MINUTES
of the
EIGHTH MEETING
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

November 1, 2017
State Capitol, Room 317
Santa Fe

November 2, 2017 — Opioid Crisis Response Summit
Santa Fe Convention Center
201 W. Marcy St.
Santa Fe

November 3, 2017
State Capitol, Room 317
Santa Fe

The eighth meeting for the 2017 interim of the Legislative Health and Human Services Committee (LHHS) was called to order on November 1, 2017 by Representative Deborah A. Armstrong, chair, at 9:20 a.m. in Room 321 of the State Capitol. A quorum was present**.**

Present
Rep. Deborah A. Armstrong, Chair
Sen. Gerald Ortiz y Pino, Vice Chair
Rep. Gail Armstrong
Rep. Rebecca Dow (11/1)
Sen. Mark Moores
Sen. Bill B. O'Neill
Sen. Cliff Pirtle (11/3)

Absent
Rep. Elizabeth "Liz" Thomson

Advisory Members
Rep. Joanne J. Ferrary
Rep. Miguel P. Garcia
Sen. Linda M. Lopez (11/2)
Sen. Cisco McSorley (11/2, 11/3)
Sen. Howie C. Morales (11/1)
Sen. Nancy Rodriguez (11/2)
Rep. Nick L. Salazar (11/1, 11/3)
Sen. William P. Soules
Sen. Elizabeth "Liz" Stefanics
Sen. Bill Tallman
Rep. Christine Trujillo

Sen. Gay G. Kernan
Rep. Tim D. Lewis
Rep. Rodolpho "Rudy" S. Martinez
Sen. Mary Kay Papen
Rep. Patricia Roybal Caballero
Rep. Angelica Rubio

Guest Legislators
Rep. D. Wonda Johnson (11/1, 11/2)
Sen. James P. White (no per diem requested)

(Attendance dates are noted for members who did not attend the entire meeting.)

Staff
Michael Hely, Staff Attorney, Legislative Council Service (LCS)
Karen Wells, Contract Staff, LCS

Guests
The guest list is in the meeting file.

Handouts
Handouts and other written testimony are in the meeting file.

Wednesday, November 1

Welcome and Introductions
Committee members and staff introduced themselves.

Rio Arriba Behavioral Health Investment Zone Update
Lauren Reichelt, director, Department of Health and Human Services (RAHHS), Rio Arriba County, described a grant for behavioral health investment zones (BHIZs), of which Rio Arriba County is a grantee. The grant in Rio Arriba County has two goals: 1) to reduce the death rate; and 2) to create an accountable care network using internet technology. The following outcome measures were reported: 85% of clients received case management follow-up within 30 days of discharge from an inpatient facility; 97% of clients with a diagnosis of alcohol or drug dependency received additional services within 30 days of the initial visit; and 77% of clients who received detox services completed the full seven days. Many additional services were implemented, including strong participation of law enforcement in crisis intervention, resulting in a significant reduction of incidents of overdoses. The RAHHS has introduced all clients into a database called "Pathways" to track the care and services provided among multiple entities. Case management services are recognized as foundational to recovery. A medication-assisted treatment (MAT) task force is beginning in November. The RAHHS has introduced efforts to increase public awareness and understanding of opioid use disorder as a chronic disease. Rio Arriba County was featured in a PBS NewsHour segment as a county that is employing best practices in all sectors to address addictions. Several powerful educational videos were shown to the committee that will hopefully air on television. Monica Griego, Sancre Productions, was introduced as the producer of the videos. She provided additional information about their creation and future distribution.

Ms. Reichelt noted that without the financial commitment of managed care organizations (MCOs), it will be impossible to identify fully the cost of *not* providing treatment. So far, the MCOs have been unwilling to participate, except for care coordination participation at meetings.

Committee members asked questions and made comments regarding the following:

- clarification regarding ways to avoid incarceration for pregnant women living with substance dependence; the goal is to care for them under house arrest with aggressive case management services;
- clarification of the other BHIZ grant in Gallup;
- acknowledgment that Medicaid is the only way to sustain the efforts and achievements already made in Rio Arriba County; participation and commitment from MCOs are crucial;
- clarification regarding anticipated markets for the videos — radio and TV — targeted to specific demographics;
- ways in which HOY Recovery Program, Inc., services have changed; HOY has grown from a simple sobering model to a very sophisticated, state-of-the-art program;
- encouragement to include access to breastfeeding for incarcerated mothers, once they deliver; Ms. Reichelt is hoping to create a video on this topic;
- recognition that senior citizens can become dependent upon prescription medications; the RAHHS conducts brown-bag medication reconciliation events to raise awareness about this issue;
- recognition that since substance dependence is multigenerational in nature, families should be included in treatment; this is difficult; case managers and behavioral health providers try to facilitate this, but families are often "burned out"; and
- encouragement to pursue national attention for the videos with help from the New Mexico congressional delegation to find funding.

Wayne Lindstrom, director, Behavioral Health Services Division (BHSD), Human Services Department (HSD), indicated his willingness to work with MCOs to gain their involvement in these initiatives in Rio Arriba County.

Primary Care Safety Net Update

Eileen Goode, chief executive officer (CEO), New Mexico Primary Care Association (NMPCA), introduced herself and described her background. She also described the membership of the NMPCA and outlined the presentation to be given.

David Roddy, health policy director and chief financial officer, NMPCA, offered statistics of the patients and clients served by primary care clinics in New Mexico, noting that 42% are covered by Medicaid and 26% have no insurance coverage at all. NMPCA clinics serve 62% of all New Mexicans living below 200% of the federal poverty level. A breakdown of the age, race and ethnicity of those served was presented. Of the 282 primary care clinics in the state, 80% are in rural areas. Mr. Roddy noted that in 2016, over $57 million was provided in

discounts to the uninsured and through uncompensated care. He reviewed staffing challenges and successes. He presented statistics regarding behavioral health data.

Ms. Goode discussed quality processes and tools being implemented in medical homes and through care coordination. She described health information and technology challenges, primarily due to cost and management. The NMPCA is creating a health-center-controlled network to promote integrated data management. Preliminary data reported through this network were presented. Robust outcome measures that are aligned with national Healthy People 2020 goals are being tracked and reported.

