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

August 22-24, 2016
Taos County Commission Chambers
105 Albright Rd.
Taos

The fourth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order on August 22, 2016 by Senator Gerald Ortiz y Pino, chair, at 1:09 p.m. in the Taos County Commission Chambers in Taos.

Present
Sen. Gerald Ortiz y Pino, Chair
Rep. Deborah A. Armstrong
Rep. Miguel P. Garcia (8/22, 8/23)
Sen. Gay G. Kernan (8/23, 8/24)
Sen. Mimi Stewart (8/22, 8/23)

Absent
Rep. Nora Espinoza, Vice Chair
Rep. Tim D. Lewis
Sen. Mark Moores

Advisory Members
Sen. Craig W. Brandt
Rep. James Roger Madalena (8/22, 8/23)
Sen. Cisco McSorley (8/22, 8/23)
Sen. Mary Kay Papen (8/22, 8/23)
Sen. Nancy Rodriguez (8/22)
Rep. Patricio Ruiloba
Sen. William P. Soules
Rep. Christine Trujillo
Sen. Jacob R. Candelaria
Rep. Gail Chasey
Rep. Doreen Y. Gallegos
Sen. Daniel A. Ivey-Soto
Sen. Linda M. Lopez
Rep. Terry H. McMillan
Sen. Howie C. Morales
Sen. Bill B. O'Neill
Sen. Sander Rue
Sen. Benny Shendo, Jr.
Rep. Don L. Tripp

Guest Legislator
Rep. Debbie A. Rodella (8/22, 8/23)

(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, Staff, LCS
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.

Monday, August 22

Welcome and Introductions

Senator Ortiz y Pino welcomed members to the fourth meeting of the LHHS. Members of the committee and staff were asked to introduce themselves. President Pro Tempore Papen appointed Senator Brandt as a voting member of the LHHS for the duration of the August meeting.

Update on Medical Cannabis

Panel 1

Natalie Riggins, Medical Marijuana Registry (MMR) Program manager, Colorado Department of Public Health and Environment (CDPHE), addressed the committee via teleconference about the past, present and future of the Colorado MMR. Ms. Riggins provided a general overview of the program and the organization of the medical marijuana industry in the State of Colorado (please see handout for more information). The CDPHE directly oversees the registry, but other components of enforcement and regulation fall under the purview of the Colorado Department of Revenue, Colorado Department of Regulatory Agencies and Colorado Bureau of Investigation. There is also a CDPHE Medical Marijuana Scientific Advisory Council and Retail Marijuana Public Health Advisory Committee. The Colorado Department of Revenue is tasked with overseeing the Marijuana Enforcement Division. Ms. Riggins briefly explained the roles of each division. The Constitution of the State of Colorado mandates that the MMR be a confidential database; patient-specific data are never shared with anyone other than the patient and the physician, except when required for law enforcement purposes. The MMR has multiple stakeholders, from patients and physicians to caregivers (individuals cultivating or transporting medical marijuana). The role of the MMR is to maintain the confidential database of registered patients; issue MMR cards to qualifying patients; and review petitions for adding debilitating medical conditions for medical use of marijuana. Ms. Riggins gave the committee an overview of the program's history, from inception to future goals. As of July 2016, there are 102,620 active patients, and the MMR processes 10,000 applications and 1,000 change requests per month. The MMR currently has six operations staff processing 500 to 1,500 requests per day. In Colorado, there are 154 physicians currently recommending medical cannabis to active patients. Ms. Riggins explained the registration process for the MMR. At this point, only paper applications are accepted, and the process is entirely patient-driven.

Yonette Hintzen-Schmidt, MMR Program support manager, CDPHE, also addressing the LHHS by teleconference, discussed the legal process for denying or revoking cards. Card revocation can occur when a patient has been convicted of a drug-related offense, a physician has revoked his or her signature on a patient's physician certification or a patient has violated the

provisions of the constitution or statute. Denied applications and revoked and voided cards are posted on the MMR website and shared with law enforcement and dispensaries. Denied patients must wait six months before reapplying, and revoked patients cannot reapply for one year. Per Colorado state statute, patients have the right to appeal the CDPHE's decision to deny their applications or revoke their cards. Ms. Hintzen-Schmidt explained the physician requirements and noted that Colorado requires an annual renewal, regardless of medical condition.

Ms. Riggins reviewed the process improvements that the CDPHE has made to make the MMR more user-friendly. The CDPHE has made several changes to its website, which has included making all resources available online. Anyone can now sign up for the new LISTSERV used for sharing program information. Ms. Riggins shared plans for the new online MMR System, which is scheduled to go live January 1, 2017. Some key new features of the MMR System will include offering: patients, physicians and caregivers online account access; online credit card payment capability; the ability to print patient cards at home or use a mobile device, similar to a boarding pass; and access to contact registry personnel online. After a one-year transition period, the goal for the CDPHE is to eliminate paper applications. Ms. Riggins emphasized that steps have been taken to ensure security and confidentiality of data, much like electronic health records. Her handout to the committee included illustrations of how to navigate the new website and the MMR System.

In response to the representatives from the CDPHE's presentation, members of the LHHS inquired about the following topics:

- the role of the Colorado State Laboratory in the medical marijuana program;
- a medical marijuana research grant program at several state universities;
- limiting prescriptive authority to physicians;
- registration changes for caregivers and plant limits;
- separation of retail sales of marijuana and sales of medical marijuana at dispensaries;
- wait time for processing of patient cards and how the CDPHE addressed former backlogs;
- potential revenue from medical marijuana programs;
- replication of the Colorado program in other states;
- patient authorization for viewing confidential information;
- registration of physicians in the new MMR System;
- explanation of how the Colorado Department of Revenue collects sales tax on marijuana, both retail and medical;
- the potential for growing and producing cannabis on Native American lands;
- the self-funding nature of the MMR System for system updates and maintenance; and
- residency requirements for cards and possession.

Panel 2

Lynn Gallagher, secretary-designate, Department of Health (DOH), informed the committee that the department is participating with a number of national workgroups regarding medical cannabis. The Medical Cannabis Program (MCP) was created under the Lynn and Erin Compassionate Use Act in 2007. The purpose of the act is to allow the beneficial use of medical cannabis in a regulated system for alleviating symptoms caused by debilitating medical conditions and their medical treatment. Unlike Colorado, New Mexico's MCP is administered solely under one agency, the DOH. Secretary Gallagher provided a handout to the committee that covered the recent growth in the program and the department's efforts to address issues (please refer to the handout for more information). In 2010, there were 3,818 patients in the program; now there are more than 29,000. Since December 2015, there has been an increase of 9,500 patients. Secretary Gallagher informed the committee that the department is now in compliance with the 30-day processing and five-day mailing period required by statute. According to Secretary Gallagher, some delays are due to a lack of proper information; the DOH now has checklists available to ensure that information is current and applications are complete. Another issue has been patients submitting renewals within 30 days of expiration.

