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

September 20-23, 2016
San Juan College
4601 College Boulevard
Henderson Fine Arts Center
Conference Room 9008/9010
Farmington

The fifth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order as a special subcommittee on September 20, 2016 by Senator Gerald Ortiz y Pino, chair, at 9:04 a.m. at the Henderson Fine Arts Center in Farmington.

Present
Sen. Gerald Ortiz y Pino, Chair
Rep. Deborah A. Armstrong (9/20, 9/21, 9/22)
Sen. Mimi Stewart

Absent
Rep. Nora Espinoza
Rep. Miguel P. Garcia
Sen. Gay G. Kernan
Rep. Tim D. Lewis
Sen. Mark Moores

Advisory Members
Rep. Gail Chasey (9/21)
Rep. James Roger Madalena (9/21, 9/22, 9/23)
Sen. Cisco McSorley
Sen. Howie C. Morales (9/20)
Sen. Nancy Rodriguez (9/22)

Sen. Craig W. Brandt
Sen. Jacob R. Candelaria
Rep. Doreen Y. Gallegos
Sen. Daniel A. Ivey-Soto
Sen. Linda M. Lopez
Rep. Terry H. McMillan
Sen. Bill B. O'Neill
Sen. Mary Kay Papen
Sen. Sander Rue
Rep. Patricio Ruiloba
Sen. Benny Shendo, Jr.
Sen. William P. Soules
Rep. Don L. Tripp
Rep. Christine Trujillo

(Attendance dates are noted for members not present for the entire meeting.)

Staff
Michael Hely, Staff Attorney, Legislative Council Service (LCS)
Shawn Mathis, Staff Attorney, LCS
Rebecca Griego, LCS Staff
Alexandria Tapia, Contractor, LCS

Guests
The guest list is in the meeting file.

Handouts
Handouts and other written testimony are in the meeting file. Handouts can also be found at https://www.nmlegis.gov/Committee/Interim_Committee?CommitteeCode=LHHS.

Tuesday, September 20

Welcome and Introductions
Senator Ortiz y Pino welcomed members to the fifth meeting of the LHHS. Members of the committee and staff were asked to introduce themselves.

Home Care Workers and Federal Fair Labor Rules
Caitlin Connolly, campaign coordinator, Home Care Fair Pay, National Employment Law Project (NELP), provided the committee with background on the NELP and its efforts to promote good jobs and opportunities for work. The NELP is a nonprofit organization that focuses on laws both at the federal and state levels affecting home care workers. According to Ms. Connolly, 90 percent of older adults want to stay in their homes, which is often less costly than institutional care. Home care accounts for between 70 percent to 80 percent of hands-on care for the elderly. In 2010, there were seven family caregivers for every one adult that needed care; by 2050, that number will drop to three for every one. At the same time, the aging population is growing, with more than 10,000 Americans turning 65 every day. With fewer individuals to meet this need, Ms. Connolly contended that a paid workforce will help address this issue. During the presentation, Ms. Connolly discussed recommendations for the creation of a home care task force requiring interagency collaborations, compliance with new federal rules and funding and extending wages and overtime to home care workers based on state regulation. The NELP is a willing resource for the committee and the state on this issue.

Ms. Connolly provided several handouts detailing recent changes to U.S. Department of Labor (USDOL) Home Care Rules and the federal Fair Labor Standards Act (FLSA). First, the FLSA changed the scope and definition of "companionship services". Second, third-party employers are now excluded from getting companionship exemption and overtime exceptions. Third-party employers must now pay overtime for individual consumers and workers must be paid for all time worked, including travel time between clients. Ms. Connolly noted that good examples of implementation of these rules are being seen all over the country, citing several states as examples. The best examples include allowing for a robust exception to capped hours if

it is in the best interest of the client and efforts to keep professionals in the field. The Centers for Medicare and Medicaid Services (CMS) is reimbursing for overtime and travel time cost; in New Mexico, that reimbursement rate is 71.13 percent. States are responsible for making sure individuals are not at risk for institutionalization. Ms. Connolly noted that correct classification of workers as employees is key to securing their legal protections and ensuring fair competition by law-abiding businesses. Referring to home care workers as "independent contractors" is a misclassification that leads to the denial of basic workplace protections and benefits. The NELP calls on states to invest in their home care programs and New Mexico legislators to help ensure the implementation of new rules with the passage of a memorial creating a task force. In closing, Ms. Connolly urged the committee to extend state and overtime wage protections to home health care workers, adding that it is not just good social policy, but also good fiscal policy.

Adrienne R. Smith, New Mexico Direct Caregivers Coalition (NMDCC), informed the committee about direct care workers in New Mexico. The NMDCC advocates for direct care workers' education, training, benefits, wages and professional development so that they may better serve people who are elderly and those with disabilities. The direct care workforce is the fastest-growing sector in the state and the second-fastest-growing sector in the country. There are currently 47,963 wage-earning direct caregivers in New Mexico, including personal care assistants, home health aides and nursing assistants. Ms. Smith shared some demographics of caregivers, who are primarily women and face educational barriers (see handout for more information). Ms. Smith stated that many caregivers often work as "contract workers" and are frequently in need of more hours to support themselves, working two and even three jobs. The NMDCC would like to play a part in drafting a memorial to create a task force and to work with disability rights groups.

Joie Glenn, executive director, New Mexico Association for Home and Hospice Care (NMAHHC), described her organization, which is made up of members that are skilled home health, hospice health and non-skilled home health agencies. Home health care is a high-value, low-cost provider with experience in caring for complex patients. Ms. Glenn stated that skilled home health care and personal care services (PCS) save Medicaid money by assisting managed care organizations (MCOs) with care coordination in many aspects. Ms. Glenn focused on the multiple unfunded mandates imposed by the federal Patient Protection and Affordable Care Act (ACA) and Medicaid expansion that have created an additional burden to PCS providers. These agencies have also been affected by the one percent budget cuts in response to the current state budget crisis. Additionally, a new ruling, effective in December 2016, will add a required supervisory service that is considered non-reimbursable. Agencies have been under-reimbursed for a long time and continue to have further requirements placed upon them. Several agencies are conducting studies to understand what the impact will be from the cuts, rule changes and mandates. The NMAHHC supports the creation of a task force.

Nancy Smith-Leslie, director, Medical Assistance Division (MAD), Human Services Department (HSD), recognized that all four Centennial Care MCOs were present in the audience. Ms. Smith-Leslie proceeded to discuss the two key policy changes, which became effective in

January 2014, that are driving increased utilization and expenditures for home- and community-based services (HCBS): approval of the Centennial Care waiver allowing any individual enrolled in Centennial Care who meets a nursing facility level of care to receive HCBS waiver services, including PCS, without having to wait for a waiver slot; and Medicaid adult expansion, which allows newly eligible adults also able to receive HCBS services without a waiver slot if they meet nursing facility level of care. Ms. Smith-Leslie shared data illustrating the effect of the two policy changes on PCS utilization and expenditures (see handout). Angela Medrano, deputy director, MAD, HSD, added that the community benefit program, or HCBS, continues to grow as more people are qualifying for the program. More than 1,000 individuals have been added to those slots since the beginning of 2016 alone, and it is likely that this increase will continue. Centennial Care also added the requirement for MCOs to implement an electronic visit verification system (EVV) to verify that PCS are being delivered as authorized. Ms. Smith-Leslie stated that MCOs are working closely with providers and are bearing the total cost of the system. As part of Medicaid cost-containment efforts, the Provider Payments Cost-Containment Subcommittee was charged with making recommendations for reducing provider reimbursement rates effective July 1, 2016 in accordance with the General Appropriation Act of 2016. Recommendations from the subcommittee included a one percent reduction for community benefit providers. Despite the need for additional reductions to achieve a savings goal of $30 million in General Fund dollars, the HSD elected not to increase the one percent reduction for community benefit providers.

In response to committee members' questions, the following points were discussed with the panel:

- new rules and implementation time lines;
- the USDOL as the enforcement agency for new rules;
- coordination efforts with the CMS;
- the need for updated state regulations and potential legislation;
- the lack of alternatives for agencies to cover cost of overtime pay increases;
- a proposed memorial creating a task force to be brought for committee endorsement based on language in Senate Bill 222 (2016);
- the need for rewarding models of care that reduce hospital admittance while keeping individuals healthy;
- the impact of Medicaid expansion on providers;
- challenges associated with serving the Medicaid expansion population;
- collaboration with universities for training programs to expand the home care workforce;
- the potential impact of workforce development on rural communities; and
- a recent op-ed discussing cost savings regarding long-term care.

Representatives from the four Centennial Care MCOs were invited to respond to the panel's remarks. Consensus among the MCOs was a willingness to work with the panelists and continue to explore options for saving costs while reducing the number of hospitalizations. It

was stated that from a cost-containment perspective, serving patients in their own community is a best practice. It also benefits members by improving their health and quality of life.

J. Paul Taylor Task Force Update

Kim Straus, chair, foundation manager, Brindle Foundation, provided the committee with an update on the J. Paul Taylor Task Force. The task force was established in 2013 with the goals to improve collaboration among early childhood development stakeholders, to better identify children at risk of child abuse and neglect, to develop an early childhood mental health plan, to improve the early childhood services system and to promote evidence- and community-based early childhood programs throughout the state. Mr. Straus applauded the work of the legislature for the investment in New Mexico children and discouraged any future cuts to early childhood programs. The task force recognizes the budget challenges faced by the state, but at the same time, the task force emphasizes the urgent need to preserve the integrity of existing, foundational early childhood and family support services and infrastructure. The potential for leveraging Medicaid funding to expand home visiting programs should be explored in the future. The following recommendations were made as a result of the last four years of work by the task force (please see handout for full details).

1. *Increase funding for early childhood programs.* The task force encourages the legislature to maintain or increase General Fund appropriations for early childhood programs. Further, the task force recommends that the legislature and administration enact polices that leverage current state investments in evidence-based health programs, such as home visiting and postpartum visits, including Medicaid financing and other strategies.

2. *Expand screenings to identify young children at risk.* These screenings include continued compliance with the existing Medicaid Early Periodic Screening, Diagnosis and Treatment federal regulations and the inclusion of adverse childhood experiences in health risk assessments administered by Medicaid Centennial Care MCOs.