Mr. Roddy identified challenges for clinics in the areas of workforce, prescription drugs, the complexity of regulations, new payment methodologies and integration of behavioral health into clinics. Funding from the state's Rural Primary Health Care Act has declined by $6 million since 2016. He identified the serious impact that a tax on nonprofit entities would have on primary care clinics, as well as a projected loss of Medicaid patients due to program cutbacks. Ms. Goode noted that 70% of federal funding for federally qualified health centers (FQHCs) expired in September 2017. All National Health Service Corps (NHSC) funding will likewise expire if Congress fails to act. Finally, proposals previously considered to repeal and replace the federal Patient Protection and Affordable Care Act (ACA) would have a devastating impact on New Mexico primary care clinics.

Committee members had questions and made comments covering the following areas:

- whether the impact of proposed Centennial Care 2.0 revisions to establish co-payments and premiums would affect primary care clinics; the NMPCA is not opposed to co-payments philosophically; however, they would be expensive to implement; the NMPCA does oppose premiums, as it projects that 30% of beneficiaries would fall off Medicaid coverage; HSD revisions to the original proposals have mitigated these impacts somewhat;
- whether there are other proposed changes that would affect primary care clinics; the proposal to shift case management to providers would be welcome; reductions to dental access would be a serious problem and could increase costs to providers as well as patients;
- whether proposals for residency programs at primary care clinics are valuable; the NMPCA has concerns about the cost and scope of the proposals;
- clarification regarding the potential for a tax on nonprofits and the impact on primary care clinics;
- whether the NMPCA has made any plans for development of clinics in additional rural areas; it has been several years since this was done; by and large, clinics exist where they are sustainable;
- whether there is promise for mobile clinics in rural areas; it is possible but very costly and hard to sustain;

- whether there is congressional activity to fund or restore funding for threatened programs like the NHSC; a bill is expected to be presented this week; however, to fund the program, other prevention funds are proposed to be cut;
- whether vaccines are funded at FQHCs; yes, through the federal Vaccines for Children Program; this funding is coming from now-threatened prevention program funding;
- clarification regarding data-sharing for clinics that are not part of the network; the NMPCA obtains data from nonparticipating clinics and shares data internally; and
- clarification regarding the reduction in vaccinations; it is a reflection of changes to federal requirements for reporting and giving vaccinations.

Public Comment

Tracy Perry of Direct Therapy Services in Las Cruces commented on the impact of Centennial Care 2.0's proposed changes to therapy services, which will result in increased costs and decreased access to services. Although some of the changes are for services that are rarely used, they nonetheless are vital services and should not be eliminated.

Robert Kegel provided an historical review of programs and services provided to developmentally disabled persons in New Mexico from 1891 to the present. He proposed that the legislature appropriate at least $25 million to eliminate the waiting list for services and to provide adequate services to this vulnerable population.

Minutes

A motion was made and seconded to approve the LHHS minutes for October 4 and October 16-18, 2017 and to approve minutes for the Disabilities Concerns Subcommittee for September 29 and October 11, 2017. The motion was adopted without objection.

Report of the J. Paul Taylor Early Childhood Task Force; Early Childhood Screening

Andrew Hsi, M.D., M.P.H., F.A.A.P., professor, Department of Pediatrics, University of New Mexico (UNM) Health Sciences Center (HSC), and Matthew Bernstein, staff attorney, Pegasus Legal Services, were invited to address the committee.

Mr. Bernstein presented the findings of a report titled "Wellness Check-up", which calls for increasing the use of social-emotional screening to reduce the incidence of adverse childhood events (ACEs) and help parents understand what their children need in order to grow and thrive. He described social-emotional screening and identified its importance. Despite a federal mandate, New Mexico does not require this type of screening. There is no list of approved screening tools for providers, nor does Centennial Care 2.0 adequately promote screening. Pegasus has three recommendations to address this: 1) create an HSD-approved list of screening tools; 2) create an addendum to the current schedule for well-child visits to address social-emotional needs; and 3) improve the referral and provider structure for MCOs to lessen the burden on doctors regarding referral infrastructure. He noted that the full report is available online and will be posted on the legislature's website.

Dr. Hsi emphasized the importance of screening. As a pediatrician, he is aware of the impact of ACEs in the family home. Six out of 10 children in the state experience at least one ACE. Combined with a difficulty in dealing with social-emotional issues, this puts children at great risk. The goal of reducing ACEs for a child living at home with a parent who has a mental health issue relies on directing the parent to appropriate services and coordination of the parent's care with the social-emotional health of the child. The J. Paul Taylor Early Childhood Task Force recommends that the legislature direct the HSD to convene a task force to identify and recommend specific legislative action to prevent ACEs in children, including three measures for evaluating the impact and effectiveness of screening for ACEs by case managers in MCOs and legislation specifically to enhance screening by MCOs for ACEs and social-emotional risks.

Committee members had questions and comments in the following areas:

- an observation of the long-term detrimental effect of ignoring these needs;
- a suggestion that the LHHS endorse legislation to accomplish the legislative requests brought to the committee by Dr. Hsi;
- clarification regarding the appropriate entity or provider to accomplish the screening; it depends on the level of complexity arising out of an ACE;
- whether the proposal suggests redirecting screening from MCO care coordinators to providers; obligating providers to engage in screening will lead to better outcomes for children in the first six to 12 months of life; however, 80% of children are covered by Medicaid, so requiring MCOs to conduct ACE screening affects a larger volume of children and allows a stronger partnership among doctors;
- a suggestion that screening could be provided during home visits;
- recognition that many existing assessments are time-consuming, complicated and duplicative, without resulting in the needed care coordination; the proposed screening tool is accomplished through the power of the primary care physician relationship, thereby producing better results;
- how results can be conveyed to a child care center; there is a release that permits the sharing of this information for public health purposes;
- whether parents would willingly take part in a screening process that is burdensome and whether there is a way to streamline the process; an MCO case manager could become the single point of contact for obtaining and sharing data;
- recognition that there is an inevitable disconnect among all agencies conducting various assessments and screenings and the compelling need for facilitating better data-sharing;
- whether the recommendation calls for a new task force or broadens the scope of the J. Paul Taylor Early Childhood Task Force; it could be accomplished through a memorial to expand the scope of the current task force;
- whether the J. Paul Taylor Early Childhood Task Force is funded; it is not;
- clarification regarding the current composition of the task force; Legislative Finance Committee (LFC) staff participates, as does the Department of Health (DOH) staff, but there is no legislative representation;

- a suggestion that representation from children's courts be added to the membership of the task force; and
- an observation that many of the recommendations could be accomplished by the MCOs voluntarily; their participation on the task force would be valuable.