There are currently 35 licensed nonprofit producers (LNPPs) in the state and 43 dispensaries in 15 counties. As of August 2016, there are 6,333 personal production licenses (PPLs). Secretary Gallagher contends that even with the increase in patients, there is more than enough product available. The plant count limit for LNPPs has been tripled from 150 to 450 plants. Secretary Gallagher explained some of the new rules adopted in 2015 and 2016 to increase patient access. Steps have been taken by the DOH to address issues with processing applications, and temporary changes have been implemented while program enhancements are put into place. Patients are urged to submit renewal applications well in advance of expiration to avoid delays and any potential lapse in access to medication. The MCP continues its outreach efforts to educate medical providers and law enforcement agencies about the use of medical cannabis. The fiscal year 2016 revenue from the MCP was $1,979,953.

Timothy Keller, state auditor, summarized some of the information that was presented during his testimony to the Disabilities Concerns Subcommittee (DCS) of the LHHS on August 4, 2016. The Office of the State Auditor (OSA) had received various complaints about providers. Auditor Keller noted that the OSA has limited jurisdiction over the matter, which falls under the purview of the DOH. Some of the other complaints received by the OSA's 1-800 hotline included plant count increases, tensions between large and small growers, annual renewal requirements for cards and excessive delays in card issuance. According to testimony at the DCS and complaints filed with the OSA, patients were waiting up to 90 days to get their registry cards; statute allows the department 30 days to process applications and renewals. The OSA views the card renewal backlog as a public health issue and gave the department a deadline of August 23, 2016 to get into compliance with state statute. In the view of the OSA, this is not an issue of cost or red tape; these delays were avoidable and the growth in the number of persons participating in the MCP was foreseeable. Auditor Keller added that the state needs to be aware of liability exposure for failure to comply with laws that relate to public health, such as the Lynn and Erin Compassionate Use Act. The OSA will continue to monitor the DOH. Auditor Keller

was pleased to hear that the DOH had announced extensions on card validity for patients while the issue is addressed.

Duke Rodriguez, president and chief executive officer, Ultra Health, believes the increase in patients in the MCP illustrates the success of the program. With the program in its eighth year, Mr. Rodriguez believes it is too late to claim that problems with implementation of the program are the result of "growing pangs". Despite the DOH's assurances that production is better than in the previous year, with the increase in patient enrollment, the amount in the inventory would allow for 11.91 grams per patient statewide. Every patient has a legal right to 2.6 grams per day; the amount in the inventory is simply not enough to meet the need. PPLs provide a tremendous relief valve because commercial providers are not allowed to produce enough to meet the need. Producers recently paid $2.8 million in licensure fees to the DOH. Mr. Rodriguez raised concerns about data tracking and reporting errors in the program. Currently, there are 21 conditions approved by the DOH for treatment with medical cannabis, including posttraumatic stress disorder (PTSD). Approximately 46.3 percent of the 26,568 patients in the MCP are being treated for PTSD. Mr. Rodriguez provided a presentation on the status of medical cannabis in New Mexico with statistics from both PPLs and LNPPs. In his view, the priorities of the state and the DOH are wrong, and it is the patients who suffer from the inadequate supply. Patient growth per quarter has shown increasing and steady growth; this is a predicable trend that will continue to grow (please see presentation for market analysis). Colorado dispensaries along the border have testified that 60 percent of their patients are from New Mexico. Mr. Rodriguez advocates for more producers at all levels. A chart was shared with the committee explaining the MCP's usage of "units" based on software company BioTrack's calculations. The allowable number of units is supposedly designed to meet the needs of the patients, yet every other state program uses grams as measurement. Mr. Rodriguez explained that patients often use different types of medical cannabis, and the use of units complicates how they are able to purchase their medicine. Ultra Health shared its recommendations for legislation to improve the program.

William Ford, managing director, Reynold Greenleaf & Associates, stated that 230 units is not enough for any patient when taking into account the different methods of ingestion. The spirit of the law was to allow a patient to possess enough medical cannabis to have an uninterrupted supply for 90 days. The DOH has changed the program, making it more restrictive and complex. Mr. Ford believes that a lot has been done to create stable partnerships with LPPs and the DOH. Extending the time that registry cards remain valid is a positive sign from the department. There have been many issues associated with the increase in patients and resulting growth of the program. The program could benefit from a committee that brings in experts from the field and stakeholders to discuss problems and come up with potential solutions. Mr. Ford thinks it is absurd to believe that some conditions like multiple sclerosis are going to go away; the state needs to eliminate the hassle and unnecessary cost of requiring annual renewal for some conditions. The DOH and members of the industry have a responsibility to provide for patients. Mr. Ford calls on the DOH to subsidize delivery systems or create incentives to reach out to patients in rural parts of the state.

Stephanie Waddell, president, New Mexico Medical Cannabis Patient's Alliance, expressed several concerns with the MCP in addition to those mentioned by the other presenters. The excessive wait for renewal of patient registry cards is a real problem. She suggested that the issuance of a letter can be used to access medicine while the patient waits for the registry card to arrive. Ms. Waddell noted that while the extensions by the DOH are helpful, they do not help first-time patients who are having to wait for approval. The suggestion of "lifetime" cards for lifetime conditions was made. Ms. Waddell also echoed concern about units as measurement for permissible amounts of medical cannabis. Some patients have also received cards with typographical errors, causing the need for cards to be reissued. Ms. Waddell says there is a shortage of medical cannabis supply in the state that continues to rise as the program grows. The alliance is asking the DOH to increase the plant count to address patient need. Frequent meetings are needed among the MCP administrators, patients and producers to learn what is working for patients and what needs improvement.

Jason Barker, patient and organizer, LECUA Patients Coalition of New Mexico, was unable to stay at the meeting, but his comments were sent to the committee.

Following the presentation from the panel, members of the LHHS had the following comments and questions:

- the purpose of the medical review process and role of the medical director for the MCP;
- the types of providers that are allowed under state law to recommend medical cannabis;
- a physician's ability to adjust the dosage and responsibility to work with patients to find the best dosage to manage pain;
- the ability of tribal governments to produce medical cannabis;
- what can be done by the DOH and the legislature to speed up the processing of registry cards;
- ensuring best practices for the program and for patients;
- the classification of cannabis as a Schedule I drug under the Controlled Substances Act;
- concern for patient confidentiality when collecting data;
- issues with email access for patients;
- steps being taken to increase communication with patients and producers;
- the potential for lifting some restrictions based on patient needs;
- the need for addressing the influx of patients coming into the program;
- information on additional staff, both temporary and permanent, hired by the DOH to address the backlog in processing requests for registry cards and renewals;
- changes in administrative rules;
- consideration of Colorado's move toward an online system;
- removal of the tetrahydrocannibinol (THC) limit in state law;
- the complexity associated with using units to measure allowable quantities of medical cannabis or products containing cannabis concentrates or extracts;

- questions about BioTrack and its involvement in the MCP;
- the impact of plant limits on the amount of raw material needed to conduct research;
- presumptive eligibility for patients;
- whether registry card renewals should be annual and whether exceptions should be made for those with certain chronic or incurable conditions; and
- a request that the DOH provide a list of program requirements (whether by statute or rule) to LCS staff.