3. *Promote and expand postpartum visiting programs to assist families with newborns.* These visiting programs assist with breastfeeding issues, conduct screenings, offer information on family well-being and ensure that families are connected with community resources and opportunities. This is particularly important in rural communities.

4. *Increase access to early childhood mental health services.* The task force again recommends that the requirement of a serious emotional disturbance (SED) diagnosis for access to mental health services be eliminated and that definitions needed to access mental health services be expanded.

5. *Support and coordinate training community health workers in assisting families with young children.* This recommendation urges the continued support from the HSD, the Department of Health (DOH) and MCOs for expanding the number of community health workers

in the state along with implementation of programs assisting families in connecting with needed services while identifying at-risk children and families.

6. *Align information and referral systems.* The task force recommends support for aligning existing information and referral systems in an online, shared, accessible, statewide, comprehensive, community-based resource directory to link families with young children to needed resources.

7. *Continue the task force.* The task force will be seeking continuation by the legislature for its work in 2017 with the passage of a memorial.

Following the presentation from Mr. Straus, members of the committee discussed the findings and asked various questions regarding the recommendations set forth by the task force. With the current state budget situation, Mr. Straus believes that leveraging Medicaid funding for home visiting programs would save money spent by other departments such as the Children, Youth and Families Department (CYFD). The state should also consider alternative sentencing options in order to reduce costs to the overall state budget. A question was raised regarding the Early Learning Advisory Council and the potential sunset of legislation authorizing its continuation; LCS staff will follow up with the CYFD on this matter. The LHHS also requested LCS staff to draft a bill that increases the dialogue between the HSD and its Behavioral Health Services Division (BHSD) and looks at the potential for broadening the definition of medical necessity for children.

Public Comment

Brenda Parker, executive director, San Juan Center for Independence, explained that PCS providers such as her organization work to keep people in their communities. Ms. Parker addressed how the new rules, one percent rate reduction and the roll-out of the EVV, according to which home care workers must check in and out when delivering in-home care, have affected the organization. Having just received the last of the electronic tablets required for the EVV, the San Juan Center for Independence has not been able to fully implement usage. The EVV presents many challenges in rural communities, including poor service signals and lack of data access to operate tablets. San Juan Center for Independence pays $9.50 per hour, which is one of highest wage payers in the county. As a nonprofit organization, there are limited areas where the center can save money. Ms. Parker stated that PCS providers are working for the benefit of the state but the more regulations that are placed on them, the more likely it is that they will have to shut down services. The closure of organizations like San Juan Center for Independence will result in more individuals being institutionalized in nursing facilities.

Carol Maestas advocated for families of children with Rett syndrome. Ms. Maestas is asking that Rett syndrome be added as a qualifying condition for the developmental disabilities waiver. Senate Memorial (SM) 81 was sponsored by Senator Michael Padilla last year but it did not make it to the floor for a vote in the senate. Ms. Maestas stated that her son has a daughter living with Rett syndrome and described to the committee the challenges faced by individuals

with this condition and their families. The level of severity of the condition varies from individual to individual, with some requiring 100 percent dependence on care. Early intervention can help reduce the severity of the condition, she explained, but commercial insurance will only pay a portion of the required therapy. Senator Padilla has requested the drafting of a duplicate memorial, and Ms. Maestas is requesting the support of the LHHS for its passage. Senator Ortiz y Pino requested that Ms. Maestas prepare a one-page summary for the committee and informed her of the committee's endorsement process. Members of the committee also encouraged Ms. Maestas to work with other developmental disabilities organizations in the state to support the effort.

Reporting Pursuant to SM 52 (2015): Domestic Violence

Pamela Wiseman, executive director, New Mexico Coalition Against Domestic Violence, provided the LHHS with a summary of findings and recommendations from the Batterer Intervention Program (BIP) Task Force created in 2015. SM 52 charged the task force with studying the effectiveness of BIPs in New Mexico by reviewing the current state of batterers' intervention services; offender assessment; curricula and implementation; research; and the criminal justice system response. There are currently 40 BIPs across New Mexico, 22 of which receive CYFD funding. BIPs are a court-ordered sentencing alternative to jail requiring participation in a 52-week group education program. Judges can use the programs as a sorting mechanism, identifying individuals who want to change and individuals who will be likely to commit future domestic abuse. Ms. Wiseman explained that BIPs can make a real difference for children. When children witness that a violent parent has changed, not only does it stop the negative effects on the child, but it also helps reverse some of the damage, thus providing for a better outcome for their future. Children who are exposed to violence begin to see the world as a dangerous place, instilling in them an aggressive response. Ms. Wiseman believes that BIPs are also a valid method of combating recidivism rates in the state. Programs are in need of facilitators, which cost between $9.00 and $14.00 per hour. Programs also need the support of the court systems to remain viable and to hold individuals accountable. The courts must have a uniform process of enforcing consequences for individuals who drop out of programs.

Ms. Wiseman shared the findings and recommendations of the task force with the committee (please see handout for full report). In 2013, *Forbes Magazine* reported the annual costs of domestic violence nationwide to be $8.3 billion. A small subgroup of domestic violence offenders is responsible for most of the re-offenses: 20 percent to 25 percent of offenders commit 75 percent to 80 percent of re-offenses. Ms. Wiseman acknowledged rumors on the national level about the inefficiency of BIPs, adding that research on the programs is confounded by inconsistences in implementation and the criminal justice system response. One example of this is the Duluth model. The Duluth model had a component of BIP, but it was part of a large program. When it was determined that the Duluth model did not work, the belief that BIP did not work was largely accepted. The task force recommends that the state establish an advisory group to consider and recommend specific curricula to the CYFD and to develop training and supervision sufficient to implement select curricula.

Wendy Buchanan, Family Crisis Center, shared what is being done locally to address issues of domestic violence in Farmington. The Family Crisis Center found that there were no measurable ways to demonstrate if individuals were making changes under BIP and that offenders were only required to attend the groups. The center has been working with a different program called HEAL, developed by a group in Michigan. Ms. Buchanan explained the difference between the two programs and the benefits found with HEAL in the community. The more the facilitators are able to keep individuals coming and participating in the program, the more changes in attitudes and motivation are seen. Individuals in the program are integrated with others at various stages, inspiring them to continue. The Family Crisis Center has ongoing interaction with the program creators, and facilitators receive ongoing training.

In response to the presentation, the committee addressed the following topics with Ms. Wiseman and Ms. Buchanan:

- reach and scope of the two programs;
- statewide incident reports of domestic violence;
- other services available to address the issue of domestic violence;
- the need for comprehensive statistics on domestic violence and other crimes to better understand correlations;
- development of criminal justice system strategies to reduce recidivism and promote the safety of victims;
- enforcement of BIP referrals and disconnect with courts;
- the lack of reporting and accountability;
- the need for prioritization of domestic violence as a major issue for the state;
- reoccurring issues with lack of funding for program staff, current programs and increased quality training;
- the cost of incarceration versus the cost of funding prevention programs;
- predispositions to violence due to other conditions, such as traumatic brain injury;
- program availability for female offenders;
- occurrence of intimate partner violence; and
- a desire for a memorial during the upcoming session to continue the task force's work and address issues with referrals from the court system.

Child Welfare Matters: Annie E. Casey KIDS COUNT Report

Amber Wallin, director, KIDS COUNT, New Mexico Voices for Children (NMVC), addressed the committee regarding child welfare matters in the state. KIDS COUNT is an initiative based on government-collected data that calls attention to child well-being issues. New Mexico is ranked forty-ninth overall for child well-being, with next-to-bottom rankings for economic well-being, education, health and family and community. Ms. Wallin shared statistics relating to those four categories (please see handout for full details). Each category has seen significant improvements for both short- and long-term trends. One big issue for the state is food insecurity among children. Twenty-seven percent of New Mexico's children, roughly 145,000 children, are food insecure. Supplemental Nutrition Assistance Program (SNAP) benefits are not

adequate to address food insecurity in the state. On average, 80 percent of SNAP benefits are used up within the first half of the month, affecting children's test scores in school and increasing chances for hospitalizations and behavioral issues in the classroom. New Mexico children also have increased exposure to trauma, and abuse cases are on the rise. Ms. Wallin noted that ethnic disparities exist in every indicator, with Hispanic and Native American children facing increased challenges. While New Mexico faces many issues in addressing child well-being, research shows that policy matters and that positive and comprehensive support systems lead to better outcomes for children. Progress is possible and the state is making some important gains in the four categories, notably: 74,000 more New Mexicans have health insurance this year as compared to the previous year; nearly 5,000 more kids gained access to pre-kindergarten since 2010; 2,000 more New Mexican families receive home visiting; and big improvements in teen drug use and birth rates have been seen.

Bill Jordan, senior policy advisor/government relations officer, NMVC, provided some background on the tax policy and spending cuts that have led to the current issues facing the state. According to Mr. Jordan, tax cuts have made New Mexico's tax system even more regressive and less revenue is available for essential services. New Mexico families with the lowest incomes pay the highest rates in state and local taxes. Mr. Jordan discussed how the current tax system is punitive for working families and suggested the reversal of several tax policies that have been implemented under the promise of job creation. In the face of impending state budget cuts, the state needs to reconsider some of the failed tax cuts while raising new revenue through increased taxes on tobacco, alcohol and internet sales. At the same time, some initiatives, such as raising the minimum wage and expanding paid sick leave and family medical leave, could have big impacts on working families without any additional cost to the state's General Fund. Mr. Jordan believes that the state should fully fund early childhood care and learning programs through a 1.5 percent investment from the Land Grant Permanent Fund. In addition, the state could draw down federal Medicaid funds for home visiting, which has been proven to improve parent involvement in education and decrease child abuse. Mr. Jordan concluded that the budget is a moral document and a reflection of the state's values, and New Mexico children should not have to sacrifice their well-being as a result of budget cuts.

Following the presentation, members of the committee discussed the findings of the KIDS COUNT report. Some key points addressed were:

- various questions about statistics in the presentation with a request for additional statistics and data in the four categories;
- a request for comparisons with the national average;
- potential effects of repealing or "freezing" tax credits;
- the impending special session addressing the budget crisis;
- future presentations to other committees and ongoing collaboration with the Revenue Stabilization and Tax Policy Committee;
- the need to create a "family friendly" state in order to attract jobs and companies to the state;

- the potential for creating an early childhood development department;
- issues and challenges under the current education policy;
- recent issues with SNAP administration and the impact on the state; and
- the CYFD's Pull Together Campaign and potential for allocation of funds for other programs.