Health Insurance Market Update

Paige Duhamel, Esq., health care policy manager, Office of Superintendent of Insurance (OSI), introduced herself and the role of the OSI. She briefly reviewed the yearly responsibilities of insurance companies, including the setting of premiums, the review of claims experience and the prediction of what is coming up to inform risk determinations. She noted that the highly disruptive current landscape makes the ability of carriers to do all of that very challenging. She briefly reviewed the way in which small businesses and individuals obtain health insurance in New Mexico. About 72% of New Mexicans are eligible for cost-sharing. The reason that insurance premiums have dramatically increased is because carriers are now responsible for cost-sharing provisions previously covered by the federal government but withdrawn by executive order. She identified the impact on purchasers at this time. The OSI introduced a comparison tool to help people both on and off exchange plans to estimate their health care and insurance costs and compare plans in the future.

Lisa Cacari Stone, Ph.D., College of Population Health; and assistant director, Robert Wood Johnson Foundation Center for Health Policy, UNM HSC, introduced her colleagues: Nicholas Edwardson, Ph.D., School of Public Administration, UNM; Claudia Diaz Fuentes, Ph.D., Department of Economics, UNM; and Melissa Roberts, Ph.D., College of Pharmacy, UNM. She also recognized several members of the team of researchers and some students. Dr. Cacari Stone noted that seven health policy briefs have been developed addressing this topic. She identified marketplace enrollee characteristics in 2016 by age group, race and ethnicity.

Dr. Edwardson discussed the characteristics of uninsured people who entered the marketplace in 2016, noting that the data suggest populations that are likely to have high health care costs. He identified changes in behaviors relative to obtaining coverage, health care consumption and use of ancillary services, such as ambulatory and dental care. Finally, he noted that low-income people experience the highest out-of-pocket burden.

Dr. Roberts asserted that 70% of those buying insurance on the exchange in the state are receiving some cost-sharing. She noted that states that chose to expand Medicaid had higher enrollment in health insurance. She highlighted that New Mexico requires a carrier wishing to offer a plan in the exchange to offer it statewide, lending stability to the exchange. Data illustrate that in states where there is little to no competition, the rates are high. New Mexico has high competition and low premiums. The Medicaid expansion states with two or more carriers in the exchange also are shown to have lower deductibles and premiums.

Dr. Fuentes noted that in non-Medicaid expansion states, counties with a larger percentage of Spanish speakers had fewer uninsured people joining the marketplace. The greater

the proportion of Spanish speakers, the higher the likelihood that they will remain uninsured. This trend is more profound in rural parts of the state.

In conclusion, the research done in New Mexico shows that New Mexico as an expansion state has acted as an important buffer for the private market. Even though enrollment is degrading a bit, it is still higher than the national average. Dr. Cacari Stone emphasized the critical nature of collaboration with the OSI, the HSD and the insurance exchange. Ms. Duhamel stressed the importance of continued dialogue with the legislature.

Committee members had comments and asked questions in the following areas:

- clarification regarding what entity has the primary responsibility to reshape the essential benefit package; states have the option of setting the benchmark for coverage on and off the exchange for health plans; the OSI has no role in identifying coverage in Medicaid;
- whether plans are different on and off the exchange; cost-sharing and value-added benefits are the only differences;
- clarification regarding why carriers do not want to participate in the exchange; they want to be able to appeal to purchasers who have more money; people over 400% of the federal poverty level receive no particular benefit by purchasing on the exchange;
- encouragement to have broad public participation when considering changes to the essential benefit plan;
- clarification regarding grievances and appeals; insurance companies have toll-free numbers to file a complaint; the OSI's Managed Health Care Bureau can also be notified of grievances through a toll-free number and a website when complaints are not resolved through the insurance company;
- whether a promised OSI report on surprise billing will be released soon; yes;
- whether family planning is a required benefit in the private and exchange markets for both men and women; yes, it is in line with federal contraception mandates;
- clarification regarding insurance companies' recourse if they suspect fraudulent provider billing practices; that would be handled through the Office of the Attorney General;
- clarification regarding the suggestion to diversify the risk pool; the OSI is trying to ensure that younger, healthier people are in the risk pool to keep premiums lower;
- an observation about the importance of having adequate provider networks to attract individuals, especially in rural areas, to become insured;
- an observation that the availability of claims data will be very informative in identifying who is buying insurance and why;
- an observation that merely obtaining health insurance has an impact on health;
- a request for the LHHS to look at health disparities during the interim next year;
- an observation that premiums for children have gone up significantly and whether it is anticipated that this will result in a drop in coverage for this group; this is not known yet;

- an observation that the insurance exchange, "bewellnm.com", is not using the health plan comparison tool, which also allows users to identify whether a particular provider is part of a health plan;
- whether the OSI is aware of any federal discussion regarding the need to continue to support states with cost-sharing and other provisions; no, there is no indication that any funding will be available to help states implement changes to the ACA;
- an assertion that the OSI is not asking for increases in funding but just to have its budget remain flat and to make temporary positions permanent;
- whether the OSI is conducting an analysis of behavioral health interventions and implementation of mental health parity; it is partnering with the Robert Wood Johnson Foundation on a survey to help determine regulatory changes in this area;
- an observation that information about the impact of people going on and off Medicaid is needed; and
- an observation that carrier reports to justify network adequacy are inaccurate as the carriers are all claiming the same providers as part of their network.

Ms. Duhamel identified Section 1332 waiver applications as a potential avenue to stabilize the market. Many states are leveraging these funds to establish reinsurance pools. New Mexico is trying to ensure that the most costly patients' needs are met without disruption of markets. Section 1332 waivers may be an avenue to accomplish this.

Representative Armstrong noted that use of a Section 1332 waiver application may not be the best way to go; the high-risk pool already gets federal funds. The OSI believes that there may be a way to get a Section 1332 waiver and still receive federal funds for a high-risk pool and a Medicaid match. Alaska has a model that is being studied.

Recess

The committee recessed for the day at 5:10 p.m.

<u>Thursday, November 2</u> — Opioid Crisis Response Summit, Santa Fe Convention Center

Welcome and Introductions

Representative Armstrong reconvened the meeting at 9:09 a.m. She welcomed the committee and members of the audience and thanked participants for their presence. Committee members and staff introduced themselves.

Welcome from Santa Fe County and the Santa Fe Prevention Alliance

Anna Hansen, commissioner, Santa Fe Board of County Commissioners, and Jennifer Romero, chair, Santa Fe Prevention Alliance, extended their welcomes to the legislators and participants. Commissioner Hansen emphasized the importance of the opioid crisis and related a personal experience of losing a niece to a heroin overdose. She noted that Santa Fe County is a leader in the state in dealing with the opioid crisis, with five community partners committed to it. She provided statistics that demonstrate the impact of opioid addiction and overdoses.