Public Comment

Brian Cox, a patient in the program for five years, believes that the DOH does not listen to patients. His main concern is with alleged violations of patients' federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) rights. According to Mr. Cox, both Colorado and New Mexico are violating HIPAA by bringing in temporary employees and granting them access to patients' health information. Mr. Cox conducts audits on companies that violate HIPAA laws, and he is currently preparing a lawsuit against a medical facility for violations. Mr. Cox has Cushing's disease, a rare autoimmune condition. Individuals with autoimmune conditions tend to have more than one health issue. To him, the DOH is "a joke", and it is not appropriate for DOH employees with no medical background to be making decisions about what patients need. Mr. Cox wants to see these issues addressed or he will begin seeking legal action for HIPAA violations.

Scott Pleadwell, a veteran, was one of the first 3,800 patients in the MCP. Mr. Pleadwell treats his PTSD with medical cannabis, which has helped him quit two prescriptions of oxycodone. Mr. Pleadwell was a legal grower, but despite paying all fees and submitting necessary documentation, he never got his card renewed. His card is now a year and a half out of date. Taos County lacks the resources to help individuals dealing with opioid addiction. Due to the difficulty of getting a card, many individuals do not even attempt to get into the program, even though they need it. Mr. Pleadwell believes the program needs to be dismantled and started over.

Tori Moorman, patient, testified during the August 4 DCS hearing. Ms. Moorman believes that it is wrong and cost-prohibitive to require patients to see a doctor every year as part of the requirements to renew a medical cannabis registry card. Since Medicaid no longer covers the doctor's evaluation for the prescription of medical cannabis, the burden falls on the patient. The amount of time it takes to receive cards is a real issue. Ms. Moorman knew three cancer patients who passed away while waiting to receive their cards. She shared several academic papers that have been published in Canada on the dosing of medical cannabis, noting that there are evidence-based data to support its usage. States with medical cannabis programs have also seen significant savings in Medicaid expenses. Ms. Moorman shared that her previous medications cost over $1,200 per month, but medical cannabis has replaced all of her prescriptions, which has been a savings to Medicaid. Ms. Moorman believes that the DOH needs to reevaluate the use of units and urges the addition of autism as a qualifying condition.

Garth Wilson, patient, drew attention to the fact that medicating outside one's home is still illegal. This is a real issue and an inconvenience for patients. Mr. Wilson has been asking the DOH to provide a medical exception for consumption outside the home. As his own producer, he feels he needs a higher plant count in order to properly manage his condition.

Nicole Morales expressed concern with producers not growing their full limit and the use of a 70 percent cap for THC levels. She stated that patients are getting organized with the New Mexico Medical Cannabis Patient's Alliance. Experts from the field need to be brought in to work with producers and the DOH. She believes that patients are not getting the help they need. Dispensaries are taking on the responsibility of educating patients.

Jonathan Sanchez, vice president, New Mexico Medical Cannabis Patient's Alliance, interacts with patients and LPPs on a regular basis and noted their agreement on these issues. Mr. Sanchez thanked the committee for acknowledging the problems that patients are having and for seeking more information. He recently spoke with Darren White, owner of Pure Life, about some of the issues that new producers face, including plant limits.

Tulima Mauga was present at the DCS meeting on August 4, but was too nervous to speak. Ms. Mauga shared her story with the committee about how PTSD and other conditions have dramatically altered her life and her ability to function. Because of medical cannabis, she is able to manage her medical conditions without having to take multiple prescriptions, including opioids. New Mexico might not be number one in a lot of things, but Ms. Mauga believes this is one area where the state should be excelling.

Victoria Bartlow urged the committee to support the removal of cannabis as a Schedule I drug, which would encourage research. Medical cannabis has helped her handle several surgeries.

Recess

The committee recessed for the day at 5:53 p.m.

Tuesday, August 23

Welcome and Introductions

The second day of the LHHS meeting was reconvened at 8:38 a.m. by Senator Ortiz y Pino. He welcomed all of those present and asked members of the committee and staff to introduce themselves.

PAX Good Behavior Game

Wayne Lindstrom, Ph.D., director, Behavioral Health Services Division (BHSD), Human Services Department (HSD), introduced members of the panel along with several teachers in the audience from around the state. The LHHS has received a previous presentation regarding the PAX Good Behavior Game (please see handouts for more information). Dr. Lindstrom provided a brief history of the program. The BHSD provided funding in March 2016 to launch PAX in

New Mexico elementary school classrooms during the spring of 2016. The goal, he said, was to improve academic success while simultaneously fostering self-regulation that has been proven to protect children from mental, emotional and behavioral challenges throughout life. The pilot project involved 3,300 students in school districts in Santa Fe, Espanola and Bloomfield. Each district's implementation of PAX was a little different, but, overall, the data and feedback from teachers and students were positive.

Dennis D. Embry, Ph.D., PAXIS Institute, stated that one out of two children will have a mental or emotional disorder by age 19, which is an epidemic in the country. Dr. Embry, who is a developmental and child psychologist, explained that what happens to a child during first grade has a significant impact on the rest of the child's life. PAX seeks to increase psychological safety and flexibility and reinforce pro-social behaviors while reducing or minimizing toxic influences and limiting problematic behaviors. Dr. Embry talked about the results of PAX in New Mexico following the pilot project. PAX uses "'spleem' counts", which are disruptive behaviors identified and counted discretely, to provide indications about various aspects of the mental health of individual students. "Spleem", Dr. Embry explained, is a made-up word to indicate disruptive behaviors without coloring them with known words like "bad", "disruptive" or "noncompliant". The project pilot, which involved 172 classrooms, saw a decline of approximately 40 percent in spleem counts. Students loved the game, and teachers reported changes in their classrooms that were characterized by more focused learning, ease and collaboration. New Mexico is the first state in the country to invest significantly at the state level in a program like PAX. In other areas that have tried PAX, there have been huge reductions in mental health issues in students, increased graduation rates, reductions in teen pregnancy and increased chances of college enrollment. PAX is also the only elementary school program proven to reduce suicide rates. The cost of PAX is about $75.00 per child; in comparison, childhood vaccinations cost about $2,500 per child. In his view, this should be treated as a "social inoculation", as positive behaviors instilled in children at this stage of development will carry through the rest of their lives. Dr. Embry added that students are taught that they are "PAX students" and when asked what that means, they respond, "I better my world and I better myself.". He urged the continued support and expansion of this program.

Deborah Mitchell, principal, Alcalde Elementary School, Espanola Public School District, noted that Espanola schools do have a certain reputation. She invited the committee to come to her school and see the impact that PAX has had on its students and teachers. Ms. Mitchell believes that the main concern should be the well-being of the children. In Espanola, a large number of students are being raised by their grandparents for various reasons. Ms. Mitchell shared a story about one child living with his grandparents because his parents were in jail. The child was a threat to the other students and had very low self-esteem. With the introduction of PAX to the school, the child began to realize that only he was responsible for his behavior. The child is now doing significantly better and making great progress in school and at home.

