National Advisory Committee on Rural Health and Human Services

Fall Meeting
Santa Fe and Las Vegas, New Mexico
September 4th – 6th, 2024

The Rural Opioid and Substance Abuse Crisis: Supporting Rural Families

Meeting Summary

The 95th meeting of the National Advisory Committee on Rural Health and Human Services (NACRHHS) was held September 4th in Santa Fe, New Mexico, and September 5th – 6th in Las Vegas, New Mexico. The meeting topic was The Rural Opioid and Substance Use Crisis: Supporting Rural Families.

The committee members in attendance: The Honorable Steve Bullock, Former Governor of Montana, Committee Chair; Amanda Aguirre, April Anzaldua, Isabel Garcia-Vargas, Alva Ferdinand, Craig Glover, Clifford Hunter, Ruby Kirby, Michelle A. Mills, Kellie Phillips-Asay, Mathew Probst.

Committee staff present: Tom Morris, Senior Policy Advisor to the Committee and Director, Federal Office of Rural Health Policy (FORHP), Department of Health and Human Services (HHS); Sahira Rafiullah, Executive Secretary to the Committee and Chief Advisor, FORHP; Sarah Heppner, Associate Director, FORHP; Mebrat Tekle, Public Health Analyst, FORHP; Steve Hirsch, Public Health Analyst, FORHP; Jocelyn Richgels, Committee staff and Director, National Policy Programs, Rural Policy Research Institute .

Additional attendees: Ben Smith, Indian Health Services (IHS); Darci Graves, Special Projects Office of Minority Health, Office of Minority Health (OMH); Aleta Myer, Administration for Children and Families (ACF); Lisa Zingman, ACF; Kellie Kubena, United States Department of Agriculture (USDA); Percy Devine, Administration for Community Living (ACL); Jalima Caulker, Substance Abuse and Mental Health Services (SAMHSA), Krishnan Radhakrishnan, MD, SAMHSA; Peter Kaboli, Veterans Health Association (VHA); Carolyn Montoya, Interim Dean and Professor, College of Nursing, University of New Mexico and former NACRHHS committee member.

Santa Fe, New Mexico
Hilton Santa Fe, Historic Plaza
Wednesday, September 4, 2024

WELCOME AND INTRODUCTIONS

Former Governor of Montana and Committee Chair the Honorable Steve Bullock

Committee Chair, the Honorable Steve Bullock convened the meeting. He shared that he served as Montana's Attorney General from 2008 - 2013, and the Governor of Montana from 2013 - 2021. The issue of opioid addiction was a focus when he was attorney general and governor. It is important to consider the clinical and health aspects of opioid use as well as the human services implications. In 2008, when elected the Attorney General of Montana, he spoke to emergency room doctors about the challenges of opioid addiction. Governor Bullock said that when he was on his campaign, whether it was a group including an auto body technician or a professional, people were telling him about their struggles with addiction. Every community, large or small, is facing opioid addiction challenges still today. Governor Bullock thanked committee member, Matt Probst, for organizing and hosting the meeting. He stated that following the meeting, the Rural Health and Human Service National Advisory Committee will prepare a policy draft to submit to the Secretary of Health and Human Services.

WELCOME TO SANTA FE

Matt Probst
Director, Office of Community Health, University of New Mexico
Committee Member

Matt Probst thanked Governor Bullock and the committee for choosing New Mexico as the location for the meeting. He stated that the documentary, The Providers (2019), is about rural health care in America and was filmed in New Mexico. It includes his practice and demonstrates what it is like to be a medical professional in a rural community. The documentary gives a human face to the physician shortage and opioid epidemic in rural America. The committee will have a chance to watch a portion of the documentary during the meeting. Mr. Probst said that on the ride from the airport, the committee got to see the Sandia Mountains and San Domingo, the Native American Pueblo community between Santa Fe and Albuquerque. He shared that Santa Fe, New Mexico is one of the oldest cities in America.

Mr. Probst stated that New Mexico is a place of rich history and very much a part of who he is. There was the civil war battle near Las Vegas, New Mexico, and the Mexican American war was in Santa Fe. He shared that his father was part of the civil rights movement during the time of the Rio Arriba County courthouse raid, a reaction to New Mexicans feeling that the access to communal lands was being taken from them by the federal government. His mom's cousin was a deputy shot during the raid. There has been so much conflict in New Mexico and despair comes from the conflict. When it feels like there is no opportunity, there is despair. Dr. Probst said that he grew up in ground zero of the opioid crisis, which was also the suicide capital of the United States.

Mr. Probst shared that the week before the meeting was the 100th year of a traditional event called the Burning of Zozobra, which is a huge, monstrous marionette made of wood, wire, and cloth. New Mexican's write their fears and anxieties on papers and are inside the marionette.

Burning Zozobra releases hopelessness and burdens of the past year and is a sacred ritual of purification and rebirth.

Mr. Probst is a product of the health care workforce movement. His first job in health care was in Las Vegas, New Mexico, where he had only visited while a student participating in sporting events. The primary care clinic where he is a provider serves seven villages that were founded to protect the Santa Fe trail. Two years into his career, he felt hopeless because the community was dealing with so many illnesses, diseases, despair, and effects of the opioid epidemic. The clinic parking lot was also the school bus stop where Mr. Probst spent his days caring for the student's parents and grandparents. The teenagers would get off the bus and smoke cigarettes and joints, and he realized that the change was going to have to come through the children in the community. Social determinants of health must be considered due to trauma and hopelessness. People in the communities need opportunities to progress so that they can feel hopeful and better their lives. New Mexico ranks the highest in opioid use and is last in education due to a lack of resources. Throughout the years of his career new drugs have been introduced into the community so it takes continued education to find the correct treatment for people with drug use disorder and the most effective path to recovery.

Semillas de Salud, a primary care clinical program, started a pilot program for children in elementary and middle school. Through this program, the children in Las Vegas travel to Albuquerque to take a tour of the University of New Mexico (UNM). The children are so excited to learn about the programs and technology. One young girl asked him if he believed that she could ever go to college at UNM. He answered, of course. Visiting the college opened her mind to the possibilities of higher education and the ability to choose a fulfilling profession.

Mr. Probst ended by telling the committee that community leaders know what is needed to support their people, the only component missing is the necessary funding. He used the saying, "let us fish, instead of teaching us how to fish."

THE RURAL OPIOID AND SUBSTANCE USE CRISIS: A NATIONAL PERSPECTIVE
The National Centers of Excellence for the Rural Community Opioid Response Initiative

Governor Bullock introduced the first panel, which offered a national perspective on the current state of the opioid and substance use crisis in rural America.

Ken Conner, Psy.D.
Professor, Recovery Center of Excellence
University of Rochester

Dr. Ken Conner said that it is a pleasure to speak to the committee and explained that he and his colleagues represent the three Health Resources and Services Administration (HRSA) Rural Centers of Excellence (RCOEs). Dr. Conner shared that he is the Director of the Center of Excellence for Suicide Prevention and that in the past, he was chair of the Substance Abuse and Mental Health Services Administration (SAMHSA) Committee.

In relation to overdose deaths in the United States, there have been four waves of the epidemic. The most prevalent cause of overdose deaths in the fourth wave is due to stimulants, such as Methamphetamine, being mixed with Fentanyl, because users of stimulants do not know they are ingesting opioids. Overdose deaths in rural and urban settings are comparable, overall Hispanics and Latinos are more at risk.

