provision</p>	Local governments, local hospitals, behavioral health providers and agencies, substance abuse treatment providers.	<p>Research viable dispense options for Narcan: EMS, Fire, vending machines, etc.</p> <p>Host additional locally based certification programs for CPSWs</p> <p>Identify where CCBHC services could be expanded and what would be necessary for expansion</p> <p>Build capacity and expansion within current community BH services such as the UNM FOCUS program, BH providers within Valencia hospital, and increased access to MAT services</p> <p>Add new services such as mobile based services such as detox, immunization, and screening & increase access to a forensic assertive community treatment (FACT) team</p>	<ul style="list-style-type: none"> • # of Narcan does distributed • # of peer workers trained • # served by the CCHBC • #of overdose trainings conducted • # of community services available (detox, screening, FACT, etc) 	<ul style="list-style-type: none"> • Reduced wait times • Increase in peer led services such as drop-in centers, etc. • Increased access to UNM FOCUS program • Clear goals for expanding CCBHC services 	<ul style="list-style-type: none"> • Addition of new BH services to continuum of care creating more balanced utilization of appropriate levels of care • Increased early intervention for children at risk • Decrease recidivism & justice system involvement • Reduced overdose deaths or hospitalizations
PRIORITY 3 <i>Care Coordination,</i>	Hire regional coordinator to monitor, maintain, and support closed loop referral system utilization, Medicaid billing support, and provider support for EHR system integration and data gathering	Cibola County (AE), CYFD representatives, Tribal governments, detention centers, behavioral health providers, hospitals,	<p>Review county level positions to identify if a coordinator role can be incorporated</p> <p>Collaborate with CYFD to identify where they may offer support within the</p>	<ul style="list-style-type: none"> • # of referrals entered in close-loop referral system • Referral completion rate • # of participating agencies • # of local hubs 	<ul style="list-style-type: none"> • Increased system coordination for all levels of BH services • Increased data support for referrals and encounters to 	<ul style="list-style-type: none"> • Two years of solid referral and Health Record data collected to assist in making data driven decision related to the regions BH continuum of care

PRIORITY	INPUTS / RESOURCES	ACTORS	ACTIVITIES	OUTPUTS	SHORT-TERM OUTCOMES (1–2 years)	LONG-TERM OUTCOMES (3–4 years)
<i>Navigation & Continuity of Care</i>	<p>Identify where CYFD can coordinate and collaborate with youth BH services</p> <p>Hire tribal liaison/cultural brokers within clinical services to assist with appropriate referrals to traditional services.</p> <p>Coordinate reentry for individuals leaving detention centers, hospitals, and inpatient/residential treatment centers</p> <p>Develop community hubs/ Add additional telehealth hubs/services with access to peer support workers</p> <p>Hire navigators and place them in local community spaces</p>	courts and court programs.	<p>community to offer increased support to youth and families in services</p> <p>Support local agencies in hiring cultural liaisons and brokers and address how this position can be funded</p> <p>Purchase of additional technology/assist organizations in hiring additional licensed professionals to offer services</p> <p>Research Medicaid covered services to sustain hiring additional navigators</p> <p>Identify locations these community hubs could be located and what they will offer in terms of services (access to employment support, registration for Medicaid, showers, laundry, etc.)</p>		<p>assist in data driven decision making</p> <ul style="list-style-type: none"> Identified space for “hub” and initial drafting of policy and procedures 	<ul style="list-style-type: none"> More balanced utilization across behavioral health continuum of care Increased culturally responsive service referrals Increased coordination of reentry services Decreased justice system involvement and recidivism
PRIORITY 4 <i>Housing, Transportation & Basic Needs</i>	<p>Advocacy and braided funding for housing initiatives that are behavioral health continuum aligned and adjacent.</p> <p>Work with local agencies currently offering emergency shelters or who could expand to include emergency shelter services for youth and adults</p> <p>Survey transportation issues and identify areas within county and city planning where transportation enhancement could be made</p> <p>Identify where current transportation options can be expanded to meet the need of a larger identified population</p>	Local governments, transportation providers, shelters and agencies, housing authority.	<p>Work with local governments to assess where transportation and housing gaps need supports</p> <p>Through additional BHRHA activities identify additional state and federal funding that could assist in these projects</p> <p>Identify opportunities to expend current transportation services that can address visits to the state hospital and detention centers for continued familial supports</p> <p>Identify programs and agencies with the capacity to expand allowing providers to travel to the more rural parts of the region to provide services</p>	<ul style="list-style-type: none"> # of Beds the region has access to # of housing units # of individuals housed # of reentry placements completed 	<ul style="list-style-type: none"> Identify areas where local government could expand public transportation including walking and biking paths Increased number of individuals seeking more permanent and stable housing options Decreased law enforcement engagements resulting in arrests Increased number of family visits at detention centers and hospitals Increased housing options across housing continuum 	<ul style="list-style-type: none"> Expanded public transportation options Increased provider interactions within rural communities Reduced Homelessness Reduced Recidivism

PRIORITY	INPUTS / RESOURCES	ACTORS	ACTIVITIES	OUTPUTS	SHORT-TERM OUTCOMES (1–2 years)	LONG-TERM OUTCOMES (3–4 years)
PRIORITY 5 <i>Workforce Development, Training & Provider Support</i>	<p>Target marketing for all positions within BH continuum</p> <p>Regional workforce dashboard where all open jobs are posted with a public facing portal and a back end that demonstrates time open and barriers to filling the role</p> <p>Hosting local trainings for CEUs/Certifications that require little to no travel expense</p> <p>Expand telehealth offerings through agencies with capacity to support expansion</p>	Behavioral health providers, school districts, higher education institutions, training providers.	<p>Develop workforce dashboard and identify support role for keeping the dashboard up to date and relevant as well as providing monthly data reports to the stakeholder committee and accountable entity</p> <p>Identify targeted marketing strategies from high school, colleges, professional associations etc.</p> <p>Develop prosocial community activities and local social enhancements to attract young professionals to live locally</p> <p>Build competitive employment packages to include salary and benefits as well as student loan forgiveness and college tuition reimbursements</p>	<ul style="list-style-type: none"> • # trained • # of vacancies filled • # of new certifications obtained 	<ul style="list-style-type: none"> • Increased workforce capacity • Increase number of prosocial events within each community • Completion and roll out of functional regional workforce dashboard • Increase local training opportunities by 20% 	<ul style="list-style-type: none"> • Increase number of “grow your own” workforce • Increase recruitment by 50% • Increase local training opportunities by 50% • Increase number of prosocial activities as supported by community engagement

Region 13 – Behavioral Health Provider List

Source: NMBHPA Behavioral Health Providers Association of New Mexico

*Providers as of August 2, 2025

13TH JUDICIAL DISTRICT / REGION 13 – Cibola, Sandoval, Valencia Counties

Agency	Contact Person & Title	Email
The Enhancement Center	Jim Shotwell, Executive Director/Owner	jim.shotwell@enhancement-center.com
New Mexico Solutions	David Ley, Executive Director	ley-david@rvbh.com
Open Skies Healthcare	Christine DeBell, Executive Director	christiner@openskieshealthcare.org
Presbyterian Medical Services	Stacey Romero, Director BH	stacey.romero@pmsnm.org
Proud Moments	Sarah Baca, Member Manager	sbaca@proudmomentsaba.com
TeamBuilders Behavioral Health	Sun Vega, COO/Executive Director	sun.vega@teambuilders.org

Source: NM Recovery Resources <https://nmrecovery.org/resources/>

CCBHC:

- UNM Sandoval Regional Medical Center (Sandoval)

FQHCs:

- Grants Family Health Center (PMS)
- First Choice Community Health Care
- Cuba Health Center (PMS)
- El Pueblo Health Services Inc
- Counselor Clinic (PMS)
- Rio Rancho Family Health Center (PMS)
- PMS Family Health Center
- Santo Domingo Health Center
- Pueblo of Acoma
- San Felipe Pueblo

Inpatient Treatment Center:

- New Mexico Wellness LLC Residential Treatment (Rio Rancho – Sandoval)

Hospitals:

- Cibola General Hospital (Cibola)
- UNM Sandoval Regional Medical Center (Sandoval)
- Presbyterian Rust Medical Center (Sandoval)

Cibola County Agencies:

- Casa San Jose
- Full Circle Recovery
- GD PSYCH SERVICES LLC

(36 Listed Practitioners in Cibola County)

Sandoval County Agencies:

- KEWA PUEBLO HEALTH CORPORATION
- POSITIVE HOPE COUNSELING LLC
- DUCKS IN A ROW LLC
- CORRALES THERAPY LLC
- NEW MEXICO GUIDED HEALING LLC
- PINWHEEL HEALING CENTER LLC
- UNM MEDICAL GROUP INC
- GUADALUPE PSYCHIATRIC AND MENTAL
- GUIDANCE FOUNDATION INC
- UNIVERSAL COUNSELING LLC
- NEW MEXICO WELLNESS LLC
- RESTORATIVE PATHS COUNSELING LLC
- ANCHORS OF CHANGE PSYCHOTHERAPY LLC
- NEW MEXICO COUNSELING CENTER LLC
- FOUR WINDS BEHAVIORAL HEALTH INC
- NEW MEXICO COUNSELING ASSOCIATES LLC
- THRIVE COUNSELING SERVICES
- TRANSFORMATIONAL JOURNEYS
- TRAUMA TREATMENT CENTER LLC
- DESERT MOUNTAIN HEALING IOP
- LOBO BEHAVIORAL HEALTH
- RIO RANCHO FAMILY COUNSELING CENTER
- GD PSYCH SERVICES LLC
- CRAVENS MENTAL HEALTH SERVICES
- RECYCLED MAN LLC
- NEW MEXICO WELLNESS CENTER LLC
- PETROGLYPH COUNSELING LLC
- DAYSPRING COUNSELING AND WELLNESS
- MASN LLC
- BLOOM HAVEN BEHAVIORAL HEALTH
- POSITIVE POTENTIAL NM
- WAVES BEHAVIORAL HEALTH
- PHOENIX SUPPORTS
- ELLIE MENTAL HEALTH
- FROM DARKNESS TO LIGHT COUNSELING SERVICES LL
- ACB COUNSELING AND CONSULTING LLC
- MOUNTAIN CREST COUNSELING
- PRICKLY PEAR THERAPY LLC
- VALUED HEALING LLC
- THE ROCK FAMILY THERAPY LLC
- OASIS WELLNESS LLC

- KINTSUGI BEHAVIORAL HEALTH LLC
- TEAMBUILDERS BEHAVIORAL HEALTH
- MARCIA R FILIPIAK
- COUNSELING CONNECTIONS LLC
- ANN R PETERSEN
- DAYSPRING COUNSELING AND WELLNESS LLC
- HOLLY D BAUER LCSW
- NICOLEH T LARIOS LMHC
- MICHELLE A CHAVEZ VALENZUELA LMHC
- TEAMBUILDERS BEHAVIORAL HEALTH

(567 Listed Practitioners in Sandoval County)

Valencia County Agencies:

- RECOVERY SERVICES OF NEW MEXICO
- SELF-DISCOVERY RECOVERY LLC
- HERRON SOLUTIONS LLC
- FULL CIRCLE RECOVERY
- MANDALA GROUP INC
- HEART SOUL OF NM INC
- JOURNEY TO WELLNESS COUNSELING LOS
- H2 ACADEMIC SOLUTIONS
- SOLEA WELLNESS
- HERRON SOLUTIONS LLC
- TEAMBUILDERS BEHAVIORAL HEALTH
- CAITLIN E TALTY LMSW
- DEANNA OSBORN LCSW
- ELIZABETH READER LCSW
- BRANDY L CASTILLO LCSW
- TEAMBUILDERS BEHAVIORAL HEALTH

(127 Listed Practitioners in Valencia County)

County Plan Approvals

June 2026

2026015160 06/25/2026 09:16:42 AM
MISCELLANEOUS Pg.1 of 79
Anne Brady-Romero Sandoval Cnty Clerk B: 429 P: 15160



Region 13:

— • BEHAVIORAL HEALTH • —

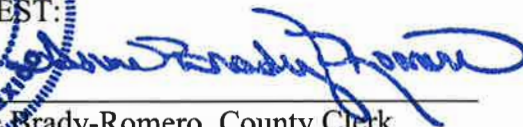
Region 13 – Cibola, Sandoval, Valencia

Regional Plan Proposal

June 2026



ATTEST:


Anne Brady-Romero, County Clerk

APPROVED AS TO FORM:

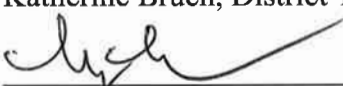

Michael Eshleman, County Attorney

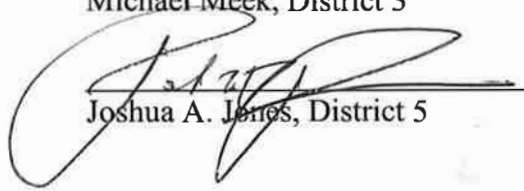
SANDOVAL COUNTY COMMISSION:


Jordan Suarez, Chairman


Jon Herr, Vice Chairman


Katherine Bruch, District 1


Michael Meek, District 3


Joshua A. Jones, District 5



RESOLUTION NO. 2026-42
A RESOLUTION ADOPTING THE REGION 13 (CIBOLA, SANDOVAL AND
VALENCIA COUNTIES) BEHAVIORAL HEALTH REGIONAL PLAN PROPOSAL
AND AUTHORIZING PARTICIPATION IN ITS IMPLEMENTATION

WHEREAS, the Board of County Commissioners of Valencia County met upon notice of a regular meeting duly published and posted as required by law at the Valencia County Administration Building, 444 Luna Avenue, Los Lunas, NM 87031, on the 24th day of June, 2026; and

WHEREAS, the Board of County Commissioners exercises the powers of the County as a body politic and corporate pursuant to Section 4-38-1 NMSA 1978; and

WHEREAS, the State of New Mexico has established the Behavioral Health Reform and Investment Act to strengthen behavioral health systems, improve access to services, and promote coordinated regional planning and investment; and

WHEREAS, Cibola County has been designated as the designated Accountable Entity for Region 13, consisting of Cibola, Sandoval, and Valencia Counties and collaborating with participating Pueblos, Tribes, Nations, service providers, stakeholders, and community partners in developing a comprehensive regional behavioral health strategy; and

WHEREAS, Region 13 undertook an extensive planning process that included stakeholder meetings, listening sessions, Enhanced Sequential Intercept Mapping, technical assistance from the Administrative Office of the Courts and the University of New Mexico Health Sciences Center, and collaboration with local governments, Tribal partners, providers, and individuals with lived experience; and

WHEREAS, the resulting Region 13 Plan identifies regional priorities including crisis response, clinical treatment and recovery services, care coordination, housing and transportation supports, workforce development, and other initiatives intended to improve behavioral health outcomes throughout the region;

WHEREAS, the Regional Plan is intended to guide strategic investment of available behavioral health funding, promote regional collaboration, strengthen continuity of care, and expand access to evidence-based and culturally responsive behavioral health services while recognizing the unique needs of rural and Tribal communities;

WHEREAS, adoption of the Regional Plan does not obligate Valencia County to expend funds beyond those lawfully appropriated, nor does it commit the County to any specific project, procurement, contract, or future financial obligation absent subsequent approval by the Board of County Commissioners as required by law; and

WHEREAS, the Board finds that adoption of the Regional Plan serves the public interest by providing a coordinated framework for behavioral health planning and implementation within Region 13.