Trina Raper, executive director of curriculum and professional development, Santa Fe Public School District, advocates on behalf of her teachers. The teacher is the most important

person in the classroom, and time on task is a crucial part of the educational process. Ms. Raper explained that PAX shortens the time a teacher spends on corrective behaviors, which increases the amount of time the teacher can spend on instruction. The program gives teachers clear strategies on how to manage spleems. Ms. Raper provided a demonstration for the committee on how the program's games are incorporated during instructional time with the use of a harmonica. PAX does not call out children or shame individuals. In the Santa Fe Public School District, 120 teachers have been trained in PAX. The district hopes to have more trained during the next round of funding. Ms. Raper explained that one cannot prepare educators for everything they will encounter in the classroom during college; this is the type of support they need during their second year in the classroom.

Following the presentation from the panel, the chair invited educators present in the audience to share their experiences with PAX.

Jodie LaRue, early childhood specialist, Farmington, has been using PAX for six years. Ms. LaRue admitted to some initial reluctance regarding PAX, thinking the games seemed too good to be true and yet another training to endure. She shared her experience with the program and a story about one student who was in foster homes who has now become one of the top students in the school. She feels like PAX handed her the key to success. PAX instills lifelong skills in students that will benefit their lives far beyond graduation. The committee is welcome to visit her classroom and see how PAX is benefiting students.

Tina Hudson, sixth grade teacher, Bloomfield, stated that she previously had a very chaotic classroom. Students lacked the discipline and regulation to function neither in a classroom setting, she said, nor in the "real world". Ms. Hudson was interested in PAX and conducted a preliminary spleem count, which revealed an overwhelming issue. There was a lot of frustration in the classroom and instruction was hampered. Ms. Hudson told the committee that she had called into question her career choice during that time. Then she implemented PAX in her classroom, and students began working together, were more engaged and were more excited about coming to class. Ms. Hudson shared several examples of changes and demonstration of leadership by her students, adding that PAX saved her students and helped her regain control of the classroom.

Sadie McDaniel, licensed social worker, Bloomfield, conducts the initial spleem testing in schools and then follows up to measure improvement. During the presentation, Ms. McDaniel conducted a spleem count on the committee to demonstrate how it works. She noted that spleems are also moments of distraction or lack of attention to what is being said. She conducted an assessment on 524 fifth and sixth grade students. Of those students, 72 were identified with behavioral, emotional or social issues. Some had severe concerns, including self-mutilation and suicidal tendencies. With the introduction of PAX, there was a decrease in office referrals and calls home, and spleem counts went down significantly. The reactions of the teachers were very telling, and she noted that teachers were leaving the classrooms smiling and on-time. More teachers have wanted to get involved in the program. Two students have even told her they have

stopped cutting themselves as a result of PAX. Ms. McDaniel invited the committee to come to the school and see the program in action.

In response to the presentation, the committee addressed the following topics with the panel:

- the current status of the PAX program in schools;
- lack of money to continue funding the initiative;
- commitment by teachers and presenters to continue the program, regardless of funding;
- the state budget crisis and impact of pending budget cuts on school districts around the state;
- the current number of trained teachers and site implementations;
- outside funding through grants;
- a suggestion to present before the Legislative Education Study Committee;
- efforts to incorporate parents to reinforce techniques in the home;
- concern with the tendency of behavior modification models to change frequently;
- questions about the cost and copyrights on the program;
- a distinction that PAX is a skill set, not a curriculum;
- the long-term positive impacts on Medicaid, law enforcement and the criminal justice system;
- long-term costs to the state if early predictors go untreated;
- the use of the system in ethnically diverse classrooms; and
- the potential for universities to develop courses based on the PAX model.

Turquoise Lodge Letter

The committee discussed the letter from Secretary Gallagher regarding the closure of the adolescent treatment program at the DOH's Turquoise Lodge specialty hospital in Albuquerque. The letter addressed various questions raised by the LHHS at its previous meeting. In response to questions from the committee, Dr. Lindstrom stated that the closure falls within the context of the overall issue the state is dealing with in terms of the budget crisis. Departments are having to make some difficult decisions on priorities, he said, and he believes that the DOH would have looked at this differently if the financial environment were different. Dr. Lindstrom stated that there is an opioid crisis in this state and there is a need for medical substance dependence detoxification (medical detox) capability. Under Medicaid, medical detox is a benefit and emergency departments are doing appropriate screenings and teaching hospital officials on the appropriate management of individuals. The need for medical detox is likely to grow with the continuation of drug usage in the state. Dr. Lindstrom noted that he was not consulted about the closure.

Members of the committee expressed their concern with individuals, particularly adolescents, undergoing medical detox treatment in emergency departments. Members questioned the referral process, the amount of time it was taking to get an individual into treatment at the facility and the use of Suboxone for the medically assisted substance dependence

treatment of adolescents. The issue of the closure was set to be discussed further during the next meeting of the LHHS with representatives from the DOH. The committee requested staff to send a follow-up letter to the DOH regarding statistics on the success and completion rate for adolescents in the Turquoise Lodge program. Members also wanted to know what the Legislative Finance Committee had said about Turquoise Lodge in its recommendations on budget cuts. Staff was directed to draft the letter and send it to committee members for approval.

Local Behavioral Health Update — Judicial and Law Enforcement Panel

Sarah Backus, district court judge, Eighth Judicial District Court, discussed the beneficial use of drug courts in the area. There are four drug courts in the Eighth Judicial District, which includes portions of Taos and Colfax counties. In addition to hearing adult and juvenile cases, the courts also handle competency hearings. Judge Backus explained that with funding from drug courts, the district is able to fund intensive outpatient treatment programs for nonviolent offenders. These year-long programs are effective, life-saving and an inexpensive alternative to incarceration. Individuals in the area are in a habitual state of addiction and the only detox facility in the county closed in March. There is no place for individuals to detox from drugs and alcohol. Also making things difficult, there are few resources for long-term drug and mental health treatment. Judge Backus expressed concern about the potential five percent budget cuts during the upcoming special session of the legislature. These cuts will largely affect salaries and possibly the operation of the drug courts; she believes this is a vital service to protect. Judge Backus urged the committee to keep drug court funding intact. Barbara Arnold, court executive officer, Eighth Judicial District Court, previously managed the drug courts. She testified to witnessing several heroin addicts and multiple offenders turn their lives around during the year they spent in the drug court program. Ms. Arnold recognized several representatives present from the community involved with drug courts.

Jerry Hogrefe, sheriff, Taos County Sheriff's Office, is a first-term sheriff with over 20 years of law enforcement experience with numerous agencies. Sheriff Hogrefe recently attended the annual conference of the New Mexico Sheriffs' Association. He shared what he considered to be the following "wish list" of priorities for law enforcement.