In urban settings the age range for overdose deaths is twenty-five through forty-four compared to in rural settings the age range is forty-five to sixty-four. Native Americans and American Indians have the highest risk of overdose deaths in rural areas. African Americans and Latinos have the highest rates of overdose deaths in metro areas than in rural communities.

There was a decrease in overdose deaths in the United States from 2022-23. Fentanyl deaths decreased from 2022-23, while Methamphetamine deaths increased.

The HHS Overdose Prevention Strategy includes improving delivery of interventions, facilitating the implementation of evidence-based programs, and providing recovery support.

Rural Center of Excellence (RCOE) Primary Prevention Pilot Projects include:

- Community-Driven Interventions for Trauma-Informed Substance Use Disorder (SUD) Prevention in Rural Youth (Heatly, Stiles, Malcom, and Alpert-Gillis)
- Addressing Rural Adolescent E-Cigarette Use (Russell)
- Opioid Stewardship in Primary Care (Russell and Malcho)
- Post-operative Pain Management (Kaufman)
- Post-operative Oral Surgery Pain Management (Ren)
- Community Conversations on Opioid Use Disorder (OUD) (Ashrafioun)
- Reducing Stigma Related to Methadone (Morales, Baciewicz)
- Addiction-Informed Suicide Prevention Program (Pisani)
- Engaging Patients with SUD in Rural Care Settings (Conner)

The Recovery Center of Excellence is working to reduce stigmas around Medication for Opioid Use Disorder (MOUDs) by developing educational materials and programs to support opioid use disorder (OUD) health care workforce training.

Valarie Harder, Ph.D.
Associate Professor, Center on Rural Addiction
Larner College of Medicine. University of Vermont

Dr. Valarie Harder shared that she would be discussing substance use treatment, specifically MOUDs, and harm reduction as a first line treatment. According to the National Academy of Sciences, Engineering, and Medicine, the most effective, evidence-based treatments for OUD include Methadone and Buprenorphine, with better outcomes than other treatments including detoxification, antagonist treatment, residential services alone, and intensive behavioral health treatments. Rural areas have less access than other places to MOUDs and more than half of

small, rural counties lack a provider able to prescribe Buprenorphine. Rural hospitals have lower odds of prescribing MOUDs. Two barriers to treating patients with OUD are stigma, time, and staffing constraints.

Rural areas have less access to harm reduction because there are fewer Methadone and Buprenorphine offices in rural communities. There are transportation challenges, so people are not able to travel distances to have access to MOUD. There are fewer pharmacies dispensing Narcan and fewer syringe exchange programs. Stigma towards harm reduction is more prevalent in rural areas. Rural first responders have more negative views about Narcan, and rural clinicians focus more on abstinence orientation than prescribing MOUD.

It is essential to promote conversations about harm reduction with clinicians and educating them on building trust and using non-judgmental language. It is important for clinicians to assure people with OUD that their office is a safe space to discuss drug use. Recommendations for the committee to consider include increasing evidence-based harm reduction strategies and increasing interventions and policies to reduce provider and community stigma toward harm reduction and people with OUD.

Contingency Management (CM), where patients are provided with incentives to reinforce positive health behaviors, is an evidence-based treatment that has exhibited success in reinforcing positive health behaviors. The challenges with implementing a contingency plan are a lack of transportation in rural communities, long drives to contingency management providers, and fewer behavioral health providers.

Recommendations the Committee should consider for improving treatment for individuals with OUD include improving provider education and training, expanding telehealth options for CM, advocating for safe harbor protections for CM, and encouraging states to apply for 1115 Waivers.

Dave Johnson
CEO, The Fletcher Group
Rural Center of Excellence

Dave Johnson stated that the Fletcher Group is dedicated to expanding capacity, improving the quality of recovery housing, additional recovery services, and conducting research and program evaluation that supports rural communities across the United States. Mr. Johnson stated that the Fletcher Group understands that every rural community is different, so it is important to collaborate individually with each community to develop their recovery plan. Community organizations are a major source of support that can bring communities together and support those with OUD.

Recovery Support in Rural Areas Include:

- Local and State Officials
- Hospital and Health Systems
- Medical Providers
- Behavioral Health Service Organizations

- Community Based Organizations
- Public Health
- Criminal/Legal System
- Faith Based Communities
- Public Safety and First Response
- Transportation
- Housing Providers
- Human Services
- Educational and Workforce Development Institutions
- Technology/Internet Access

Rural recovery service challenges include a lack of mental health and substance use treatment services, lack of access to broadband, and stigma related to OUD and MOUDs. Individuals with OUD, living in rural communities, are more likely to live in a household with someone with alcohol or substance use. Twenty-three percent of individuals in rural areas over the age of sixty-five are facing OUD and alcohol use. People are isolated and do not receive treatment or get the support needed.

Policy challenges are that funding seems to be either for rural programs or non-rural programs. States are not considering rural counties when receiving funding. It is necessary to allocate resources for continuum of care that includes prevention, treatment, and recovery. The clinical model is important but so is the social model that builds on peer support. There is a need to have value-based payments instead of fees-for-service. Medication for OUD is an important part of recovery so medical professionals who do not want to prescribe MOUDs need education to better understand the benefits.

Mr. Johnson stated that recovery housing works. He spoke about a recovery campus in Henderson, Kentucky where there is a population of thirty thousand people. It started as a recovery center and now has additional apartments and housing complexes for long-term arrangements. It is a recovery community, where people with OUD can continue to support each other in their recovery journey.

Q&A

Governor Bullock addressed Dr. Harder, expressing concern that over a half of rural counties do not have providers who prescribe buprenorphine as a form of treatment for individuals with OUD. Pharmacies must monitor buprenorphine because it is an opioid, so it is no different than oxycodone when prescribing. The Drug Enforcement Administration (DEA) will investigate pharmacies who are prescribing MOUDs. Has there been consideration of law enforcement challenges of treating buprenorphine and other opioids the same when it comes to monitoring and reporting? Also, have there been reviews of Naloxone verses Nalmefene for treating individuals with OUD in rural areas and reviews about the challenges when addressing overdose in rural areas?

Dr. Harder responded that she has not seen a review comparing Naloxone and Nalmefene, but the question prompts her to investigate it. There are physicians that think that medications for

opioid use disorders are replacing one drug for another. This leads to stigma and bias, which is a widely held belief. MOUDs help people with substance use disorders and save lives. She shared that she had not worked directly with pharmacies but had heard the complaints about prescribing MOUDs. It would be interesting to know if this is an issue with rural and urban pharmacies or only rural.

Mr. Probst shared that in 2018**,** he was working at a Federally Qualified Health Center (FQHC), and they received the first rural community opioid response planning grant (RCORP). During that time, within the seven-county service area, physicians were prescribing considerable quantities of buprenorphine. Eighty-five percent of the providers in the seven-county service area began prescribing buprenorphine. The district attorney met with him and asked why they are using suboxone strips in the jail because he believed it is the same as using drugs. It takes eight hours of training for a physician to get the X-Waiver to prescribe buprenorphine, but he could prescribe oxycodone without training. The data did not change even though the physicians were prescribing MOUDs. There was a summit with students, and they shared that the rate of people needing recovery and housing went from seventy people to seven hundred, particularly in Rio Ariba County. The data did not reflect that the number of individuals with OUD increased significantly. Mr. Probst asked if data is available about primary prevention and its impact from a public health perspective.