Ms. Romero identified a goal of bringing many people together to join forces and identify actions to address the opioid crisis in the state. She recognized all of the partners who helped make this event possible.

Overview of the Opioid Use Crisis in New Mexico

Michael Landen, M.D., M.P.H., state epidemiologist, DOH, presented data regarding drug overdose rates in New Mexico and the United States. The incidence in New Mexico far outpaces the national average. New Mexico ranks fifteenth in the nation for drug overdose deaths. Statistics by county were provided, including overdose rates for selected drugs. He identified fentanyl as a major contributing factor to overdose deaths. Other related outcomes include neonatal abstinence syndrome. Emergency department visits related to overdoses are steadily rising. He discussed the economic cost to the state of opioid misuse, which totals an estimated $1 million per year. The top-three successful interventions are reducing high-risk prescribing, increasing access to naloxone and increasing MAT. He highlighted New Mexico's progress in each of these areas. New Mexico has a prescription drug monitoring program (PMP) and the Prescription Drug Misuse and Overdose Prevention and Pain Management Advisory Council. The state is a leader in access to naloxone. Progress with MAT is enhanced by removing the preauthorization requirement for buprenorphine and by a statute that permits nurse practitioners and physician assistants to prescribe buprenorphine. Dr. Landen noted that legislation has already addressed many provisions called for in a federal public health emergency declaration; however, a long-term, ongoing approach to the crisis is still needed.

Controlled Substance Prescribing and Clinician Education

Joanna G. Katzman, M.D., executive medical director, UNM Pain Center, noted that drug overdose deaths exceed deaths due to car accidents and gun violence. She emphasized that many other substances besides opioids contribute to this trend, including legal substances, such as alcohol. It is important to remember that there is an epidemic of chronic pain in the nation. The White House's Office of National Drug Control Policy has identified three targeted approaches to treating opioid addictions: 1) MAT; 2) access to naloxone; and 3) safe-prescribing education to all clinicians with prescriptive authority. New Mexico is ahead of the curve in many areas in dealing with pain and substance use disorders. Dr. Katzman discussed federal Centers for Disease Control and Prevention (CDC) guidelines for treating chronic pain, which New Mexico adopted in 2016. Prescribing patterns revealed as a result of New Mexico's PMP were presented and showed a slight decline in prescribing practices. High-dose prescriptions have similarly declined, as shown by the PMP. Based on the CDC guidelines, New Mexico has seen remarkable progress in high-dose dispensing, multiple prescriptions and other areas. Dr. Katzman emphasized the critical need of mandates for clinician training, whether at the state or federal level.

Overdose Death Prevention: Increasing Access to Naloxone

Bernie Lieving, M.S.W., principal, The Lieving Group, LLC, identified grants that are funding overdose prevention and access to naloxone in the state. The HSD has a federal Substance Abuse and Mental Health Services Administration grant to distribute naloxone in four

counties. A state-targeted response grant is funding distributions by first responders in all 33 counties. General Fund money in the amount of $500,000 is targeted to jails and prisons. Dr. Lieving highlighted the local impact in five areas: 1) a county jail pilot project; 2) Santa Fe Fire Department overdose survivor outreach; 3) reported overdose reversals; 4) state-targeted opioid responses in law enforcement training; and 5) prescription drug/opioid overdose highlights, including during probation or parole.

Role of Pharmacies in the Prevention of Opioid Overdose

Brianna Harrand, Pharm.D., Southwest CARE Center, noted the pivotal role of pharmacies in training, improving prescribing practices, expanding MAT and developing processes to ensure safe distribution of naloxone. She believes there are opportunities to further enhance distribution, including encouraging MCOs to include at least two naloxone products on all plan formularies at the lowest-tier cost. Safe opioid practices could be improved by providing standardized educational material to clients and patients at all pharmacies. She also recommended that third-party payers reimburse pharmacist clinicians for their services. Access to MAT could be expanded through allowing mid-level practitioners and pharmacist clinicians prescriptive authority for buprenorphine when treating opioid addiction.

Questions for presenters and comments by committee members covered the following areas:

- clarification regarding the age range most affected by opioid addiction; the peak age range is between 35 and 54; however, there are trends of increased use among very young and elderly populations;
- clarification regarding the legal use of buprenorphine; it is an opioid, but it does not engage all of the receptors that opiates do, so it can be used in treatment of opioid addictions;
- whether buprenorphine and naloxone are the primary treatments for opioid addiction; yes; however, their use can be much more widely implemented;
- whether buprenorphine could be prescribed in lieu of Oxycontin; its primary beneficial use is to stop the craving for Oxycontin; research has shown that it can be used indefinitely;
- whether buprenorphine still provides pain relief; yes, it is extremely effective in patients with both substance abuse disorder and chronic pain;
- whether there are other drugs that can be prescribed off-label as a substitute for opioids; at pain clinics, the first line of treatment is a non-prescriptive approach; if the pain is not controlled in that way, clinics might consider use of buprenorphine if their prescriptive authority covers it;
- an observation that the federal Food and Drug Administration (FDA) does not recognize buprenorphine as a treatment for pain; it is not known whether there are any plans for the FDA to consider this;
- recognition that special waivers are required for many practitioners to prescribe buprenorphine;

- clarification regarding the use limits established by some states for acute pain following surgery; there are several studies that look both at the need for severe pain relief as well as the likelihood of an addiction, but they are not definitive; New Mexico does not have evidence that these limits decrease the number of deaths, but there is evidence of increased addictions;
- an observation that rural parts of the state have higher addiction rates and less access to MAT, pain management and naloxone;
- whether medical marijuana is an effective alternative to treat pain and why this is not more widely used; pain is on the list of approved conditions to treat with cannabis; however, it is not yet recognized as a best practice for this purpose; its overall efficacy is mostly anecdotal;
- the need for consistent regulation of PMPs;
- possibilities for inclusion of pharmacist clinicians as those who can prescribe drugs for opioid overdose;
- acknowledgment of the availability of different naloxone products through government-funded insurance and recognition that many patients cannot afford co-payments for those products;
- the possibility to increase nontraditional access points in places such as state and county detention facilities and to increase available treatment on demand;
- the importance of education in preventing opioid overdoses;
- recognition of results of a study by the UNM Pain Center indicating more favorable outcomes for substance use disorder patients who do not get a prescription but, instead, are given naloxone and overdose education onsite;
- recognition of studies that are being conducted with respect to issues affecting patients in chronic pain;
- identification of cost-effective products that are either currently available or may become available to overdose patients;
- how to help patients who have a legitimate need for some medications for pain management while avoiding addiction;
- a request to research the most successful program providing treatment on demand in each state and the cost of each program, in addition to similar information with respect to successful international treatment-on-demand models;
- consideration of loan forgiveness for doctors and physician assistants who work at treatment-on-demand centers;
- reasons for the increase in neonatal abstinence syndrome and possibilities for outreach to women and treatment for children with the syndrome; and
- how funding for monitoring the Zika virus has provided an opportunity for better birth defect surveillance.