1. Lapel cameras. Equip every law enforcement officer with a lapel camera and provide training for use through the New Mexico Law Enforcement Academy of the Department of Public Safety. Lapel cameras protect officers and strengthen evidence in cases.

2. Usage of Narcan by law enforcement officers. Recent legislation allowing law enforcement to carry and administer Narcan has been very successful, demonstrating that death from overdose is preventable. Taos County sheriffs were among the first to be trained under the new legislation. The training is only two hours long. Sheriff Hogrefe explained how Narcan is administered during an overdose and shared several success stories. Legislation to make carrying Narcan by law enforcement mandatory should be supported.

3. Tourniquets. Law enforcement personnel should carry tourniquets in their kits at all times. These are inexpensive and life-saving.

4. Shark gloves. These gloves are used to replace latex and are puncture resistant. The use of these gloves would protect officers from harm and diseases during searches.

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

- effects of the massive changes in the behavioral health system on programs in the area;
- the large turnover of providers, which complicates the system for offenders;
- the crucial services jeopardized by changes;
- the drug court program as a proven effective model;
- gaps in the system of care for individuals with mental illness and the lack of options for law enforcement when dealing with these individuals;
- the passage and implementation of the assisted outpatient treatment legislation;
- the likelihood of budget cuts during the upcoming special session;
- the jail diversion program in Santa Fe;
- the need to view addiction as a public health issue instead of a public safety issue;
- DOH funding for Narcan, which was not renewed;
- rates of utilization of Narcan during the last year;
- the closure of the adolescent detox treatment facility at Turquoise Lodge;
- the impact that the closure of the local detox facility has had on the community and law enforcement; and
- the need for a local medical and social detox center in Taos.

Local Behavioral Health Update — Provider Panel

Sue Mulvaney, Tri-County Community Services, addressed the committee along with other providers about the status of behavioral health in the state. Ms. Mulvaney discussed some of the services the organization provides. Tri-County Community Services provides behavioral health and drug addiction services in Union, Colfax and Taos counties. The provider offers a nine-month intensive outpatient program for substance abuse treatment with a step- down component for those who want to continue. Assertive community treatment is available for individuals with severe mental illness. Individuals who are very disabled have access to comprehensive community support services and opportunities for socialization through Tri-County Community Services. Ms. Mulvaney explained that some conditions can be maintained with proper medication. Through the use of telemedicine and a traveling provider, individuals have greater access to services. Tri-County Community Services offers the "Roadrunner Program", which helps individuals with developmental delays get the socialization they need. A new program, in partnership with the counties, is working to provide jail diversion. Ms. Mulvaney explained that her organization was working with LDWI but lost funding for the program. In a new pilot program, the organization will work with individuals in jail to start them on Medicaid and provide case management to aid with support services after they are discharged.

Larry Herrera, substance abuse counselor, Rio Grande ATP, Inc., co-chair, Recovery Friendly Taos New Mexico, noted that there is a stigma for these individuals, and organizations are working to shine a light on recovery in hopes of reducing that stigma. In 2012, a summit was hosted with more than 300 attendees and representatives from law enforcement, legal, mental health and faith-based organizations and youth groups. The summit provided a networking opportunity for the various organizations and professional fields. The initial intention was to make the summit a yearly event, but one has not been held since. In 2014, Recovery Friendly Taos New Mexico premiered the movie *Anonymous People*, a film reaching out to individuals in recovery and encouraging them to "come out". Last year, the organization hosted a recovery walk with more than 200 participants promoting recovery and attempting to address the stigma. In September, the organization will be hosting the Night of Hope featuring a film by Jimmy Santiago Baca, documenting his experiences and journey to recovery. Mr. Herrera spoke of clients that are in need of detox now but there is no place to send them. He explained that some individuals in need of help commit crimes to get immediate help through the jail. There has been an increased use of heroin and methamphetamines in the area. Hoy has been working to open up a detox facility, but the need in Rio Arriba County alone would fill up a facility. The state needs a long-term residential treatment program in northern New Mexico.

Julie Blau, manager, Substance Abuse Prevention Program, Taos Health Systems, shared information regarding some of the federal and state funding sources that support prevention programs in the community. Taos Health Systems assists medical providers and law enforcement in acquiring Narcan, funded through the DOH's Epidemiology and Response Division. Taos Health Systems assesses the community, youth risk and resiliency data yearly and then examines capacity to see what already exists in the community. Ms. Blau believes that it is about fostering cooperation among different services and discouraging organizations from working in silos. Different organizations are working together to build a coalition and trying to make connections with services that already exist. Increasing communication between different departments to address issues is key. Alcohol and prescription drug use are the top two priorities for the organization.

Beth Scott, executive director, Rio Grande ATP, Inc., stated that the area is in need of both social and medical detox. There is also a need for residential programs with varying length of stay options. Rio Grande ATP, Inc., has been in business for 25 years and is currently serving 50 clients in Taos and 40 in Las Vegas. Some individuals have been through the program more than once. Most of the clients are court-committed and there are some self-referrals, but there is no place to send individuals for detox. Ms. Scott noted that addiction is a chemical disease of the brain. One program offered through the BHSD is grief and loss support. In many instances, addiction can be tied to the loss of employment, a spouse or children. Ms. Scott cautioned that the state cannot continue to rely on revenues from oil and gas.

Dorothy Forbes, program director, Circle of Life Behavioral Health Network, stated that one in five Americans is diagnosed with a mental illness. When government cuts funding from behavioral health, it exacerbates the problem and affects every other system.

Kathy Sutherland-Bruaw, founder/executive director, Inside Out Recovery, was present to advocate for detox and treatment. Inside Out Recovery serves between 80 and 90 people per month in Taos alone. She shared a folder with the committee containing the obituaries of individuals who have died of overdoses in the last 10 weeks from Rio Arriba County and who had come to her organization seeking help, only to learn that resources were not available for them. Ms. Sutherland-Bruaw stated that programs were full or had long waiting lists for treatment, specifically Turquoise Lodge. The detox facility that used to be open in Taos was wonderful and served people from Taos and Rio Arriba counties; even though it only offered social detox, it saved lives. She added that addiction has no barriers and affects people from all walks of life. Without detox, New Mexico will face an epidemic of overdose deaths.

Joshua Trujillo, Inside Out Recovery, is a former heroin addict and is now in recovery serving as a certified peer support worker. Mr. Trujillo likes to challenge the notion that a person cannot come back from addiction and become a productive member of society. Many people like himself are in long-term recovery and are making amazing contributions to their communities. Addiction is a disease and it is progressive, but with the right support and treatment, it can be put into remission. Mr. Trujillo works with a group in jail, adding that 80 percent of individuals in jail are not criminals but are there because of an addiction. People are dying as they wait for services or they end up committing additional crimes to get back into jail. A high percentage of individuals with addiction are being treated as criminals. Mr. Trujillo made the comparison that a diabetic does not have to wait 12 weeks to get the help the diabetic needs.