Girls in New Mexico's Juvenile Justice System

Denicia Cadena, policy and cultural strategy director, Young Women United, presented on the challenges facing girls and young women in the juvenile justice system. Young Women United leads policy change and community organization for women of color and families most impacted by challenging issues facing New Mexico communities. Ms. Cadena provided background on the creation of the Juvenile Detention Alternatives Initiative (JDAI) in Bernalillo County. The JDAI seeks to reduce reliance on incarceration without sacrificing public safety through program reform in partnership with community agencies and government at the state and local levels. There has been collaboration from over 40 community agencies and leaders, families and youth, mental health providers and justice system stakeholders. The JDAI has focused on reducing racial and ethnic disparities, but has recently been examining gender disparities in the system. Ms. Cadena explained that a "Deep End youth" is a young person who has been identified as waiting for placement in out-of-home placements such as group homes, treatment foster care, residential treatment and long-term commitment. Youth stay an average of 17.5 days in the Bernalillo County Youth Services Center, where as Deep End youth stay up to three times longer. Deep End youth are consistently close to 30 percent of the total juvenile detention population in the youth services center. These youth tend to have more complex needs, but have not always committed more serious offenses.

Esperanza Dodge, Mamas Justice organizer, Young Women United, shared an overview of girls and young women in the juvenile justice system based on Bernalillo County and national data. In the last 15 years, the JDAI has safely reduced the unnecessary use of detention by 74 percent. Between fiscal year (FY) 2012 and FY 2014, there was an eight percent decrease in the number of girls detained, compared to a 26 percent decrease for boys. During the same time period, there was a 12 percent increase in girls' average length of stay compared to a 22 percent decrease for boys. Girls of color make up the majority of those booked and held, as well as those who are committed. Young Women United recognizes that there are needs specific to girls and young women in the juvenile justice system. Girls in the juvenile justice system have disproportionately high rates of past physical and sexual abuse and trauma. Girls reported sexual abuse at 4.4 times the rate of boys. Approaches to dealing with this population must be trauma-informed, gender-specific and culturally relevant.

Ms. Cadena stated that diversion is effective, but New Mexico lacks programming options, especially for girls. There are only five residential treatment centers in the state and only one in Albuquerque that accept girls and young women. Ms. Cadena noted the additional challenges facing members of the lesbian, gay, bisexual, transgender and questioning (LGBTQ) community. Girls who identify as lesbian or bisexual are at a significantly greater risk than

straight peers of being expelled from school, stopped by police and subjected to juvenile arrest and conviction or adult arrest and conviction. Nearly 14 percent of boys in the juvenile justice system identify as LGBTQ; for girls, that figure jumps to almost 40 percent. Ms. Dodge highlighted the need to consider the needs of young parents and expectant young women. There are more young mothers and expectant young women in the juvenile justice system than in the general population of the same age group. Ms. Cadena outlined the objectives of the Deep End girls group and recommendations by Young Women United, which include: exploration of mechanisms for youth other than detention; refocusing on family engagement and crisis intervention; increasing diversion prior to youth entering the system; consideration of specific needs for girls and young women; and listening to the experiences and expertise of girls and young women in the system.

Lyssa Lopez, youth leader, shared her personal experience with the juvenile justice system. Now 19 years old, Ms. Lopez entered the system at age 15 following domestic violence charges. Due to probation violations for running away, she finally ended up in commitment. During the commitment, staff assumed she was LGBTQ; she was subsequently treated differently and harassed by other girls and staff. Ms. Lopez shared various stories of mistreatment that she and other girls experienced. She believes that she would not have ended up in a commitment if there had been other programs available. She stated that the only benefit she received from the experience was the knowledge of not wanting to go back. If there were more places and options for girls, there would be different and better outcomes for individuals.

Members of the committee and the presenters discussed several topics, including:

- the historic decline in the number of residential treatment centers for adolescents in the state;
- the lack of options for alternatives to detention;
- the prevalence of gender disparities;
- inquiries about medication usage in facilities;
- efforts to gather information from individuals in detention regarding their experience and treatment;
- the lack of funding for diversion programs and initiatives;
- an explanation and the benefit of tools like a "stress pass", which allows for a cooling-off period without probation violation;
- collaboration with the CYFD, probation and parole entities and other law enforcement entities;
- inquiries about what is being done statewide and the potential to expand the JDAI;
- efforts to host culturally competent trainings around the LGBTQ community;
- the expansion of programs for sheltering and reintegration for youth;
- the frequency of juveniles arrested on alcohol-related charges; and
- efforts being made to reduce the number of people being entered into the system on minor, nonviolent charges.

Recess

The first day of the LHHS meeting in Farmington recessed at 5:24 p.m.

Wednesday, September 21

Welcome and Introductions

The second day of the LHHS meeting was reconvened at 8:52 a.m. by Senator Ortiz y Pino. Members of the committee and staff introduced themselves.

Update on Access to Community Behavioral Health and Substance Use Disorder Services (Local Panel)

Krista Lawrence, court programs coordinator, drug court, treatment court, juvenile specialty courts and pretrial services, Eleventh Judicial District, works with both adult and juvenile populations. Ms. Lawrence shared the struggles facing the community from a lack of psychiatric providers, therapists and independent living programs for both adults and juveniles. There has been an increase in heroin and opioid abuse in the region. A new program for medically assisted treatments has been started, but it is struggling to find providers who can prescribe methadone and Suboxone.

Laura Ann Crawford, R.N., director, Northwest Region, Presbyterian Medical Services (PMS), noted that behavioral health services start as early as local Head Start programs because they have seen an increase in need due to parental problems. Ms. Crawford described some of the programs in the area, including Farmington Health Services, psycho-social rehabilitation, comprehensive community support services, substance abuse programs and various therapy options. The community does its best to partner within the field to address needs, but it continuously struggles with the lack of providers. Ms. Crawford noted that she has been trying to recruit psychiatric providers for the last several months. When successful in recruiting, psychiatric professionals average about three years in the community before moving. The same challenges exist in recruiting mental health therapists to the area. A few years back, the field experienced several providers not only leaving the area but the profession itself for various reasons. As a result, the wait time for mental health assessments went from one week to up to five weeks. In a tri-county partnership, San Juan County has opened an 11-hour sobering center to help get intoxicated persons off the streets and into a safe environment. Since its opening in March, the facility has served more than 3,100 individuals. This facility is part of the Totah program — a year-long program housed on a three-building campus. Totah is not a detox facility, but the sobering center does have medical staff through its partnership with San Juan Regional Medical Center (SJRMC).

Kim DuTremaine, chief executive officer (CEO)/clinical director, Adult and Adolescent Behavioral Health and Substance Abuse Programs, Cottonwood Clinical Services, discussed some of the services her organization provides in the area. Cottonwood Clinical Services contracts with the CYFD, federal probation and parole and most MCOs and private insurances. It offers intensive outpatient services for adolescents and adults, DWI court and behavioral health

services. Cottonwood Clinical Services has nine clinicians who are dually licensed with both substance abuse and independent practice licenses. On average, 500 people are seen each week in group therapy; this does not include any individual services. There has been an issue with heroin and opioid use in the community; however, only three providers can accept private insurance, making referrals difficult. Ms. DuTremaine expressed frustration with the constant issue of understaffing. Programs at state colleges are graduating students, but graduates are facing difficulty passing licensing examinations and meeting the requirements from MCOs. Responding to a question from a committee member, Ms. DuTremaine explained that the disconnect with graduates gaining licensure is unclear, and she does not know whether graduates are not prepared to pass licensure tests or if they are just not seeking licensure. Additionally, access to service has been severely hampered by a lack of providers. Unless it is an emergency, it takes between three and five weeks to receive care. PMS has been unable to provide some of the substance abuse services it had previously offered. Cottonwood Clinical Services has nowhere to refer patients. Efforts have been made to refer patients to primary care providers who are able to prescribe psychotropic medications, but many primary care physicians will not take Medicaid. Ms. DuTremaine reported no difficulties in working with OptumHealth.

Erin Hourihan, CEO, Childhaven, and board member, Behavioral Health Planning Council, described some of the trends seen locally. According to the CYFD's Protective Services Division, the three main reasons children come into custody are parental substance abuse, mental or behavioral health issues and domestic violence. Alcohol abuse is still the number one reason that children are placed in protective custody in the county. There has also been an increase in the number of newborns testing positive for opioids. More than 150 children have been placed in out-of-state residential treatment centers, limiting their access to family visits and community. This increased number indicates major systemic issues facing the child care system. Ms. Hourihan attributes the start of this issue to the behavioral health disruption in 2013. It is difficult to quickly rebuild a dismantled system, and there is less access to services for children at all levels of care. Overall, there is a reduction in the number of beds for treatment, including those for mental health, foster care and substance abuse. Ms. Hourihan frequently receives calls from all over the state seeking placement for children, but she noted the concern with mixing populations in a shelter facility.

Since 1969, Childhaven has been providing shelter services to children from birth to age 18. It is consistently working with children needing a higher level of care, making it increasingly difficult to find homes with people able to care for the children. Due to financial issues, Childhaven was forced to close its comprehensive community support services in July. While it does serve some urban populations, Childhaven also provides services to rural areas of the Navajo Nation, Shiprock and Kirtland. It does not receive reimbursements for travel to rural areas or for the planning of wraparound services. Ms. Hourihan stated that there is not enough flexibility in funding to provide necessary services. Childhaven has a child advocacy program that works with the courts and law enforcement to determine the best placement options for children. Ms. Hourihan also noted the difficulty her organization experiences in hiring therapists. She believes that one issue adding complexity to the system is having four MCOs.

According to Ms. Hourihan, this has reduced the direct care workforce, as providers compete with the MCOs offering higher salaries to these workers to serve in administrative positions. There is also added complexity due to the lack of uniform billing and credentialing requirements across the four MCOs. Childhaven and other providers have met with partners and state agencies to suggest solutions for addressing problems, with little success. Ms. Hourihan referred to less-than-cordial relations with the CYFD while serving more than 210 children in state custody. She explained how parents are trained to accept more challenging children into foster care. The $350,000 in cuts by the CYFD this year to shelters and regular foster homes is short-sighted and not in the best interests of New Mexico's children. She asked that legislators keep in mind during the upcoming special session the vital work that organizations like Childhaven do for the state.