Dr. Harder responded that the purpose of the programs of the Administration for Children and Families (ACF) is to go upstream and work on prevention, The National Institute on Drug Abuse (NIDA) and SAMHSA have information about primary prevention. One of the ways to decrease the demand is to focus upstream with a focus on prevention.

Craig Glover asked if there are more regulatory problems for rural pharmacies than for urban pharmacies. In rural areas there are more independent pharmacies instead of national chains. Are there regulations that may make it more difficult for rural pharmacies to have MOUDs? If so, are there recommendations that the committee could make so it would be easier for independent pharmacies to prescribe MOUDs?

Dr. Harder said that she is not aware of regulatory challenges that pharmacies face in rural areas, but she can follow up on it.

THE RURAL OPIOID AND SUBSTANCE USE CRISIS: A STATE PERSPECTIVE

José Acosta, MD
Director, Public Health Division
New Mexico Department of Health

Dr. José Acosta said that it is an honor to speak to the committee. He shared that New Mexico is the fifth largest state in terms of landmass with a population of 2.1 million people and 25.5 percent of the state is rural. Dr. Acosta spoke to residents in Jal, New Mexico, and they shared that there are still issues with access to health care even in areas that are considered urban. In New Mexico, 17.6 percent of the population live below the federal poverty level.

Dr. Acosta shared that the NM Public Health Division encompasses the public health offices, epidemiology, programs, medical cannabis, scientific lab, and public health operations across the state.

He stated that everyone acknowledges that substance use disorder is a huge concern. There are forty-nine deaths per one hundred thousand individuals in the State of New Mexico due to drug overdose. There is a robust harm reduction program in New Mexico that includes Naloxone, to reverse opioid overdose, and syringe exchange. There are fifty-two public health offices in the State of New Mexico. Suboxone, a MOUD, is offered in thirty-five public health offices across the state.

School-based health centers provide critical primary care and behavioral health treatment to school-aged children in New Mexico. The centers are a collaboration between the state and the federal government providing services in schools.

The governor and legislature are committed to fighting the opioid epidemic. This includes expanding MOUDs and working upstream with the children who are being exposed to the effects of opioids and trying to prevent it going forward.

Timothy Shields, PhD
Executive Director/Hospital Administrator
New Mexico Behavioral Health Institute

Dr. Timothy Shields relayed that he grew up in Albuquerque and moved to numerous states in the U.S. working with youth and families. He moved to Nebraska as an undergraduate, then moved to Seattle for graduate school and did an internship in New York City and spent twelve years working in that area. Dr. Shields is now the administrator of the New Mexico Behavioral Health Institute (NMBHI). He stated that the issues he would discuss are prevalent in all the communities where he has worked, including the difficulty of getting people into treatment.

His specialty is behavioral health in the mental health field. His dissertation was on substance use, but he cannot treat for substance use because he earned the certificate but did not have the hours to be licensed. The requirement to choose a specialty limits a physician from providing the best treatment to people in the community but is necessary so that physicians are trained and qualified to provide treatment.

Silos excludes who doctors can treat, for example, treatment centers are not able to provide services for an individual who has taken methadone recently because they must detox first or, if a person is psychotic, they must find another service first. The regulations create barriers that cause people not to receive treatment when they are seeking help. From the state perspective, as soon as someone has a civil order for treatment they will be treated regardless of diagnosis or history.

Residency requirements are another barrier. An individual who goes to a facility in Santa Fe, but is not a resident, may not get treatment because residents are priority. Other treatment centers may be a long distance from where a person lives and they do not want to travel to get treatment.

Q&A

Kellie Phillips-Asay asked Dr. Acosta if the 2022 statistics concerning forty-nine deaths per one hundred thousand individuals, include tribal health centers and Indian Health Service in rural communities.

Dr. Acosta responded that it does not include tribal information, but it includes all other facilities.

April Anzaldua asked if they have looked at the number of people who have referrals but do not go to treatment centers that are a long distance away. Also, who transports people to treatment centers when they are a long distance away.

Dr. Shields responded that there is no data at this time, but a large majority do not follow through because it takes too long to find a treatment center available and because of the distance. Individuals with substance use disorder are not mandated to have treatment, but someone with mental health issues that are considered a threat to themselves or others, are mandated to go for treatment. Family members, ambulance services, or law enforcement usually transport people to the treatment center. There are outpatient treatment centers where people go when they are charged with a crime and are given the choice of treatment or detention.

Michelle Mills asked what happens when someone is in crisis at a Critical Access Hospital (CAH) because of a psychiatric episode or substance use.

Dr. Shields responded that it can be difficult to tell if someone has substance use disorder or mental health issues when they are in crisis. At a CAH, the emergency room physician must advise that the person meets criteria for inpatient treatment. Detox is an issue, because there are medical complexities involved, so it depends on if the hospital can implement detox treatment.

Clifford Hunter asked Dr. Shields, with regard to the negative effects of siloed services that he discussed, if there are regulation barriers or payment for service issues that cause services to be separate regarding substance use and crisis stabilization verses long-term care.

Dr. Shields responded that payment is an issue because the main source of payment may be for one service so another service that is slightly outside of the scope may not be covered.

THE RURAL SUBSTANCE USE CRISIS: A COMMUNITY PERSPECTIVE

Stacy L. Martin
CEO

The Santa Fe Recovery Center

Stacy Martin explained that the Santa Fe Recovery Center was founded in 2005 and is committed to breaking down the barriers and working collectively with state, federal, and local organizations to eliminate behavioral health disparities. There has been significant growth in the growth in opioid and behavioral health crisis in the past couple of years. The opioid crisis underscores and highlights historical issues that have been part of the behavioral health system particularly in rural communities. The center will be integrating the Certified Community Behavioral Health Clinic (CCBHC) model into their historically treatment focused model. With the assistance of federal and state partners, the center is creating innovative and evidence-based practices to increase prevention and recovery strategies. If people with opioid use disorder can make it to the five-year mark without using, their lives in recovery are much easier. The goal is to create a New Mexico where treatment is not needed at all.

The focus of the center is unique because it is to treat people in the communities who may not otherwise have access. In 2023, the center served about thirty-five hundred people, including thirty-percent uninsured and the remainder receiving Medicaid. The staff demographics reflect the communities being served, which is critical to client outcomes. Peer workers are employed as residential service providers and with prevention and recovery services. Many people being served are unhoused, so case management is critical for addressing social determinants of health. The Santa Fe Recovery Center is the only facility in the state that provides residential services for pregnant women and postpartum women and their children. A goal is to make sure the children never have to go into the child welfare system and do not have to encounter substance use in the future.

The opioid crisis has exacerbated the ongoing challenges in rural New Mexico that have existed for decades. In rural areas of New Mexico there are disproportionately high rates of overdoses and deaths because of lack of resources, limited access to emergency medical care, and limited access to overdose reversal medications. The governor has taken action to ensure there are rural hospitals in the state because rural hospitals have been closing across the country which has a huge effect on rates of death for people suffering from substance use disorder. The health infrastructure is under resourced and overburdened. There is a shortage of behavioral health providers and very few specialize in addiction treatment in rural communities.