NOW, THEREFORE, BE IT RESOLVED by the Board of County Commissioners of Valencia County that the Region 13 Plan is hereby approved and adopted as the official regional behavioral health plan for purposes of participation in the State's Behavioral Health Reform and Investment Act initiatives, and that the Board supports Cibola County's service as the Accountable Entity for Region 13 and authorizes County staff and administration to carry out administrative, fiscal, reporting, coordination, and implementation activities consistent with the adopted Regional Plan and applicable state law, grant requirements, and funding agreements.

BE IT FURTHER RESOLVED that County staff are authorized to continue collaborating with Sandoval County, Valencia County, participating Pueblos, Tribes, Nations, behavioral health providers, state agencies, and other regional stakeholders to implement the goals and priorities identified in the Regional Plan, and that implementation of any individual project, contract, procurement, intergovernmental agreement, or expenditure contemplated by the Regional Plan shall remain subject to applicable procurement laws, budgetary appropriations, grant conditions, and any approvals otherwise required by law or County policy.

APPROVED, ADOPTED, AND PASSED this 24th day of June, 2026.

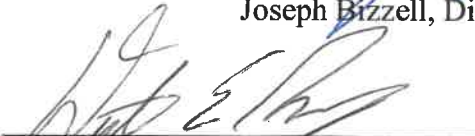
BOARD OF COUNTY COMMISSIONERS


Gerard Saiz, Chair, District I


Morris Sparkman, Vice-Chair, District III

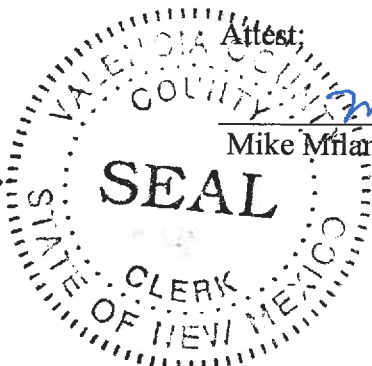

Troy Richardson, District II


Joseph Bizzell, District IV


Dante Berry, Vice-Chair, District V

Attest:

Mike Mflam, County Clerk





**CIBOLA COUNTY BOARD OF COUNTY COMMISSIONERS
RESOLUTION NO. 2026-35**

**A RESOLUTION ADOPTING THE REGION 13 (CIBOLA, SANDOVAL AND
VALENCIA COUNTIES) BEHAVIORAL HEALTH REGIONAL PLAN PROPOSAL
AND AUTHORIZING PARTICIPATION IN ITS IMPLEMENTATION**

WHEREAS, the Board of County Commissioners of Cibola County met upon notice of a regular meeting duly published and posted as required by law at the Cibola County Administration Building, 700 East Roosevelt Avenue, Suite 50, Grants, New Mexico 87020, on the 25th day of June, 2026; and

WHEREAS, the Board of County Commissioners exercises the powers of the County as a body politic and corporate pursuant to Section 4-38-1 NMSA 1978; and

WHEREAS, the State of New Mexico has established the Behavioral Health Reform and Investment Act to strengthen behavioral health systems, improve access to services, and promote coordinated regional planning and investment; and

WHEREAS, Cibola County has served as the designated Accountable Entity for Region 13, consisting of Cibola, Sandoval, and Valencia Counties and collaborating with participating Pueblos, Tribes, Nations, service providers, stakeholders, and community partners in developing a comprehensive regional behavioral health strategy; and

WHEREAS, Region 13 undertook an extensive planning process that included stakeholder meetings, listening sessions, Enhanced Sequential Intercept Mapping, technical assistance from the Administrative Office of the Courts and the University of New Mexico Health Sciences Center, and collaboration with local governments, Tribal partners, providers, and individuals with lived experience; and

WHEREAS, the resulting Region 13 Plan identifies regional priorities including crisis response, clinical treatment and recovery services, care coordination, housing and transportation supports, workforce development, and other initiatives intended to improve behavioral health outcomes throughout the region;

WHEREAS, the Regional Plan is intended to guide strategic investment of available behavioral health funding, promote regional collaboration, strengthen continuity of care, and expand access



to evidence-based and culturally responsive behavioral health services while recognizing the unique needs of rural and Tribal communities;

WHEREAS, adoption of the Regional Plan does not obligate Cibola County to expend funds beyond those lawfully appropriated, nor does it commit the County to any specific project, procurement, contract, or future financial obligation absent subsequent approval by the Board of County Commissioners as required by law; and

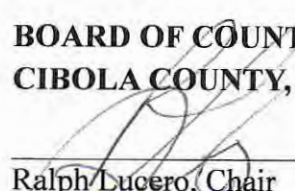
WHEREAS, the Board finds that adoption of the Regional Plan serves the public interest by providing a coordinated framework for behavioral health planning and implementation within Region 13.

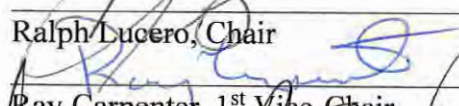
NOW, THEREFORE, BE IT RESOLVED by the Board of County Commissioners of Cibola County that the Region 13 Plan is hereby approved and adopted as the official regional behavioral health plan for purposes of participation in the State's Behavioral Health Reform and Investment Act initiatives, and that the Board reaffirms Cibola County's role as the Accountable Entity for Region 13 and authorizes County staff and administration to carry out administrative, fiscal, reporting, coordination, and implementation activities consistent with the adopted Regional Plan and applicable state law, grant requirements, and funding agreements.

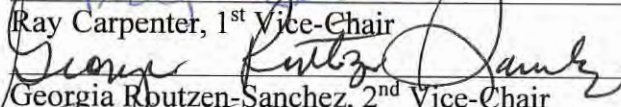
BE IT FURTHER RESOLVED that County staff are authorized to continue collaborating with Sandoval County, Valencia County, participating Pueblos, Tribes, Nations, behavioral health providers, state agencies, and other regional stakeholders to implement the goals and priorities identified in the Regional Plan, and that implementation of any individual project, contract, procurement, intergovernmental agreement, or expenditure contemplated by the Regional Plan shall remain subject to applicable procurement laws, budgetary appropriations, grant conditions, and any approvals otherwise required by law or County policy.

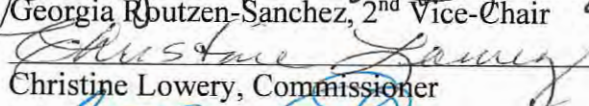
APPROVED, ADOPTED, AND PASSED this 25th day of June, 2026.

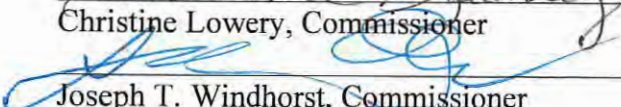
**BOARD OF COUNTY COMMISSIONERS
CIBOLA COUNTY, NEW MEXICO**


Ralph Lucero, Chair

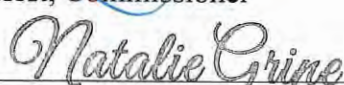

Ray Carpenter, 1st Vice-Chair


Georgia Routzen-Sanchez, 2nd Vice-Chair


Christine Lowery, Commissioner


Joseph T. Windhorst, Commissioner

ATTEST:


Natalie Grine, Cibola County Clerk



Letters of Support and MOUs

Letters of Support:

- Sandoval County
- Valencia County
- Pueblo of Acoma
- Pueblo of Laguna
- Ramah Chapter House
- Santo Domingo Pueblo
- Pueblo of Zia
- Village of Milan
- City of Grants
- Cochiti Pueblo
- Santa Ana
- Presbyterian MCO

Letters of Support or MOUs In Progress of Tribal Approval:

- San Felipe
- Jemez Pueblo

SANDOVAL COUNTY

STATE OF NEW MEXICO



MICHAEL MEEK
Chairman, District 3

JORDAN JUAREZ
Vice Chairman, District 4

KATHERINE A. BRUCH
District 1

JON HERR
District 2

JOSHUA JONES
District 5

LINDA P. GALLEGOS
Assessor

ANNE BRADY-ROMERO
Clerk

EDWARD W. LOVATO
Probate Judge

JESSE JAMES CASAUS
Sheriff

JENNIFER TAYLOR
Treasurer

WAYNE A. JOHNSON
County Manager

November 12, 2025

Re: Letter of Support for Cibola County to Lead Senate Bill 3

To Whom It May Concern,

This letter is to express our support for Cibola County taking the lead in Region 13 regarding Senate Bill 3. Behavioral health issues are prevalent in our entire state, affecting all municipalities and tribal communities. We are eager to participate in this initiative and will actively assist Cibola County in its efforts. We are committed to collaborating with neighboring counties and tribal entities to develop a comprehensive plan and collectively address the behavioral health crisis in our respective areas.

We eagerly anticipate learning about the strategies employed by other counties and collectively brainstorming various ideas and planning steps to secure funding for these efforts. We would like to express our gratitude to Cibola County for taking the initiative and are delighted to contribute and be a part of these ongoing efforts.

Sincerely,


Wayne A. Johnson
Sandoval County Manager





*Valencia County
Office of the County Manager
444 Luna Avenue ♦ P.O. Box 1119
Los Lunas, New Mexico 87031
Office: 505.866.2011*

October 17, 2025

To Whom It May Concern,

I am writing in strong support of Cibola County serving as the regional representative for SB 3 funding. With its proven administrative capacity and history of successful regional collaboration, including with tribal and municipal partners, Cibola County is uniquely equipped to manage and distribute these resources equitably and effectively. The County's commitment to transparency, community engagement, and strategic planning makes it the ideal entity for this important role. I fully endorse their leadership in this effort.

Thank you

A handwritten signature in black ink, appearing to read "Jh" followed by a stylized flourish.

Jhonathan Aragon
County Manager

*Gerard Saiz, Chair, District I ♦ Troy Richardson, Vice-Chair, District II
Morris Sparkman, District III ♦ Joseph Bizzell, District IV ♦ Dante Berry, District V
Jhonathan Aragon, County Manager*



OFFICE OF THE GOVERNOR

Charles P. Riley, Governor
Loren Aragon, 1st Lt. Governor
Ted Ortiz, 2nd Lt. Governor
Ardell Concho, Tribal Secretary
Norman F. Torivio, Tribal Interpreter

25 PINSBAARI DRIVE ACOMA, NM 87034

PO BOX 309 ACOMA, NM 87034

PHONE: 505-552.6604

FAX: 505-552.7204

October 24, 2025

To: Cibola County, Accountable Entity

Re: Letter of Support for AOC Regional Planning Accountable Entity

Dear County Manager Kate Fletcher:

As an identified representative of The Pueblo of Acoma, I am writing this to identify Cibola County as the 'accountable entity' for the Regional Planning process with the Administrative Office of the Courts. Cibola County has our full support to occupy this position.

Sincerely,

PUEBLO OF ACOMA

Charles P. Riley
Governor

CC: Esperance Lucero, Administrative Office of the Courts



December 23, 2025

SB3 Organizer
County Manager Office
700 E Roosevelt Ave,
Grants, NM 87020.

Dear SB3 Organizers,

On behalf of Pueblo of Laguna, we are pleased to submit this Letter of Support for the Region 13 Behavioral Health Collaborative Planning process and to confirm our organization's willingness to participate in and support Cibola County as the lead coordinating entity for Region 13.

We recognize the importance of this collaborative effort across Cibola, Valencia, and Sandoval counties, including the tribal nations and pueblos within the region, and that improving both the services and support for the delivery of mental health care services in all of our communities is imperative. Our staff have been attending your SB3 sessions, and will continue to do so.

The Pueblo is excited to continue our participation in this process, contribute insight from our experience in behavioral health and community engagement in our jurisdiction, and help shape a plan that ensures accessible, coordinated, and effective care. We also look forward to future meetings to clarify how the \$45,000 in planning funds for regional convenings and needs assessments through the University of New Mexico's ESIM model, and the ~\$2 million in immediate funds, as well as future funds, will be allocated among participating entities. Will a funding formula be developed specific to each region?

While Laguna fully supports Cibola County's leadership, our participation does not preclude pursuing additional direct funding or partnership opportunities. We would also like clarification on the level of administrative leadership that will be provided for this effort by the County? We also have some substantial concerns about the protection of tribal data, if submitted? What types of non-disclosure or data sharing agreements might be required of all parties?

Due to the need for accessible, quality, culturally appropriate, progressive, and effective Behavioral Health resources to exist in Cibola County, and in the state, the Pueblo of Laguna will continue to support this effort as follows:

1. Attending meetings to evaluate the planning process. Mr. Stuart Jones is the Behavioral Health programmatic contact for the Pueblo. Representation by Pueblo leadership will be at the Governor's discretion. Other staff may attend with Mr. Jones as appropriate.

2. Participating in identifying resources connected to Behavioral Health (BH) by acknowledging stakeholders' knowledge that implement BH units/programs in region 13.

I look forward to your responses to the concerns identified in this letter. Please contact my office at 505-552-6654 or contact Stuart Jones, Behavioral Health Program Manager at 505-552-6513. Thank you for your time.

