Needs Assessment

Rural Communities Opioid Response Planning – Southern New Mexico

Grantee Organization	Southwest Center for Health Innovation	
Grant Number	G25RH33006	
Address	301 W. College Ave., Suite #5, Silver City, NM 88061	
Service Area	16 Rural Counties in Southern NM that include: Catron, Chaves, Cibola, De Baca, Eddy, Grant, Hidalgo, Lea, Lincoln, Luna, Otero, Roosevelt Sierra, Socorro, Torrance and Valencia	
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Needs Assessment and Priority Setting

A. Introduction/Background Information

Introduction

The RCORP-Planning initiative. The Rural Communities Opioid Response Program (RCORP) is an initiative of the Health Resources and Services Administration (HRSA) that supports projects to understand and address barriers to services for substance use disorder (SUD) in rural communities. The RCORP-Planning (RCORP-P) grants fund one-year projects to develop sustainable plans to improve prevention, treatment, and recovery services for opioid use disorder (OUD) in rural communities. These projects include: 1) marshaling cross-sector partnerships, called "consortia," to address OUD in rural communities; 2) conducting a needs assessment of gaps in service systems and workforce; and 3) developing strategic plans for OUD service delivery, workforce, and sustainability.

The RCORP-Southern New Mexico project. The RCORP-Southern New Mexico (RCORP-SNM) project is led by the Center for Health Innovation (CHI) and the Pacific Institute for Research and Evaluation (PIRE). The RCORP-SNM Consortium features a network of researchers, educators, policymakers, and health professionals with proven track records of innovative leadership, research expertise, and community engagement around substance use prevention and treatment in Southern New Mexico (NM). Many of the consortium have an established track record of collaboration around addressing SUD in Southern NM.

The RCORP-SNM consortium seeks to utilize implementation science frameworks and a community-driven approach to build capacity for sustainable learning health systems that can meet the prevention, treatment, and recovery needs of the rural residents of 16 counties in Southern NM, where residents are impacted by significant disparities in physical and mental health, and have been disproportionately affected by the opioid epidemic. Additionally, the consortium seeks to build on and leverage existing community and state initiatives to ensure local and state buy-in and long-term sustainability.

In July 2019, the initial seven members of the RCORP-SNM consortium were convened by CHI and PIRE. During preliminary planning conversations, consortium members identified crucial gaps in representation of behavioral health providers, law enforcement, and first responders. Four additional consortium members were agreed upon by consensus of the consortium members and invited to join the consortium in October 2019. All consortium members entered into a memorandum of understanding (MOU) to undertake the RCORP-SNM project:

Southwest Center for Health Innovation (CHI). A 501(c)(3) nonprofit organization headquartered in Silver City, NM, CHI works with communities to advance health and social justice through innovative and effective policies and programs. Its primary functions include workforce development (with a focus on primary health, behavioral health and public health), prevention, community collaboration and convenings, communications, research, development of innovative programs, training, and technical assistance. CHI is home to two of NM's three Area Health Education Centers (AHECs), serving 17 counties in Southern NM. Since its inception in 2010, CHI has been a leader in advocating for substance use prevention and rural workforce development through system, policy, and financing changes and improvements.

Pacific Institute for Research and Evaluation (PIRE). PIRE is a California-chartered 501(c)(3) non-profit research organization headquartered in Beltsville, Maryland, with a major research center in Albuquerque, NM. Researchers at PIRE have 44 years of experience studying efforts to increase the wellbeing of people around the world, especially in the areas of physical and mental health. PIRE researchers participating in the RCORP-SNM Consortium have particular expertise in community-based mixed-methods research, evaluation of opioid and other substance abuse prevention and treatment programs, and implementation science approaches to health services in diverse communities, including Southern NM.

New Mexico Department of Health (DOH). Home to the Prescription Opioid Overdose Prevention Program, DOH works with NM communities, managed care organizations, healthcare providers and pharmacists, and law enforcement agencies to address prescription opioid overdoses in NM. DOH is also the state agency responsible for opioid related data collection and surveillance.

New Mexico Human Services Department (HSD) – Behavioral Health Services Division. Housed under the HSD, the Behavioral Health Services Division (BHSD), is the Mental Health and Substance Abuse State Authority for New Mexico and addresses the need, services, planning, monitoring and continuous quality systemically across the state. HSD is a member of the New Mexico Behavioral Health Collaborative (Collaborative) and BHSD works with the Collaborative to establish policy and implement strategies to manage the behavioral health system. Currently, HSD runs the adult portion of the state's behavioral health care; children's behavioral health services are under the authority of the Children, Youth and Families Department. The Office of Substance Abuse Prevention (OSAP) is within BHSD and works to promote an integrated and comprehensive substance abuse prevention services delivery system through the promotion of sound policy, effective practice, and cooperative partnerships to ensure the availability of quality prevention.

New Mexico Behavioral Health Workforce Coalition. Formed in 2014 through joint efforts of the NM Behavioral Health Services Division and the NM Children, Youth & Families Department, members of the Coalition include psychiatric nurses, social workers, counselors, psychologists, psychiatrists, primary care providers, peer support workers, community health workers, physician assistants, colleges and universities, AHECs, and state licensure boards.

Eastern New Mexico University-Roswell (ENMUR) and Western New Mexico University (WNMU). Located in Southern NM, both universities have well-established ties within their local communities and feature degree programs in counseling, social work, and addictions or chemical dependency.

New Mexico Behavioral Health Providers Association (NMBHPA). The NMBHPA is a nonprofit association that advocates for the perspectives of providers in state policy around delivering quality and accessible behavioral health services in NM.