There are existing social determinants of health issues in rural communities that include generational poverty, lack of employment, lack of educational opportunities, and limited access to health care. The center is working on comprehensive approaches, which include living conditions, health, and wellbeing, by looking through a wider scope at all the pieces of a person's life that lead to substance use disorder.

Challenges from an organizational perspective include workforce shortages and workforce development. There are higher education institutions closing and state schools limiting the number of majors. The education level that has been mandated for entry into service provision needs to be reconsidered to eliminate barriers and make it a fulfilling career that allows people to live a robust middle-class life. Transportation to access treatment is a barrier. New Mexico has a commuter rail that is limited between Santa Fe and Albuquerque. Telehealth is an issue because

it is difficult for people to access broadband and find a private space to meet a provider virtually. Physicians need to be more comfortable with medication assisted treatment and eliminate the stigma.

Opportunities to treat people with OUD include early intervention, especially with assessments and screening based on evidence-based practices. Strengthening social determinants of health is a critical part of holistic care, wellness, and health. It is important to have case management to help people navigate systems. Recovery is different for each person, so it is necessary to help people approach recovery in their own unique way. Substance use disorder often comes with a behavioral health condition, so it makes sense to find ways to expand outpatient opportunities for behavioral health.

Ms. Martin shared a story about a fifty-four-year-old man who had struggled with alcohol dependency since he was a teenager. He attended a program at the recovery center while living at a shelter. He had been admitted to the hospital multiple times due to complications from late-stage liver cirrhosis and needed inpatient hospice care, but he was unhoused and uninsured. He wanted his remaining time to be as meaningful as possible and was admitted to the detox center. The Good Samaritan Society Hospice Program provided hospice care at the facility. He remained committed to recovery, engaged with other people in the program, and had a wonderful attitude. He successfully completed the thirty-day program which was part of his dream and passed away a couple of days after being discharged. Ms. Martin said that it was an honor to accompany him in that part of his journey.

Ms. Martin shared policy recommendations on behalf of the Center, that she would like the Committee to consider:

- Equal access to medication assisted treatment.
- Overhauling the antiquated methadone treatment system
- Addressing the social determinants of health to improve behavioral health outcomes
- Integrating initiatives with behavioral health services to create a comprehensive approach to care
- Advocating for equitable access to and coverage for the highest quality of addiction care
- Repeal of the inmate exclusion and removal of the inmate limitations on benefits under Medicare
- Increase funding for rural behavioral health workforce development.
- Reimbursement for behavioral health care organizations for clinical supervision of non-independently licensed practitioners

William Burrola
Case Manager Supervisor
The Santa Fe Recovery Center

William Burrola stated that in rural regions, especially for individuals transitioning from reservations, the need for trauma informed care is crucial. Scarcity of services can reinforce the harmful mentality that if someone wanted to change their harmful behavior, they simply would. This type of mindset overlooks the impacts of trauma, systemic barriers, and social determinants

of health. It is important for community partners to foster open dialogue so that stigma is eliminated and there are culturally responsive solutions.

One of the most impactful aspects of the recovery center program is case management with a strength-based model that empowers clients to take charge of their recovery journey. The clients identify their needs, set goals, and create personal plans to achieve those goals. This approach respects clients as experts in their own lived experiences, giving them more control and helping build their resilience. A significant innovation in the case management practice is the use of recovery capital which covers personal, social, and community domains. When the recovery capital was introduced, there was hesitation from case managers because they were concerned it would add to their workload, instead the approach reduced burn out among case managers by offering a structured framework that supports sustainable recovery and encourages self-reliance.

The three domains of recovery capital are personal, social, and community, which are also essential in trauma informed care. Personal recovery capital involves building self-advocacy skills and motivation for recovery. Social recovery capital focuses on nurturing supportive relationships and networks. Community recovery capital is about accessing resources and opportunities for growth within the community. The use of motivational interviewing aligns perfectly with the three domains, reinforcing the client's autonomy and motivation for change.

The Santa Fe Recovery Center is in the process of implementing the CCBHC model. This will expand and integrate more comprehensive wrap-around services which are crucial for addressing the highest needs of clients, from housing and employment, medical care, and social support. A vital aspect of the model is the inclusion of Certified Peer Support Workers (CPSWs). Peer support workers, particularly those involved with drug court reentry programs for individuals exiting incarceration, bring invaluable lived experience. By ensuring the peers are well compensated, supported, and given opportunities for advancement, they can offer a more empathetic and informed level of care. Having trauma informed staff who are also survivors helps to create a culture where trauma healing is normalized. Research supports the approach by demonstrating reduced readmission to acute care, fewer arrests, and better engagement in drug court when trauma informed interventions are used. There is a commitment to provide holistic, inclusive, and culturally responsive care that empowers clients and fosters sustainable recovery.

Mr. Burrola shared a story about a client who was deaf and came to the program to receive services. His treatment required an innovative and personalized approach, so the team created a care plan tailored to his needs addressing his substance use disorder and ensuring that communication was seamless throughout his treatment. A translator allowed him to fully engage in the intensive outpatient program (IOP). His commitment to recovery was unwavering and he chose to stay in one of the program's extended apartments so he could continue participating in the IOP. The inclusion of the translator ensured that he could fully benefit from the resources and support available to him.

Mr. Burrola shared there was a woman who had five children and had not seen them in over a year. She had been in an abusive relationship with her husband, and he shot her friend in front of her and her children, resulting in the removal of her children from her home. Her long-time dependency on alcohol increased due to dealing with severe trauma. She entered the thirty-day

residential treatment program, transitioned to the women's and children's ninety-day residential program, and then moved into the bridge house which is part of the sober living program. During that time, she took advantage of supported services including Circle of Security Parenting Classes and domestic violence survivor's classes. With the help of her counseling and case management team she was able to reconnect and begin to heal the relationship with her children. She was reunited with her children and returned to Gallup from Santa Fe with permanent housing, stable employment, and a lifetime restraining order against her abuser.

Q&A

Governor Bullock asked Ms. Martin if she could give more information on what antiquated Drug Enforcement Agency (DEA) policies she was referring to in the Center's recommendations. Does funding come from IHS as well as HHS and what are the opportunities and challenges?

Ms. Martin responded that the (DEA) services have a critical purpose which is keeping illegal drugs out of communities. Physicians, not the DEA, should be making pharmacological decisions because they understand the benefit of medication assisted treatment for people who are in critical cycles of addiction. It is best to have long-term access to MOUDs.

There is funding through HHS, HRSA, and SAMHSA. The Santa Fe Recovery Center shares patients with the IHS but has not figured out the best avenue of partnership with IHS. People who come from tribal areas are served in many locations.

Mr. Glover asked what the regulatory dispensing barriers are to accessing medication.

Ms. Martin responded she had broadly outlined the barriers which included eliminating pharmacological barriers.

Ms. Phillips-Asay said that one of the barriers for people accessing care is transportation. Not all tribal nations have transportation so how are people getting to treatment centers?

Mr. Burrola said that they serve individuals from the Navajo reservations that occupy portions of four states. Individuals do not have transportation across state lines. Once a client completes the program and wants to go home, there is no transportation across state lines. The center will use funding to help with a bus ticket or other forms of transportation to get them home safely. If there is no transportation available, a staff member will drive them.