Respectfully,

A handwritten signature in black ink, appearing to read 'B. Herrera', is written over the printed name.

Brandon Herrera, Chief of Operations
Pueblo of Laguna

Cc: Governor's office

Martha Garcia
President

RAMAH NAVAJO CHAPTER
HC 61, Box 13 Ramah, New Mexico 87321-9601
(505) 876-9656/9630/9517

Norman M. Begay
Council Delegate
Navajo Nation Council

Monica Yazzie
Vice-President

Tribal Office



Raquel Yazzie
Secretary/Treasurer

Leo L. Pino
Member
Eastern Navajo Land Board

Kate Fletcher
Cibola County Complex
700 E. Roosevelt Ave.
Suite 5D
Grants, NM 87020

Ramah Navajo Chapter Letter of Support for AOC Regional Planning Accountable Entity
October 14, 2025

To: Cibola County, Accountable Entity

Dear County Manager Kate Fletcher:

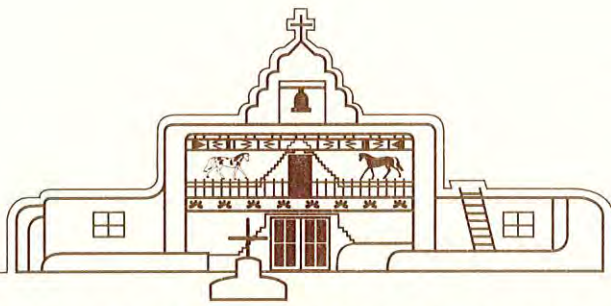
As an identified representative of **Ramah Navajo Chapter**, I am writing this to identify Cibola County as the 'accountable entity' for the Regional Planning process with the Administrative Office of the Courts. Cibola County has our full support to occupy this position.

Signature



Martha Garcia, President

cc: Esperance Lucero, Administrative Office of the Courts



Santo Domingo Pueblo

OFFICE OF THE GOVERNOR P.O. BOX 99, SANTO DOMINGO PUEBLO, NEW MEXICO 87052 TELEPHONE (505) 465-2214/2215 FAX (505) 465-2688

Date: December 9th, 2025

To: New Mexico Health Care Authority
Behavioral Health Reform & Investment Act (BHRIA)
Early Access Regional Plans Review Committee

From: Honorable Governor Thomas Moquino Jr
Honorable Lt. Governor Raymond Aguilar

RE: Letter of Support for Region 13 Early Access Regional Plan Application
Crisis Continuum of Care – Community Intervention Response Team (CIRT)
Accountable Entity: Cibola County
Implementing Partner: Kewa Family Wellness Center, Santo Domingo Pueblo

On behalf of Santo Domingo Pueblo, I am writing to express our strong support for the Region 13 Early Access Regional Plan application submitted by Cibola County in partnership with the Kewa Family Wellness Center (KFWC). This proposal advances both critically needed Residential Treatment and Crisis Continuum of Care and initiative through the development and expansion of our Community Intervention Response Team (CIRT) to serve our tribal community and the broader Region 13 area.

The Pueblo of Santo Domingo continues to face significant behavioral health challenges, including high rates of mental health crises, substance use, suicide risk, and trauma exposure. Our rural location, historical barriers to accessing culturally responsive care, and limited crisis infrastructure have resulted in disproportionate impacts on our families. Tribal first responders, Tribal Officials, EMS, and BIA Police are frequently placed in the position of managing mental health crises without the specialized support that trained crisis professionals can provide.

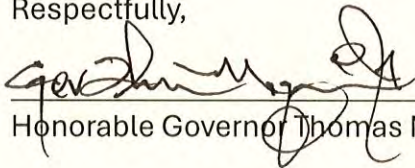
The CIRT model established by the Kewa Family Wellness Center is aligned with our community's values and cultural practices. It ensures that our people can receive immediate crisis intervention, stabilization, referral to residential treatment, follow-up services delivered by qualified, culturally grounded staff who understand our traditions, language, and way of life. The team's ability to respond quickly and reduce reliance on emergency departments and law enforcement will have a transformational impact on community safety and well-being.

We appreciate Cibola County's leadership in serving as the Accountable Entity for the Region 13 Early Access application. This partnership strengthens regional collaboration and ensures that fiscal oversight, reporting, and grant compliance responsibilities are met while enabling the Pueblo to lead the design and delivery of crisis services that meet our community's unique needs.

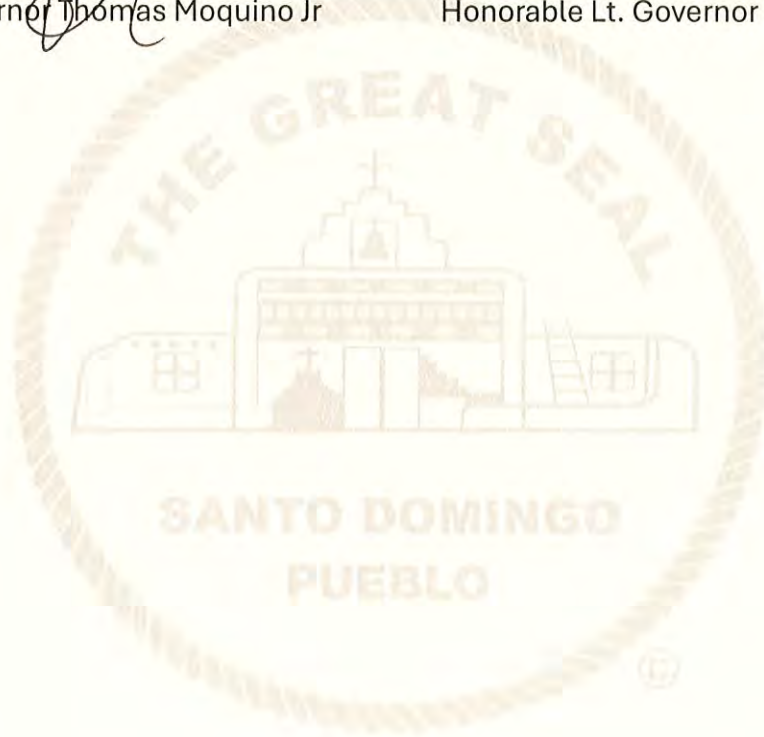
Santo Domingo Pueblo leadership fully supports this project and is committed to providing collaboration from Tribal Administration, EMS, Social Services, Behavioral Health, and public safety partners to ensure the program's success. We believe this investment will lay the foundation for a long-term, sustainable Continuum of Care as envisioned by the Behavioral Health Reform and Investment Act.

Thank you for your continued partnership and dedication to improving behavioral health systems for our Pueblo and other Tribal Communities across New Mexico.

Respectfully,


Honorable Governor Thomas Moquino Jr


Honorable Lt. Governor Raymond Aguilar



FELIX O. GONZALES
MAYOR

CANDI WILLIAMS
VILLAGE MANAGER



JAMES MERCER
MAYOR PRO TEM

TRUSTEES
CHRISTOPHER J. ARCHULETA
ROSEANNE LOPEZ
MONICA SANDOVAL

VILLAGE OF MILAN
P.O. BOX 2727 • 609 U.S. RT. 66
MILAN, NEW MEXICO 87021
(505)285-6694

Village of Milan Letter of Support for AOC Regional Planning Accountable Entity
9/29/2025

To: Cibola County, Accountable Entity

Dear County Manager Kate Fletcher:

As an identified representative of The Village of Milan, I am writing this to identify Cibola County as the 'accountable entity' for the Regional Planning process with the Administrative Office of the Courts. Cibola County has our full support to occupy this position.

Candace Williams
Manager/Finance Director

cc: Esperance Lucero, Administrative Office of the Courts

135 CAPITOL SQUARE DRIVE
ZIA PUEBLO, NM 87053-6013



PHONE (505) 867-3304
FAX (505) 867-3308

PUEBLO OF ZIA
Health and Wellness Department
135 Capitol Square Dr.
Zia Pueblo, New Mexico 87053

Date: 11/07/2025

To Whom It May Concern:

The Pueblo of Zia Health and Wellness Department is pleased to express its full support for the Cibola County Health Council in taking the initiative to lead the **Senate Bill 3– BHRIA Opportunities**. We recognize the importance of this effort in promoting community health, collaboration, and access to equitable health resources throughout our region.

The Pueblo of Zia acknowledges the Cibola County Health Council's commitment to fostering partnerships that enhance public health outcomes and align with our shared goals of improving wellness and preventive health services for all communities.

Ms. Yvette Herrera, Health and Wellness Director, has been identified as the Pueblo of Zia's representative and point of contact for this initiative. She can be reached at **(505) 677-0498** or by email at **Yvette.Herrera@ziapueblo.org** for any correspondence or coordination related to this effort.

We look forward to continued collaboration with the Cibola County Health Council and our regional partners in advancing the objectives of Senate Bill 3 – BHRIA Opportunities.

Sincerely,

Governor Pino
Governor, Pueblo of Zia



City Of Grants

600 W. Santa Fe Ave., Grants, NM 87020

(505)287-7327

City of Grants Letter of Support for AOC Regional Planning Accountable Entity.

9/29/2025

Dear County Manager Kate Fletcher:

On behalf of the City of Grants, I am writing to express our full support for Cibola County as the “accountable entity” for the Regional Planning process with the Administrative Office of the Courts (AOC). Cibola County has our full confidence in taking on this important role, and we believe their leadership will be essential in advancing regional coordination and addressing the unique needs of the communities within its region.

Thank you for considering our support, and we look forward to the continued success of this important initiative.

Andrew Valencia

City Manager/City of Grants

Phillip Quintana
Governor



Paul Herrera, Sr.
Lt. Governor

P.O. Box 255
255 Cochiti Street
Cochiti Pueblo, NM 87072-0255
CELL (505) 584-9652
OFFICE (505) 465-2500
cochiti.org

June 18, 2026

To: Cibola County, Accountable Entity

Dear County Manager Kate Fletcher:

As the Lt. Governor of Cochiti Pueblo, we are pleased to provide this Letter of Support for the Region 13 Behavioral Health Collaborative Planning process and to confirm our willingness to participate in and support Cibola County as the lead coordinating entity for Region 13.

We recognize the importance of this collaborative effort across Cibola, Valencia, and Sandoval counties and strongly support the meaningful inclusion and engagement of the tribes, nations, and pueblos throughout the region. We believe that behavioral health planning and services are most effective when they reflect the unique cultural values, priorities, strengths, and needs of Tribal communities and are developed through respectful government-to-government and community-based collaboration.

We support Cibola County's role as the accountable entity under the State's Behavioral Health Reinvestment Initiative, including its responsibilities to identify a lead partner, convene a diverse stakeholder group, and establish regional behavioral health priorities that will guide future funding, programs, and services. We encourage a planning process that values Tribal voices as essential partners in identifying solutions and improving behavioral health outcomes for all communities within Region 13.

Cochiti Pueblo is committed to participating in this process, contributing insight from our experience in behavioral health, public health, and community engagement, and helping shape a regional plan that promotes accessible, coordinated, culturally responsive, and effective care. We believe that strong partnerships among counties, tribes, nations, pueblos, service providers, and community stakeholders will be critical to addressing behavioral health needs across the region.

We appreciate the opportunity to collaborate with Cibola County and regional partners and look forward to working together to create a shared vision for behavioral health that honors and supports the diverse communities of Region 13, including the sovereign tribes, nations, and pueblos that call this region home.

Respectfully,

Paul Herrera, Sr.
Cochiti Pueblo Lt. Governor
Cc: Administrative Office of the Courts



June 29, 2026

Ms. Kate Fletcher
County Manager
Cibola County – Accountable Entity for Region 13

Subject: Letter of Support for the Region 13 Behavioral Health Collaborative Planning Process

Dear Ms. Fletcher:

On behalf of the Pueblo of Santa Ana Department of Health and Human Services, I am pleased to provide this letter in strong support of Cibola County's leadership as the Accountable Entity for the Region 13 Behavioral Health Collaborative Planning Process.

The Pueblo of Santa Ana recognizes that meaningful improvements in behavioral health outcomes require intentional regional collaboration, shared accountability, and coordinated investment across healthcare systems, tribal governments, local jurisdictions, and community-based organizations. We commend Cibola County for assuming this important leadership role under New Mexico's Behavioral Health Reinvestment Initiative and for facilitating a comprehensive planning process that brings together stakeholders from Cibola, Valencia, and Sandoval counties, including the sovereign tribal nations and pueblos that comprise Region 13.

As Director of Health and Human Services, I fully support this collaborative effort to establish a regional behavioral health framework that is data-informed, culturally responsive, trauma-informed, and focused on measurable improvements in population health. Behavioral health challenges within our region are complex and multifaceted, requiring integrated approaches that address mental health, substance use disorders, adverse childhood experiences, social determinants of health, workforce capacity, care coordination, crisis response, and long-term recovery supports.

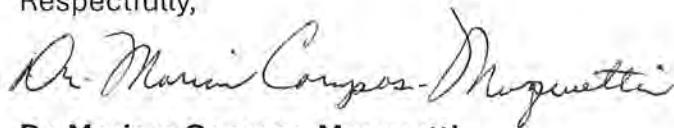
The Pueblo of Santa Ana is committed to participating as an active partner throughout the planning process. Our department is prepared to contribute clinical expertise, public health perspectives, community engagement strategies, and experience serving Native American populations through integrated behavioral health, prevention, social services, and community wellness initiatives. We believe that successful regional planning must be grounded in meaningful stakeholder engagement, respect for tribal sovereignty, culturally informed practices, and equitable access to high-quality behavioral healthcare for all communities.

We are particularly encouraged by the opportunity to collaboratively identify regional priorities that strengthen the behavioral health continuum of care, improve service coordination across systems, reduce barriers to treatment, and enhance access to evidence-based and culturally appropriate services. By working collectively, Region 13 can build a more resilient behavioral health infrastructure that promotes prevention, early intervention, recovery, and long-term wellness while reducing unnecessary disparities experienced by historically underserved populations.

The Pueblo of Santa Ana values this opportunity to collaborate with Cibola County and our regional partners in developing a shared vision that advances behavioral health outcomes throughout Region 13. We appreciate your leadership in convening this initiative and look forward to contributing to a strategic planning process that results in sustainable, community-driven solutions benefiting individuals, families, and communities across the region.