Julie Young, M.D., diplomate, American Board of Psychiatry and Neurology; and director, behavioral health, SJRMC, addressed the lack of psychiatric services for children and adolescents in the area. The SJRMC has recently contracted for telepsychiatry, an approach favored by both parents and adolescents. Young people do not mind receiving services through a video link; however, face-to-face sessions are still preferred. Dr. Young noted that these services have not been advertised because there are issues getting the MCOs to credential the telepsychiatrists. The closest inpatient facility for adolescents is in Albuquerque; if it is full, adolescents are sent to Las Cruces. This creates an additional hardship on families. The SJRMC has problems linking inpatient and outpatient services due to the lack of record tracking and communication. The community lacks a substance abuse facility, despite tremendous need. The closest residential treatment facility is in Gallup, but the wait is several weeks long. In addition to alcohol abuse treatment, there is additional need for treatment for other substances like methamphetamine and opioids. Dr. Young noted other issues of concern, such as: cases of cannabis-induced psychosis that she attributes to Farmington's proximity to the Colorado border; parental substance abuse; misuse by individuals of social security disability; misuse of emergency rooms by the same individuals on a monthly basis, tying up resources and exhausting medical professionals; patients using inpatient services to avoid law enforcement; absorbing the overflow when United States Department of Veterans Affairs facilities deny services; and the hassle of obtaining prior authorization from health insurers for common medications and dosage changes. Due to privacy laws, Dr. Young explained that some of these issues are not reported.

Following the presentation from the local provider panel, committee members had several comments and questions, including:

- the failure of recent counseling graduates to sit for licensure and efforts to encourage growth in the field;
- compensation and other incentives for hiring and retention of professionals in the community;
- the capacity and limited services offered by the sobering center;
- funding sources and potential cuts for treatment centers and specialty courts;
- additional licensing requirements for working with adolescents;

- the potential for hospitals to add residency slots;
- expansion of the telepsychiatry program;
- prescriptive authority for psychologists and clarification on supervision requirements;
- the impact of the 2013 behavioral health disruption on morale and recruitment;
- the increase in the incidence of mental illness in the juvenile justice population;
- collaboration between providers and the creation of work groups and multidisciplinary teams to problem solve;
- the lack of Suboxone prescribers;
- medical detox in emergency rooms;
- issues with SED and the medical necessity requirement for Medicaid reimbursement; and
- the benefits of early intervention and home visiting programs.

In response to an invitation from the chair, the panel made the following recommendations.

1. *Independent living options.* Sending youth and adults, post-treatment, back to the same environment that contributed to the initial problem increases the likelihood for relapse.

2. *Expansion of the Treat First Program*. PMS is a pilot site for this program, which allows providers to get individuals in crisis help without requiring a behavioral health assessment. The program allows a patient to have four sessions. By engaging patients in the first session, the likelihood for them to continue to seek services and help is increased. There are six sites around the state that have this program.

3. *Reduction of caseloads*. The managed care system's overabundance of care coordinators is not improving care, and the additional paperwork requirements are burdensome on providers.

4. *Decreasing the number of MCOs.* Fewer MCOs would decrease the administrative burden on providers and be more efficient and cost-effective.

5. *Increasing flexibility of coverage.* Allowing reimbursements for services, such as follow-up calls, would have a tremendous effect on patient satisfaction and improve health outcomes. It would decrease the number of face-to-face visits, allowing providers to see more patients.

Pregnancy Accommodation and Family Leave

Representative Chasey gave a presentation regarding legislation she intends to carry in the 2017 legislative session that would extend pregnancy accommodation and family leave to New Mexicans. Representative Chasey shared some background on the issue and a United States Supreme Court case involving a postal worker who was fired from her job due to limitations during her pregnancy. Under current federal law, pregnancy accommodation requirements exist,

but only for employers with 50 employees or more. During the 2015 legislative session, Representative Chasey sponsored the Pregnant Worker Accommodation Act (House Bill 37), a bill requiring employers to make reasonable accommodation for an employee's or a job applicant's pregnancy, childbirth or related condition. The bill was meant to be friendly to small businesses, but those opposed claimed that it would place an undue hardship on businesses, and the bill ultimately died in committee. Representative Chasey considers this legislation to be very "pro-family" by potentially decreasing terminated pregnancies.

Pamelya P. Herndon, executive director, Southwest Women's Law Center, provided the committee with several statistics related to women in the workplace. The top employers in the state are the University of New Mexico (UNM), Los Alamos National Laboratory, Sandia National Laboratories, UNM Hospital and the State of New Mexico. There are more than 67,000 state employees, the majority of whom are women. In New Mexico, working women are the breadwinners in 41 percent of families; 72 percent of single mothers work; 48 percent of women in the state are of child-bearing age; and approximately 880,000 households are living at or below the poverty line. With the high rates of poverty, working women need to work throughout their pregnancies. Losing employment during this period only makes the issue harder for women and New Mexico families. Ms. Herndon shared several examples of women who were terminated from their workplaces during pregnancy due to requests for reasonable accommodations. The proposed legislation, in its current form, would amend the human rights statutes to allow women to provide a doctor's note allowing for additional bathroom breaks, exemption from heavy lifting and options for temporary reassignment of work. Ms. Herndon added that input is currently being sought on this legislation for improvements and to increase the likelihood of passage. Representative Chasey stated that amendments made to the original bill have been taken into consideration, and several employment law attorneys will have an opportunity for input prior to requesting LHHS endorsement.

Sarah Coffey, staff attorney, Southwest Women's Law Center, noted some of the differences between the legislation proposed for the 2017 legislative session and legislation introduced in the 2015 legislative session. The term "reasonable accommodation" is being added with the intent of generalizing the bill. By not listing specific accommodations in the legislation, women and employers would be able to adjust to any potential complications that may arise during a pregnancy. The accommodation would be based on a health care provider's recommendation and would apply to any business with more than one employee. The legislation includes a provision stating that if the accommodation creates an undue hardship on the employer, it would not be required to provide it.

In the ensuing discussion, committee members raised the following ideas and concerns:

- disagreement with classifying pregnancy as a disability;
- the potential for legislation to include the term "health conditions" as a reference to short-term conditions like pregnancy and other illnesses;

- amending the Human Rights Act to include pregnancy accommodation and other potential statutes;
- other states that have passed similar legislation;
- a comparison to the federal Family and Medical Leave Act of 1993;
- other language suggestions for the proposed legislation; and
- the cost benefit of extending protection to employees of small businesses.

Update from Medicaid MCOs on Statewide Access to Behavioral Health and Substance Use Disorder Services

Quinn Glenzinski, director, Network Operations for Government Programs, Blue Cross and Blue Shield of New Mexico (BCBS), shared the current status of BCBS's provider network (please see handout). Mr. Glenzinski noted that MCOs calculate the provider network based on the number of actual providers and the number of practice locations; therefore, counts may vary and providers may be counted multiple times if they have multiple practices. BCBS monitors the provider network on a monthly basis and meets frequently with larger providers. Mr. Glenzinski addressed the recent transition with core service agencies (CSAs) in the state. He noted that the collaboration among MCOs, providers and state agencies as CSAs were leaving the state was an impressive feat. BCBS continues to work to fill those gaps, but he believes it will have a stronger network than before.

Lisa Mortensen, director, Behavioral Health, Government Programs, BCBS, discussed the clinical side of what the company offers to members. There are 200 care coordinators across the state. Of those, 33 are behavioral health care coordinators who are licensed clinicians or psychiatric nurses. Some members with mental health or substance abuse disorders do not self-report due to the fear of being stigmatized. These members can be identified due to the efforts of post-discharge complex care intervention and through community care medicine. BCBS is contracted with emergency medical technician (EMT) and ambulance services that follow up with patients to ensure that they understand discharge orders and have necessary medication. Another program used by BCBS is to send care coordinators to larger hospitals to discuss discharge plans and inquire about any potential health barriers the patient might face. A new pilot project sends a peer coordinator to UNM Hospital and Turquoise Lodge to work with patients and to help reduce the fear of being stigmatized.

Liz Lacouture, executive director of behavioral health, Presbyterian Health Plan, noted that there are some similarities among the four MCOs. In cases where patients have multiple diagnoses, the providers frequently do not code mental health and substance abuse, making it difficult to collect complete data sets. Ms. Lacouture suspects that the number of substance abuse disorders is underrepresented. Presbyterian has 289 general psychiatrists; 20 of those are child psychiatrists or are eligible for board certification. In terms of medically assisted treatment, there are 22 Suboxone prescribers who have a psychiatric specialty and more than 200 more who do not. There are 800 members per month receiving Suboxone. Presbyterian has care coordinators who are licensed or have significant experience in the field, as well as peer support specialists who work to divert individuals from emergency rooms. Ms. Lacouture explained that

work continues with the providers through contractual relationships to eliminate barriers to access. Presbyterian is working to improve its delivery system and responsiveness to substance abuse disorders. All MCOs have been working with the CYFD on systems of care grants to target some of the more complex needs of some youth. The MCOs are collaborating to increase services.

Marcello Maviglia, M.D., medical director, Molina Healthcare of New Mexico, stated that the Treat First Program is a good concept. The majority of dropouts happen during the beginning stages of treatment. By making the process more swift and less cumbersome, individuals are engaged from the start and retention rates are increased. Dr. Maviglia is a psychiatrist specializing in addiction and behavioral health. Molina believes that recovery is a holistic process that includes many components. The goal is building and sustaining a recovery community using an evidence-based approach. Access to care requires a solid plan that includes care coordination and good resources. Dr. Maviglia described different methods that Molina uses to screen patients for substance abuse disorders. About 45 percent to 60 percent of members admitted for care have a substance abuse disorder. He stressed that while heroin is a big issue, Molina sees many patients who abuse stimulants and alcohol. About 10 percent to 15 percent of those admitted for behavioral health issues show signs of substance withdrawal. Statistics reflect wait times for Suboxone in more concentrated urban areas to be between four and six weeks. There are also not enough child psychologists. Molina is working to address some of these issues by providing ongoing training for care coordinators and transitional coaches on recovery methods. Medical surgery providers and staff are being trained in recovery-based approaches to step down its members with substance abuse disorders, referring them to lower levels of care. This is about creating ties between Medicaid and non-Medicaid programs. The first training will take place in October at Memorial Hospital. Molina will also be assisting UNM hospitals with recovery approaches. In addition, care coordinators and peer support specialists are working with specific methadone clinics on ease of access. Dr. Maviglia also explained the pilot project that Molina is launching with the Bernalillo County Metropolitan Detention Center (MDC) offering incentives to providers to follow up with individuals post-release within seven to 10 days and efforts to expand the Inside-Out Prison Exchange Program.