Ms. Mulvaney expressed frustration when persons seeking help are denied services. These individuals do not have the opportunity to create a free life for themselves because they lack the tools. She noted that the ability to recruit competent professionals is a major challenge, particularly in rural areas. While telemedicine is helpful, individuals are unable to receive the human interaction that they crave. These areas are lacking the resources to pay for psychiatrists and Suboxone prescribers. The immediate solution for providers to address issues of funding has been to share resources, which is the only possible way for providers to survive. She closed by adding that none of the providers want to come back next year to inform the committee that they are shutting down.

Members of the committee thanked the panelists for their dedication and Mr. Herrera and Mr. Trujillo for sharing their recovery stories. Following the presentation, members of the LHHS discussed the following points and issues with the panel:

- potential legislation that would require counseling of patients taking prescription opioids along with a companion prescription of Naloxone;
- the need for getting individuals immediate help when they are ready for it;
- the need to diversify state revenue sources;
- the ability for local governments to increase gross receipts taxes to fund substance use disorder programs;

- urging managed care organizations (MCOs) to make timely reimbursements to providers;
- reservations of behavioral health providers to relocate to the state due to the recent allegations of fraud against several providers;
- what would be required to reopen the Taos detox facility; and
- concern that the state is not maximizing Medicaid funding.

Public Comment

Senator Kernan read a statement from Ben Maddox requesting the consideration of installing a net under the Rio Grande Gorge bridge to prevent individuals from committing suicide at the location. This has been done in San Francisco. It is unclear what the cost for such a project would be, according to Mr. Maddox, but he wished to suggest using capital outlay funding for the project.

Yale Jones, a resident of Taos, is an attorney who works with the drug court team. He recognized that Taos has a great community with individuals committed to recovery services. Mr. Jones believes that the key is prevention; more needs to be done in terms of education early on to prevent long-term issues. He hopes to see ways to address the lack of opportunity as well as poverty in communities.

John Gonzales has a passion for the electoral process and believes that without good elected officials, communities are unable to serve the needs of people. Mr. Gonzales helped coordinate the legislative agenda for a previous Taos mayor and was part of the homeless coalition. He noted that mental health is an illness and should not be stigmatized in the manner it is. The majority of people in prison and jail are there because they made a few wrong choices. Private prisons are good because they ensure that inmates receive the medical attention they need along with proper nutrition, according to Mr. Gonzales. He spoke about the 2013 credible allegations of fraud by the HSD and the impact that had on the local behavioral health system. There is a tremendous need for education, economic opportunities, support and treatment in the community.

Silvia Romero shared the personal story of her daughter who is addicted to heroin. Her daughter received services at Tri-County Community Services, where Ms. Romero believes her daughter fell through the cracks of the system due to the lack of counselors. Ms. Romero expressed frustration that her daughter has spent more time in jail for heroin than the individuals responsible for murdering her brothers. Her daughter has four felonies for not complying because she is an addict. Her daughter is currently in drug court, which Ms. Romero hopes will help her. The state needs more services for individuals battling addiction.

Senator Ortiz y Pino requested individuals who attempted to get adolescents into Turquoise Lodge to send information to the committee and staff via email or mail. The next meeting of the LHHS in Farmington will address the closure of adolescent services. The committee wants to know the scope of the issue and to find out how many individuals were unable to get into the facility before its closure.

Recess

The committee recessed for the day at 4:03 p.m.

Wednesday, August 24

Welcome and Introductions

The third day of the LHHS meeting was reconvened at 8:43 a.m. by Senator Ortiz y Pino. Members of the committee and staff introduced themselves.

All-Payer Claims Database (APCD)

Mike Nelson, deputy secretary, HSD, provided an overview of New Mexico's APCD. In 2015, the HSD was awarded a planning grant from the Centers for Medicare and Medicaid Services (CMS) to improve patient experience and health while reducing costs. The development of an APCD is one of the components of New Mexico's State Innovation Model Design plan and a critical tool for promoting transformative changes in the health care delivery system. A council was assembled and worked with stakeholders to conduct a feasibility study in March 2016. Mr. Nelson shared the outcome of that study (please see executive summary handout). After two periods of extensive stakeholder input to determine basic issues related to APCD development and implementation, New Mexico is in a strong position to move forward with an APCD. The DOH's rulemaking authority and Health Information System Act Advisory Committee structure provide the foundation for moving forward, at least for initial data collection. Mr. Nelson detailed the immediate next steps that the state should take, adding that many of the steps can occur in tandem. The main challenge will be funding. The planning grant from the CMS was approximately $2 million. The CMS will not provide implementation funding for New Mexico because the state came into the process later than others. The state will need to engage a vendor to determine the cost of the project. A full copy of the feasibility study will be provided to LCS staff.

Victoria Dirmyer, M.D., health systems epidemiologist, DOH, is a member of the Health Information System Act Advisory Committee. The rules for the creation of the Health Information System Act Advisory Committee were adopted in February 2016. The advisory committee has met twice and has been looking at what other states are doing to implement APCDs. Pursuant to the Health Information System Act (passed in 2015 as Senate Bill 323), the DOH is required to create a website by January 2018 that contains data relating to cost and quality. The advisory committee is planning to meet again on August 30, 2016.

Following the presentation, members of the committee discussed the APCD and the results of the feasibility study. Some key points addressed were:

- next steps for implementation, including creation of a work group;
- clarification about types of data maintained in the database and how the data are collected;
- benefits of tracking data;
- what type of information can be derived from the data collected;

- ability to gather data from New Mexico residents receiving medical attention from surrounding states;
- creation of a standardized document for data collection;
- concerns with the coding system and the need to ensure compliance with HIPAA;
- membership of the Health Information System Act Advisory Committee;
- use of data by other states as a transparency tool for consumers that provides the ability for consumers to shop for services;
- the need for data to be used for informing public policy;
- update to the committee regarding the closure of obstetric and gynecological (OB/GYN) services in Las Vegas;
- how the APCD fits in with the health information exchange (HIE);
- agreement and interest from stakeholders, with no opposition at this point;
- the cost for the database moving forward; and
- a request for a full list of health indicators that can be collected through coding and data collection.

Patricia Montoya, executive director, New Mexico Coalition for Healthcare Value, explained that using the HIE and the APCD would provide better information and insight. Ms. Montoya discussed what other states are doing with their APCDs to increase transparency. Medicare has recently freed up available data for usage by states. The key is getting designated organizations and agencies that work with sensitive data to work together.

Marla Shoats, lobbyist, Blue Cross and Blue Shield of New Mexico (BCBS), stated that BCBS has been involved in the process of developing the APCD. BCBS has some concerns about the cost of implementation and the recent U.S. Supreme Court decision in *Gobeille v. Liberty Mutual*, which allows self-insured entities to opt out of providing data to APCDs. In light of the current budget crisis, Ms. Shoats does not believe the APCD is something that should be a priority at this time. New Mexico should wait to see what other states are doing before proceeding.