Thank you for your leadership and your commitment to improving the behavioral health system for the residents of Region 13.

Respectfully,

A handwritten signature in cursive script, reading "Dr. Mariam Campos-Marquetti".

Dr. Mariam Campos-Marquetti

Director of Health and Human Services
Pueblo of Santa Ana

cc: Administrative Office of the Courts

June 25, 2026

Cibola County, Region 13 BHRIA Accountable Entity
700 E Roosevelt Ave; Suite 50
Grants, NM 87020

Presbyterian Health Plan Letter of Support for Cibola County - Regional Planning Accountable Entity for State of New Mexico's Region 13 Behavioral Health Reform and Investment Act

To: Cibola County, Accountable Entity

Dear County Manager Kate Fletcher:

As an identified representative of Presbyterian Health Plan, Inc. ("PHP"), we are pleased to submit this Letter of Support for the Region 13 Behavioral Health Collaborative Planning process and to confirm our organization's willingness to participate in and support Cibola County as the lead coordinating entity for Region 13.

We recognize the importance of this collaborative effort across Cibola, Valencia, and Sandoval counties, including the tribal nations and pueblos within the region. We support Cibola County's role as the accountable entity under the State of New Mexico's Behavioral Health Reform and Investment Act (BHRIA) Initiative, which requires identifying a lead partner, convening a stakeholder group, and establishing five regional behavioral health priorities to guide funding and services.

PHP is eager to participate in this process, contribute insight from our experience in behavioral health and community engagement, and help shape a plan that ensures accessible, coordinated, and effective care.

We appreciate the opportunity to collaborate with Cibola County and regional partners and look forward to contributing to a shared vision for behavioral health in Region 13.

Sincerely,



Jill Borrelli
VP, Chief Behavioral Health & Quality Officer

**MEMORANDUM OF AGREEMENT
BETWEEN CIBOLA COUNTY AND SANTO DOMINGO PUEBLO
REGARDING IMPLEMENTATION OF SB 3 FUNDING FOR
REGION 13**

THIS MEMORANDUM OF AGREEMENT ("MOA" or "Agreement") is made and entered into as of the date of last signature, below, by and between **Cibola County, New Mexico**, a political subdivision of the State of New Mexico ("County"), and **Santo Domingo Pueblo**, a federally recognized Indian tribe with inherent self-government authority ("Pueblo").

RECITALS

WHEREAS, the State of New Mexico enacted the Behavioral Health Reform and Investment Act, SB 3 ("SB 3" or "BHRIA"), which establishes regional behavioral health planning, funding, coordination, and oversight structures;

WHEREAS, SB 3 designates Region 13 as encompassing Cibola County, Sandoval County, and Valencia County, requiring collaborative regional planning, data collection, assessment of service gaps, and preparation of funding priorities; and

WHEREAS, the Entities desire to cooperate in order to apply for, secure, administer, and implement SB 3 regional funds for the benefit of residents across Region 13; and

WHEREAS, SB 3 requires coordinated action by participating counties and behavioral health stakeholders, including communication with the Administrative Office of the Courts ("AOC"), the Health Care Authority ("HCA"), and the Behavioral Health Executive Committee; and

WHEREAS, the Entities acknowledge the need for a clearly identified Lead Agency and Fiscal Agent to perform administrative, fiscal, and reporting functions necessary for Region 13 SB 3 implementation; and

WHEREAS, Cibola County is willing to assume the responsibilities of Lead Agency and Fiscal Agent to support the development, coordination, and execution of regional SB 3 funding priorities on behalf of Region 13; and

WHEREAS, Cibola General Hospital, Inc. is a key behavioral health and health services provider within Region 13 and has been identified as a recipient of SB 3 funding for approved projects or initiatives; and

WHEREAS, SB 3 requires agreements between the Lead Accountable Entity and any entity receiving SB 3 funds to define responsibilities, compliance requirements, fiscal accountability, and reporting expectations; and

WHEREAS, the parties to this MOA acknowledge that, as a general rule, State of New Mexico does not apply to and has no force on an Indian tribe such as the Pueblo; and

WHEREAS, the parties desire to enter into this MOA to establish their respective roles, responsibilities, the for implementation of SB 3 funding for Region 13.

NOW, THEREFORE, the parties agree as follows:

1. Purpose.

The parties enter into this MOA to establish the framework by which the Pueblo shall receive, manage, and expend Behavioral Health Reform and Investment Act (SB 3) funds administered by Cibola County, and to ensure compliance with all State requirements, funding conditions, reporting obligations, and regional planning objectives for Region 13, as applicable to an Indian tribe and this MOA.

2. Designation of Cibola County as the Lead Agency and Fiscal Agent and Santo Domingo Pueblo as Subrecipient

- a. Cibola County is designated as the Lead Agency responsible for the administrative coordination, reporting, contracting, recordkeeping, and financial oversight related to SB 3 activities on behalf of Region 13.
- b. Cibola County shall serve as the Fiscal Agent, responsible for:
 - i. applying for SB 3 regional funds on behalf of Region 13 and administering SB 3 funds awarded to Region 13;
 - ii. executing contracts, agreements, and procurement actions necessary to implement approved SB 3 projects;
 - iii. ensuring compliance with procurement requirements, State regulations, and SB 3 funding conditions; and
 - iv. providing regular financial and programmatic reports to Region 13 Member Counties.
- c. No duties assigned to Cibola County as Fiscal Agent shall be construed to make Cibola County financially responsible for obligations that exceed SB 3 appropriations or approved regional project budgets.
- d. Santo Domingo Pueblo is designated as a subrecipient of SB 3 funds and shall be responsible for:
 - i. implementing SB 3-funded projects in accordance with approved scopes of work, budgets, timelines, and regional priorities, as determined by the parties;
 - ii. using SB 3 funds solely for authorized and allowable purposes;

- iii. complying with all applicable federal and State laws, SB 3 requirements, grant conditions, and reporting standards, as determined by the parties;
- iv. maintaining appropriate financial records, internal controls, and documentation related to SB 3 expenditures, as determined by the parties; and
- v. cooperating fully with monitoring, audits, evaluations, and reporting requirements, as determined by the parties.
- vi. promptly notifying Cibola County of any issues, risks, or delays affecting SB 3-funded work.
- vii. The Pueblo shall not be responsible for obligations imposed on Cibola County by virtue of being the Lead Agency.

3. Financial Terms

- a. SB 3 funds shall be deposited, managed, and disbursed by Cibola County as Fiscal Agent.
- b. The Fiscal Agent shall maintain separate accounting for SB 3 funds and shall provide quarterly financial reports to Region 13 Member Counties.
- c. No Party shall be responsible for obligations that exceed the SB 3 funding available or approved for a particular project.
- d. Administrative costs, including staffing for the Regional SB 3 Coordinator, shall be paid from SB 3 allocations unless otherwise agreed.
- e. The Cibola General Hospital, Inc., shall maintain separate accounting records for SB 3 funds and shall provide financial reports, invoices, and supporting documentation as reasonably required by the County to meet State reporting obligations.

4. Costs

Each party shall bear its own costs and expenses incurred in fulfilling its responsibilities under this Agreement, including costs for personnel, materials, and equipment, without contribution or right of contribution from any other party.

5. Non-Appropriation

The parties' obligation to perform under the terms of this Agreement are contingent upon the parties' respective appropriation of sufficient funds. If any party does not appropriate funds sufficient to fulfill that parties' responsibilities under this Agreement, this Agreement will terminate upon written notice of that effect to the other parties. Each parties' determination that sufficient funds have

not been appropriated to fulfill that parties' responsibilities under this Agreement is firm, binding and not subject to review.

6. Status of Employees

Any employee of one of the parties who provides services pursuant to this Agreement shall remain the employee of that party, who shall remain responsible for the employee's salary, fringe benefits, worker's compensation benefits, and unemployment compensation. Such employees shall remain subject to the supervision of his or her employer. The relationship between the parties is not a partnership or joint venture as it relates to their respective employees.

7. Compliance with Procurement Laws

Each party shall be responsible for complying with all applicable laws, rules, and regulations governing that party's procurement of goods and/or services necessary to fulfill that party's responsibilities under this Agreement.

8. Accountability for Receipts and Disbursements

The parties shall each be strictly accountable for all receipts and disbursements of their own funds in compliance with law when engaging in the activities contemplated by this Agreement.

9. Term

This MOU shall become effective upon execution by both parties and shall remain in effect until replaced by written agreement or if terminated. Any party may terminate this MOA with thirty (30) days' written notice to the other party for cause or not for cause, provided that termination does not relieve the party of obligations related to previously approved SB 3-funded projects. Termination does not affect the Fiscal Agent's obligation to complete required State reporting for any SB 3 funds already expended. Nothing in this paragraph shall be construed to alter, limit, or restrict any County's separate and independent right to immediately terminate its participation in this Agreement upon a determination of non-appropriation. Immediate termination for non-appropriation remains fully available notwithstanding any other provision contained herein.

10. Amendments

This Agreement shall not be altered, modified, or amended except by instrument in writing executed by both parties.

11. Governing Law

This Agreement shall be governed by the laws of the State of New Mexico. Each person signing the Agreement and/or authorizing it to be signed on behalf of his/her respective party is not personally liable, either jointly or severally, for this Agreement under any circumstances.

12. Severability

If any clause or provision of this Agreement is held to be illegal, invalid or unenforceable, by a court of competent jurisdiction, then it is the intention of the parties hereto that the remainder of the Agreement shall remain in full force and effect. However, in the event that any party can no longer reasonably perform pursuant to the remaining Agreement terms, or if the purpose of the Agreement can no longer be carried out by any party, the Agreement is voidable and no damages shall accrue to any party.

13. Notices

Any required notice under this Agreement shall be sent as follows:

COUNTY OF CIBOLA
Kate Fletcher Cibola County Manager 700 East Roosevelt Grants, NM 87020
SANTO DOMINGO PUEBLO
Governor Raymond Aguilar, Jr. Lt. Governor Ivan Garcia PO Box 99 Santo Domingo Pueblo, NM 87052

14. No Waiver of Immunity

Nothing in this Agreement shall be construed as a waiver of statutory immunity, defenses, or limitations of liability under the New Mexico Tort Claims Act or the New Mexico Civil Rights Act. Nothing in this Agreement shall be construed as a waiver of the Pueblo's sovereign immunity.

15. No Third Party Beneficiary

It is specifically agreed among the parties executing this Agreement that it is not intended by the parties or by any provisions of the Agreement to create in the public or any member thereof, status as a third party beneficiary of the Agreement.

or to authorize anyone not a party to the Agreement to maintain a suit(s) for wrongful death(s), injury(ies) to person(s), damage(s) to property(ies), and/or any other cause(s) of action whatsoever pursuant to the provisions of this Agreement.

16. Liability and Insurance

Neither party shall be responsible for liability incurred as a result of any other party's acts or omissions in connection with this Agreement.

17. Privileges and Immunities

All of the privileges and immunities from liability, exemptions from laws, ordinances and rules, all pension, relief, disability, worker's compensation, and other benefits which apply to the activity of the officers, agents, or employees of the counties when engaging in the performance of the parties' respective actions taken under this Agreement shall apply to the County to the same extent they apply while engaged in the performance of their functions and duties outside this Agreement.

18. Authority

The signatories of this Agreement, by their signatures below, represent that they have the authority to enter into this Agreement and applicable laws, rules, and regulations have been complied with.

19. Duplicate Originals

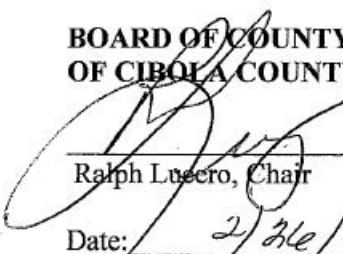
This Agreement shall be executed in no less than two (2) counterparts, each of which shall be deemed an original.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date of last signature below.

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[SIGNATURES APPEAR ON THE FOLLOWING PAGES]

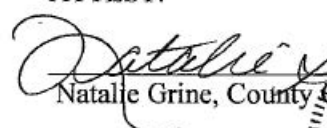
**BOARD OF COUNTY COMMISSIONERS
OF CIBOLA COUNTY, NEW MEXICO**



Ralph Lucero, Chair

Date: 2/26/2026

ATTEST:

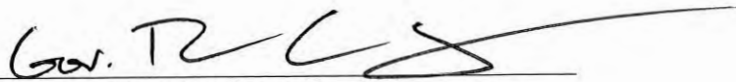


Natalie Grine, County Clerk

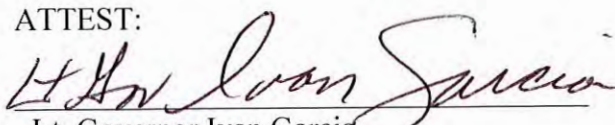


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SANTO DOMINGO PUEBLO


Governor Raymond Aguilar, Jr.

Date: 4 / 10 / 26

ATTEST:

Lt. Governor Ivan Garcia

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**MEMORANDUM OF AGREEMENT
BETWEEN CIBOLA COUNTY AND CIBOLA GENERAL HOSPITAL
REGARDING IMPLEMENTATION OF SB 3 FUNDING FOR REGION 13**

THIS MEMORANDUM OF AGREEMENT is made and entered into as of the date of last signature, below, by and between **Cibola County, New Mexico**, a political subdivision of the State of New Mexico ("County"), and **Cibola General Hospital, Inc.**, a New Mexico nonprofit corporation ("Hospital").