Detox Services and Opioid Use Disorders

Sylvia Barela, M.B.A., CEO, Santa Fe Recovery Center (SFRC), and Laura Brown, M.D., M.P.H., medical physician, SFRC, spoke to the committee about detox services. Dr. Brown identified medical detox as only the first step in treatment of addictions. MAT is a known best

practice for successful long-term recovery. Some patients of the SFRC are appropriate for social detox treatment; however, some are really in need of medical detox. Medical detox requires a registered nurse on site and access to a prescribing physician on call.

Ms. Barela described the services and programs, as well as the limitations, of the SFRC. The SFRC is dedicated to building a fully integrated system of services for people with addictions at all levels of need. She noted that not all of those in need of medical detox will qualify for admission to a hospital. She is a proponent of providing medical detox in a non-hospital setting for those who do not need, or do not qualify for, admission to an acute-care hospital. She would like to see Medicaid coverage for this level of care.

Expanding Access to MAT Providers and Services

Leslie Hayes, M.D., El Centro Family Health, spoke about MAT, which involves use of buprenorphine and methadone to treat opioid use disorder. She described the chemical process by which buprenorphine works. MAT with buprenorphine and methadone is extremely effective and cost-effective. These medications are not addictive. Patients may be dependent on buprenorphine, but they remain opioid-free long term and are far more likely to be employed, raise children and live productive lives.

MAT in Correctional Facilities

Bruce G. Trigg, M.D., asserted that in order to improve public health and safety, substance use disorder should be treated as a chronic disease. The criminal justice system can provide a unique opportunity to intervene with individuals who would not otherwise seek treatment. He described a program at the Bernalillo County Metropolitan Detention Center (MDC), which is now nationally recognized and has been shown through a UNM study to be successful. He noted that detoxing people who are incarcerated and living with substance use disorders takes a long time.

Dr. Trigg discussed effective ways to use buprenorphine and methadone for those who are incarcerated to manage detox, provide treatment, continue treatment after release, initiate treatment two to four weeks before release and provide treatment for people in community corrections. The American Correctional Association now endorses MAT as a standard of care for incarcerated individuals. Currently, buprenorphine and methadone are not used in New Mexico prisons. He noted that MAT with buprenorphine and methadone is covered by Medicaid, and there is a growing number of providers willing to provide this treatment. He pointed out that deaths from overdoses are occurring at a higher rate in New Mexico than in the nation. What is not known is how many of those deaths occur within jails or prisons in the state and how many lives can be saved and improved with proper treatment.

Committee members asked questions and made comments as follows:

- clarification regarding the lack of coverage for medical detox on an outpatient basis and what it would take to change this; possibly a Medicaid waiver;

- what it would take to implement the MDC's MAT model statewide in correctional facilities; it is not known why this is not already the case; counties will have to take the lead on this;
- how MAT is administered; it requires a nurse to be available at all times and to have a physician on call;
- whether MAT with buprenorphine and methadone is the standard of care for opioid addiction; though there is some disagreement, there is growing acknowledgment that it is the standard and best practice;
- whether abstinence-based programs are just as successful; no, they are only successful 10% of the time and have been proven to be less successful in the long term;
- what it would take to include MAT coverage under Medicaid; it would either need to be included in the Medicaid state plan or the Medicaid waiver;
- whether the BHSD agrees that there is a need for MAT; Dr. Lindstrom stated unequivocally, "yes";
- at what stage MAT is appropriate for pregnant women; women during pregnancy are extremely motivated to seek treatment; MAT is the standard of care for pregnant women and for the first year post-partum;
- an observation that New Mexico spends the least in the nation on post-prison treatment;
- clarification regarding the number of primary care practitioners who are providing MAT with buprenorphine and methadone; it was 790, but that was prior to the ability of nurse practitioners and physician assistants to administer these drugs; FQHC funding for mid-level providers to do this is restricted;
- whether primary care physicians are reluctant to administer buprenorphine and methadone; that is becoming less the case, but this is still a significant issue; younger physicians are more enthusiastically embracing it, and UNM is providing training;
- an observation regarding the critical importance of education and training for providers;
- an acknowledgement of the importance of wraparound services;
- whether a new mother who is undergoing MAT with buprenorphine and methadone can breastfeed her baby; yes, there is no danger so long as the mother is not actively using opioids; and
- clarification about what language to use when describing MAT in legislation if the legislature were to introduce a bill to require prisons to provide MAT; MAT with buprenorphine and methadone *is* the best practice, and this is the language that should be used.

Roundtable Discussions: What Can the Legislature Do to Help Turn the Curve on Drug Overdose Deaths?

Roundtable facilitators led discussions for one and one-half hours. Legislators joined the roundtable discussions. Five tables focused on prevention, and five tables focused on treatment.

Conclusions; Wrap-Up Discussion

Following the facilitated roundtable discussions, conclusions and recommendations were offered. The discussions were robust, and innovative ideas arose. Priorities were offered based on the discussions. Similarities and overlaps were noted. Written summaries of each table were incorporated.

Committee members made final observations and comments as follows:

- recognition that advocacy is needed to gain support from the governor for some of these ideas;
- acknowledgment that the opioid crisis is not a problem that will disappear soon; conversations across governmental bodies should be encouraged;
- recognition for funding and policy to expand beyond current administrations or legislatures;
- encouragement to continue to explore innovative ideas;
- that substance abuse disorder is a chronic disease;
- recognition that Centennial Care 2.0 will have another opportunity for a public comment period once the proposal is sent to the federal Centers for Medicare and Medicaid Services; and
- a suggestion from the chair that during the 2018 interim, the LHHS meet jointly with the Courts, Corrections and Justice Committee (CCJ) to discuss and consider this important issue.