Adan Carriaga, program manager, Molina Healthcare of New Mexico, provided information about a recent joint project in Albuquerque initiated by all four MCOs. The HSD provided a mini-grant for the event, which had more than 700 attendees and 45 booths from people providing services not covered by Medicaid. With some individuals wanting detox coming into the system, Mr. Carriaga explained that the MCOs decided to network with other organizations, including faith-based programs. He expanded on Molina's usage of peer support and partnership with the MDC. Molina has identified frequent users of emergency services and has been working with them to get them into long-term support. Mr. Carriaga emphasized that recovery is a very individual decision and the person has to want it. As an MCO, Molina can provide members with options and develop an atmosphere of recovery for when they are ready. Molina is also working to identify individuals with hepatitis C to encourage them to stay in programs to get help and also address addiction issues. Additionally, Molina is working with the

federal Department of Housing and Urban Development, the New Mexico Coalition to End Homelessness and faith-based recovery homes to establish supportive housing.

Dr. Denise Leonardi, chief medical officer, UnitedHealthcare Community Plan of New Mexico (UHC), is a family physician who has seen many patients come for care with substance abuse disorders. While substance abuse is a large problem for New Mexico, it is also a national problem. UHC differs from the other MCOs because it serves a larger portion of the Medicaid expansion population. The average member is 45 years of age. Approximately 21 percent of UHC's members have a severe mental illness or a substance abuse disorder. UHC has 108 psychiatrists in its network and offers similar services to the other MCOs. Dr. Leonardi stated that UHC does offer some intensive outpatient services for members age 13 and older. In terms of inpatient services, most patients are admitted through the emergency room. UHC uses accredited residential services and has contracts with four health centers. Methadone clinics can only treat people over the age of 19. There are about 400 methadone providers in the state; about 137 of those are contracted providers and the rest are cash-only providers. The number of Suboxone providers fluctuates from quarter to quarter. Dr. Leonardi discussed some of UHC's efforts in working with patients on treatment goals, emergency room diversion and reducing barriers to treatment by attempting to address stigma associated with, and lack of information about, substance abuse disorders. UHC recognizes that social determinants of health have a big impact on outcomes for these members. The challenge of addressing substance abuse goes beyond Medicaid and providers. Some issues that UHC is facing are the lack of providers to treat this population, a shortage of other health care workers and licensing barriers, particularly for licensed alcohol and drug abuse counselors. UHC is also actively involved in National Recovery Month to educate the public about addiction and recovery. It continues to work in the development of peer certification and to provide mental health first aid training.

Dr. Wayne Lindstrom, director, BHSD, HSD, joined the panel during questioning by committee members regarding:

- clarifying data presented on the number of providers within networks;
- concern about duplication of provider counts and types of providers included in the data;
- the benefits of the Treat First Program, including increased retention rates;
- expansion of the Treat First Program pilot;
- arrangements with the Corrections Department for Medicaid-eligible inmates preparing for release and a pilot program with the MDC for tracking new Medicaid members;
- collecting data across all state departments and agencies, eliminating existing silos;
- the HSD's Medicaid Management Information System;
- the number of behavioral health professionals, detox beds, methadone providers and Suboxone providers still needed in the state;
- support for hospitals in training medical staff on substance abuse and detox;
- wait times for treatment;

- the importance of step-down programs and community support services following detox;
- gathering data by ethnic group and the need for cultural sensitivity;
- the difficulty in recruiting behavioral health professionals;
- provider credentialing by the MCOs;
- the need for providers to notify MCOs if they have moved or switched practices to improve tracking data;
- changing the focus of an MCO's role from demonstrating network adequacy to identifying deficiencies in the health system;
- the complexity of rate setting;
- the need for data on the number of deaths of those members diagnosed with SED;
- other examples of pilot programs, including partnerships with the CYFD and peer support specialist home visiting; and
- the effect of the budget deficit on the state planning process.

Proposed Changes to Hours of Sale for Packaged Liquor

Jackie McKinney, mayor, City of Gallup, addressed the committee seeking support for a local option district to change the hours of sale for packaged liquor. The City of Gallup wants to delay sales until after 11:00 a.m. by referendum, and the change would only affect the city and McKinley County. Senator George K. Munoz has requested that a bill be drafted for the upcoming legislative session creating the local option district. Mayor McKinney provided some background on the issue and recent measures taken to get public support. A recent bond election asking residents whether they would support restricting sales to after 11:00 a.m. received over 70 percent approval. Gallup has had a detox center for several years with a great model. After the center closed due to lack of funding, the city entered into an agreement with the Navajo Nation to keep it open. Following a recent Navajo Nation election, this agreement is no longer in effect. Mayor McKinney stressed that the first step to recovery is detox. The city has service aides who go out nightly to pick up intoxicated individuals who are a danger to themselves and others. They are taken to the detox center, where they can be held for up to 72 hours. On average, 45,000 people per year are taken to the center, and some are the same individuals with multiple visits. The City of Gallup is working with Dr. Lindstrom on creating some new programs at the detox center and wants to commit to behavioral health investment zone funding. Currently, the detox program is funded through the local liquor excise tax on a year-to-year basis. The intent is to discontinue the revolving door policy at the detox center and provide individuals with options for treatment. Nearly half the population of Gallup is Native American, and Gallup is surrounded on three sides by tribal lands. The City of Gallup has been working with the Native American community on this proposal.

The situation in Gallup has placed an overwhelming burden on law enforcement. The City of Gallup has 68 certified police officers, which is two-and-a-half times the national average for its population. On average, police officers handle between 400 and 500 calls per month. Mayor McKinney noted that this number is more than the number of calls handled by the Albuquerque Police Department. Last year, there were 20 exposure and alcohol poisoning deaths

per month, along with multiple cases of violence among homeless individuals. The goal of the proposal to limit liquor sales to after 11:00 a.m. is to save lives. If the bill passes, the city will have the ability to hold a referendum. Mayor McKinney is confident that the community will support the measure, and the impact will be significant. He is asking for the support of the committee to pass this legislation to allow the community to make a positive social change.

Fran Palochak, city councilor, City of Gallup, has witnessed the impact of alcohol abuse in her community over the course of her life there. Ms. Palochak works in a Catholic-run soup kitchen serving breakfast to more than 100 people per day during the winter months. The soup kitchen tries to feed them during the summer but as the weather gets warmer, individuals do not want to come in at 6:30 a.m., and by 8:00 a.m. they are already intoxicated. The soup kitchen will not allow them into the building to eat if they are drunk. As a citizen and public official, Ms. Palochak believes that reducing morning hours of liquor sales will result in more individuals coming to the soup kitchen to receive a meal and increase the likelihood that they will seek help.

Mark Fleischer, lobbyist, City of Gallup, stated that people outside of Gallup do not understand how endemic public intoxication is in the area. Gallup city officials want the ability to determine how to best address this problem in their community.

Following the presentation from the panel, questions from committee members addressed the following:

- reduced detox center funding due to state budget cuts;
- increasing the liquor excise tax by $0.25;
- the burden of alcohol misuse on all taxpayers;
- the incidence of DWI in Gallup;
- the Navajo Nation's termination of its agreement to support the detox center; and
- the role of the Indian Health Service in addressing this issue and providing better health care to Native Americans.

Ruben Baca, lobbyist for the New Mexico Grocers Association, requested to see the proposal and asked to be included in discussions regarding the proposal. Mr. Baca wants to see whether the association and the City of Gallup can work together on this.

John Thompson represents liquor distributors in the state. Mr. Thompson stated that he had not heard about the proposed changes to hours of sale for packaged liquor, but he would take the information back to his clients. He expressed interest in working with the City of Gallup leadership on any potential legislation.

Mayor McKinney noted that the City of Gallup asked for voluntary help from local liquor licensees but got a very limited response. Senator Ortiz y Pino indicated that this legislation would be added to the agenda during the November meeting for potential endorsement by the LHHS.

Public Comment

Kay Peters, occupational therapist, is the director of the Occupational Therapy Assistance Program at San Juan College. Ms. Peters discussed the current scope of practice of occupational therapists, which includes working with recent stroke patients and individuals with autism. Occupational therapists will be seeking to expand their scope of practice during the 2017 session; the terminology has not been updated in 15 years. Ms. Peters requested the support of the committee for the legislation. Representative Armstrong sponsored a similar bill in 2015 that modernized the language of the practice, but upon passage by both chambers, the bill was vetoed. Representative Armstrong expressed interest in sponsoring the bill during the upcoming session.

Senator Ortiz y Pino called the members' attention to a letter sent to the committee from Torrey Moorman regarding the medical cannabis program discussed during the LHHS meeting in Taos.

Recess

The second day of the LHHS meeting recessed at 5:15 p.m.

Thursday, September 22

Welcome and Introductions

The third day of the LHHS meeting in Farmington was reconvened at 8:53 a.m. Members and staff introduced themselves.

Community Paramedicine

Andres Mercado, mobile integrated health (MIH) officer, City of Santa Fe Fire Department (SFFD), presented to the committee about the growing field of community paramedicine. In 1965, more Americans died on the roads than in combat. This caused the United States to create the emergency medical services (EMS) system. The EMS system has since become a mainstay in communities all around the country. Originally, the system was designed to stabilize and transport patients, but over the last several years, the role has changed to dealing with more general medical issues. Health care and health insurance have faced a restructuring with the implementation of the ACA. Mr. Mercado explained some of the challenges in misuse of the system that EMS personnel frequently see. People more readily call 911 for non-life-threatening illnesses, and paramedics are required to respond to calls in the same manner that they would for a vehicle accident. In Santa Fe, 0.3 percent of the population accounts for 90 percent of the emergency calls. One individual was transported to the hospital by EMS 65 times in one year, plus several additional emergency room visits. This individual had mental health and substance abuse issues and bounced between the jail, hospital, emergency room and fire department. Mr. Mercado explained the steps that the SFFD took to engage the individual to get him the services he needed. Since his needs were met, he has not called 911 once. While the SFFD cannot provide this level of service to everyone in the community, when it engages with particular individuals — known as "hotspotting" — great results occur.