RECITALS

WHEREAS, the State of New Mexico enacted the Behavioral Health Reform and Investment Act, SB 3 ("SB 3" or "BHRIA"), which establishes regional behavioral health planning, funding, coordination, and oversight structures;

WHEREAS, SB 3 designates Region 13 as encompassing Cibola County, Sandoval County, and Valencia County, requiring collaborative regional planning, data collection, assessment of service gaps, and preparation of funding priorities; and

WHEREAS, the Entities desire to cooperate in order to apply for, secure, administer, and implement SB 3 regional funds for the benefit of residents across Region 13; and

WHEREAS, SB 3 requires coordinated action by participating counties and behavioral health stakeholders, including communication with the Administrative Office of the Courts ("AOC"), the Health Care Authority ("HCA"), and the Behavioral Health Executive Committee; and

WHEREAS, the Entities acknowledge the need for a clearly identified Lead Agency and Fiscal Agent to perform administrative, fiscal, and reporting functions necessary for Region 13 SB 3 implementation; and

WHEREAS, Cibola County is willing to assume the responsibilities of Lead Agency and Fiscal Agent to support the development, coordination, and execution of regional SB 3 funding priorities on behalf of Region 13; and

WHEREAS, Cibola General Hospital, Inc. is a key behavioral health and health services provider within Region 13 and has been identified as a recipient of SB 3 funding for approved projects or initiatives;

WHEREAS, SB 3 requires clear agreements between the Lead Accountable Entity and any entity receiving SB 3 funds to define responsibilities, compliance requirements, fiscal accountability, and reporting expectations; and

WHEREAS, the parties desire to enter into this Memorandum of Agreement to establish their respective roles, responsibilities, the for implementation of SB 3 funding for Region 13.

NOW, THEREFORE, the parties agree as follows:

1. Purpose.

The parties enter into this Memorandum of Agreement to establish the framework by which Cibola General Hospital, Inc. shall receive, manage, and expend Behavioral Health Reform and Investment Act (SB 3) funds administered by Cibola County, and to ensure compliance with all applicable state requirements, funding conditions, reporting obligations, and regional planning objectives for Region 13.



2. Designation of Cibola County as the Lead Agency and Fiscal Agent and Cibola General Hospital as Subrecipient

- a. Cibola County is designated as the Lead Agency responsible for the administrative coordination, reporting, contracting, recordkeeping, and financial oversight related to SB 3 activities on behalf of Region 13.
- b. Cibola County shall serve as the Fiscal Agent, responsible for:
 - i. applying for SB 3 regional funds on behalf of Region 13 and administering SB 3 funds awarded to Region 13;
 - ii. executing contracts, agreements, and procurement actions necessary to implement approved SB 3 projects;
 - iii. ensuring compliance with procurement requirements, state regulations, and SB 3 funding conditions; and
 - iv. providing regular financial and programmatic reports to Region 13 Member Counties.
- c. No duties assigned to Cibola County as Fiscal Agent shall be construed to make Cibola County financially responsible for obligations that exceed SB 3 appropriations or approved regional project budgets.
- d. Cibola General Hospital, Inc. is designated as a subrecipient of SB 3 funds and shall be responsible for:
 - i. implementing SB 3-funded projects in accordance with approved scopes of work, budgets, timelines, and regional priorities;
 - ii. using SB 3 funds solely for authorized and allowable purposes;
 - iii. complying with all applicable federal and state laws, SB 3 requirements, grant conditions, and reporting standards;
 - iv. maintaining appropriate financial records, internal controls, and documentation related to SB 3 expenditures; and
 - v. cooperating fully with monitoring, audits, evaluations, and reporting requirements.
 - vi. promptly notifying Cibola County of any issues, risks, or delays affecting SB 3-funded work.

3. Financial Terms

- a. SB 3 funds shall be deposited, managed, and disbursed by Cibola County as Fiscal Agent.
- b. The Fiscal Agent shall maintain separate accounting for SB 3 funds and shall provide quarterly financial reports to Region 13 Member Counties.
- c. No Party shall be responsible for obligations that exceed the SB 3 funding available or approved for a particular project.



- d. Administrative costs, including staffing for the Regional SB 3 Coordinator, shall be paid from SB 3 allocations unless otherwise agreed.
- e. The Cibola General Hospital, Inc., shall maintain separate accounting records for SB 3 funds and shall provide financial reports, invoices, and supporting documentation as reasonably required by the County to meet state reporting obligations.

4. Costs

Each party shall bear its own costs and expenses incurred in fulfilling its responsibilities under this Agreement, including costs for personnel, materials, and equipment, without contribution or right of contribution from any other party.

5. Non-Appropriation

The parties' obligation to perform under the terms of this Agreement are contingent upon the parties' respective appropriation of sufficient funds. If any party does not appropriate funds sufficient to fulfill that parties' responsibilities under this Agreement, this Agreement will terminate upon written notice of that effect to the other parties. Each parties' determination that sufficient funds have not been appropriated to fulfill that parties' responsibilities under this Agreement is firm, binding and not subject to review.

6. Status of Employees

Any employee of one of the parties who provides services pursuant to this Agreement shall remain the employee of that party, who shall remain responsible for the employee's salary, fringe benefits, worker's compensation benefits, and unemployment compensation. Such employees shall remain subject to the supervision of his or her employer.

7. Compliance with Procurement Laws

Each party shall be responsible for complying with all applicable laws, rules, and regulations governing that party's procurement of goods and/or services necessary to fulfill that party's responsibilities under this Agreement.

8. Accountability for Receipts and Disbursements

The parties shall each be strictly accountable for all receipts and disbursements of their own funds in compliance with law when engaging in the activities contemplated by this Agreement.

9. Term



This MOU shall become effective upon execution by both parties and shall remain in effect until terminated or replaced by written agreement. Any party may withdraw from this MOU with thirty (30) days' written notice, provided that withdrawal does not relieve the party of obligations related to previously approved SB 3-funded projects. Termination or withdrawal does not affect the Fiscal Agent's obligation to complete required state reporting for any SB 3 funds already expended. Nothing in this paragraph shall be construed to alter, limit, or restrict any County's separate and independent right to immediately terminate its participation in this Agreement upon a determination of non-appropriation. Immediate termination for non-appropriation remains fully available notwithstanding any other provision contained herein.

10. Amendments

This Agreement shall not be altered, modified, or amended except by instrument in writing executed by both parties.

11. Governing Law

This Agreement shall be governed by the laws of the State of New Mexico. Each person signing the Agreement and/or authorizing it to be signed on behalf of his/her respective party is not personally liable, either jointly or severally, for this Agreement under any circumstances.

12. Severability

If any clause or provision of this Agreement is held to be illegal, invalid or unenforceable, by a court of competent jurisdiction, then it is the intention of the parties hereto that the remainder of the Agreement shall remain in full force and effect. However, in the event that any party can no longer reasonably perform pursuant to the remaining Agreement terms, or if the purpose of the Agreement can no longer be carried out by any party, the Agreement is voidable and no damages shall accrue to any party.

13. Notices

Any required notice under this Agreement shall be sent as follows:

COUNTY OF CIBOLA

Kate Fletcher
Cibola County Manager
700 East Roosevelt, Suite 50
Grants, NM 87020



CIBOLA GENERAL HOSPITAL

Jeff Egbert
Chief Executive Officer
1016 E Roosevelt
Grants, NM 87020

14. No Waiver of Immunity

Nothing in this Agreement shall be construed as a waiver of sovereign immunity, statutory immunity, defenses, or limitations of liability under the New Mexico Tort Claims Act or the New Mexico Civil Rights Act.

15. No Third Party Beneficiary

It is specifically agreed among the parties executing this Agreement that it is not intended by the parties or by any provisions of the Agreement to create in the public or any member thereof, status as a third party beneficiary of the Agreement, or to authorize anyone not a party to the Agreement to maintain a suit(s) for wrongful death(s), injury(ies) to person(s), damage(s) to property(ies), and/or any other cause(s) of action whatsoever pursuant to the provisions of this Agreement.

16. Liability and Insurance

Neither party shall be responsible for liability incurred as a result of any other party's acts or omissions in connection with this Agreement.

17. Privileges and Immunities

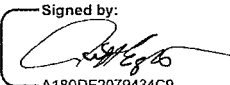
All of the privileges and immunities from liability, exemptions from laws, ordinances and rules, all pension, relief, disability, worker's compensation, and other benefits which apply to the activity of the officers, agents, or employees of the counties when engaging in the performance of the parties' respective actions taken under this Agreement shall apply to the parties to the same extent they apply while engaged in the performance of their functions and duties outside this Agreement.

18. Authority

The signatories of this Agreement, by their signatures below, represent that they have the authority to enter into this Agreement and applicable laws, rules, and regulations have been complied with.



CIBOLA GENERAL HOSPITAL, INC.

Signed by:

A180DF2079434C9
JEFF EGBERT, CEO

Date: 2/13/2026

ATTEST:

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202600376 Page 6 of 7B: 032 P: 02402 02/27/2026 08:37 AM
Natalie Grine, Cibola County, NM Clerk and Recorder

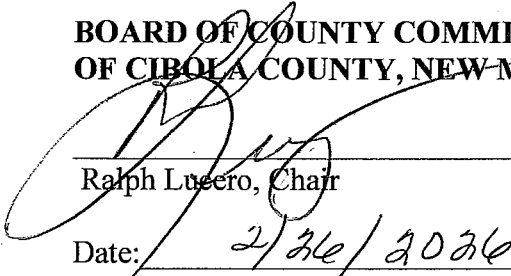


19. Duplicate Originals

This Agreement shall be executed in no less than two (2) counterparts, each of which shall be deemed an original.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date of last signature below.

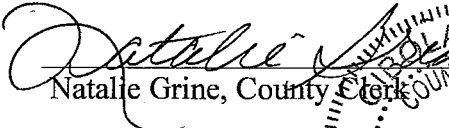
**BOARD OF COUNTY COMMISSIONERS
OF CIBOLA COUNTY, NEW MEXICO**



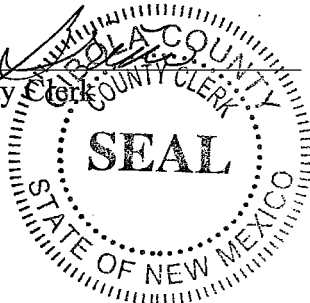
Ralph Lucero, Chair

Date: 2/26/2026

ATTEST:



Natalie Grine, County Clerk



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**MEMORANDUM OF AGREEMENT
BETWEEN CIBOLA COUNTY, SANDOVAL COUNTY, AND VALENCIA
COUNTY REGARDING IMPLEMENTATION OF SB 3 FUNDING FOR
REGION 13**

THIS MEMORANDUM OF AGREEMENT is made and entered into as of the date of last signature, below, by and among the Boards of County Commissioners of Cibola, Sandoval and Valencia Counties.

RECITALS

WHEREAS, SB 3 designates Region 13 as encompassing Cibola County, Sandoval County, and Valencia County, requiring collaborative regional planning, data collection, assessment of service gaps, and preparation of funding priorities; and

WHEREAS, the Counties desire to cooperate in order to apply for, secure, administer, and implement SB 3 regional funds for the benefit of residents across Region 13; and

WHEREAS, SB 3 requires coordinated action by participating counties and behavioral health stakeholders, including communication with the Administrative Office of the Courts (“AOC”), the Health Care Authority (“HCA”), and the Behavioral Health Executive Committee; and

WHEREAS, the Counties acknowledge the need for a clearly identified Lead Agency and Fiscal Agent to perform administrative, fiscal, and reporting functions necessary for Region 13 SB 3 implementation; and

WHEREAS, Cibola County is willing to assume the responsibilities of Lead Agency and Fiscal Agent to support the development, coordination, and execution of regional SB 3 funding priorities on behalf of Region 13; and

WHEREAS, effective implementation of SB 3 requires each County to designate an individual who holds final decision-making authority to bind their County on matters relating to SB 3 regional planning, funding decisions, and expenditures; and

WHEREAS, the Counties desire to enter into this Memorandum of Agreement to establish their respective responsibilities, the process for decision-making, and the governance structure for implementation of SB 3 funding for Region 13.

NOW, THEREFORE, the parties agree as follows:

1. Purpose.

The parties enter into this Memorandum of Agreement to establish the framework by which Region 13 Member Counties will jointly participate in, manage and implement projects and funding opportunities provided under the Behavioral Health Reform and Investment Act (SB 3), including but not limited to the development and execution of regional plans, applications for SB 3 funding, distribution and oversight of awarded funds, and coordination with the Administrative Office of the Courts (“AOC”), the Health Care Authority (“HCA”), and the Behavioral Health Executive Committee.

2. Designation of Cibola County as the Lead Agency and Fiscal Agent



- a. Cibola County is designated as the Lead Agency responsible for the administrative coordination, reporting, contracting, recordkeeping, and financial oversight related to SB 3 activities on behalf of Region 13.
- b. Cibola County shall serve as the Fiscal Agent, responsible for:
 - i. applying for SB 3 regional funds on behalf of Region 13 and administering SB 3 funds awarded to Region 13;
 - ii. executing contracts, agreements, and procurement actions necessary to implement approved SB 3 projects;
 - iii. ensuring compliance with procurement requirements, state regulations, and SB 3 funding conditions; and
 - iv. providing regular financial and programmatic reports to Region 13 Member Counties.
- c. No duties assigned to Cibola County as Fiscal Agent shall be construed to make Cibola County financially responsible for obligations that exceed SB 3 appropriations or approved regional project budgets.

3. Designation of County Representatives with Binding Authority

- a. Each Region 13 Member County shall, by separate action of its Board of County Commissioners, designate one representative (the "Authorized Representative") who is empowered to:
 - i. participate in all SB 3 regional planning, prioritization, and funding determinations;
 - ii. make final decisions regarding Region 13's funding priorities, applications, project selections, and budget allocations;
 - iii. approve, on behalf of their respective County, expenditures or commitments of SB 3 funds; and
 - iv. bind their County to decisions made collectively by Region 13, provided those decisions are within the authority delegated by their Board.
- b. Each County may also designate an alternate representative who may act in the absence of the Authorized Representative.
- c. Authorized Representatives shall meet regularly, as needed, to consider regional priorities, review proposals, evaluate funding opportunities, and allocate awarded SB 3 resources.
- d. Actions of the Authorized Representatives shall be documented in writing and maintained by the Fiscal Agent.



4. Regional Decision-Making Process

- a. Decisions regarding:
 - i. regional priorities;
 - ii. applications for SB 3 funding;
 - iii. distribution of SB 3 funds among Region 13 projects;
 - iv. approval of project budgets and amendments; and
 - v. execution of contracts or intergovernmental agreements relating to SB 3 implementation

shall be made by majority vote of the Authorized Representatives.