Representative Armstrong thanked everyone for their participation, particularly those who had personal stories to share. She thanked the Santa Fe Prevention Alliance and the city of Santa Fe and Santa Fe County for their support and participation.

There being no further business, the committee recessed at 4:40 p.m.

Friday, November 3

Reconvene

The meeting reconvened at 9:15 a.m. Committee members introduced themselves.

2017 New Mexico Health Care Workforce Committee

Richard Larson, M.D., Ph.D., executive vice chancellor, UNM HSC, presented the 2017 state workforce report. The report is an annual requirement pursuant to House Bill 19 (2012), which amended the Health Care Workforce Data Collection, Analysis and Policy Act. The law requires licensure boards to develop surveys on practice characteristics and for UNM HSC to be the steward of the data. An active and broadly representative committee analyzes the data and makes recommendations for action.

As of 2016, New Mexico had 9,457 licensed physicians and 2,017 nurse practitioners and clinical nurse specialists, an increase of 71 physicians and 86 mid-level practitioners. A map demonstrates the number of primary care physicians by county relative to national benchmarks. Ten counties are at the benchmark of providers per 1,000 residents; four counties have 10 or fewer providers per 1,000 population. Subsequent maps demonstrated the data for mid-level practitioners and physician specialists. Shortages of providers are most severe in less-populated counties. The average age of providers is 53.5 years. New Mexico has the highest percentage of physicians over the age of 60 in the country. The data reflect changes between 2016 and 2017. Eleven counties saw net gains, while 16 counties experienced net losses.

Special attention was given to behavioral health, which is in crisis in New Mexico. The Behavioral Health Subcommittee of the 2017 New Mexico Health Care Workforce Committee recommends new measures regarding continuing education, mechanisms to reimburse interns through Medicaid and expedited provision of telehealth services through participation in interstate compacts.

Specific recommendations for 2017 include the following:

- funding for efforts to support the New Mexico Nursing Education Consortium ($380,000);
- continued and expanded funding for primary and secondary residencies in the state;
- position the Higher Education Department to take full advantage of opportunities to reinstate federal matching grants that support New Mexico's loan repayment program;
- corrections to the pharmacists' survey;
- increase funding for state loan-for-service programs;
- request including pharmacists, social workers and counselors among the health professions eligible for tax credits; and
- provide funding for the New Mexico Health Care Workforce Committee ($300,000).

Committee members asked questions and made comments in the following areas:

- clarification regarding regional variations of the supply of practitioners within a county; variations may reflect area needs and/or differences in the way counties report the data;
- conditions that influence recruitment efforts to place residents in shortage areas; schools that sponsor residencies have no control over where residents are placed; local hospitals and others try to recruit residents to remain in the community to practice;
- clarification regarding the need for legislative support to adequately fund residencies; it is as important as funding for loan repayment;
- recognition that the emphasis on nurse education at the bachelor's degree level may contribute to the nurse shortage because many associate degree nurses are unwilling to go back to school;

- whether traveling nurses are counted in the report; if they consistently register with the Board of Nursing, the board would be able to report those numbers;
- an observation that not all nurses licensed in New Mexico are practicing in New Mexico; salaries in New Mexico are generally lower than in other states;
- a request for an update on the status of the Enhanced Nurse Licensure Compact (eNLC); it was noted that the New Mexico Nurses Association (NMNA) is continuing to build support among nurses and that there is political will to expedite endorsement, so a special session may not be necessary;
- whether the committee recommends extending hospital admitting privileges to nurse practitioners; the committee does not weigh in on policy decisions;
- whether an expedited process to endorse the eNLC will protect grandfathering; yes;
- whether the NMNA supports a sunset provision; yes, but it will support modified language so as not to build in disincentives for traveling nurses to practice in New Mexico;
- whether UNM HSC is working to integrate MAT services that ensure transitions for incarcerated persons when they are released from prison; yes;
- a request for an estimate of what it would cost to develop a robust and integrated program of MAT at UNM;
- whether the committee will make formal appropriation requests for its recommendations; yes;
- recognition of the importance and cost of rural residencies;
- a request for LHHS support for increased funding for Western Interstate Commission for Higher Education programs;
- recognition of the importance of the Psychology Interjurisdictional Compact, an interstate compact that facilitates the practice of psychology using interstate telecommunications technologies;
- recognition that loan repayment programs serve not only to help recruit practitioners to rural areas, but also to retain them; and
- whether there are plans to expand the annual survey to other providers, such as psychologists; yes, all behavioral health providers are included in the report.

Senate Memorial 38 (2017 Regular Session): Study Incidence of Strangulation in Domestic Violence

Sheila Lewis, director, Santa Fe Safe, described the purpose and membership of a task force led by the New Mexico Coalition of Sexual Assault Programs. She introduced other members of the task force, as well as Mary Carmody, a student at UNM working in this area.

The significance of strangulation in domestic violence has grown in importance, highlighting the need for awareness, particularly among law enforcement and first responders. The goals of the task force are twofold: 1) reduce the incidence of strangulation; and 2) address the long-term health implications of strangulation. Ms. Lewis identified the following regarding the incidence of strangulation:

- nearly 10% of women will experience intimate partner violence in their lifetime;
- New Mexico's domestic violence rate is the second-worst in the nation;
- 13% of domestic violence victims reported being strangled; and
- strangulation is frequently used during sexual assault; 35% of all rape victims were also strangled.

Strangulation often results in traumatic brain injury. It changes the life of the victim in physical, cognitive, emotional and sleep-disruptive ways. It takes a mere four pounds of pressure, and only four minutes, to kill someone by strangulation; yet often there is no external post-event evidence of injury, making prosecution challenging.

Alexandria Taylor, executive director, Valencia Shelter Services, provided justification for a public health response, and not only a criminal justice response, to strangulation. She emphasized the critical importance of education.

Julianna Koob, registered lobbyist, identified herself as a volunteer working on domestic violence for more than 30 years. She stressed the high rate of sexual violence in New Mexico. It is difficult to recognize, and therefore report, strangulation.

Lisa Weisenfeld, policy coordinator, New Mexico Coalition Against Domestic Violence, reviewed accomplishments of the task force and its hopes going forward. Multidisciplinary teams (MDTs) have been created with individuals who have received advanced training and have provided training to their colleagues. These MDT members are now considered experts in the field of strangulation. Christus St. Vincent Regional Medical Center has agreed to be a test site for a screening tool. Protocols for emergency medical technicians are ready for implementation. Prosecutors and police in Santa Fe have been trained in traumatic brain injury as a result of strangulation. The DOH is exploring opportunities to improve data collection.