Ms. Phillips - Asay stated that Montana has a new program for nurse practitioners that specialize in behavioral health, and it could be mirrored in New Mexico. Is there a specific type of provider that is needed?

Ms. Martin responded that there is a shortage of medical providers overall. Nurse practitioners who have behavioral health care as a focus are critical. The state university systems have done remarkable work trying to find what higher education can do to assist with the issue such as eliminating barriers to access in the programs, barriers caused by national tests, and eliminating financial barriers.

Carolyn Montana, stated that, as a clinician educator at The University of New Mexico College of Nursing, they are short six to seven thousand nurses. New Mexico is one of twenty-eight states that has full scope practice for nurse practitioners. There is an extreme poverty level in New Mexico, so the financing of education is problematic, but there are scholarships for students who are obtaining a Bachelor of Science in Nursing degree. When an individual wants to become a nurse practitioner, it is more difficult. HRSA has grants that pay for tuition for nurse practitioners. At the University of New Mexico, the nurse practitioner students are required to have rural experience. Nurses like to spend time with their patients and in a rural setting it is easier to spend more time and get to know them. There are about six nurse practitioners who have their own practices in New Mexico.

Mr. Probst said that the National Health Service Corp supports the primary care workforce and has a specific piece for addiction.

COMMITTEE DISCUSSION: FEDERAL PERSPECTIVES

Governor Bullock stated that there are other federal agencies attending the meeting and asked representatives from those agencies to share based on the information that has been presented.

Lisa Zingman stated that ACF has specific programs that assist families who are dealing with substance use issues and most of the programs are related to the child welfare system. There is a regional partnership grant that focuses on supporting children and families affected by substance use. The prevention services program provides funding for time limited prevention services for mental health, substance use prevention, and treatment. There are also the in-home parenting skills programs for families that have children who are candidates for foster care. Two focuses of AFL are connectivity with Medicaid and ACF programs, so there is the ability to pay for care inclusive of substance use and assuring the involvement in crisis response for behavioral health. There is multi-system involvement to support the family through the crisis and avoid removing children from their families.

Aleta Myer, with ACF, shared The Office of Planning, Research and Evaluation (OPRE) uses applied research of human services to identify solutions to specific challenges of ACF programs. Priorities are identified in collaboration with program partners to create materials, briefs, and resources that are operational. There is a continual need for updates to services since the needs are ever changing.

Percy Devine shared that he is with ACL and the agency has been charged with HHS to lead adult protective services and there are new rules and operational definitions. There have been adult protective service training sessions in all the states. A topic that was discussed was older adults putting prescriptions in a place where their grandchildren cannot find them. The theme that is being discussed during the meeting is there is a balance between drug assisted treatment and addiction. Twice a year there is drug take back day when people can take medications to their local law enforcement agencies to be discarded.

Darci Graves with CMS shared that she grew up in Missouri and went to college in an area where people were making cars into mobile meth labs. CMS created health equity service codes at the start of the year as part of a broader program that also focuses on health-related social needs. The services designed for Community Based Organizations (CBOs) to be able to use and bill by, so it is an opportunity for reimbursement going back into the community. The committee may want to consider 1115 waivers and projects that CMS has in place to research what is working in communities so those initiatives can be used throughout other rural, tribal, and geographically isolated communities.

Ben Smith with IHS stated that in 2017, the HHS Secretary declared a public health emergency for the opioid crisis so there may be additional opportunities for funding. The president recently issued Executive Order 14112 that is based on reforming federal funding and supporting tribal nations in promoting the next era of tribal self-determination. The executive order reforms how the federal government funds and supports tribal nations. It is important to incorporate culturally competent care for federal grants and allow innovative approaches through federal grant funding. The American Indian and Alaska Native data reporting may have racial misclassification, missing data, or other quality issues that impede the representation of the population, so it is necessary to improve federal standards for data and collection reporting. DHHS is working to finalize a data sharing policy with tribal epidemiology centers which include state partners and local entities to assist with the exchange across the system. In addition, there is a 1115 Waiver that is important to IHS and those served which is the consideration of traditional medicine. IHS has been working with CMS to provide waivers that would allow for traditional healing reimbursement. It is a vital component to the holistic care of the patient that includes spiritual, social, mental, and physical aspects of the patient, and includes how to accurately code and bill for the services.

Peter Kaboli with the Veteran's Health Administration (VHA) said that the administration spends more per capita on the veteran population for mental health treatment but is still facing many challenges. The VHA focuses on broadband, telehealth, workforce, geography and distance, and social determinants of health. Regarding telehealth, about ninety-five percent of veterans have access to broadband and internet and ninety percent have broadband speeds fast enough that they can participate in telehealth. Due to stigma, most veterans prefer telehealth visits for their mental health care instead of going to the mental health clinic. Due to the Secretary of HHS declaring the opioid epidemic a public health emergency, buprenorphine can be prescribed when necessary. There will never be enough methadone clinics because of regulations but the veterans can get buprenorphine through telemedicine. The VA has enough primary care doctors, but they are not in rural communities, so the doctors utilize telehealth. Workforce is a challenge everywhere so there must be support for rural workforce training. Social determinants of health are supported by increasing care coordination so that veterans have access to social services.

Krishnan Radhakrishnan MD, with SAMHSA, shared that every year the Evidence-Based Resource Center Team identifies issues that need to be addressed and publishes reports that address the topics. Opioid use treatment retention is a challenge, so there is a need to identify strategies for keeping people in treatment centers. Because of the shortage of behavioral health workforce, SAMSHA is considering how to expand a community-based behavioral health

workforce. SAMSHA is working with George Washington University on coordinating efforts with historically African American colleges, Hispanic serving institutions, and community colleges to increase the behavioral health workforce.

Kellie Kubena, with the USDA rural development innovation center, shared that they are also working on a maternal health project and substance use disorder is a crucial factor to maternal health. Farmers and ranchers are a percentage of those in rural communities with mental health and substance use issues, but a majority do not seek treatment because of time constraints as well as a hesitance to reach out for support. In the farm bill, the Distance Learning and Telemedicine Grant Program (DLT) in Rural Development, the Rural Health, and Safety Education Grant Program (RHSE), and the National Institute of Food and Agriculture Grant Program (NIFA) have set asides for substance use disorder projects.

COMMITTEE DISCUSSION: KEY THEMES AND POSSIBLE RECOMMENDATIONS

Governor Bullock said that states will be receiving funding from opioid settlements to address opioid use disorder. The federal government can provide guidance, use best practices, and outline a plan on how the funding can be utilized to best address the opioid crisis.

Amanda Aguirre shared that in Arizona, the sustainability of programs cannot depend on state or federal governments, because grants are not long-term. There must be an infrastructure in local communities to self-sustain services. Local stakeholders in rural areas have a willingness to work together and focus on solutions from the bottom up. A sustainability model including higher reimbursement for medical professionals and with a focus on recruiting people to work in rural health and human services would be most beneficial.