New Mexico Department of Workforce Solutions (NMDWS). Included in the NMDWS' responsibilities pertaining to employment and labor in NM is oversight of statewide workforce development programs. This includes analyzing gaps and developing initiatives to understand and

address workforce shortages—such as the state's well-documented behavioral health workforce shortage—through innovative economic development and education strategies.

Emergency Services Outreach Inc. and the Center for Advanced Medical Training (ESO). A 501(c)(3) nonprofit organization, the ESO provides health and safety education to the public, first responders, and healthcare providers, with particular expertise in rural, underserved, underrepresented, and impoverished communities. The ESO features programming on opioid response for first responders.

State of New Mexico Office of the Attorney General (NMOAG). The NM Attorney General has identified fighting the opioid crisis as a central priority. They have taken major legal actions against opioid manufacturers and also are committed to educating the public on the potential dangers of misuse of opioids.

In addition to the members of the consortium, the RCORP-SNM project is guided by the **RCORP-SNM Community Advisory Group (CAG)**, a group of Southern NM-based behavioral health providers, members of local prevention coalitions, public health advocates, peer support specialists, and individuals in recovery from OUD. In keeping with community-engaged approaches to research and intervention among indigenous and other underrepresented and racial/ethnic-minority populations,[1] the members of the CAG draw on their experience relating to opioid prevention and treatment to review and give feedback into system, organizational, and community-specific issues, help identify participants for data collection and troubleshoot recruitment problems, and assist in prioritizing data analysis, interpreting findings, and developing strategic, workforce, and sustainability plans.

Target Area Overview. The RCORP-SNM project spans 16 counties (Figure 1). This includes the residents of 12 HRSA-designated rural counties (Catron, Chaves, Cibola, De Baca, Eddy, Grant, Hidalgo, Lea, Lincoln, Luna, Otero, and Roosevelt). The target area also includes residents of Sierra and Socorro Counties, which the Federal Office of Rural Health Policy (FORHP) designates as rural, and the FORHP-designated rural residents of Torrance County (zip codes 87009, 87016, 87032, 87036, 87061, 87063, and 88321) and Valencia County (zip codes 87023 and 87006).[2] Table 1 below represents the target area by three subregions, Southwest, West-central and Southeast. This subregion approach was created to illustrate some diversity among these southern counties, for ease of data analysis, and are somewhat based upon existing economic, political and organizational relationships in the area.

[1] Minkler, M., & Wallerstein, N.B. (2003). *Community-based participatory research for health.* San Francisco: Jossey-Bass.
Wallerstein, N.B., & Duran, B. (2006). Using community-based participatory research to address health disparities. *Health Promotion Practice, 7*(3), 312-23.

[2] With the exception of population size, demographic and socioeconomic data for Torrance and Valencia counties encompass the entire county, not only the rural zip codes.