Mr. Mercado explained that there is an international trend for expanding the EMS system. There are two terms being used in the field: community paramedicine and MIH. Community paramedicine has been around for a long time in rural environments, and the licensure level has higher clinical responsibilities. Community paramedicine is now being deployed in less rural areas. By comparison, MIH has a team focus where EMTs work with clinicians, social workers and pharmacists. More robust programs have physician assistants as part of the team. MIH has the ability to identify some of the individuals tying up emergency resources and to work to get them the help they need. Since these are individuals with interdisciplinary problems, they need interdisciplinary teams. Mr. Mercado stated that the hotspotting program is just the beginning; MIH can provide an alternate response to calls instead of ambulance deployment and help with emergency room diversion. The SFFD is exploring follow-up care, response to senior falls, flu clinics and presentations on health and safety. Mr. Mercado recognized telemedicine as a tremendously powerful tool. The way communities are delivering health care is evolving, and the SFFD is taking measures to transform its services by integrating physical and behavioral health, while addressing the social determinants of health.

David Burke, deputy fire chief, Farmington Fire Department, stated that Farmington is still in the beginning stages of implementing community paramedicine and MIH, but it is moving toward MIH to address similar issues in the community as Mr. Mercado described. Deputy Chief Burke said the city is looking at community data to see what can be done proactively. Financially, it makes good sense to strategically employ services without tying up critical resources. Deputy Chief Burke explained that the SJRMC provides regional EMS, and the fire department also responds to all calls. The first responder community continues to build relationships among hospitals, law enforcement and EMS, he stated.

Darren Braude, M.D., professor of emergency medicine and anesthesiology, UNM Health Sciences Center (HSC), noted that as with all other programs, funding is a big issue. However, there are creative ways that fire departments and counties are making these programs work. Rio Rancho has a program where personnel are required to proactively go out and make at least one visit instead of waiting for a 911 call. Albuquerque has expanded this to include visits to hospice patients. Other departments have been doing programs like these for some time, just without an official name. Now that it has a name, Dr. Braude believes that entities can collaborate better.

The committee thanked the panelists for their contribution to comprehensive care and discussed the following points:

- the ability to add members to the team based on the needs of the patient and the community;
- state and local involvement;
- state oversight by the DOH's EMS Bureau and medical committee membership;
- inquiries about the scope of practice for MIH;
- acknowledgment that every community has different needs and how MIH can be adapted to address those;

- details about training and curriculum through UNM and community colleges;
- the issue of coverage and expanding services into the more rural regions of the state;
- explanation of how transportation and emergency service costs are billed and reimbursed;
- budgetary limitations of individual departments;
- the goal to reduce utilization while meeting needs of the community;
- the lack of return from MCOs despite costs savings by departments;
- MCOs' claims of similar use of care coordinators;
- the prevalence of volunteer EMS and fire services in the state;
- Medicaid expansion impact on emergency services;
- potential termination of the NurseAdvice New Mexico line;
- data collection and tracking currently being conducted to demonstrate program value;
- utilization of existing infrastructure; and
- the paradigm shift of placing emphasis on preemptive care.

San Juan County Juvenile Justice Services

Traci M. Neff, administrator of juvenile services, San Juan County, provided the committee with an update on juvenile justice services in the region (please see handout). The juvenile facility began operations at its new location in January 2004. Since opening, the facility has received several awards and continues to add to its array of services. Ms. Neff emphasized that just because agencies are closing their facilities for juveniles does not mean the need is not there. She provided an overview of services and challenges that the county faces. San Juan County currently offers the following services.

1. *Crisis shelter*. To date, the crisis shelter has served a total of 3,034 adolescents in San Juan County, with an average of 253 per year. Adolescents being referred are high need/high risk due to the system seeking alternatives to detention. By design, the crisis shelter is a short-term option, and adolescents stay in this placement between three and six months. Education is a requirement during an individual's stay and the individual must be enrolled in school. San Juan County funds the crisis shelter at 100 percent.

2. *Residential treatment center*. The residential treatment center has served a total of 646 adolescents from San Juan County and other surrounding counties, averaging 54 clients per year. San Juan County provides this service through a contract with PMS on an annual basis. PMS provides treatment services and staffing, and the county provides the building, utilities, maintenance, meals for clients and education of residents. This allows PMS to only focus on treatment and care. It currently receives more than 30 referrals a month, but it has only 12 beds.

3. *Detention/community safety*. San Juan County has served a total of 5,864 juveniles in detention, with an average of 451 per year. While in detention, juveniles receive education, mental health (including psychiatric) care and programming focused on life skills, budgeting and overall health and wellness. While the detention population has decreased, the number of high-need juveniles being detained more frequently and for longer periods of time has increased. The

detention facility is challenged by the "revolving door" of juveniles who continue to violate conditions of release by the court or conditions of probation.

4. *Committed juveniles to the CYFD*. In January 2007, the CYFD contracted with San Juan County to provide regional long-term care for committed juveniles. San Juan County is the only county in the state serving youth under a long-term contract. By design, the facility is only able to serve a male population. Regionalization has proven to be more beneficial to juveniles so that they can engage in face-to-face family therapy and continue to engage with community providers for their schooling, cultural services and juvenile probation officers. Transition back into the community is more seamless and allows the juvenile a better opportunity to succeed.

Ms. Neff stressed the importance of education for these individuals. For most of these juveniles, their education has been fragmented. The Farmington Municipal School District provides the same curriculum and testing that students would receive in a traditional classroom. Online programs and college courses through San Juan College are also available to juveniles in the facility. San Juan County has strong partnerships with many community providers, law enforcement and the juvenile justice system in the region.

Matthew Kaufman, public defender, Eleventh Judicial District, represents the majority of juvenile delinquency cases in the area. He is proud of the work that San Juan County has done, and he recognized Ms. Neff's many accomplishments. The community partnerships are very cohesive and a great model for other communities. However, there are still gaps and institutional challenges that the system faces. In response to a question about the length of commitments, Mr. Kaufman explained that time served is not taken into account. The court defers to recommendations from professional need and risk assessments to determine the length of commitment. If the recommendation is for longer than a year, then a two-year commitment is ordered to provide for services. Other states have more alternatives for detention. In New Mexico, juveniles end up in detention because it is the best place for them to receive the services they need, including more access to Medicaid benefits.

Nick Costales, deputy director of field services, CYFD, joined the panel to respond to inquiries from the committee. In response to questions from committee members, the panel addressed the following issues:

- Medicaid benefits for juveniles while in detention;
- the need for more alternatives to detention and for building up detention programs in other parts of the state;
- long-lasting negative effects of detention, including stigma and damaged self-image;
- the critical need for support services after release to prevent reentry from violations;
- the value of having a facility under contract with the CYFD;
- recommendations by the Legislative Finance Committee to terminate the contract with the CYFD;
- alternative funding mechanisms for programs;

- limitations with Juvenile Justice Advisory Committee funding;
- the state to scale initiative in collaboration with the New Mexico Supreme Court, the CYFD and the New Mexico Association of Counties;
- contributions from the Annie E. Casey Foundation for staff training;
- explanation of the layout and capacity of the facility;
- more violent juveniles and sexual abuse cases;
- committee requests for recidivism rates;
- the need for supportive housing programs throughout the state;
- collaboration with the Navajo Nation and efforts to address the needs of the Native American population;
- referrals to treatment facilities like Sequoyah Adolescent Treatment Center (SATC); and
- the need for a facility specifically for females.

Public Comment

Glenn Ford advocates for families of those who have a brain injury. Brain injuries can have both a cognitive and a behavioral health effect on an individual. Mr. Ford stated that MCOs do not know how to service these individuals. The number of people living with brain injuries is comparable to those who have behavioral health conditions. Nationally, 60 percent of individuals who have experienced abuse have a brain injury; yet screening is not being conducted. The Centers for Disease Control and Prevention has screening tools, and there are tools for states to use. Mr. Ford stated that unfortunately, brain injury was relegated to the Aging and Long-Term Services Department (ALTSD) and was inadequately funded. Currently, brain injuries are within the purview of the developmental disability community and are being handled in the same manner as intellectual and developmental disabilities. This is not the appropriate place for them, according to Mr. Ford. The New Mexico Brain Injury Alliance has been working with people for over 30 years, and one of the leading surgeons in the world, Dr. David Durham, is in Farmington. The New Mexico Brain Injury Alliance board is composed of individuals with brain injuries and their family members. Mr. Ford noted that schools are not screening for brain injuries, and Disability Rights New Mexico has been filing lawsuits against schools. Carrie Tingley Hospital in Albuquerque is a tremendous resource for children with brain injuries.

Mr. Ford expressed concern that the state is regressing rapidly in this area and that people are suffering. Detention centers are increasingly becoming the de facto place to deal with these individuals. With proper diagnosis and treatment, individuals can become valuable, contributing members of society. Members of the committee discussed other potential agencies to oversee this condition and what other states are doing. The potential for a Medicaid waivers was raised, but it was noted that only 10 percent of individuals with brain injuries would qualify for Medicaid. Members were interested in learning more about the model created in New York to address screenings. Mr. Ford agreed to send information to LCS staff for potential drafting of a memorial to study the need for screenings and implementation.

DOH Programs Update

A panel of representatives from the DOH testified to the committee regarding updates on Turquoise Lodge Hospital, SATC and boarding home licensure (please refer to handout for details of the presentation). Both Gabrielle Sanchez-Sandoval, deputy secretary, DOH, and Judith Parks, deputy director, Division of Health Improvement, DOH, participated in the panel via teleconference.