Mr. Hunter said that he collaborates with Fathers Among Men Program (F.A.M.), which is funded through the Healthy Marriage and Responsible Father Grant (HMRF). F.A.M. is designed to support men in spending more time with their children. Mr. Hunter is the father liaison and designed the project in a way that fathers will trust the program and take part in the services. Men who have spent time in long-term recovery centers experience grief and shame because they have lost their families. A father may have been working a construction job and taken opioids to get through the day and become addicted. A man enters a recovery center and works forty to sixty hours a week to pay for staying at the recovery center so when he leaves, he has no money. Families visit but there has not been any healing or restoration, so problems are not resolved. Men leave the recovery center with a stigma and a bias that causes a vicious cycle of opioid use. People in communities treat those with opioid addiction like it is their fault and they should just stop using, but it is not that straightforward. There must be a rebuilding of confidence for these fathers and support for dealing with the grief of losing their bond with their children, confidence, and self-respect. This all plays a significant role in childhood trauma and Adverse Childhood Experiences (ACEs) for the children whose fathers are not active in their lives, dealing with addiction, and not receiving the necessary mental health and substance use treatment.

Mr. Glover said that one of the common themes throughout the day is the stigma associated with opioid use and believing that people can stop using opioids if they try hard enough. Opioid use

begins as a prescription to get through pain and people become addicted. A recommendation could be to create outreach so people can be educated about opioid addiction and understand the challenges and to reduce stigma.

Another recommendation to consider is if small, local pharmacies in rural communities have more limited access to MOUDs because of regulatory barriers. Pharmacists may also have stigmas and do not want substance users to come to the pharmacy to pick up MOUD prescriptions while other customers are picking up their prescription.

Ms. Anzaldua stated that clinician stigma is also an issue, especially when they are the ones to provide treatment.

Ms. Mills shared that Project ECHO could be a good model for providers to become more informed about environmental influences on child health care outcomes. Digital equity grants could help with educating patients who utilize technology to better navigate a telehealth visit. Establishing Centers of Excellence in rural communities create links between county programs to address social determinants of health.

Tom Morris summarized the key committee considerations brought out by the day's discussions:

- Requesting federal agencies research specific topics related to opioid use in rural communities.
- The committee could discuss contingency management.
- Identifying which 1115 Waivers have a rural dimension.
- What regulations are causing challenges for methadone access and opioid treatment programs in rural areas?

PUBLIC COMMENT
No Public Comment

Las Vegas, New Mexico
Historic Plaza Hotel
September 5 – 6, 2024

Thursday, September 5, 2024

SITE VISITS

The Committee toured several facilities in the community including the West Las Vegas School-Based Health Center (operated by Sunrise Clinics), Grace Youth and Family Center, and the New Mexico Behavioral Health Institute

Local Stakeholders who lead the tour of site visits included: Matt Probst, Committee member; Chris Lopez, San Miquel County Sheriff; Juan Montaño, the former Chief of Police for the City of Las Vegas; Superintendent Christopher Gutierrez, West Las Vegas School District; Timothy Dodge, Sunrise School-Based Health Center Manager.

West Las Vegas School-Based Health Center provides medical assistance and mental health services to members of the community, regardless of an individual's ability to pay. The center is located on the West Las Vegas High School Campus. There are services available for individuals with opioid use disorder and substance use disorder that include medical assisted treatments (MAT). Medical staff includes a medical doctor, nurse practitioner, a certified family nurse practitioner, nurse practitioner and two certified physician assistants. Telehealth is available so that patients can meet with a specialist when necessary.

New Mexico Behavioral Health Institute is the state-owned psychiatric hospital with five clinic divisions and provides in patient care for adult psychiatric patients.

San Miguel Public Health Office provides services that include breast and cervical cancer screenings, children's medical services, family planning, harm reductions, HIV testing and counseling, STD testing and treatment, immunizations, tuberculosis treatment and a WIC assistance program.

SITE VISIT DISCUSSION

Governor Bullock stated that progress is being made in New Mexico with programs including early childhood education, family support, and substance use disorder treatment. Some of the benefits and progress may not be immediately recognized but community leaders and stakeholders are laying the foundation for long-term change.

Superintendent Christopher Gutierrez shared that about thirty to forty percent of children in Las Vegas, New Mexico are living with grandparents or other family members. Grandparents are raising grandchildren because their parents are deceased or incarcerated. There is a Medicaid representative that assists with these situations, and the school system monitors school attendance rates. There is a Head Start Program with one hundred and forty students and around sixty students in Early Head Start. There is a pregnant mom's program as well. The Boys and Girls Club, and other after-school programs, are important support systems.

Local stakeholders spoke about the importance of training family members, community leaders, and health and social service representatives about trauma informed care. Training was implemented districtwide for every employee in the schools, including teachers, administrators, food service workers, and custodians. It can be difficult for grandparents, parents, and extended family members to attend classes because of varied work hours. Another challenge is the

shortage of certified trauma informed care trainers in the community. Social Determinants of Health (SDOH) are also a huge factor in the health and wellbeing of community members. These are the nonmedical factors that include poverty, racism, and other inequities influence people's mental and physical health.

TREATMENT PANEL DISCUSSION: MEDICATIONS FOR OPIOID USE DISORDER (MOUD)

Chris Alliman, M.D.
Medical Director
Krossroads Integrative Health and Recovery Solutions

Dr. Chris Alliman said that throughout his medical school career and practice he has worked in many underserved communities. In Kansas City, he worked at a safety-net clinic with HIV care. Dr. Alliman joined an FQHC in Albuquerque treating people with substance use disorder, specifically opioid use disorder. About a year ago, Dr. Alliman started working as the medical director and director of detox at Krossroads Integrative Health and Recovery Solutions. Patients are being admitted to a detox treatment center that has just been established at the Alta Vista Regional Hospital in Las Vegas, New Mexico. Detox alone is not the answer so other parts of the cohesive system include residential and inpatient treatment, housing, behavioral health therapy, psychiatric care, and medications. Krossroads has offices in Las Vegas, Santa Fe, and other rural locations. Access is always an issue, so telemedicine is an option as well as local clinics.

Dr. Alliman said that policies are geared towards urban settings, and it is assumed that people have transportation and can easily make it to their appointments. It is a challenge for people because there is a lack of providers, lack of transportation, and economic disparity. It would be beneficial if there could be a policy that makes telehealth a standard and accepted process. In rural areas there are peer and community support workers who need more training but there is not enough reimbursement to train and fully staff the positions. Community support workers should be involved as part of the treatment group.

Dr. Alliman said that it is difficult launching a detox facility. Many medication regulations are geared towards an urban setting which makes it difficult in rural areas. The board of pharmacy requires that a pharmacist reviews a medication twenty-four hours after it is dispensed. If a pharmacist must drive one or two hours to a rural center, it can be an issue to meet the deadline. It is also difficult to get a detoxification living facility licensed. Outpatient centers do not require as many regulations, but it is difficult in rural communities for inpatient centers to meet requirements.

Pharmacies have a limit on the amount of Suboxone they can have in supply. The New Mexico Society of Addiction Medicine has drafted a letter to the governor to allow pharmacies to have more Suboxone in stock because it is essential to the care of those with substance use disorder.

Leslie Hayes, M.D.
Chief Clinical Officer

El Centro Family Health

Dr. Leslie Hayes shared that her grandfather was an alcoholic from the age of fifteen until around the age of sixty-five. He went into detox and became a lifelong member of Alcoholics Anonymous (AA). When Dr. Hayes started medical school, her grandfather took her to AA meetings so she could learn about it. Through that experience, she became interested, and she started doing rotations in addiction treatment centers while in medical school. There were very few medication treatments at that time, so it was essential that physicians provide compassionate care and assist people with getting treatment.