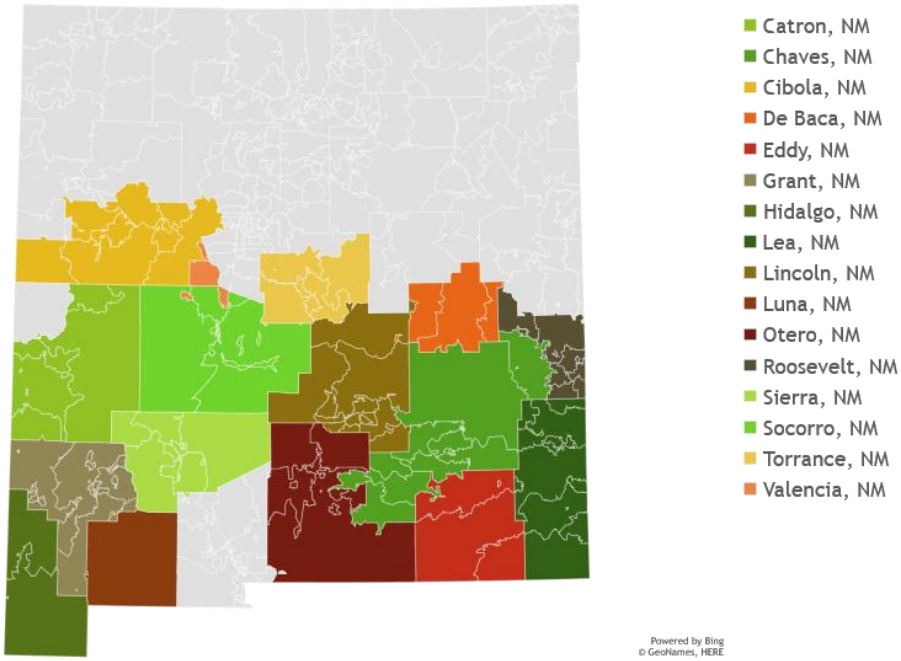


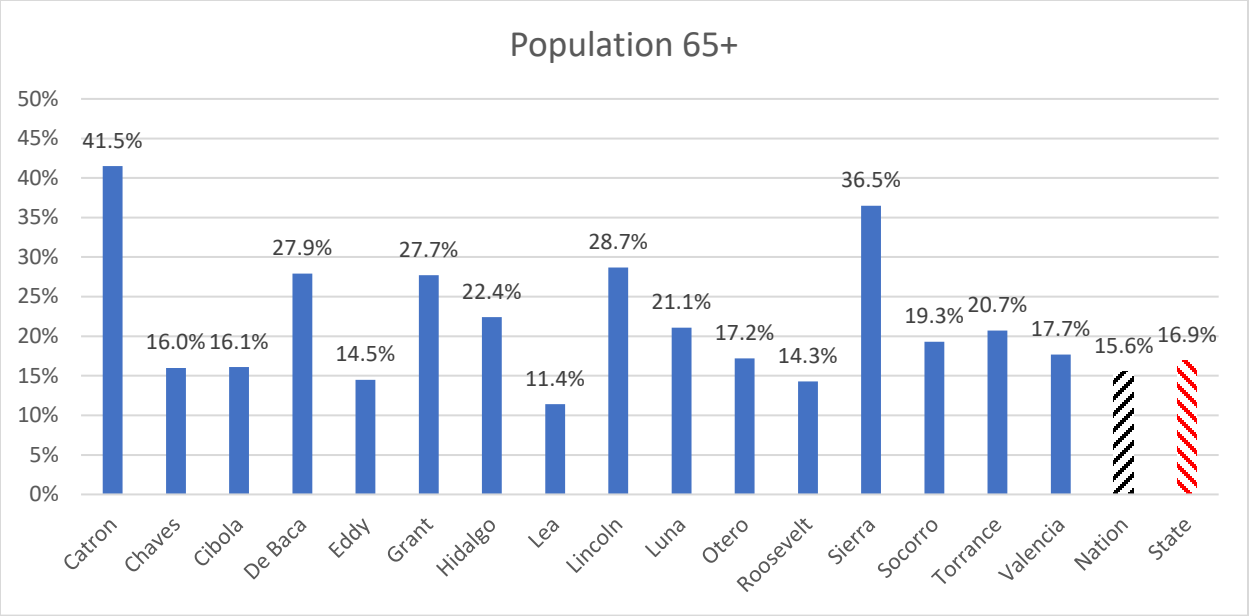
Figure 1. Map of RCORP-SNM target area

Table 1. RCORP-SNM subregions		
Southwest	West-Central	Southeast
• Grant County • Hidalgo County • Luna County	• Catron County • Cibola County • Sierra County • Socorro County • Rural parts of Torrance County • Rural parts of Valencia County	• Chaves County • Eddy County • Lea County • Lincoln County • De Baca County • Roosevelt County • Otero County

Like many rural areas, where the aging population is high and increases with remoteness, Southern NM is home to a large proportion of older adults—a population that the Centers for Disease Control (CDC) indicate may be at increased risk for opioid-related death and hospitalization.[3] Numbers of individuals over the age of 65 exceed state and national averages in all but five of our target counties (Figure 2).[4] In Catron county, for example, nearly half the population (41.5%) is over age 65.

[3] Benson, W.F., and Aldrich, N. (2017). Rural older adults hit hard by opioid epidemic. *Aging Today.* Retrieved from https://www.asaging.org/blog/rural-older-adults-hit-hard-opioid-epidemic#:~:text=Almost%2044%20percent%20of%20the,adults%20ages%2065%20and%20older).&text=Almost%20half%20of%20opioid%20deaths,or%20taking%20someone%20else's%20prescription).

[4] U.S. Census Bureau, American Community Survey, 2018



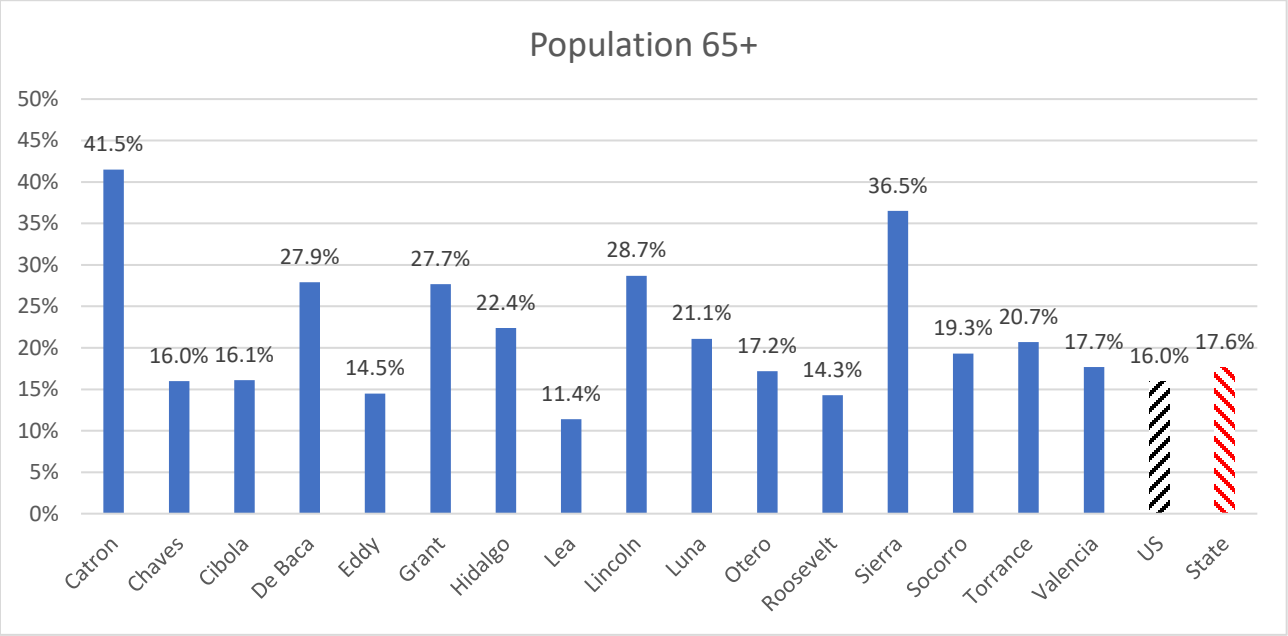


Figure 2. Percentage of target population age 65 or over, US Census Population estimates, July 1, 2018