A final report of the task force will include specific recommendation for training, screening, treatment protocols, data collection and future policy initiatives. This report will be sent to the CCJ, with the request for endorsement of an appropriate criminal justice response.

Ms. Taylor reported on training provided to child protective services providers with the Children, Youth and Families Department. Requests for training for law enforcement have surfaced.

Ms. Koob requested that the LHHS support requests to the LFC for funding for training. She also would like the final report distributed to the LHHS and for members to review it carefully and send it to the LFC with recommendations for increased funding.

Committee members had questions and made comments as follows:

- whether training on the effect of strangulation is occurring in schools; not so far; the focus has been on domestic violence and the impact on children in the home;
- clarification regarding the impact on children who are witnesses to strangulation; training regarding forensic interviews with children is occurring; training is critically important in many environments to help and support children who have been witnesses of domestic violence;
- a recommendation that the Aging and Long-Term Services Department also be included in training, as it manages adult protective services;
- acknowledgment of past difficulties in obtaining legislative support to identify strangulation;
- recognition that victims themselves may not report incidents or even recognize strangulation as a crime;
- whether a victim of strangulation can observe that the victim has experienced a traumatic brain injury; it can be difficult; victim training in this regard is crucial;
- whether the incidence of strangulation among immigrants is known; no;
- whether there is training occurring at the New Mexico Law Enforcement Academy; not yet;
- whether training is occurring at the Albuquerque Family Advocacy Center; yes;
- a suggestion that staffers of home visitation programs and also the Brain Injury Advisory Council receive training;
- recognition that treatment of victims is as important as prevention; and
- recognition of the powerful impact, both physically and emotionally, on the life of a victim of strangulation who has experienced a traumatic brain injury.

New Mexico Adult Guardianship Study Commission (AGSC) Report

The Honorable Wendy York, retired district court judge, chair, AGSC, and Senator Ortiz y Pino, who is a member of the AGSC, were invited to address the committee.

Senator Ortiz y Pino stated that the report is the work of a committee appointed by the New Mexico Supreme Court. He introduced Tim Gardner and Emily Darnell-Nunez, members of the AGSC. He provided background regarding the impetus and goals for the commission. Problems and deficiencies in the current system were initially published in the newspaper, creating a groundswell of concern. Additionally, there was an agency that was alleged to have engaged in fraud, further raising concern. The commission held a series of meetings around the state. At the same time, the Uniform Law Commission has been working on revising the laws governing guardianship and has a revised uniform law to recommend. Senator Ortiz y Pino noted his personal belief that families are central to the process of providing for family members. Once the courts become involved in determining a guardian, family members become marginalized. He also has growing concerns regarding the lack of oversight for the process and system of guardianship. The lack of accountability is alarming to him. To address these concerns, it will be necessary to increase financing. Current budgeting cannot cover all that is required to improve the system.

Judge York noted that a full, extensive report is posted on the legislature's website. The commission, during the time it met, has come to believe that the problems can only be addressed by both the legislature and the courts. She described three scenarios in which a family pursues guardianship or conservatorship for a parent. The court appoints a professional guardian or conservator when it is clear that the family cannot get along. A second scenario is one in which the person needing a guardian does not have resources. The third scenario occurs in the case of a young adult who is developmentally disabled and unable to manage his/her affairs. Some situations are more complicated than others.

There are 17 recommendations that have been submitted to the New Mexico Supreme Court in the final report. Five of the recommendations are directed to the legislature. Implementation of the remaining recommendations are within the purview of the court, which has already indicated a willingness to address these issues.

Judge York briefly noted that the Uniform Law Commission's recommendations for revisions go a long way toward standardizing the process. They require that the protected person be provided an attorney. In the case of a person without resources, the Office of Guardianship would become responsible for paying legal fees.

Patricia Galindo, staff attorney, Administrative Office of the Courts (AOC), identified the scope of the problem. She highlighted flaws in the case management system and in monitoring older cases. The oldest cases date back to 1950. She noted that in 2016, 450 new cases were filed, making the review process manageable. It is critical to be able to collect, track and manage open cases. She reviewed the recommendations of the Uniform Law Commission for improving the system. She emphasized the importance of adequate funding, stressing that funding should not supplant funding that is already in place to manage the existing needs of the Office of Guardianship. Legislative support is sought for the following:

- to establish an oversight board;
- to authorize the AOC to hire special masters or commissioners;
- to fund the necessary technology and staffing to modernize the accounting system;
- to fund appropriate personnel, including monitors and auditors;
- to require bonding or an alternative asset-protection arrangement; and
- to require certification of professional guardians and conservators by a national organization.

Committee members asked questions and made comments in the following areas:

- the system needs to find ways to treat protected people with the respect to which any independent person is entitled;
- an expression of support for the recommendations, especially accountability measures;

- acknowledgment of the challenge of giving protected adults the rights to which they are entitled;
- recognition of the oversight duties of the Office of Guardianship and holding it accountable to the job for which it is responsible;
- recognition that the recommendations of the Uniform Law Commission address many of the concerns raised by the AGSC;
- whether news reports have addressed other judicial districts; no; however, anecdotal information from phone calls and emails indicates that the problems are widespread;
- an expression of appreciation for the time and work spent by the AGSC to accomplish this task;
- clarification regarding the extent of the authority of guardians and conservators and whether they have access to the protected person's trust; yes, this has been a frequent concern of those testifying to the AGSC; there is a recommendation dealing with this;
- whether there is potential to further refine the list of recommendations; and
- clarification regarding requirements for becoming a guardian or conservator; those details were not provided.

Oversight of Contract Guardians and Conservators

Sarita Nair, general counsel and chief government accountability officer, Office of the State Auditor (OSA), and John Block III, executive director, Development Disabilities Planning Council (DDPC), were invited to address the committee.

Ms. Nair referred the committee to a letter from the OSA that, in summary, provides an emergency risk advisory arising out of an indictment of Ayudando Guardians, Inc., on charges of embezzlement. The OSA found a widespread failure to protect individuals against fraud and abuse by contract guardians. The OSA recommends that the Office of Guardianship immediately be subject to more oversight and management, including an evaluation of whether the DDPC is the appropriate agency to house the Office of Guardianship.