Brent Moore, legal representative for America's Health Insurance Plans, voiced appreciation for the efforts of working toward this database. When individuals shop for coverage, they are looking at the overall cost of a plan, not necessarily for a particular procedure. The most affordable coverage and the ability to have provider choice are typically the main drivers for the consumer. Mr. Moore believes the APCD represents a big unknown at this time.

Ellen Pinnes noted that despite claims about Medicaid being characterized as a "runaway" program in terms of costs, there has been only a one percent increase in cost to the state since the expansion of Medicaid. At the same time, there has been a one percent decrease per enrollee over the last year. There are more people in the system, which Ms. Pinnes stated is a positive thing.

Health Care Costs and Quality Case Study: Hip and Knee Replacements

Ms. Montoya presented to the committee about a recent health care costs and quality case study on hip and knee replacements (please see handout for full details of the presentation). As part of the CMS Comprehensive Care for Joint Replacement Model, the CMS designated over 500 hospitals across the country to participate in this mandatory delivery system reform. The mission was to foster health care transformation by finding new ways to pay for and deliver care that can lower costs and improve care. The goal is better care, healthier people and smarter spending. Ms. Montoya provided a brief history of Medicare hip and knee replacements. Hip and knee replacements are the most common inpatient surgery for Medicaid beneficiaries; however, there are a growing number of young people seeking these procedures as a result of sports injuries. There were more than 400,000 procedures in 2014, costing more than $7 billion just in hospitalizations alone. Ms. Montoya noted that the cost of the same procedure can range greatly from one geographical area to another. The average cost for a knee replacement in New Mexico is $32,600; the average range in Santa Fe is $23,800 to $36,500; and the average range in Albuquerque is $29,000 to $37,300. There have not been enough incentives to coordinate care from surgery to recovery. The Comprehensive Care for Joint Replacement Model seeks to address multiple issues, including high cost and low quality and hospital accountability for related care post-procedure. The episode of care would have one "bundled payment" that would include all pre-operation, operation and post-operation services. The CMS has designed a payment structure to provide hospitals with an incentive to work with physicians, home health agencies, skilled nursing facilities and other providers. In New Mexico, Albuquerque and its three main hospitals were designated: Lovelace Health System, Presbyterian and University of New Mexico Sandoval Regional Medical Center, Inc.

In July, an educational seminar was held for employers around the state that addressed many questions that the New Mexico Coalition for Healthcare Value had posed. Ms. Montoya discussed some of the participants, panels and highlights from presentations at the seminar. Seminar participants were able to voice concerns and gain a better understanding of the objectives of the initiative. At the seminar, a representative from the CMS shared some of Medicare's goals. The CMS is moving toward value-based payment. Additionally, 85 percent of Medicare fee for service (FFS) will be tied to quality or value by the end of 2017 and 90 percent by 2018. Providers and suppliers will continue to be paid via Medicare FFS. Ms. Montoya explained that participating hospitals will receive prospective episode target prices that reflect spending for an episode. After the performance year, actual episode spending will be compared to the episode target price. If the aggregate target is greater than actual episode spending, hospitals will receive a reconciliation payment, pending their quality performance. If the aggregate target price is less, hospitals will be responsible for making a payment to Medicare. The idea is shared savings and shared risk. Hospitals and medical providers will have to make some changes in how they handle medical procedures before, during and after. One of the biggest changes and challenges for providers will be having the hospital delivery system strongly connect and communicate with post-acute providers. Ms. Montoya concluded that during this time of budget challenges, the state and agencies should aim at not just cutting budgets across the board, but assessing what is working and supporting those efforts.

On questioning, Ms. Montoya and the committee members discussed the following topics:

- clarification about bundling payment and how entities receive payment;
- an explanation of payment distribution;
- issues with using only one type of device for replacements;
- the possibility of doctors not wanting to participate in this type of program;
- the importance of patient responsibility post-operation;
- across-the-board move from FFS to value-based pricing;
- the need for coordination of care after procedures;
- concern with loosening restrictions on home health care;
- the need for examining best practices and ensuring that the right programs and systems are being funded; and
- the overall reconceptualization of health care and the creation of a culture of health.

Representative Trujillo introduced her niece, Erica Parra, who is an emergency medical services (EMS) provider in Taos County. Ms. Parra requested that providers in the community get taken care of. The EMS provider in Taos is a county agency and private agencies have not been allowed to come into the community. She stated that there are many fixed-income or low-income persons for whom an ambulance ride is very expensive and who would not be able to afford this service if it was private. Ms. Montoya and the committee discussed the use of EMS throughout the state and the need for increased coordination of care to reduce usage by "frequent flyers" who tie up resources for individuals in need.

Cardiac Calcium Scans

Philip Eaton, M.D., professor emeritus, Department of Internal Medicine (DOIM), University of New Mexico (UNM) Health Sciences Center (HSC), presented to the LHHS about creating healthy hearts for all New Mexicans. There have been rapid advances in medical science to understand the nature of heart attacks. Heart attacks are the leading cause of death, killing more people than all cancers combined. Heart attacks are an acute event of a chronic disease. By dealing with the disease, the acute event can be prevented. Until now, there has been no way of identifying individuals who had the hidden chronic disease. Dr. Eaton shared the medical breakthrough known as a coronary calcium scan that now allows doctors to identify individuals at risk for heart attacks. Coronary calcium scans allow heart attacks to be prevented. The coronary artery calcium virtual biopsy scan uses an old-fashioned scanner to obtain a blade-less biopsy. The scan is totally non-invasive and only takes 10 minutes, providing multiple three-dimensional x-ray slices through the heart depicting plaque. Dr. Eaton shared several images in a handout of what the scan produces and explained what happens during a heart attack. The scan calculates the amount of calcium: the higher the score, the greater the risk of heart attack. The cost of the scan is $150, which is an inexpensive test compared to the costly expense of other procedures that are required with an untreated problem.

David Schade, M.D., professor, DOIM, UNMHSC, helped bring the coronary artery calcium virtual biopsy scan to the UNMHSC with the hope to provide access to the working

poor. The UNMHSC has paired with the UNM Foundation to make the coronary artery calcium virtual biopsy scan available to everyone. Medicare now covers the cost of the scan, and New Mexico Health Connections will begin coverage in 2017. Texas is the only state that has passed legislation to allow coverage for the scan. The goal of the presenters is to create legislation to add a $150 benefit for a cardiac calcium scan to all appropriate insurance programs. They are requesting that the LHHS endorse the proposed legislation they have included for the upcoming regular legislative session.

Representative Trujillo requested staff to prepare legislation for endorsement during the November meeting of the LHHS. She expressed desire to sponsor the bill. Committee members inquired about the following information:

- the benefit of legislation in terms of cost-effectiveness;
- the low-cost advantage of the scan;
- support from national associations for the use of this technology;
- potential opposition from MCOs of adding scans as a benefit;
- use of the scans for the last 10 years was widely accepted and was not experimental;
- hospitals in New Mexico currently performing the scans;
- the need for recognizing heart attack as a chronic disease;
- how the technology for the scans is added to existing computed tomography (CT) scanning equipment;
- advantages of the scan over other available tests; and
- the ability to create risk assessments for patients and determine treatment and management options.