Like the rest of the state, Southern NM population is primarily non-white, with Hispanic/Latinx residents making up about half of the population (Figure 3).[5]

[5] U.S. Census Bureau, American Community Survey, 2018

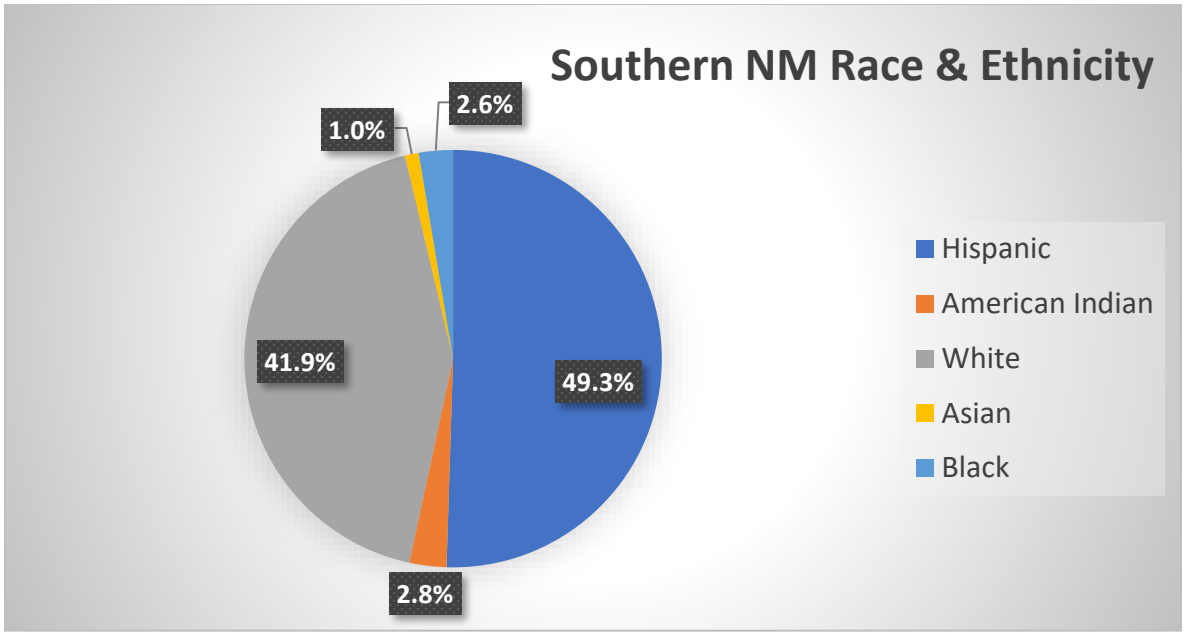


Figure 3. Race and ethnicity of target population, US Census Population estimates, July 1, 2018

Many of the Hispanic/Latinx residents in NM are descendants of historic Spanish and Mexican settlers. However, because of its proximity to the Mexican border, Southern NM is also home to a large population of documented and undocumented migrants, many of whom prefer to speak Spanish or have limited English-speaking ability and face additional obstacles to accessing and utilizing behavioral health care and health insurance. Fear around disclosure of immigrant status and experiences of stigma also constrain utilization of healthcare services among immigrants. Additionally, the state has limited resources to culturally and linguistically appropriate services. While data are limited regarding these populations, American Community Survey data show that substantial numbers of residents in many Southern NM counties speak a language other than English at home (Figure 4).[6]