Turquoise Lodge

Shauna Hartley, administrator, Turquoise Lodge Hospital, DOH, provided the committee with background on the facility and the decision to close the adolescent treatment wing. Turquoise Lodge was founded in 1952 for adults in need of substance abuse treatment and both medical detox and social rehabilitation. An adolescent program began in June 2013. The program for adolescents was designed by community stakeholders from various organizations, including the CYFD, the juvenile justice system, CSAs, Bernalillo County and other concerned community partners. According to Ms. Hartley, the average number of days from request for treatment to offer of a bed was five days, and nine days from request to admission. Approximately 20 percent of all referrals were not assessed due to the DOH's inability to contact the individuals after three attempts, the individuals were no longer seeking treatment or referral sources chose other options for detox and treatment. Of all referrals assessed, 17 percent were not approved because they did not meet admission criteria. Ms. Hartley added that other intensive outpatient programs must be attempted prior to inpatient committal. The adolescent program at Turquoise Lodge contained 20 beds and was designed as a voluntary treatment program for youth ages 14 to 18. No waiting list was ever established for the adolescent program due to underutilization of available beds. The highest level of utilization that the wing experienced was 10 to 12 individuals at one time, according to Ms. Hartley. From January to June 2016, the hospital underwent a heating, ventilation and air conditioning (HVAC) renovation, which required closure of one wing of the unit. The boys' wing remained open due to greater utilization of services. In July 2016, the unit for girls was reopened, and girls were admitted at that time. Ms. Hartley explained that there has always been a greater need for adults seeking detox. For FY 2016, the adolescent program had 198 requests for treatment and 98 admissions. Conversely, the adult program had 2,922 requests for treatment and 1,002 admissions. Both the medical detox and social rehabilitation programs for adolescents were ultimately shut down in August.

Dr. Babak Mirin, medical director, Turquoise Lodge and SATC, testified that an individual seeking detox at an emergency room would receive service if the individual is actively experiencing withdrawal. Insurance companies do not reimburse for planned detox. There is an issue with people not being properly diagnosed by primary care providers and, therefore, not properly treated. Dr. Mirin stated that the majority of adolescents seeking detox have issues other than behavioral health conditions. The system is fragmented, and access to care is a real issue in the state.

Members of the committee expressed outrage and disappointment over the DOH's decision to close the adolescent program at Turquoise Lodge. The following points and inquiries were made in regard to Turquoise Lodge:

- details about admission criteria for the facility (the DOH will send a full list of criteria to the committee);
- justification by the DOH of underutilization;
- inquiries regarding considerations and attempts to remain open, including a reduction in the number of beds;
- a description of the layout and design of the facility;
- safety reasons and the practical need for separation of populations within the facility;
- the funding source for the HVAC upgrade;
- medical detox practices and procedures at the facility for both adolescents and adults;
- emergency rooms and outpatient programs as the only available options for adolescents seeking detox;
- contradictions with provider testimony about the availability of medical detox at emergency rooms;
- extensive testimony previously given to the LHHS from individuals and providers seeking adolescent beds at Turquoise Lodge prior to closure;
- the juvenile justice system as the largest referrer to the program and issues the facility witnessed with youth wanting to avoid detention;
- efforts for outreach to increase utilization;
- the decrease in referrals following the credible allegations of fraud in the behavioral health system;
- difficulty in treating and retaining adolescents;
- the benefit if one provider stays with the individual throughout the process, creating a level of consistency and continuum of care;
- the original intent and design of the facility to serve adults;
- partial response to financial issues of the state and the need to look at what services are reimbursable;
- no statutory mandate for the facility;
- the collective decision to close the adolescent program following evaluation of the department budget and examination of utilization data;
- the Office of the Governor was informed of the decision;
- concerns about the reappropriation of funding from the adolescent program to the adult program and the intent of the legislature for the initial allocation of funds;
- medical detox is reimbursable by Medicaid, whereas social rehabilitation is not;
- programmatic system gaps created by leveraging federal Medicaid funding;
- attempts made to combine services and funding with other providers in the state;
- Turquoise Lodge as the only facility in the state that provided specific services, namely medical detox; and
- an official request for a list of individuals that the DOH consulted with on the closure.

SATC

Carmela Sandoval, administrator, SATC, discussed the admission criteria for the facility and highlighted some improvements since the 2015 summit with the LHHS. SATC operates a male adolescent 36-bed facility in Albuquerque for individuals who are violent or have a history of violence, have a mental disorder and are amenable to treatment. The facility has increased its services to male adolescents from 58 admissions in FY 2014 to 98 admissions in FY 2016. SATC has decreased its usage of physical holds and is no longer using mechanical restraints. As part of the model of care improvements, SATC has five certified teachers providing education in core subjects, including a physical education and health component. Ms. Sandoval noted some of the successes of the educational program and improved communication with parents. As part of the recommendation from the SATC, a task force was established pursuant to SM 15 in 2015, and a "Clinical Learner's Circle" was developed with membership of local entities that provide psychiatric care to adolescents in a residential treatment setting. The group meets quarterly to discuss challenges in facilities.

In response to a question from the committee, Ms. Sandoval explained that due to the current structure of the facility, SATC is unable to offer services to female adolescents. Desert Hills is another facility in the state that offers similar services to females. SATC averages 30 individuals per month, with the average length of stay between six and nine months. A member of the committee requested a breakdown of utilization by month. Ms. Sandoval confirmed that community referrals are consistent, and SATC is working on an active referral list daily. SATC is always recruiting staff and is currently maintaining a steady budget. An admission committee determines if an individual meets the criteria, but the number of rejections or how many adolescents are being sent out of state is not tracked.

Boarding Homes

Ms. Parks provided the committee with information regarding the licensure of boarding homes in New Mexico. The DOH does not license any facility that does not provide health services. The DOH's role is purely regulatory, and it does not contract with facilities to provide care. If a complaint is filed, the DOH will investigate the complaint and will refer nonjurisdictional complaints to the appropriate oversight entities. Ms. Parks noted that the DOH can seek a cease and desist order if an entity is providing health care and operating without a license. Because boarding homes typically have a landlord-tenant relationship, they do not fall under the purview of the DOH. However, if the facility is providing health care, it is licensed by the DOH as an "assisted living facility". Under New Mexico statute, an assisted living facility is a facility operated for the care of two or more adults who need or desire assistance with one or more activities of daily living (ADLs). Ms. Parks listed several examples of ADLs and made the distinction between ADLs and instrumental activities of daily living (IADLs), which are activities related to independent living.

As previously requested by the LHHS, Ms. Parks shared data relating to assisted living facilities in the state. As of June 2, 2016, there were 204 assisted living facilities in New Mexico. The DOH has six surveyors and has completed 53 surveys from January to June 2016.

Since 2011, only one cease and desist order has been issued for operating without a license. According to Ms. Parks, the following data are not retrievable from the database in a usable format: the number of assisted living facilities closed by the DOH; owner/operator name and address; and affiliation with a corporation or chain. The number of people residing in each facility is not tracked or collected because the numbers change daily.

Members of the committee had the following inquiries:

- the purpose of tracking data if data cannot be accessed as a report;
- inconsistencies between the number of Board of Pharmacy permits for medication assistance and the DOH's list of facilities;
- the issue of substandard and inadequate care in boarding homes;
- reconsideration of the DOH's role in overseeing boarding homes;
- the inaccurate description of boarding homes as a landlord/tenant relationship; and
- the critical need to define terms accurately.

ALTSD Update

Myles Copeland, secretary, ALTSD, discussed the strategic plan for the agency (please see handouts). Secretary Copeland acknowledged Homer Post from the Farmington Senior Center, noting the important role of volunteer service in improving the daily lives and functions of seniors. The primary goal of the ALTSD is to promote lifelong independence and healthy aging. Secretary Copeland provided an overview of the multiple functions and initiatives of the department while addressing some of the major challenges in the state, including poverty, isolation, a growing elder population, disabilities and language and cultural barriers. The department's strategic priorities are derived from assessments of need, trends and challenges associated with the increasing number of older New Mexicans, as well as compliance with multiple governmental acts and statutes. These priorities include the following.

1. *Safeguard vulnerable adults and elders.* The ALTSD has four programs to protect vulnerable adults and elders: the Adult Protective Services Program (APS), Long-Term Care Ombudsman Program, Senior Medicare Patrol Program (SMP) and Legal Services. The APS responds to situations in which functionally incapacitated adults are being harmed, are in danger of mistreatment, are unable to protect themselves and have no one else to assist them. Self-neglect accounts for 53 percent of all substantiated allegations investigated by the APS in FY 2016. The Long-Term Care Ombudsman Program works to educate people on their rights and has the ability to refer cases to the APS with strict guidelines for confidentiality. The ombudsman program is operated by 80 volunteers who work with individuals, families and staff in facilities. The SMP helps to identify instances of Medicare fraud by educating beneficiaries on identity theft and other fraudulent practices. The ALTSD contracts with organizations for the provision of legal assistance to older New Mexicans for a wide variety of legal issues, such as landlord/tenant issues and powers of attorney.

2. *Support caregivers*. Approximately one in five New Mexicans serves as a family caregiver during any given year, which is an annual total of 419,000 people. Family caregivers provide 80 percent of all long-term care, with an average of 18.4 hours of care per week. The total economic value of this care is estimated to be $3.1 billion annually. The Aging and Disability Resource Center works with family caregivers to assess needs, gather information, make plans and find support. Classes are provided to teach caregivers on how to deal with a loved one's condition such as Alzheimer's disease. These classes are taught by volunteers in the community, so issues of cultural competency are addressed. The Senior Services Bureau helps provide meals, transportation and respite for caregivers.

3. *Encourage healthy and independent aging*. The ALTSD has multiple programs to promote independence and empowerment of elders: health promotion, transportation, volunteer programs, senior employment, care transitions, prescription drug assistance program, state health insurance assistance program and veteran-directed HCBS program. The senior employment program works with seniors to help them present their value to employers and connect them with opportunities for employment. The ALTSD also supports and contracts with the New Mexico Senior Olympics.

4. *Combat senior hunger*. Over 75 percent of health care costs are due to chronic conditions, and food insecurity is an indicator for some chronic conditions. More than 42,000 New Mexico seniors are estimated to be living with food insecurity. Due to the commitment of combating this issue, New Mexico is now the seventh-best in the nation in senior food security, up from second-worst in the nation. Multiple partnerships around the state have aided in addressing this issue by increasing access to food pantries, home delivery of meals and expanding meal programs at senior centers. About 92 percent of seniors believe home delivery of meals is what allows them to be able to live independently.

Following the presentation, members of the committee discussed the strategic plan presented by Secretary Copeland. Some key points addressed were:

- the potential impact of the state budget on ALTSD programs;
- collaboration with the 19 pueblos and two tribes in the state;
- intergenerational programming;
- details about the transportation program and how seniors can request services;
- performance measures and inquiries about how surveys are conducted;
- issues with calculating data on food insecurity to gain an accurate picture of need;
- the need for continuation of food programs as a priority despite tremendous improvements;
- the types of facilities visited by the Long-Term Care Ombudsman Program;
- training of ombudsmen and other volunteers;
- a request for more information regarding past undercover evaluations of facilities;
- usage of the New Mexico MEDBANK Program;

- a previous presentation on home care workers and encouragement for the use of senior companions;
- SNAP benefits supplements for seniors; and
- how the department continues to deal with budget cuts and efforts to reduce effects on seniors and programs.