- b. The Fiscal Agent shall not commit or expend SB 3 funds without written approval from the Authorized Representatives.
- c. Any project or expenditure that binds a specific County to continuing obligations after the expiration of SB 3 funding must be separately approved by that County's Board of County Commissioners.

5. Responsibilities of Member Counties

- a. Participate actively in regional planning and mapping processes required by SB 3.
- b. Assign personnel as needed to support data collection, outreach, and project execution.
- c. Make timely decisions to enable submission of regional plans and grant applications.
- d. Assist the Fiscal Agent in fulfilling reporting obligations to AOC, HCA, and the Behavioral Health Executive Committee.
- e. Ensure that their Authorized Representative acts within the scope of the authority delegated by their Board.

6. Financial Terms

- a. SB 3 funds shall be deposited, managed, and disbursed by Cibola County as Fiscal Agent.
- b. The Fiscal Agent shall maintain separate accounting for SB 3 funds and shall provide quarterly financial reports to Region 13 Member Counties.



- c. No County shall be responsible for obligations that exceed the SB 3 funding available or approved for a particular project.
- d. Administrative costs, including staffing for the Regional SB 3 Coordinator, shall be paid from SB 3 allocations unless otherwise agreed.

7. Costs

Each party shall bear its own costs and expenses incurred in fulfilling its responsibilities under this Agreement, including costs for personnel, materials, and equipment, without contribution or right of contribution from any other party.

8. Non-Appropriation

The parties' obligation to perform under the terms of this Agreement are contingent upon the parties' respective appropriation of sufficient funds. If any party does not appropriate funds sufficient to fulfill that parties' responsibilities under this Agreement, this Agreement will terminate upon written notice of that effect to the other parties. Each parties' determination that sufficient funds have not been appropriated to fulfill that parties' responsibilities under this Agreement is firm, binding and not subject to review.

9. Status of Employees

Any employee of one of the parties who provides services pursuant to this Agreement shall remain the employee of that party, who shall remain responsible for the employee's salary, fringe benefits, worker's compensation benefits, and unemployment compensation. Such employees shall remain subject to the supervision of his or her employer.

10. Compliance with Procurement Laws

Each party shall be responsible for complying with all applicable laws, rules, and regulations governing that party's procurement of goods and/or services necessary to fulfill that party's responsibilities under this Agreement.

11. Accountability for Receipts and Disbursements

The parties shall each be strictly accountable for all receipts and disbursements of their own funds in compliance with law when engaging in the activities contemplated by this Agreement.

12. Term

This MOU shall become effective upon execution by all Region 13 Member Counties and shall remain in effect until terminated or replaced by written agreement. Any County may withdraw from this MOU with thirty (30) days'



written notice, provided that withdrawal does not relieve the County of obligations related to previously approved SB 3-funded projects. Termination or withdrawal does not affect the Fiscal Agent's obligation to complete required state reporting for any SB 3 funds already expended. Nothing in this paragraph shall be construed to alter, limit, or restrict any County's separate and independent right to immediately terminate its participation in this Agreement upon a determination of non-appropriation. Immediate termination for non-appropriation remains fully available notwithstanding any other provision contained herein.

13. Amendments

This Agreement shall not be altered, modified, or amended except by instrument in writing executed by both parties.

14. Governing Law

This Agreement shall be governed by the laws of the State of New Mexico. Each person signing the Agreement and/or authorizing it to be signed on behalf of his/her respective party is not personally liable, either jointly or severally, for this Agreement under any circumstances.

15. Severability

If any clause or provision of this Agreement is held to be illegal, invalid or unenforceable, by a court of competent jurisdiction, then it is the intention of the parties hereto that the remainder of the Agreement shall remain in full force and effect. However, in the event that any party can no longer reasonably perform pursuant to the remaining Agreement terms, or if the purpose of the Agreement can no longer be carried out by any party, the Agreement is voidable and no damages shall accrue to any party.

16. Notices

Any required notice under this Agreement shall be sent as follows:

COUNTY OF CIBOLA

Kate Fletcher
Cibola County Manager
700 East Roosevelt
Grants, NM 87020

COUNTY OF SANDOVAL

Wayne Johnson



Sandoval County Manager
1500 Idalia Road, Building D
Bernalillo, NM 87004

COUNTY OF VALENCIA

Jhonathan Aragon
Valencia County Manager
444 Luna Avenue
Los Lunas, NM 87031

17. No Waiver of Immunity

Nothing in this Agreement shall be construed as a waiver of sovereign immunity, statutory immunity, defenses, or limitations of liability under the New Mexico Tort Claims Act or the New Mexico Civil Rights Act.

18. No Third Party Beneficiary

It is specifically agreed among the parties executing this Agreement that it is not intended by the parties or by any provisions of the Agreement to create in the public or any member thereof, status as a third party beneficiary of the Agreement, or to authorize anyone not a party to the Agreement to maintain a suit(s) for wrongful death(s), injury(ies) to person(s), damage(s) to property(ies), and/or any other cause(s) of action whatsoever pursuant to the provisions of this Agreement.

19. Liability and Insurance

Neither party shall be responsible for liability incurred as a result of any other party's acts or omissions in connection with this Agreement.

20. Privileges and Immunities

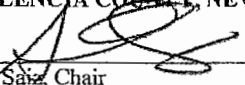
All of the privileges and immunities from liability, exemptions from laws, ordinances and rules, all pension, relief, disability, worker's compensation, and other benefits which apply to the activity of the officers, agents, or employees of the counties when engaging in the performance of the parties' respective actions taken under this Agreement shall apply to the parties to the same extent they apply while engaged in the performance of their functions and duties outside this Agreement.

21. Authority

The signatories of this Agreement, by their signatures below, represent that they have the authority to enter into this Agreement and applicable laws, rules, and

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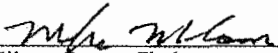
**BOARD OF COUNTY COMMISSIONERS
OF VALENCIA COUNTY, NEW MEXICO**



Gerard Sainz, Chair

Date: 02-18-2026

ATTEST:



Mike Milam, County Clerk



Memorandum of Agreement between Cibola, Sandoval and
Valencia Counties for Implementation of SB3
Page 9 of 10



regulations have been complied with.

22. Duplicate Originals

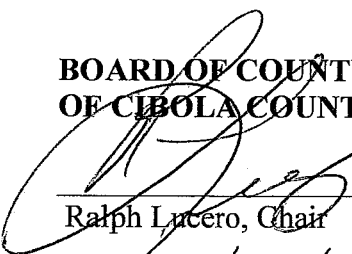
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IN WITNESS WHEREOF, the parties have executed this Agreement as of the date of last signature below.

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[SIGNATURES APPEAR ON THE FOLLOWING PAGES]

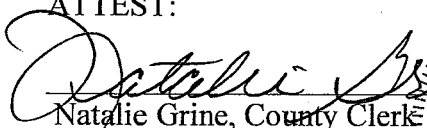
**BOARD OF COUNTY COMMISSIONERS
OF CIBOLA COUNTY, NEW MEXICO**



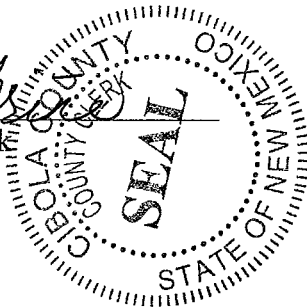
Ralph Lucero, Chair

Date: 2/26/2026

ATTEST:



Natalie Grine, County Clerk



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Tribal Plans

Pueblo of Laguna
Submission



Pueblo of Laguna of Support for Cibola County - Regional Planning Accountable Entity for Region 13

June 18, 2026

To: Cibola County, Accountable Entity

Dear County Manager Kate Fletcher:

As an identified representative of Pueblo of Laguna, we are pleased to submit this Letter of Support for the Region 13 Behavioral Health Collaborative Planning process and to confirm our organization's willingness to participate in and support Cibola County as the lead coordinating entity for Region 13.

We recognize the importance of this collaborative effort across Cibola, Valencia, and Sandoval counties, including the tribal nations and pueblos within the region. We support Cibola County's role as the accountable entity under the State's Behavioral Health Reinvestment Initiative, which requires identifying a lead partner, convening a stakeholder group, and establishing five regional behavioral health priorities to guide funding and services.

Pueblo of Laguna is eager to participate in this process, contribute insight from our experience in behavioral health and community engagement, and help shape a plan that ensures accessible, coordinated, and effective care.

We appreciate the opportunity to collaborate with Cibola County and regional partners and look forward to contributing to a shared vision for behavioral health in Region 13.

Regards,

A handwritten signature in blue ink, appearing to read "Harry A. Antonio, Jr.", is positioned above the printed name.

Harry A. Antonio, Jr., Governor

cc: Administrative Office of the Court
Brandon Herrera, Chief of Operations
Behavioral Health Manger

David Deutsawe
Tribal Secretary

Angela F. Duran
Executive Assistant



OFFICE OF THE TRIBAL SECRETARY

June 17, 2026

Ramona Dillard, Community Health & Wellness Director
Stuart Jones, Behavioral Health Manager
P.O. Box 194
Laguna, New Mexico 87026
Electronic Delivery: rdillard@pol-nsn.gov & sjones@pol-nsn.gov

RE: Staff Officers Resolution No. 24-26

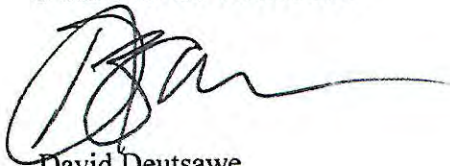
The Pueblo of Laguna extends its gratitude for your presentation to the Staff Officers regarding your request for ***“Approval to submit the Strategic plan as a proposal as part of the New Mexico Senate Bill 3 (SB3) Behavioral Health Reform and Investment Act application, to receive funds under the State funded grant, as part of the NM geographic area, Region 13, to expand Behavioral Health - Prevention Services within the Pueblo of Laguna”*** is attached for your records.

We sincerely appreciate the time and effort you have contributed to these initiatives. We also wish you continued good health and success.

Should you have any questions or require further assistance, please do not hesitate to contact my office.

Sincerely,

PUEBLO OF LAGUNA



David Deutsawe
Tribal Secretary



PUEBLO OF LAGUNA STAFF OFFICERS

Resolution No. 24-26

Re: Approval to submit the Strategic plan as a proposal as part of the New Mexico Senate Bill 3 (SB3) Behavioral Health Reform and Investment Act application, to receive funds under the State funded grant, as part of the NM geographic area, Region 13, to expand Behavioral Health-Prevention Services within the Pueblo of Laguna.

At a duly called meeting of the Pueblo of Laguna Staff Officers held on the 16th day of June, 2026, the following resolution was adopted.

WHEREAS, the Pueblo of Laguna ("Pueblo") is a federally recognized Indian Tribe with a constitution and all the inherent governmental power of a sovereign; and

WHEREAS, the Pueblo of Laguna Council (Council) is the governing body of the Pueblo, with the authority and responsibility to ensure the safety and welfare of the members and community; and

WHEREAS, Article IV§ 2(c) of the Pueblo of Laguna Constitution, authorizes the Pueblo to negotiate and enter into contracts with Federal, State, and Local Governments; and

WHEREAS, the Pueblo of Laguna Council has delegated the authority to the Pueblo of Laguna Staff Officers to approve the submission of grant and contract applications and proposals to outside funding sources for services, operations and special projects of the Pueblo of Laguna through Resolution 16-11; and

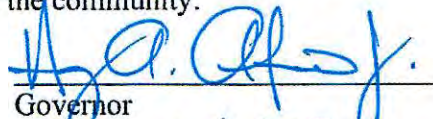
WHEREAS, the purpose of the (SB3) Behavioral Health Reform and Investment Act is created to support leaders, service providers, and community members to learn about behavioral health, understand the New Mexico Behavioral Health Reform and Investment Act (SB3), and identify ways to participate in the SB3 planning, coordination, implementation; and

WHEREAS, the SB3 Behavioral Health Reform and Investment Act, creates a pathway for Tribal participation in regional behavioral health planning, supports efforts to expand access in rural and remote areas. Encouraging coordination across systems (health, behavioral health, crisis, justice), strengthening the continuum of care, including providing prevention, recovery support, and promotes workforce development and integrated care; and

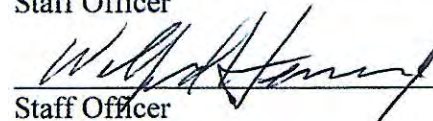
WHEREAS, the Laguna Behavioral Health seeks approval to submit the POL SB3 Plan via an application process; for supporting improvements within our behavioral health program, the expansion of services will promote infrastructure, continuity of care, healthier lifestyle, a balance of Mind, Body and Spirit through our cultural/traditional values, evidence base practices, by promoting the healing of our people and communities; and

NOW, THEREFORE, BE IT RESOLVED, through this request that Staff Officers hereby authorize the participation in this funding for expansion of services for the BHS – Prevention Service Program through the SB3 planning/application process; and

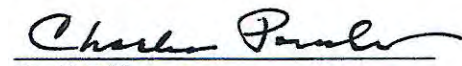
BE IT FURTHER RESOLVED, that Staff Officers direct and authorize the Governor, Treasurer, Chief Financial Officer and Chief of Operations to execute any documents and take any actions necessary to submit the SB3 strategic plan for funding towards the expanding of services to fulfill its purpose of providing care for the people of the community.

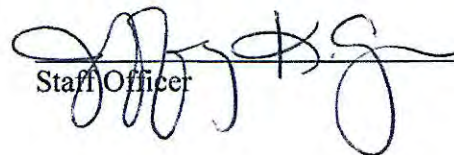

Governor


Staff Officer


Staff Officer


Staff Officer

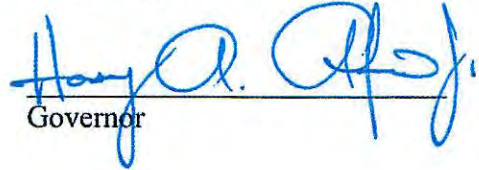

Staff Officer

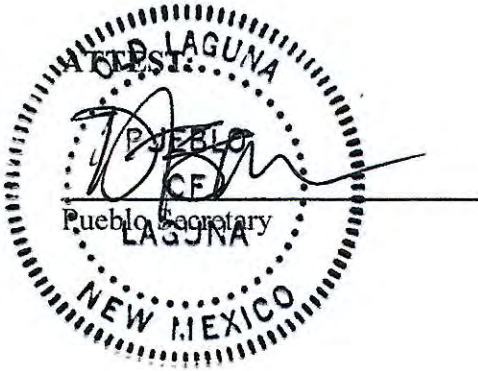

Staff Officer



CERTIFICATION

The foregoing resolution was enacted upon by the Pueblo of Laguna Staff Officers on the 16th day of June, 2026, by a vote of 6 for, and 0 opposed, at a duly called meeting at which a quorum of the Staff Officers was present.