[6] 2013-2017 American Community Survey 5-Year Estimates

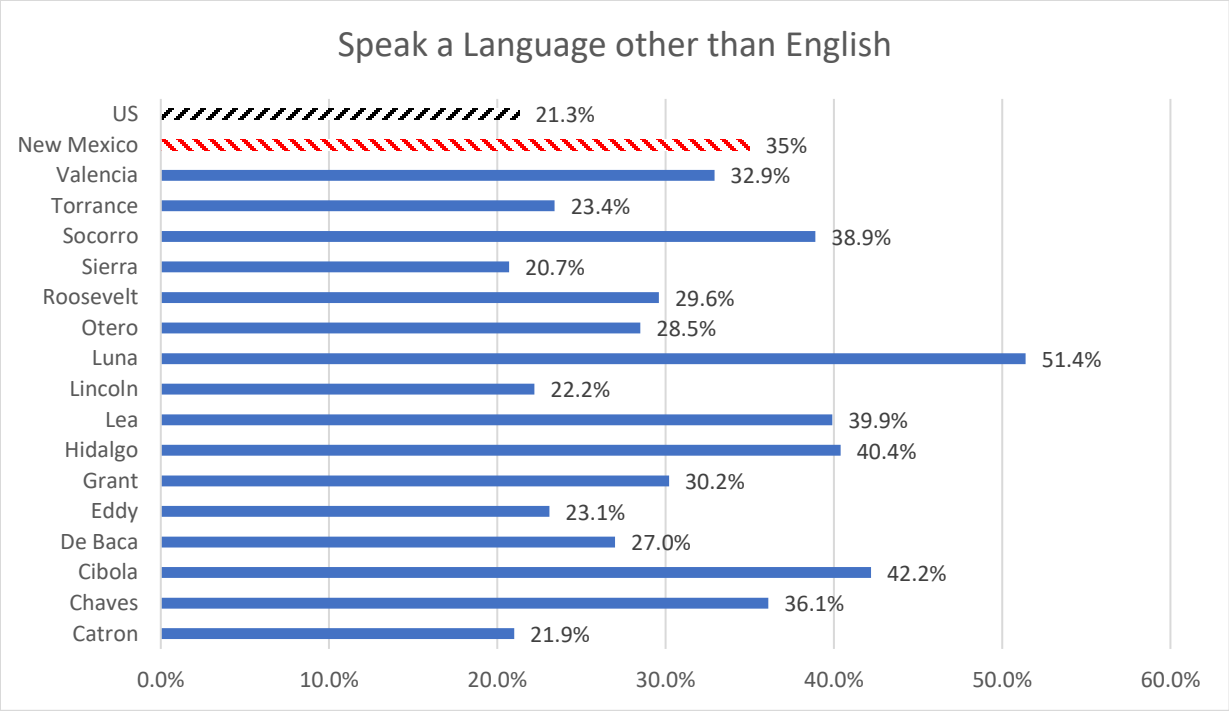


Figure 4. Percentage of target population speaking a language other than English at home, American Community Survey 2013-2017 5 year estimates

While most Southern NM counties have an American Indian population of 2%-6%, this population is higher in Cibola (43.7%), Socorro (14.4%), Otero (8.1%), and Valencia (6%) counties, home to diverse federally recognized American Indian nations, including Pueblo, Apache, and Navajo tribes. Importantly, Hispanic/Latinx and American Indian communities have generations of history in NM and have experienced similar forms of racial and socioeconomic marginalization, including the loss of much of their historic land base and a subsequent shift toward wage labor, rising land and housing prices, and persistent everyday forms of racial, cultural, and linguistic discrimination.

In addition to these forms of marginalization, residents of many Southern NM counties frequently express a sense of cultural, political and economic alienation from the rest of the state, especially the northern cities of Albuquerque and the state capital, Santa Fe, where decision-making power for the remainder of this rural state rests. Other northern communities are known widely as popular tourist destinations (e.g., Santa Fe, Taos) as well as notorious for a history of drug misuse, especially opioid related harms (e.g., Rio Arriba County). Southern New Mexicans noted in qualitative interviews that both attention and resources are frequently scarcer "south of the line [i.e., I-40]."

The region has a rich heritage in the farming, ranching, oil/gas, and mining industries, some of the most dangerous industries in the country. Residents are diverse in socioeconomic status and educational attainment; however, percentages of unemployed residents and families living below the poverty line generally meet or exceed both state and national averages (Figure 5).[7]

[7] U.S. Census Bureau, American Community Survey, 2018

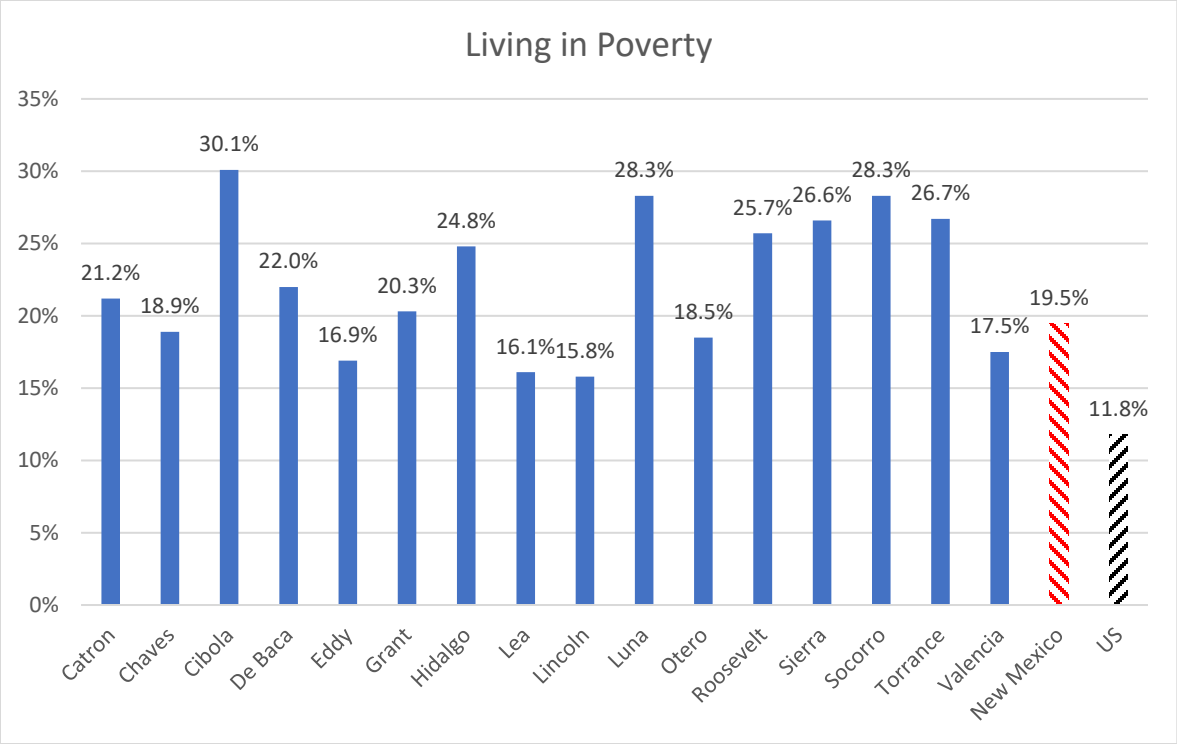


Figure 5. Percentage of target population under the Federal Poverty Level, US Census Population estimates, July 1, 2018

Additionally, census data on employment do not capture shorter cycles of employment and unemployment, which are known to fluctuate substantially in Southern NM counties as seasonal and temporary employment (e.g., agriculture, mining) are common, along with unofficial (i.e., unreported) forms of income generation that are typical in border communities (Table 2).[8]