A woman was seeking treatment for opioid use, but there was only inpatient treatment available, and the waiting list was six weeks. She was on the waiting list for two to three weeks but relapsed before there was space available for her in a treatment center. She finally disappeared completely, and a year later she had been arrested. Two years later she went into treatment through the court system because she chose to go to treatment instead of going to jail. She had tried on her own to receive treatment for so many years without success until it was court ordered.

Dr. Hayes shared that most patients do not have the technology in their home to have a video call or the experience to participate in telemedicine. Many patients are more comfortable talking to their physician on the phone rather than meeting via a video appointment.

Medications for Opioid Use Disorder (MOUDs) are evidence-based treatments that work, with or without counseling being a part of the treatment. Methadone and buprenorphine allow people to stabilize and block cravings and withdrawal. Pregnant women who are prescribed MOUDs are less likely to have still birth, postpartum hemorrhage, and preterm labor. Modernizing the Opioid Treatment Access Law would allow addiction certified physicians to prescribe methadone to patients with OUD. The nearest methadone clinic to Gallup is one hundred and twenty miles away from Albuquerque. A bus transports people two hours each way to get methadone treatment OUD. People are motivated to get treatments so if there were physicians in rural areas who could prescribe MOUDs, it would be a huge benefit.

Q&A

Ms. Phillips-Asay asked how long a patient must take suboxone for opioid use addiction.

Dr. Hayes said that most patients must take suboxone for a lifetime. Many patients will be around others in their home or community who are still using opioids, so it makes it more difficult, so the medication keeps them from relapsing.

Ms. Aquirre said that county health departments have 340B access for pharmacists. Would it be possible to expand the 340B to recovery centers?

Mr. Probst There is 340B access at the FQHC and pharmacies but there are limitations to what medications can be stocked.

Dr. Hayes said that some clinics used to stock Suboxone, but due to theft, they no longer keep controlled substances. The rural clinics could not meet the regulations.

WORK PANEL DISCUSSION

Masie Estep
Coordinator
San Miquel County Early Childhood Coalition

Masie Estep shared that the coalition began in 2022 out of response from a gathering of early childhood educators, college deans, families, and other stakeholders to collaborate and work together to address issues. The Early Childhood Education and Care Department (ECECD) provided a grant for every county in New Mexico to begin coalitions.

Every county has unique needs with some being urban and some being rural, so the ECECD allowed flexibility. Each community created a needs assessment and strategic plan. The state continues to fund the initiative so it will be a solid solution.

The coalition hosts monthly Noches de Familia events where they provide a meal, activities, and have representatives including the Women, Infants, and Children Program (WIC), Department of Health (DOH), early intervention services, and other organizations who can assist with providing services. The Noches de Familia Initiative was originally coordinated by Cruz Flores, a local social worker. His vision was rooted in culture and community and having a gathering where resources and knowledge are shared while enjoying fun activities and a meal together. Having events in the evenings makes it more feasible for people to attend, including grandparents who are raising their grandchildren and working one or more jobs. The event is rotated to various locations every month.

ECECD has many programs including early intervention, families first, home visiting, and childcare assistance. The state has increased early childcare provider pay and the state is also paying for people to go back to school to obtain degrees.

Cultural humility and learning from families are the best ways to gain knowledge from a community. Families drive long distances for appointments or to give birth. In a rural community where there is no access to OB or delivery services, there are midwives or doulas. Many midwives are retiring and there is not a new generation of providers. There is a lack of partnerships with hospitals, and the insurance is too expensive to be an independent midwife. Doulas are being covered through Medicaid and that allows them to have insurance and make a living wage. Rural communities would benefit if Medicaid could expand coverage to midwives and give incentives for people to become midwives.

Valerie Romero-Leggott, M.D.
Vice President and Executive Director,
University of New Mexico Health Sciences Center Office for Diversity, Equity, and Inclusion
Professor of Family & Community Medicine

Dr. Valerie Romero-Leggott shared that New Mexico is the fifth largest state geographically but thirty-sixth in population. Thirty-two of thirty-three counties are health profession shortage areas. There are many health disparities and seventeen percent of the population lives in poverty. New Mexico is one of the most rural and frontier states in the nation.

The Communities to Careers Program is about growing a health care workforce from the youth in the community. The program cultivates health equity by increasing access to health career pathways, focusing on identity and cultural strengths, distributing, and diversifying the health care workforce. There are twelve program models that begin in elementary school and continue through middle school, high school, undergraduate school, and into health professional studies. Communities to Careers has programs in six regional hubs serving nineteen counties and tribal nations in the state. Seventy-two percent of the students in the Communities to Careers Program are from rural areas, sixty-nine percent are female, and seventy-four percent are from racial/ethnic backgrounds that are underrepresented in the New Mexico health care workforce.

The University of New Mexico Combined BA/MD Program's mission is to improve the health and wellbeing of New Mexicans by addressing the physician shortage through providing educational opportunities to a diverse group of students committed to serving New Mexico communities. Two thirds of the students in the program are from rural communities. Sixty percent of the students who are admitted are from race and ethnicity groups that are underrepresented in medical professions. The BA/MD students participate in community service-learning experiences in rural areas and in medically underserved areas. The program outcomes include eighty-one practicing physicians, with sixty-five percent of those working in New Mexico. Twenty-three percent of the graduates are working as physicians in their hometowns, and sixty-two percent are from minority groups that are underrepresented in medicine.

Nora Lamartine, M.D.
Program Director
Medicos De El Centro

Dr. Nora Lamartine said that family medicine is the answer to the rural health care shortage because it is diverse. Medicos De El Centro (MDEC) is a family medicine residency in Española, New Mexico. It is a rural program that is affiliated with El Centro Family Health (ECFH), a Federally Qualified Health Center that was established in 1972.

The mission of Medicos de El Centro Family Medicine Residency is to train well rounded family medicine doctors to provide high quality health care to a medically vulnerable and underserved population in northern New Mexico. Physicians learn to provide care and advocacy in a rural environment, partnering with patients to overcome economic, literacy, transportation, and language challenges. The vision of Medicos de El Centro Family Medicine Residency is to bring graduate physician training to the communities of greatest need in New Mexico. Physicians who are well prepared for these underserved settings will thrive, improving patient health care outcomes, access, and experience.

Medicos De El Centro (MDEC) family medicine residency sponsoring institution is The New Mexico Primary Care Training Consortium (NMPCTC). They were founded several years ago with federal funds from FFORHP through a network development grant to help support rural programs across the state. NMPCTC applied for a Rural Residency Program Development (RRPD) Grant and MDEC is a product of the grant and was able to receive technical assistance.

MDEC's family medicine residency model is centered out of an FQHC because it is diverse, has an interdisciplinary workforce, and serves underserved communities. It is difficult to fund residencies at FQHCs, so the FQHC is partnering with Presbyterian Health Services and Christa St. Vincent to collect the funding that is funneled back to the FQHC. A recommendation to the committee is to amend the policy to allow FQHCs to directly collect graduate medical education (GME) financing because it will expand the opportunity for family medicine residencies in rural locations.

Statistically, seventy percent of residency graduates practice within a hundred miles of their residency locations. If students do their residency in the rural communities, then three-quarters of them are going to stay. Medical residents receive substance use disorder training during the first week of residency and can prescribe MOUDs for opioid use disorder and treat patients for other substance use disorders.