Governor





Pueblo of Laguna Priority Plan

Region 13 Priority category:

Care Coordination, Navigation, and Continuity of Care

Priority Title and Description

Priority 1: Expansion of Behavioral Health Healing and Prevention Services – Seek to obtain property, expand infrastructure (purchase of modular building), host culturally based practices through holistic, experiential and community centered traditions of our Pueblo/traditional ways in life, serving all individuals and six communities in the Pueblo of Laguna.

Priority 2: Policy – Seek to identify where current policies that create undue barriers to service access and provision and to make recommendations or changes, if possible, to increase access and enhance continuity of care.

Demonstration of Need

Within our tribal communities, the barriers of not having transportation, lack of technology infrastructure and affordable equipment (computers, Wi-Fi), and the continuum of substance use related/mental health concerns impact our tribal communities, families and people. As a behavioral health unit in the Pueblo of Laguna, the process of having individuals seek treatment are minimal to moderate. The process is only focused on the individual, who is identified as the person with concerns, and is based in western mental health philosophy. As research has identified in our Native American population, the root cause is historically deep-rooted into our communities. Historical trauma was a life changer for all Native American Tribes. The process of forced assimilation resulted in devastating changes in our culture. From not being able to speak our language to rupturing traditional spiritual practices, these imposed mandates have caused severe damage to our family systems and cultural identity. From a Pueblo perspective, the Spanish invasion led to slavery that was unwillingly bestowed on our people and followed by death and torture. The continuum continued after the invasion within our Tribes through generational trauma. From the boarding school era, to the forced policies by the federal government, to the loss of life and culture still impact our lives in Indian Country. The implanted and modeled behaviors that are associated with past traumatic experiences continue, and continues to impact Tribal communities today.



In addressing these traumatic moments in life, the current results of these assimilative matters exposed our future generations. In order to prevent these impacts of intergenerational trauma from diminishing our people through death, addiction, and mental illness. The purpose of re-visiting our roots as Native People must be reconnected to positively enhance our cultural identity.

The expansion and enhancement of our prevention program can make a major difference towards the solution of creating a positive environment for our communities, People, family systems, and our future.

In the continued healing of the Laguna Pueblo community through adding additional space (e.g. modular building infrastructure) for our prevention activities, taking the teachings of our ancestors and elders in educating our communities and People on the impacts on how these traumatic moments infected and became a normalized belief in our generational systems are imperative to healing. In order to heal, we all must learn the root causes by processing our emotions that are a result of these traumatic events.

The building will be dedicated to hosting specific therapeutic groups utilizing various therapeutic modalities that are focused on mindfulness and trauma informed care by our Licensed Professional Therapist. The protection and confidentiality of participants is also predominant factor. The building will be used for additional teachings for all age groups, by providing psycho-educational groups. These groups will be evidence-based initiatives designed to reduce risks and promote protective factors, aiming to prevent health issues, substance misuse, and violence before they begin. As part of the process, the implementation of values of our Pueblo culture through the teachings of our traditional ways will be infused. The purpose is to include our roots from a positive view, leading to our identity as Pueblo people. The process would include our traditional arts, cultural cooking/baking, storytelling by our elders, and language.

As we strengthen our connection with our people, we also build trust and honesty with our people and communities. The vision is to extend our services to our six villages and other local communities within the boundaries of the Pueblo of Laguna. Including schools (early childhood, headstart, elementary, middle and high schools), tribal entities/organizations, and other across the lifespan resources.



Expansion of services increases the process of reaching out to our people, known as outreach. The process helps, educate, and support specific groups (e.g., elderly, low-income, or disabled individuals) to improve their well-being, provide essential resources, or enhance awareness of services. Our goal is to support the process of healing our communities and people. By reaching out, the continuity of services will provide the teachings through preventative measures that will create a much safer and more positive environment for our future generations.

Project Name and Description

Project: Modular Building: To expand healing and prevention services to our communities in the Pueblo of Laguna.

Target Population	POL Communities & People
Sampling	<ul style="list-style-type: none"> • Stratified Sampling
Evaluation Approach and Methods	<ul style="list-style-type: none"> • Impact Evaluation
Data Collection	<ul style="list-style-type: none"> • Quantitative Methods
Implementation Timeline:	<ul style="list-style-type: none"> • Quarterly
Contacts for Annual Progress Updates	Stuart Jones, 505.552.6654

Budget Justification

I. Budget Category	Total Cost (\$)	Purpose & Justification
Personnel & Administrative Costs		Describe key staff roles and administrative supports essential to project management (e.g., clinicians, coordinators, fiscal oversight, reporting) explain how these positions sustain or expand behavioral health access
Direct Services	Policy: No cost	Identify services to be launched or expanded (e.g., MAT program, residential beds, crisis response)
Training & Workforce Development		Summarize how funds will build or strengthen the workforce (e.g., provider training)
Infrastructure & Equipment	Prevention Program: Extension of Service, to purchase a Modular Building.	Include technology, facility upgrades, or essential equipment that enables service delivery



	Building: \$500,000.00 Technology: \$5,000.00 Equipment: \$7,500.00 Total= \$512,500	
Operational Costs		Describe costs directly tied to daily operations and program delivery (e.g., facility expenses, communications, supplies, data systems, IT maintenance, or service coordination)
Evaluation & Performance Tracking		Describe how evaluation activities (e.g., data collection, reporting, performance measurement) will demonstrate outcomes and inform sustainability
Other		

Santo Domingo Submission

**Tribal Regional Plan Priority
Santo Domingo Pueblo
Kewa Family Wellness Center**

Priority Title and Description

- Priority 1: Social Detox: Increase utilization of evidenced based social detox for Santo Domingo Pueblo tribal members, through addition of 1.0 FTE Client Navigator
- Priority 2: Mobile Crisis Response: Increase behavioral health clinical expertise of the Santo Domingo Mobile Crisis Team through expanding team membership and structure to include a dedicated licensed mental health clinician.
- Priority 3: Navigation and Access: Behavioral Health focused CHR Comprehensive Home visits to screen and address social determinants of health (SDOH), Depression, Anxiety, and substance use/misuse using validated screening tools.

Demonstration of Need

Santo Domingo Pueblo is a rural, geographically isolated tribal community in Sandoval County, New Mexico, where the convergence of historic oppression, systemic poverty, and the opioid and methamphetamine crises has produced a behavioral health burden that significantly outpaces the Pueblo's current service infrastructure.

Substance Use Disorder remains the most acute and immediate driver of need. New Mexico consistently ranks among the highest states nationally for drug overdose mortality, and AI/AN communities bear a disproportionate share of this burden. KFWC operates at or near capacity across its treatment components, with a persistent inability to manage transition points between acute stabilization, residential placement, and aftercare. Thus resulting in preventable treatment failures at the moments clients are most vulnerable.

Mental Health need is substantial and substantially under identified. AI/AN individuals experience serious psychological distress, PTSD, depression, and suicidality at rates well above national averages, yet are significantly less likely to receive treatment. The majority of Pueblo members with behavioral health needs never present to KFWC, not because need is absent, but because they are never identified or connected to care through a culturally trusted pathway.

Crisis Response gaps are concrete and consequential. CIRT currently operates without an embedded licensed clinician, limiting the team's ability to conduct psychiatric risk assessments, initiate evaluation processes, or provide clinical documentation in the field, resulting in unnecessary ED transports and lost engagement opportunities.

Social Determinants of Health: poverty, housing instability, food insecurity, and transportation barriers are active drivers of behavioral health burden and among the primary mechanisms by which treatment referrals fail to produce treatment engagement.

Workforce and infrastructure deficits limit KFWC's ability to expand. Inadequate physical space, no dedicated data analytical capacity, and chronic difficulty recruiting licensed clinicians to a rural tribal setting constrain service delivery despite strong organizational capacity and community trust.

The behavioral health needs of Santo Domingo Pueblo's community members are severe, multidimensional, and imperfectly matched by the current configuration of KFWC's service infrastructure. The priority areas addressed by this project plan (social detox navigation, mobile crisis clinical expansion, community-based BH screening and outreach, physical infrastructure, and data capacity) were not selected arbitrarily. They were identified through the direct clinical experience of KFWC staff working daily at the intersection of community need and program limitation, through analysis of national, state, and local epidemiological data, through the Pueblo's own governmental priorities for health and wellness, and through the concrete, observable gaps in the continuum of care that result in preventable treatment failures, repeated crisis contacts, and unmet need across the behavioral health spectrum. This proposal represents KFWC's most targeted and evidence-grounded effort to close those gaps and move toward a more complete, culturally responsive, and sustainable continuum of behavioral health care for the Kewa Pueblo community.

Project Name and Description

1: Social Detox — Client Navigator (1.0 FTE)

Target Population

The primary target population is Santo Domingo Pueblo community members presenting with acute or chronic substance use disorders who require coordinated access to social detoxification services, inpatient or residential treatment, and post-discharge step-down supports. This population disproportionately presents with co-occurring medical and behavioral health conditions, unstable housing, limited transportation, and significant systemic barriers to engaging with off-Pueblo treatment systems. Secondary beneficiaries include family members and household units of individuals in active recovery, as well as IHS-eligible beneficiaries served by the Kewa Family Wellness Center (KFWC) who are engaged across multiple program areas simultaneously and require coordinated navigation to avoid gaps, duplication, or loss to follow-up.

Evaluation Approach and Methods/Timeline: A mixed-methods evaluation framework will be used, combining quantitative service utilization metrics with qualitative client experience data

collected at key program milestones. The Client Navigator will maintain a standardized case registry tracking all active navigation episodes, including referral source, presenting need, services coordinated, and disposition. Process measures will be assessed quarterly and include: number of individuals navigated into social detox or residential placement, average time from intake contact to placement, percentage of clients with completed warm hand-offs to step-down services, and 30 and 90-day post-placement contact rates. Outcome measures assessed semi-annually will include: rate of successful transition to outpatient or aftercare programming, and client-reported satisfaction with navigation services. Interim evaluation reports will be produced at 6 and 12 months, with a full end-of-year program evaluation submitted to KFWC leadership and the funding agency.

Data Collection

The Navigator will utilize KFWC's existing electronic health record (EHR) system for all clinical documentation and will maintain a supplemental Navigator-specific tracking spreadsheet capturing variables not routinely collected in the EHR, including referral outcomes, placement wait times, and barriers encountered. Client consent for data collection will be obtained at initial contact and documented in the clinical record. De-identified aggregate data will be compiled monthly by the Navigator and submitted to the project Data Analyst for integration into the program-wide evaluation dashboard. Qualitative data will be collected through brief structured exit interviews administered at case closure, using a standardized instrument developed during the project's first 60-day implementation phase. All data collection procedures will comply with HIPAA, 42 C.F.R. Part 2, and applicable tribal privacy policies.

2: Mobile Crisis — Expand CIRT Team with Licensed Mental Health Clinician

Target Population

The target population is Santo Domingo Pueblo community members of all ages experiencing acute behavioral health crises, including psychiatric emergencies, acute suicidality, substance-induced crises, and trauma-related acute destabilization, who are encountered by the Community Incident Response Team (CIRT) in field or community settings. This population frequently includes individuals who have not engaged with traditional clinic-based behavioral health services and who present in non-clinical environments; homes, schools, public spaces, or in coordination with SDP-EMS and law enforcement. Special emphasis is placed on youth and adolescents, individuals with prior psychiatric hospitalizations, and community members with co-occurring SUD and serious mental illness (SMI) who cycle through crisis contacts without connection to sustained treatment. The expanded CIRT structure will increase KFWC's capacity to respond to this population with clinical-level assessment and intervention at the point of crisis, rather than defaulting to emergency transport or law enforcement resolution.

Evaluation Approach and Methods/Timeline

Evaluation will assess both process fidelity and clinical outcomes across the project period. Process metrics tracked monthly will include: total CIRT activations, proportion of activations involving the licensed clinician, and proportion of crisis contacts resolved in the community without emergency department transport or law enforcement involvement. A pre/post comparison will be conducted at 6 and 12 months comparing CIRT Behavioral Health Intervention's levels of Compassion Satisfaction and Fatigue using the validated Professional Quality of Life Scale (ProQOL) from the period prior to clinician expansion versus the project period. The licensed clinician will participate in monthly peer consultation or supervision with KFWC's clinical leadership to support fidelity to evidence-based crisis intervention models and maintain documentation standards.

Data Collection

All CIRT activations will be documented using a standardized CIRT encounter form capturing presenting concern, interventions provided, risk assessment findings, disposition, and follow-up plan. The licensed clinician will complete all documentation in the EHR within 24 hours of each encounter. De-identified CIRT encounter data will be submitted monthly to the Data Analyst for trend analysis and dashboard reporting. Aggregate data on ED diversion rates will be collected in coordination with SDP-EMS using existing transport records.

3: Navigation and Access — Behavioral Health-Focused CHR

Target Population

The primary target population is Santo Domingo Pueblo community members who are not currently engaged with KFWC or other behavioral health services but who are at elevated risk for behavioral health conditions, particularly depression, anxiety, trauma-related disorders, and substance use disorders, as identified through community-based outreach. This population includes individuals who face significant barriers to clinic-based care: transportation, stigma, work or caregiving obligations, prior negative experiences with health systems, or limited health literacy, and who are more likely to be reached through trusted community-based contacts such as the Community Health Representative (CHR) program. Secondary target populations include current KFWC clients who have disengaged from treatment, individuals recently discharged from inpatient or residential programs who require proactive outreach to prevent relapse or re-crisis, and household members of active clients who may be experiencing secondary impacts of a family member's behavioral health condition. The BH-focused CHR role bridges the gap between community-level public health outreach and formal clinical services by embedding behavioral health screening and social determinants of health (SDOH) assessment within a trusted, community-integrated CHR service model.