Table 2. Fluctuating unemployment rates in target counties

	Catron	Chaves	Cibola	De Baca	Eddy	Grant	Hidalgo	Lea	Lincoln	Luna	Otero	Roosevelt	Sierra	Socorro	Torrance	Valencia
Unemployment Rate in % (September 2019)	5.0	4.7	6.0	3.8	3.0	4.5	4.2	3.6	4.2	8.1	4.4	4.4	5.6	5.6	6.2	5.2
Unemployment Rate in % (previous month)	5.7	5.1	6.7	4.4	3.3	5.0	4.6	4.1	4.4	8.7	5.1	5.0	6.3	6.4	7.8	5.8
Unemployment Rate in % (previous year)	6.1	4.8	6.1	5.2	3.3	4.9	3.6	4.1	4.5	8.2	5.0	4.5	6.0	5.1	7.2	5.5
Percent change in rate over the year (as of September 2019)	-1.1	-0.1	-0.1	-1.4	-0.3	-0.4	0.6	-0.5	-0.3	-0.1	-0.6	-0.1	-0.4	0.5	1.0	-0.3

Table 2: Unemployment rates, NM Department of Workforce Solutions, https://jobs.state.nm.us/LAUS.

[8] Labor force, employment, and unemployment in NM, September 2019, NM Department of Workforce Solutions: https://jobs.state.nm.us/LAUS

Compared to the national average, residents of Southern NM counties report higher rates of a variety of negative physical and mental health outcomes, including diabetes, arthritis, depression, and disability (see Section C). Lack of health insurance is implicated in these disparities as Southern New Mexicans under age 65 in 11 of our 16 counties are insured at a lower rate than the state and/or national average (Figure 6).[9]

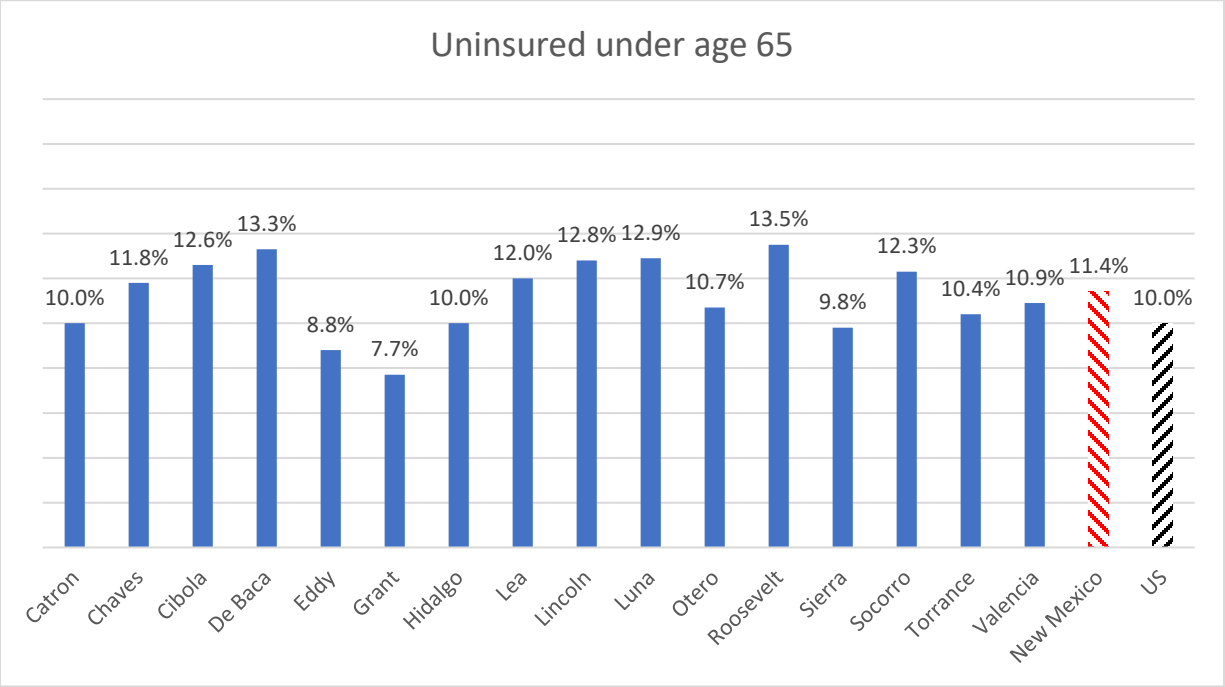


Figure 6. Percentage of target population under age 65 without health insurance coverage

Finally, the opioid problem in Southern NM cannot be understood without acknowledging a pivotal event known locally as "The Shake-Up." In 2013, NM HSD announced that an audit of behavioral health agencies had revealed $36 million in Medicaid overpayments to nonprofit agencies in NM. Publicly accusing practitioners of fraud and abusive practices, HSD suspended reimbursements to 15 agencies, affecting tens of thousands of patients, including those in the Southern part of the state. In the years after, no criminal fraud was found. Yet, lack of payment forced agencies to close across the state, creating massive gaps in care and widespread feelings of betrayal and distrust among behavioral health providers that persist today.

[9] U.S. Census Bureau, American Community Survey, 2018

B. Planning Values

The following RCORP-SNM project **planning values** were identified with input from the Consortium and CAG members:

Health Equity

Southern New Mexicans have been persistently affected by disparities in physical and mental health outcomes, as well as access to and utilization of healthcare services, especially behavioral health. These disparities are rooted in multilevel barriers, including stigma and discrimination, resource scarcity, and political neglect. For this reason, efforts to improve health and health care in these communities must emphasize eliminating the inequities that prevent Southern New Mexicans from experiencing health and wellbeing.