Licensure for Doctors of Naturopathic Medicine

Catherine Stauber, D.C., N.D., D.H.A.N.P., president, New Mexico Association of Naturopathic Physicians (NMANP), stated that her organization is not actively seeking licensure but is looking at the feasibility of introducing legislation in the near future. Ms. Stauber explained that there is a difference between naturopathic physicians and "naturopaths", describing the schooling and clinical hours required. Naturopathic physicians, or naturopathic doctors, attend four years of pre-medicine and four years at an accredited naturopathic school, fulfill clinical hours and take a national licensing examination. Naturopaths do not receive any formal training. In 2003 and 2005, the NMANP sought legislation for licensure, but efforts were stalled due to confusion between the two groups. In 2009, the passage of the Unlicensed Health Care Practice Act allowed naturopathic doctors to practice in the state, but with limitations. There are currently 20 states that license naturopathic physicians. The NMANP would like to be governed under its own board, but recognizing fiscal challenges, Ms. Stauber stated that the NMANP would consider being under the oversight of an existing related board. Ms. Stauber noted the scope of practice in various states (see handout). The benefit of naturopathic physicians is illustrated best in the area of preventative care prior to formation of chronic disease. Naturopathic physicians have been involved in integrated medicine, working with different types of medical doctors and conducting research at Yale University and the Mayo Clinic.

Traci Hobson, J.D., American Association of Naturopathic Physicians (AANP), has a background in indigenous people's policy. Ms. Hobson stated that the AANP is advocating for licensure in all 50 states. She believes licensure helps differentiate between naturopathic physicians and naturopaths.

Denise Clark, N.D., past president, Colorado Association of Naturopathic Doctors (CAND), noted that Colorado is one of the newest states to grant licensure to naturopathic doctors, passing legislation in 2013. The lack of distinction between the two groups is at times problematic. The Colorado law allows naturopathic doctors the ability to diagnose and treat patients. Ms. Clark informed the committee that she orders cardiac calcium scans for individuals and performs minor office procedures. The CAND carries malpractice insurance up to $1 million. In 2015, two more bills were passed, one adding the ability to treat infants. The legislation comes up for sunset review in 2017, and the CAND is looking at the possibility of further expanding the scope of practice.

Lilly-Marie Blecher, N.D., D.O.M., opened her practice in Taos back in 2012. She provided some of her personal and professional background for the committee. Ms. Blecher carries malpractice insurance under her D.O.M. license but does not believe it is enough to cover all of the services she can provide. Chronic care is one of her biggest treatment areas. She is able to provide guidance with lifestyle choices and collaborate with other doctors of medicine, massage therapists, healers and chiropractors. Ms. Blecher believes there is a large demand for holistic medicine, particularly in northern New Mexico, and she would like patients to have more access to this type of care.

Juliette Mulgrew, N.D., Ayurveda, cited the growing recognition of naturopathic doctors at the national level. Individuals seeking education as a naturopathic doctor are eligible for the same educational loans as students in other medical fields. Medicaid in Oregon covers naturopathic medicine, but it is not yet covered by Medicare. Naturopathic doctors can provide consultation to patients about potential interactions between pharmaceuticals and supplements. Ms. Mulgrew highlighted programs that aid in veteran care and work with the Indian Health Services (IHS). Naturopathic medicine seeks the treatment of mind, body and spirit, and the use of herbs as medicine is in alignment with native philosophies. She lives in Jemez Springs, but because the center in Jemez Springs is no longer contracted with the IHS, she is unable to provide services in her community. Naturopathic doctors are the bridge between western medicine and alternative medicine with the ability to communicate with professionals on both sides. Naturopathic doctors can work to create integration and help patients get the care they need.

In response to the presentation, the committee addressed the following topics with the panel:

- further clarification between the two groups;
- examples of scope of practice of naturopathic doctors;

- educational requirements for licensure in other states, including information about the national licensing exam;
- growth of the field with the passage of legislation around the country;
- the number of naturopathic doctors in New Mexico and the increasing number of individuals leaving the state due to lack of licensure;
- the ability of naturopathic doctors to address needs in rural areas;
- potential for job creation with the opening of practices in communities;
- prescriptive authority in different states;
- the increasing number of females in the field of naturopathic medicine;
- work with midwives and birthing centers;
- the prevalence of traditional communities in the state with a interest in holistic approaches;
- prescriptive authority for medical cannabis; and
- the ability of naturopathic doctors to work more closely with patients than most medical doctors, thus providing education and communication.

Senator Ortiz y Pino encouraged the panel to keep seeking licensure and explained how to get help from staff to draft potential legislation. He suggested looking at existing legislation from other states and modeling a program after one that fits best for New Mexico. A member of the committee expressed interest in sponsoring future legislation.

Public Comment

Janet Gabriel shared her story of trying to find sustainable methods of managing her chronic illness. After many years of trying different types of medicine, Ms. Gabriel began treatment with a naturopathic physician. Her daughter is now a naturopathic physician and would like to return to New Mexico to practice medicine, but she is unable to practice in the state under existing laws. Ms. Gabriel questioned why the state would not welcome doctors to work within their scope of practice to help people cope with chronic illness without dangerous drugs. Letters from Charles "Mac" Powell, president, Bastyr University, and Celeste Griego (Ms. Gabriel's daughter) were distributed to the committee.

Joan Krohn shared her letter to the editor of the *Las Vegas Optic* regarding the closure of OB/GYN services at Alta Vista Regional Hospital. Ms. Krohn stated that where you are born matters, which is something that is being overlooked during the closure of obstetric services. She believes that the hospital in Las Vegas abandoned patients and has the responsibility to make sure expectant mothers get the help they need. Ms. Krohn took the issue to the Attorney General's Office, where it is currently under examination to determine if the discontinuation of services is illegal.

Nina Scolera and Irene Loy, Dream Tree Project, addressed the committee regarding behavioral health issues discussed during the previous day's meeting. Youth needs are not being met and teens are facing significant barriers. There are limited openings for residential treatment for youth. The Children, Youth and Families Department (CYFD) frequently struggles to meet the need for beds in emergency situations. Dream Tree has been working with the CYFD to

attend to the matter while exploring other ways to better serve children in New Mexico. Dream Tree will also be part of the CYFD's Pulling Together Initiative.

Julia Klause spoke about the challenges she faced to get insurance coverage after a surgery. She traveled to other states and Mexico to receive cancer treatment from alternative providers. She is now cancer free and in better health than ever before. Ms. Klause urged support of legislation allowing licensure of naturopathic doctors in New Mexico.

Adjournment

There being no further business before the committee, the fourth meeting of the LHHS adjourned at 3:43 p.m.