Q&A

Ms. Anzaldua asked if medical professionals train specifically how to treat individuals for substance use disorders.

Dr. Romero - Leggott responded that opioid use, obesity, and mental and behavioral health are part of the training for all the beginning students. A major part of the Workforce Diversity Center of Excellence is integrated behavioral health.

Ms. Phillips - Asay said that Ms. Estep shared that health care organizations are no longer allowing midwives to practice. Bridging that gap in communities would be a huge piece of the puzzle that is needed, in tribal and rural communities. Are there ways of bridging the gap between the health care organizations and midwives?

Ms. Estep responded that training midwives and having resources available for families to locate midwives who practice in their area is a way to connect with health care organizations. Midwives who understand the cultural beliefs of the mother offer a unique level of support.

Ruby Kirby asked if rural residents in the FQHCs were hired in the community would they be required to have privileges at the hospitals.

If there is an FQHC in an outlying community that does not have a hospital, would the resident be required to travel outside of the area for the hospital experience?

Dr. Lamartine stated that every residency program has different requirements and family medicine falls under the Accreditation Council for Graduate Medical Education (ACGME). At

the end of the residency, under family medicine, the physician must be adept at obstetrics, vaginal delivery, adult, and pediatric inpatient medicine.

The residents go to the hospital in Albuquerque to do their pediatric rotations, so they get a larger volume for learning and their housing is provided.

PUBLIC COMMENT

Mrs. Donna Ortiz
The Dream Makers Health Careers Program Advisor
Robertson High School
Las Vegas, New Mexico

The Dream Makers Health Careers Program (DMHCP) is offered to middle and high school students in collaboration with the UNM Health Sciences Office of Diversity, Equity, and Inclusion to provide opportunities and resources for students. It is a student run and teacher facilitated program. Teams include diabetes prevention & awareness, mental health first aid, suicide prevention & awareness, reproductive health, community service, and many more.

Youth peer health education is crucial in rural NM for several reasons:
Cultural relevance and trust: in our community, peer educators can effectively connect with other youth by using shared experiences, language, and values. This fosters trust and openness, which is essential for addressing sensitive issues like mental health, reproductive health, and opioid prevention, areas that might otherwise be stigmatized or ignored.

Addressing barriers to access: Rural areas often face challenges such as limited health care infrastructure, fewer mental health services, and a lack of reproductive health resources. Peer educators can fill these gaps by providing accurate information, resources, and support, reducing isolation, and helping their peers make informed decisions.

Grants like HCOP (Health Careers Opportunity Programs) are important because they provide the necessary funding and resources to train and empower local youth as peer educators. This support is critical in rural areas where financial and infrastructural limitations can hinder access to health care education and services. With HCOP, there can be sustainable programs that equip young people with skills and knowledge needed to address pressing health issues. High school students are all CPR/First Aid certified, trained as Question, Pursued, Refer (QPR) Suicide Prevention Gatekeeper, and will soon be certified, with the financial support of our Area Health Education Center, in Mental Health First Aid, equipping them with essential skills to respond to health emergencies and support their peers.

Over the past fifteen plus years of the program, UNM BA/MD recipients and recipients from other colleges have pursued medicine and other health care degrees in nursing, physical therapy, pharmacy, and as physician assistants (PAs), family nurse practitioners (FNPs), and biomedical engineers. Former participants in the DMHCP program come back and share their knowledge and expertise with current students. It has become a beautiful relationship with people supporting people to continue to grow the next generation of health care workers. Mrs. Ortiz said that it is

with immense pleasure, pride, and certainly heart that she continues to advise the health careers program at Robertson High School in Las Vegas, New Mexico.

Amy Greene
Director for Communities to Careers at the University of New Mexico Health Sciences Office for Diversity, Equity & Inclusion
Albuquerque, New Mexico

Amy Green shared that she has experience as a Co-Principal Investigator (Co-PI) and Sr. Program Manager for Title VII HRSA grants, including HCOP and Center of Excellence (COE). Communities to Careers' mission is to grow New Mexico's diverse health care workforce through community-based K-20+ health career pathway programs and partnerships.

Through the work on campuses statewide and in community, students from rural and tribal backgrounds in New Mexico have shared they wanted access to health career pathway programs like UNM Health Sciences Office for Diversity, Equity & Inclusion Communities to Careers, earlier in their educational journeys, and offered directly in their schools and local communities. With a twenty-year record of replicable and high impact programs, we are poised to respond to this need with adequate funding.

As it relates to the OUD crisis, Communities to Careers is growing the health care workforce for New Mexico by supporting the career pathways of students, who are at high risk of exposure to OUD or SUD in their households, schools and communities, in order to empower a future health care workforce for New Mexico that can provide compassionate and attuned care that can help address the OUD crisis.

A priority is to deliver OUD educational curriculum, like peer health education strategies, and Narcan training to all high school and college level participants to deliver immediate tools that the youth can use to make a difference in their communities, opening the door for them to be a critical part of the solutions to OUD.

This is critical, yet longitudinal work, which must ensure longer-term, more frequent, and consistent funding streams nationally for rural states. School and community partners are standing by to do their part to address OUD alongside clinical providers and policymakers.

Mrs. Greene recommended the Committee to strongly affirm their support of the current level of funding for HRSA training grants like HCOP, COE, and AHEC, as well as Indian Health Service training grants like InMED which have been the foundation of our Communities to Careers program efforts, and are essential for states and educational institutions to increase our capacity to provide localized regional, rural health career training for K-20+ students.

Friday, September 6, 2024

Governor Bullock welcomed the committee to the final day of the national advisory committee meeting. He stated that the committee would discuss themes for the policy brief and discuss recommendations that will be submitted to the Secretary of Health and Human Services.

Additionally, Governor Bullock announced that Sahi Rafiullah, Executive Secretary to the Committee, would be retiring from the Federal Office of Rural Health Policy. Her work for FORHP has been invaluable, and she will be greatly missed. The committee members thanked Sahi for her support, guidance, dedication, and friendship.

Mr. Morris stated that FORHP would draft a policy brief, and the committee would have the opportunity to review it and suggest edits or additions. The policy brief will then be submitted to the Secretary of Health and Human Services and posted to the Federal RHHS website.

Governor Bullock thanked Mr. Probst for hosting the meeting in Las Vegas, New Mexico and for supporting and continuing to build his community.

Committee members discussed some of the major themes that resonated with them over the course of the meeting, including the potential impact of rural-specific allocations of the opioid settlement funds; the challenges people in recovery face in advancing in their careers; and, the importance of prevention efforts and focusing efforts on children.

The Committee discussed potential recommendations to be offered in the policy brief. Staff will draft language and share it with members to assure their intent is captured.

The Committee then discussed topic ideas and the location for the Spring 2025 meeting. These will be finalized in the coming weeks.

PUBLIC COMMENT
No Public Comment

The meeting was adjourned.

NOTE OF ACKNOWLEDGEMENT

Prior to the meeting, representatives from the Western Governors Association (WGA) requested that *WGA Policy Resolution 2024-04, Combating the Opioid Crisis,* be acknowledged in the official meeting record. Inclusion of *WGA Policy Resolution 2024-04* in meeting record does not necessarily constitute an endorsement of the resolution by the Committee, any member of Committee staff, or the Committee Chair, the Honorable Steve Bullock.