Community-Driven Assessment, Priority Setting, and Planning

Due to Southern NM's demographic diversity and complex history, we emphasize the importance of soliciting perspectives from individuals at multiple levels, from administrators of behavioral health systems to healthcare providers to recipients of OUD services.

Empowering Local Stakeholders and Building Local Capacity to Create Change

Similarly, efforts to improve OUD prevention, treatment, and recovery services in Southern NM must rely on local champions and community capacity building to both leverage the region's scarce resources and ensure relevance and acceptability.

Cross-Sector Collaboration

The OUD problem in Southern NM touches multiple sectors of society, from physical and behavioral health care to law enforcement to employment. Our approach seeks to marshal cross-sector collaboration to meet the needs of clients and providers of OUD services.

Evidence-Based Practices

We emphasize the importance of practices that are rooted in research. This includes health interventions, such as medication-assisted treatment (MAT), and strategies for systems change, such as those advanced by implementation scientists (see Section C).

Long-Term Practicability and Sustainability

Through practice of each of the above values, we seek to advance solutions that are feasible in Southern NM communities under present sociopolitical and economic circumstances and that will create lasting change over the long term.

Moreover, the RCORP-SNM project uses a **"learning health systems"** approach to meet the behavioral health needs of Southern New Mexicans. The Agency for Health Care Research and Quality defines learning health systems as those in which "internal data and experience are systematically integrated with external evidence and that knowledge is put into practice."[10] The

[10] "Learning Health Systems," September 8, 2017, https://www.ahrq.gov/professionals/systems/learning-health-systems/index.html.

National Institutes of Health and Institute of Medicine have emphasized the importance of cultivating such systems, which foreground the continuous improvement of care. In learning health systems, data are collected to understand the experiences and outcomes of practicing service providers and service recipients, and quality assurance activities involving use of iterative feedback take place on a regular basis. Learning health systems can thus generate practical knowledge that takes into consideration the needs of both patients and providers, which can be rapidly diffused and iteratively improved over time.

C. Needs Assessment Methodologies

Conceptual Framework

Implementing effective treatments for OUD in everyday service environments can be inconsistent and ineffective because they are delivered in complex, multi-layered social contexts impacted by language, culture, and the social attitudes of service providers and recipients (e.g., stigma toward OUD and promising treatment modalities, such as MAT).[11] In rural areas, these challenges are compounded by additional stigma, geographical distance and lack of transportation, and widespread workforce shortages and provider turnover.[12] Attempts to apply and sustain prevention, treatment, and recovery interventions targeting OUD must address these "real-world" factors.

The field of implementation science emphasizes comprehensive frameworks to guide the selection and integration of effective and locally-relevant prevention, treatment and recovery interventions from start to finish. To organize our data collection and strategic planning efforts, the RCORP-SNM utilizes the Exploration, Preparation, Implementation, and Sustainment (EPIS) framework (Figure 7), a well-respected conceptual model comprising four phases: Exploration (considering new innovations, their evidence, and "fit" in service systems/communities), Preparation (planning for implementation), Implementation (training and treatment provision), and Sustainment (maintaining interventions with fidelity). This model examines factors at two levels: outer context (i.e., system environment) and inner context (i.e., practitioner/organizational environment). The EPIS thus prompts "systems thinking" (i.e., understanding relationships and applying strategies at and across multiple levels), a necessity to ensure long-term systemic public health impact of prevention, treatment, and recovery interventions. Our use of the EPIS is designed to ensure that the efforts of the RCORP-SNM Consortium will be strategically applied, oriented towards action, and systematic in developing, implementing, and evaluating OUD services and workforce development efforts.

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[11] Gregory A. Aarons, Michael Hurlburt, and Sarah McCue Horwitz, "Advancing a Conceptual Model of Evidence-Based Practice Implementation in Public Service Sectors," *Administration and Policy in Mental Health* 38, no. 1 (January 2011): 4–23, https://doi.org/10.1007/s10488-010-0327-7; Sarah McCue Horwitz et al., "Improving the Mental Health of Children in Child Welfare Through the Implementation of Evidence-Based Parenting Interventions," *Administration and Policy in Mental Health and Mental Health Services Research* 37, no. 1 (March 1, 2010): 27–39, https://doi.org/10.1007/s10488-010-0274-3; Douglas K. Novins et al., "Use of the Evidence Base in Substance Abuse Treatment Programs for American Indians and Alaska Natives: Pursuing Quality in the Crucible of Practice and Policy," *Implementation Science: IS* 6 (June 16, 2011): 63, https://doi.org/10.1186/1748-5908-6-63; Yngvild Olsen and Joshua M. Sharfstein, "Confronting the Stigma of Opioid Use Disorder--and Its Treatment," *JAMA* 311, no. 14 (April 9, 2014): 1393–94, https://doi.org/10.1001/jama.2014.2147.

[12] "Rural Healthy People 2010: A Companion Document to Healthy People 2010. Volume 2" (College Station, TX: The Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center, 2003).