Evaluation Approach and Methods/Timeline

Evaluation will focus on the CHR's effectiveness as a point of detection, engagement, and warm linkage to behavioral health services. Process metrics tracked monthly will include: number of home visits completed, number of individuals screened using validated instruments (PHQ-9, GAD-7, AUDIT-C, and an SDOH screening tool such as PRAPARE or AHC-HRSN), proportion of screens indicating elevated risk, and proportion of elevated-risk individuals successfully linked to KFWC within 14 days. Outcome metrics assessed semi-annually will include: rate of follow-through on referrals generated through CHR visits, including addressing the SDOH needs at 90-day follow-up. Evaluation reports will be prepared at 6 and 12 months.

Data Collection

The BH-focused CHR will document all home visits and community contacts using a structured CHR encounter form within the EHR that includes SDOH screening results, validated behavioral health screening scores, identified needs, referrals made, and follow-up plan. Validated screening tools (PHQ-9, GAD-7, AUDIT-C) will be administered verbally or on paper per client preference and scored at the time of visit, with scores entered into KFWC's EHR. Referral outcomes will be tracked through coordination with the Patient/Client Navigator and KFWC intake staff. Aggregate anonymized SDOH data will be compiled quarterly and submitted to the Data Analyst for integration into the program evaluation dataset. All data collection will comply with applicable privacy regulations and tribal data governance policies.

4: Expanded Office Space for New Staff: Construction

Target Population

The direct beneficiaries of expanded office space are the new staff positions funded under this grant initiative — the Patient/Client Navigator, licensed mental health clinician embedded with CIRT, BH-focused CHR, and Data Analyst — all of whom require dedicated, private, clinically appropriate workspace to perform their functions in compliance with HIPAA, 42 C.F.R. Part 2, and applicable accreditation standards. The indirect and ultimate beneficiaries are the Santo Domingo Pueblo community members served across all priority areas of this project, whose access to services, confidentiality, and quality of care depend on KFWC's physical capacity to accommodate expanded staffing without compromising existing service delivery. Current KFWC facility space is at capacity, and the addition of new clinical, navigation, and data staff without corresponding infrastructure expansion would create documented risks to service quality, confidentiality compliance, and staff safety — particularly for crisis intervention and social detox navigation functions that require private communication and documentation environments.

Evaluation Approach and Methods/Timeline

Construction progress will be tracked against a project timeline developed in coordination with the selected contractor, with milestone benchmarks established at contract execution, 25%, 50%, 75%, and 100% completion. KFWC leadership will conduct monthly progress reviews with the contractor and document any scope changes or timeline deviations. Upon completion, a functional assessment will verify that all new spaces meet applicable confidentiality, accessibility (ADA), and clinical environment standards prior to occupancy.

Data Collection

Construction documentation will include: executed contractor agreement, project timeline and milestone records, and any change orders or scope modifications with associated cost documentation. All construction expenditures will be tracked in KFWC's financial management system and reported as required under the grant agreement.

5: Data Analyst (1.0 FTE) — Cross-Project Evaluation and Data Collection

Target Population

The Data Analyst position serves all KFWC programs and all populations reached through this grant initiative — directly supporting the Patient/Client Navigator, CIRT licensed clinician, BH-focused CHR, and program leadership by providing the analytical infrastructure necessary to measure, monitor, and improve services across each priority area. The ultimate beneficiaries are the Santo Domingo Pueblo community members whose health outcomes depend on KFWC's ability to identify service gaps, track program effectiveness, respond to emerging trends, and report credibly to funding agencies. The position also supports the Pueblo's broader health data sovereignty interests by building internal analytical capacity rather than relying on external or IHS-administered data systems for program evaluation.

Evaluation Approach and Methods/Timeline

The Data Analyst will design and maintain a unified program evaluation dashboard aggregating data from all four clinical/service priority areas into a single reporting structure, enabling cross-program trend analysis and integrated outcome reporting. Within the first 60 days, the Analyst will conduct a data infrastructure assessment: inventorying existing data collection tools, EHR capabilities, and reporting gaps, and will then develop a Program Evaluation Plan that specifies indicators, data sources, collection frequency, and reporting formats for each priority area. Quarterly evaluation reports will be produced for internal KFWC leadership review, and semi-annual summary reports will be prepared for submission to the funding agency. The Analyst will lead the design of all evaluation instruments (encounter forms, client satisfaction surveys, exit interviews) developed under this grant and will coordinate their implementation across program areas. An end-of-year comprehensive program evaluation report will be produced at

the close of the project period, summarizing progress toward all stated goals and outcomes, data quality observations, and recommendations for program refinement.

Data Collection

The Data Analyst will establish and maintain a secure, de-identified program database drawing from EHR exports, Navigator case logs, CIRT encounter forms, and CHR screening records submitted monthly by each program area. Data quality audits will be conducted quarterly to identify missing data, entry errors, or inconsistencies across sources. The Analyst will work with KFWC's EHR to maximize use of existing system reporting functions and reduce manual data entry burden on clinical staff. All data will be stored in compliance with HIPAA, 42 C.F.R. Part 2, and applicable tribal data governance and privacy policies. Aggregate, de-identified data sets will be used for all external reporting; no individually identifiable information will be transmitted to the funding agency. The Analyst will also coordinate with IHS data systems (RPMS/GPRA) to align internal program metrics with federally required reporting indicators where applicable.

Budget and Justification

Total Request:

- **Year 1: \$718,605.32 (see below for detailed justification)**
- **Year 2: \$423,071.98 (ongoing personnel costs with 5% COLA)**
- **Year 3: \$438,358.44 (ongoing personnel costs with 5% COLA)**

Personnel Costs

Patient/Client Navigator (1.0 FTE) \$58,000 This position is essential to the operational integrity of the Social Detox priority area and serves as the connective tissue across all five project components. The Navigator will manage active referral and placement coordination for individuals requiring social detoxification or residential treatment, execute warm hand-offs to step-down services, and maintain longitudinal contact with clients across program transitions. In a community where transportation barriers, limited broadband access, and distance from off-Pueblo treatment facilities create significant attrition risk at every transition point, a dedicated Navigator positioned within KFWC, trusted by the community and familiar with both tribal and external provider systems, is not duplicative of existing clinical staff but fills a documented structural gap. This position directly expands behavioral health access by reducing time-to-placement and increasing the proportion of referred individuals who successfully engage with recommended services.

Licensed Mental Health Clinician CIRT (1.0 FTE) \$82,000 The addition of a licensed mental health clinician to the Community Incident Response Team (CIRT) represents the most clinically significant workforce expansion in this budget. CIRT currently responds to acute community

behavioral health crises without embedded clinical expertise capable of conducting structured psychiatric risk assessments, initiating involuntary evaluation processes, or providing evidence-based crisis stabilization interventions at the point of contact. This gap results in over-reliance on emergency transport, law enforcement involvement, and costly ED utilization for crises that could be safely resolved in the community with appropriate clinical support. The licensed clinician position directly addresses this gap, enabling real-time risk stratification, clinical documentation, and same-day linkage to KFWC services. Salary reflects New Mexico licensure-level compensation (LCSW, LPCC, or equivalent) consistent with current regional market rates for licensed behavioral health practitioners in tribal settings.

BH-Focused Community Health Representative (1.0 FTE) \$47,840: This position operationalizes the Navigation and Access priority area by embedding behavioral health screening and SDOH assessment within the trusted CHR outreach model. The BH-focused CHR will conduct comprehensive home visits using validated screening instruments (PHQ-9, GAD-7, AUDIT-C, PRAPARE) to identify unmet behavioral health needs among community members not currently engaged with clinic-based services. This role is intentionally positioned at the intersection of public health outreach and behavioral health access — reaching individuals who would not otherwise present to KFWC — and is expected to generate significant new engagement with KFWC's existing clinical programs. Compensation reflects the CHR pay scale consistent with IHS CHR program standards and KFWC's existing compensation structure.

Data Analyst (1.0 FTE) \$62,000: A dedicated Data Analyst necessary for the project to ensure that all priority areas will generate consistently formatted data that can be meaningfully aggregated, analyzed, and reported against grant performance measures. The Data Analyst will design and maintain the unified program evaluation dashboard, conduct quarterly data quality audits, produce interim and final evaluation reports, and coordinate with KFWC's EHR administrator and Microsoft based data tools. This position also builds permanent internal data infrastructure that will outlast the grant period, directly supporting KFWC's long-term capacity to demonstrate program outcomes to current and future funders.

Fringe Benefits (24.51%): \$61,235,78 The fringe rate of 24.51% is consistent with KFWC's current approved fringe benefit rate and covers FICA, health insurance, retirement contributions, workers' compensation, and unemployment insurance for all grant-funded positions.

Supplies \$12,500

Covers essential workstation equipment and office setup for four new FTE positions. Includes \$3,000 per FTE for computer stations to support EHR access, documentation, and data management functions; \$500 per FTE for cell phones necessary for field communication and crisis coordination; \$2,000 for workstation desks; and \$2,500 in miscellaneous program supplies

including printing, screening materials, and office consumables directly tied to daily program operations.

Cell Phone Service \$2,064

Monthly cell service at \$43/month per FTE for four positions (\$172/month; \$2,064 annually). Field-based staff including the BH-focused CHR, Patient/Client Navigator, and CIRT clinician require reliable mobile communication for home visits, crisis response coordination, warm hand-offs, and same-day client contact. This rate reflects a standard tribal government mobile plan.

Travel and Training \$14,000

\$3,500 per FTE allocated for professional development, licensure-required continuing education, evidence-based practice training (trauma-informed care, motivational interviewing, crisis intervention), and conference participation. Workforce development is essential to maintaining clinical quality standards and supporting licensure progression for new staff in a rural tribal setting with limited local training infrastructure.

Vehicle Gas \$3,600

\$300/month to cover fuel costs for community-based program operations including CHR home visits, Navigator client transport accompaniment, CIRT field response, and community outreach activities. Transportation is a non-negotiable operational requirement given Santo Domingo Pueblo's rural location and the community-facing nature of three of the four new positions.

Vehicles \$94,000

Program vehicles dedicated to the Patient/Client Navigator and the Behavioral Health CHR positions, both required for the mobile nature of their respective scopes of work. The Navigator's core function coordinating and accompanying clients through social detox placement, residential treatment intake, and community-based transitions requires reliable, dedicated transportation. Santo Domingo Pueblo's rural location and the absence of public transportation options make a dedicated vehicle not a convenience but a clinical necessity; without it, the neither position can fulfill their primary function of closing the identified treatment gaps. The BH-CHR's primary function will be conducting comprehensive home visits throughout Santo Domingo Pueblo to administer behavioral health and SDOH screenings, deliver prevention education, and link community members to KFWC services and is entirely field-based and cannot be performed without reliable, dedicated transportation. Sharing a vehicle with the Patient/Client Navigator is not operationally viable. Both positions require simultaneous, independent access to transportation on a daily basis.

Remodel / Office Construction \$150,000

KFWC's current facility is at physical capacity and cannot accommodate four new FTE positions without displacing existing clinical operations or violating HIPAA and 42 C.F.R. Part 2 confidentiality requirements. Private, soundproofed workspace is a regulatory and clinical standard (not optional) in a behavioral health setting where substance abuse records, crisis documentation, and sensitive case navigation occur daily. Construction costs cover renovation of existing KFWC controlled space including materials, labor, permitting, and tribal inspection, and represent a one-time infrastructure investment that will sustain expanded program capacity beyond the grant period.

Region 13 BHRIA Budget		
Agency Name:	Kewa Family Wellness Center	
Agency Contact:	Lucas O'Laughlin	
Project Title:	Tribal Project Plan	
Expenditure Category	Project Total Cost Yr1	Detailed Description
Personnel Costs		
Salaries & Wages	\$ 249,840.00	Description and breakdown in Detailed Personal Tab
Payroll Taxes and Employee Benefits	\$ 61,235.78	Description and breakdown in Detailed Personal Tab
Total Personnel Costs	\$ 311,075.78	
Operating Costs * – Direct		
Supplies	\$ 12,500.00	\$3,000 for computer station per FTE, \$500 Cell Phone/FTE, \$2,000 for desks, \$2,500 misc
Cell Phone Bill	\$ 2,064.00	\$43/mo per FTE
Travel and Training	\$ 14,000.00	\$3,500 per FTE
Vehicle Gas	\$ 3,600.00	\$300/mo for gas
Vehicle	\$ 94,000.00	Vehicles for Patient Navigator and CHR (\$47,000 each)
Remodel to add new offices	\$ 150,000.00	Necessary to accommodate new staff members
Total Operating	\$ 276,164.00	
Total Direct Costs (Personnel & Operating)	\$ 587,239.78	
TOTAL Indirect Costs:	\$ 131,365.54	22.37%
Total Project Expenses	\$ 718,605.32	

Personnel Detail:

FTE on Project	Base Salary	Position Title	Position Total Salary
1.00	58,000.00	Client Navigator	58,000.00
1.00	47,840.00	Clinician	82,000.00
1.00	82,000.00	BH CHR	47,840.00
1.00	58,000.00	Data Analust	62,000.00
Salaries & Wages this Page			249,840.00
Payroll Taxes and Employee Benefits			61,235.78
Total Personnel Costs			311,075.78

	Salary and Wage		
Fringe Calculations	\$ 249,840.00	7.65%	\$ 19,112.76
FICA	\$ 249,840.00	2.56%	\$ 6,395.90
Workers Comp	\$ 249,840.00	3.00%	\$ 7,495.20
Pension	\$ 249,840.00	5.00%	\$ 12,492.00
health Insurance	\$ 249,840.00	1.23%	\$ 3,073.03
Unemployment	\$ 249,840.00	0.54%	\$ 1,349.14
Dental	\$ 249,840.00	0.61%	\$ 1,524.02
Vision	\$ 249,840.00	1.96%	\$ 4,896.86
Life	\$ 249,840.00	1.96%	\$ 4,896.86
Accident			\$ 61,235.78

Tribal Priorities will need to be added to the Regions Plan and submitted to the Executive Committee for Approval. However, because there is a separate Tribal Allocation, these dollars may be accessed at any time across a fiscal year. To note, if the money is not used it will revert back to the Behavioral Health Trust Fund.