Mr. Block offered a clarification regarding the fund balance that caused the OSA concern. The guardianship program is permitted by statute to maintain a balance to cover unexpected future expenses. He summarized the role of the DDPC in guardianship and conservatorship. Its main function is to provide legal services to eligible, low-income, incapacitated adults needing a guardian. Services are provided through contracts. The DDPC handles complaints against guardians, including family and corporate guardians. The DDPC petitions the courts for conservatorship. It does not have staff with the training and expertise to handle financial audits of contract guardians or staff who are trained to identify fraud, exploitation or abuse. Mr. Block said that the DDPC has reviewed the findings of the OSA and has begun to resolve the complaints, including updating policies and reorganizing guardianship staff to provide for more compliance and efficiency of processes.

Questions and comments by committee members covered the following areas:

- clarification regarding what activities are accomplished by monitors; review of contractors to ensure accurate invoicing;
- whether monitoring visits include visits with the clients; that is not certain; however, DDPC staffers have visited clients around the state on other occasions;
- clarification of income limits; Medicaid does not allow more than $2,000 per month in income to qualify for state-supported guardianship;
- clarification regarding the statute that permits fund balances; Office of Guardianship funds do not revert; however, DDPC balances do revert;
- identification of the number of complaints received last year; two formal complaints were received and were formally investigated;
- clarification regarding the number of staff members in the Office of Guardianship; there are six; they have different responsibilities covering intake coordination, program management, billing and contract oversight; there is one vacancy;
- clarification regarding the caseload; there are 900 clients;
- whether the Office of Guardianship has any responsibility over private cases at Ayudando Guardians; it has no responsibility;
- an observation that the Office of Guardianship is underfunded to oversee the volume of work for which it is charged;
- whether the Office of Guardianship has had to cut staff in recent years; there have been changes in duties and responsibilities;
- clarification regarding the size of the waiting list for guardians; some have been waiting one and one-half to two years; in an emergency, guardians may be able to act more quickly;
- clarification regarding the amount of the annual budget that is reserved for clients and how much is dedicated to operations; out of $5 million, an estimated $600,000 covers operations;
- clarification of why the fund balance is not being spent; there are attempts to prioritize and increase the caseload, but resources need to be preserved for unexpected attorney costs;
- clarifications regarding efforts to recruit staff, especially attorneys; the DDPC is working with the state bar and local leadership training programs, and there are agreements for pro bono work;
- clarification regarding the 18 months needed to certify guardians; potential guardians must be trained and serve in a mentorship program;
- whether the DDPC is the appropriate place for the Office of Guardianship to reside; wherever it would be transferred to, adequate resources must be provided;
- clarification regarding the original decision to transfer the Office of Guardianship from the Office of the Attorney General to the DDPC; Doris Husted, policy director, The Arc New Mexico (Arc), testified that the attorney general does not want it and that advocates have argued that it should not be attached to an entity that provides direct services; the DDPC has stepped up and offered to take it on; Ms. Husted believes it would be better placed at the AOC;

- recognition that the DDPC has been given a very big job with very few resources, and the legislature should find funding; and
- a request for a budget prediction from the DDPC and the LFC that reflects true needs; Eric Chenier, fiscal analyst, LFC, notes that the Office of Guardianship has a fund balance of over $3 million.

Public Comment

Valerie Romero spoke on behalf of foster youth. She was a foster child with posttraumatic stress disorder (PTSD). She does not think people with PTSD should be criminalized. She advocates for a better venue for communication.

Lorraine Mendiola is the mother of an adult son under guardianship. She feels that the process for providing input to the AGSC is not transparent and not responsive. Regarding the Office of Guardianship, she emphasized the critical importance of accountability. She asserted that the Office of Guardianship has failed miserably in the case of her son.

Ms. Husted, who is the legal guardian of her adult daughter, provided a written copy of remarks she gave to the AGSC. These comments identify the role of Arc in providing guardianship services. She is available to answer questions.

Ms. Darnell-Nunez spoke on behalf of a family member of an adult with a guardian. She advocated for a more robust system of assessment prior to assigning a guardian to an adult. She emphasized the vital importance of transparency.

Mr. Gardner, who is also the legal director of Disability Rights New Mexico (DRNM), said DRNM represents people only with regard to the disability of the protected person. He generally likes the recommendation of the Uniform Law Commission but feels New Mexico can do better to protect the most vulnerable people. As an agency, DRNM has suggestions about how to improve guardianship in New Mexico. Senator Ortiz y Pino asked for its recommendations to be provided to the LHHS.

Marcia Southwick, National Association to Stop Guardian Abuse, agrees that the Uniform Law Commission recommendations do not go far enough, especially in the private pay arena. Its strength is that it protects the rights of the individual more than the guardian. She noted that the commission gives broad powers to people under guardianship. She believes that if families really knew the obligations of guardians, they would be more involved.

Joe Bob Nunez provided a personal story of a very restricted life with no rights experienced by his mother-in-law for five years. Her living trust was invaded, and she had no access to it. The system is in dire need of repair.

Jim Jackson, DRNM, stated that the process of guardianship needs to protect the rights of people in need of a guardian. The person alleged to be incapacitated should have a real advocate

in the legal process. He would like to see more alternatives to guardianship. Once a guardianship is established, there must be strong oversight to ensure full protection of the individual. Periodic field visits to see a situation first-hand are crucial.

Jim Ogle noted that people with mental illness can recover with treatment and proper care and could improve to a degree that they no longer need a guardian. A professional guardian should have training in behavioral health in order to recognize this possibility.

Bill Garcia offered a personal story of his father-in-law, who identified his daughter as being in charge of his life and finances, and he specified it in his will. Two other daughters fought this in court and created a huge problem. In the end, his wishes were not observed. The court assigned a guardian and gave his father-in-law's money to a third party to manage. The law should not allow this.

David Heater, a concerned senior citizen, asserted that the courts are no help. Transparency is important.

Cheryl Yerby, who owns a guardianship agency, wished to clarify requirements of certification for guardians. They are permitted 18 months to become certified; one-half of the hours of training must be in person. She asserted that payees and guardians can be one and the same.

Nat Dean identified herself as a traumatic brain injury survivor. She provided written material regarding guardianships for adults with disabilities and alternatives to guardianships for those same individuals. She said her brother claimed she was incompetent because of her brain injury. It is critical for people to be involved who really understand and are prepared to advocate for the protected person.

Lucinda Martinez shared her story regarding drug overdose. She is a grandmother raising her granddaughter. Her son was addicted to heroin and has spent time in prison. She worries about the trend of treating all addicts with drugs and the effect of this on society. She believes that holistic paradigms, including the use of curanderas, should be recognized. Society is judgmental about addiction.

Adjournment

There being no further business, the meeting was adjourned at 4:35 p.m.