Public Comment

Doris Husted noted that some adolescents with developmental disabilities are violent and would not be able to qualify for SATC. These are the individuals being sent out of state for needed treatment. She believes that not only is this more costly, it is unhelpful for the individual and the family. More services need to be made available for adolescents, she stated.

Recess

The third day of the LHHS meeting recessed at 4:50 p.m.

Friday, September 23

Welcome and Introductions

The fourth day of the LHHS meeting in Farmington was reconvened at 8:45 a.m. Members of the committee and staff introduced themselves.

Chiropractic Physician Scope of Practice

Steve Perlstein, D.C., practices chiropractic medicine in Santa Fe. Dr. Perlstein explained that previous legislation afforded chiropractors prescriptive rights and allowed chiropractic physicians to provide additional services to patients. Traditionally, this has been a drugless profession, but the ability to prescribe muscle relaxants as part of a treatment program has proven to be very effective for patients. There have been no recorded adverse effects of chiropractic physicians having prescriptive authority. Dr. Perlstein shared several stories of patients who experienced success and pain relief through the combination of chiropractic and medication treatment. For example, the use of injections for knee issues to reduce inflammation has been an effective approach for patients. Given the primary care shortage in the state, chiropractic physicians are seeking to expand their scope of practice through legislation during the upcoming session.

Dr. Robert C. Jones noted that there is a national and state shortage of primary care physicians. Chiropractic education is a doctorate degree program, and chiropractors receive the same graduate level of medical education as any other medical doctor. Dr. Jones acknowledged that there are some deficiencies in their training; for example, chiropractors do not currently receive pharmaceutical training. Educational programs are working on addressing training deficiencies and integrating these components into the profession. Neck pain and lower back pain continue to be the leading reasons for individuals seeking medical attention. Because of ongoing shortages, it is difficult to get patients the help they need. Dr. Jones believes that chiropractors are being left out of the medical profession because other providers are concerned

with the lack of prescriptive authority. He summarized a statement from the Federal Trade Commission: while state legislators and policymakers are rightly concerned with patient safety, an important goal is to foster quality competition in the medical field. Lack of access to medical care is also a safety risk. Dr. Jones stated that chiropractors are conservative prescribers and can be a beneficial contribution to the continuum of care.

Dr. Perlstein presented an outline of the legislation being proposed, highlighting the key components. Current law has certified the advance practice of chiropractors as "level 1". There are about 120 providers with this certification; however, that provision sunseted in 2012. Dr. Perlstein explained that "level 2" certification has plenary prescriptive authority, but one has to first obtain level 1 certification. The proposed legislation would bring back level 1 certification, eliminating the sunset. The training for chiropractors would be comparable to a certified nurse practitioner in terms of core requisites and would require 650 hours of clinical rotation. Two accredited medical schools have agreed to oversee the clinical rotation program. Addressing the concern of adding more prescribers of opioids, Dr. Perlstein noted that 25 states have naturopathic programs, 19 of which allow prescriptive authority.

Several local chiropractors were in the audience and stood in support of expanding the scope of practice to include prescriptive authority. The group of chiropractors agreed that this expansion would help them to provide care to more individuals in their communities. Dr. Ezekiel Brimhall voiced concern about individuals being unable to get appointments with primary care doctors. As a result, more individuals are using urgent care to get necessary treatment. Chiropractors are doing what they can to help patients but they are limited by law on what they can provide. Dr. Brimhall believes this would be a huge asset to the community and the state. Dr. Ryan T. Rowe added that many chiropractic practices are intergenerational, and professionals remain in their communities. Chiropractic treatment programs can be very beneficial to patients due to alternative approaches to health and wellness.

Following the presentation, members of the committee posed the following questions and concerns:

- inquiries about the proposed legislation;
- ensuring proper credentialing for recognition by the MCOs;
- the opportunity to meet needs in communities;
- prescriptive authority requested as a plenary license;
- currently, prescriptive authority is limited to formulary and injections;
- concern over opioid usage in the state;
- the ability of chiropractors to have time to understand the needs of the patient, allowing for early intervention through diet and lifestyle changes;
- the use of electronic medical records and issues with electronic prescribing;
- the medical professional shortage in the state at all levels of care;
- the expansion of authority as voluntary for chiropractors; and
- the potential for Medicaid reimbursement.

Senator Ortiz y Pino informed the presenters of the committee endorsement process and invited them to present a draft of the proposed legislation during the November meeting of the LHHS.

Occupational Therapy: Scope of Practice Update

Carla Wilhite, O.T.D., assistant professor, UNM HSC, stated that occupational therapists are seeking a refinement of their scope of practice. With the ACA, there have been many changes to the profession and the types of service occupational therapists provide. Ms. Wilhite provided background on the founding of the profession, noting that the field of occupational therapy has been in existence for almost 100 years with origins in mental health. A recent independent study published efficacy outcomes citing skilled occupational therapy as the only one of 19 total distinct spending categories to effectively and statistically reduce readmission rates to hospitals. Through the use of everyday activities, occupational therapy practitioners promote mental health and support full participation in life for people with or at risk of experiencing psychiatric, behavioral and substance abuse disorders.

Rachel A. Gillespie, O.T.D., provided the committee with a fact sheet along with a draft of the proposed legislation (please see handouts). The scope of practice for occupational therapy is over 11 years old and the update would refine the scope while addressing typographical and grammatical changes. In 2015, the scope of practice bill was pocket vetoed. Ms. Gillespie stated that the issue with the 2015 legislation regarding the definition of supervision aids has been removed. She provided an overview of the draft legislation, highlighting key aspects. The refined scope of practice includes definitions of both ADLs and IADLs, evaluation and assessment processes and various language updates.

The panel discussed the following aspects relating to the scope of practice expansion and the field of occupational therapy:

- patient successes with occupational therapy;
- a willingness to collaborate with the New Mexico School for the Deaf;
- differences between the 2015 legislation and the current proposed draft;
- limitations by the current scope in providing supports for mental and behavioral health;
- the benefit of hands-on therapy for rehabilitation; and
- the potential to help address the deficit of providers in the state.

Senator Ortiz y Pino informed the presenters of the committee endorsement process and invited them to present a draft of the proposed legislation during the November meeting of the LHHS.

New Mexico Trauma System Overview

Razvan N. Preda, student, Doctorate of Nursing Practice Program, UNM HSC, stated that trauma is the leading cause of death for ages one to 44 in the United States. One person dies every three minutes from trauma, and the associated medical costs are $671 million every year. The goal is to fund and sustain a statewide system of trauma centers. In 2007, New Mexico developed its trauma system. Hospitals are designated as trauma centers by the DOH and the American College of Surgeons. There are four levels of trauma centers; level 1 provides the most comprehensive care while also conducting research and providing education. UNM Hospital is the state's only level 1 trauma center, and there are six level 3 and five level 4 hospitals also in the state. Mr. Preda stated that funding for the system comes from the state budget. In recent years, the funding has decreased by almost 50 percent while the number of centers has quadrupled. Mr. Preda added that this presentation is meant to provide information to the committee about the role and importance of the trauma system for New Mexico.

Liana Lujan, trauma system coordinator, DOH, assesses facilities around the state and explained how a hospital becomes designated. A hospital seeking designation sends a letter of intent to the DOH, and a site verifications survey is scheduled following submission of the hospital's application. The DOH evaluates the site for compliance with state regulations and the need for a center in the community. Following completion of the survey by a trauma surgeon and a trauma system coordinator, recommendations for designation are made to the secretary of health. Money appropriated by the legislature goes to the state Trauma System Fund, established pursuant to the Trauma System Fund Authority Act, where funds are distributed based on the level of designation. Ms. Lujan noted that the trauma center in Lubbock has let its designation by New Mexico lapse, but it is still seeing New Mexico patients.

Kim McKinley, executive director, clinical information/stroke/trauma, UNM Hospital, explained that the purpose of the Trauma System Fund Authority Act was to encourage smaller rural hospitals to develop and improve services in their communities. This allows for patients to remain within their communities, making it easier on patients and families. These small hospitals have grown in number from three to 12 with very little funding. A trauma center must have an operating room, a surgeon and an anesthesiologist available 24/7. Funds go toward the purchase of big equipment items for these centers.

Dr. Stephen Lu, former trauma medical director, UNM Hospital, talked about what the trauma system means for patients. Dr. Lu explained how patients are airlifted and transferred to centers following accidents. The system involves a huge amount of resources spread over the fifth-largest state. When someone is hurt, hospitals have resources to treat them regionally, and few individuals have to leave their community. Improvements in communication and the transportation system have been helpful for the system. Stroke and trauma response are both time-critical emergencies, requiring excellent coordination to get patients the resources they need quickly. Dr. Lu expressed the need to continue to expand the trauma system to all four corners of the state.

Dr. Duane Gibbs, present as a private citizen, works at the SJRMC and noted that not all trauma centers are equal in capabilities, even within the same designation level. The SJRMC receives patients from the Four Corners area, including patients from other states. After UNM Hospital, the SJRMC is the second-busiest trauma center in the state. Dr. Gibbs shared a few examples of trauma patient care, emphasizing that coordination among hospitals is key to saving lives. UNM Hospital is consistently inundated with patients; at least 50 percent of trauma patients from a level 3 hospital get transferred to UNM Hospital. It is critical to develop trauma centers that are robust and able to care for patients without requiring transfers.

Committee members engaged in discussion with the panel about the presentation, noting the following:

- the need to eliminate cuts to funding;
- trauma centers in surrounding states and coordination as part of the overall system;
- the lack of level 2 trauma centers in the state;
- recognition of regional efforts to develop comprehensive care;
- a request for statistics regarding patients, cause of admittance and success rates;
- the need for education about the system and its importance;
- the absence of federal funding for trauma centers;
- the diversity of medical specialties at trauma centers;
- emergency rooms around the state with excessively long wait times and the need for additional beds for patients; and
- suggestion of the documentary "Code Black" on Netflix.

Adjournment

There being no further business before the committee, the fifth meeting of the LHHS adjourned at 11:58 p.m.