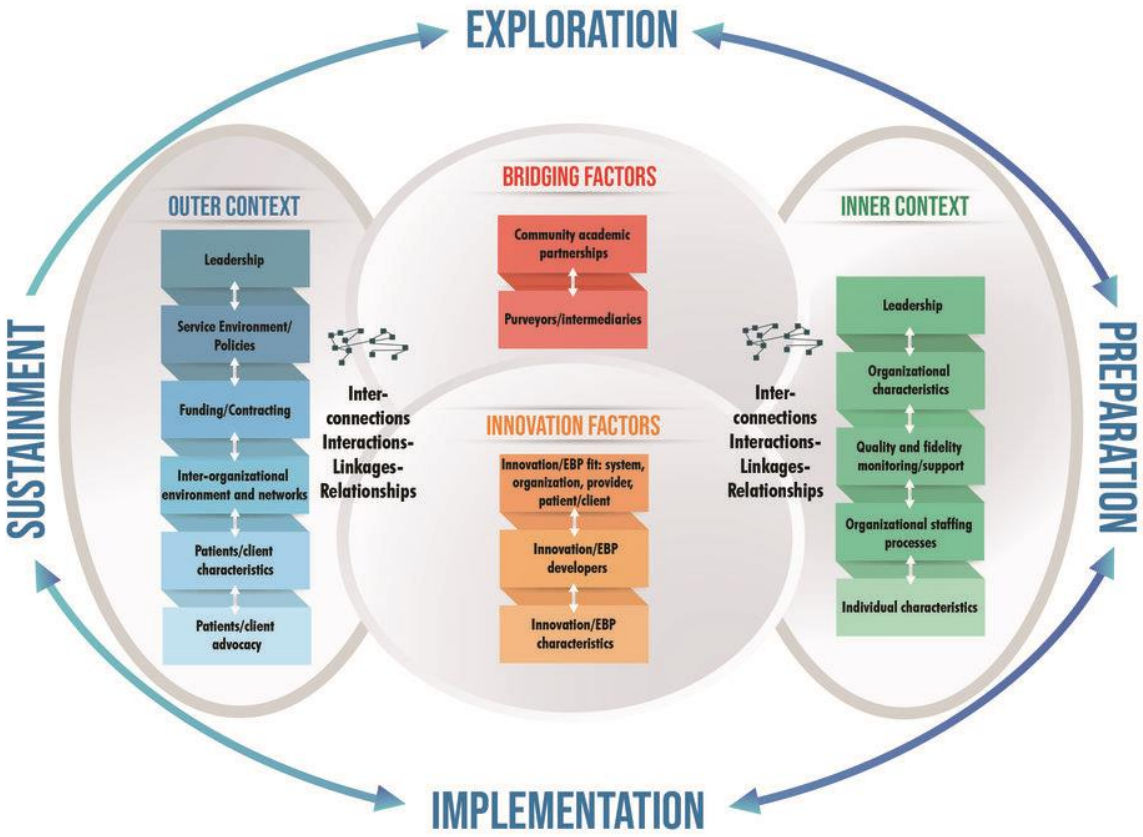


Figure 7. The EPIS framework

Per the EPIS, our needs assessment attends to factors at multiple levels, including individuals (e.g., language, experiences with and perspectives of OUD care), communities (e.g., availability of clinics), organizations (e.g., support for interventions), and system/policy (e.g., certification programs, reimbursement procedures, state and federal resources).

Quantitative Data

In order to understand the scope of the OUD problem in Southern NM, as well as existing services and resources to prevent and treat OUD, we collected and analyzed data from a number of existing state, federal, and organizational data sources. These included:

U.S. Census Bureau, American Community Survey. This consists of county demographic data reported above.

New Mexico Department of Health. This consists of state and county death and overdose data, the Prescription Monitoring program, and the NM Youth Risk Behavior Survey (YRBS), which is part of the NM Youth Risk and Resiliency Survey (YRRS) that was collected most recently in 2017). The NM DOH has offered us these data up to the most readily available dates (2018 for most). Further data can be provided upon request.

New Mexico Office of Substance Abuse Prevention, New Mexico Human Services Department. Adult survey data on prescription opioid use and a prescriber survey are collected annually across the state under PIRE supervision under contract with the NM OSAP, HSD. For this project, PIRE conducts further analysis (e.g., by county, HRSA region, age group, gender, race/ethnicity) in order to provide a deeper perspective on variables such as prevalence of ACEs, opioid use, access to and reasons for using opioids, perception of risk of harm of opioids, and Naloxone access as collected via the New Mexico Community Survey (NMCS). Designed in order to gather contributing factor data for especially rural population-based interventions, the NMCS is a convenience-sample survey about substance use (namely alcohol and prescription opioids). It is collected annually via social media and direct recruitment by NM OSAP-funded communities in a manner designed to obtain a representative sample for each community (most frequently counties or American Indian Tribal nations). Results are not weighted unless otherwise reported (by race/ethnicity, gender, and age). The most recent data provided for this assessment were collected in 2019; further data can be provided upon need and request[13].

The NM Prescriber Survey (NMPS) asks prescribers recruited through the NM Pharmacy Board about their opioid-prescribing practices and beliefs. Participation is voluntary, yet robust. Starting in 2017, the NMPS is collected bi-annually as supported by the NM Strategic Prevention Framework Prescription Opioid (SPF Rx) grant. Starting in 2019, PIRE was able to assess results by county where the provider practiced, thus allowing us to assess results by HRSA region. The most recent data provided for this assessment were collected in 2019; further data can be provided upon need and request[14].

New Mexico Department of Workforce Solutions. This dataset consists of unemployment data and employment and training provider program data, including programs eligible for financial assistance under the Workforce Innovation & Opportunity Act (WIOA). The Local Area Unemployment Statistics (LAUS) program publishes estimates of monthly civilian labor force employment and unemployment rates monthly using concepts and definitions that are consistent with those of the Current Population Survey (CPS), also known as the household survey. Data are produced for the United States, the state of NM, the four metropolitan statistical areas (Albuquerque, Farmington, Las Cruces, and Santa Fe), all 33 counties, and cities with populations of 25,000 and over. The LAUS data are closely followed because they are among the earliest economic data indicating current economic conditions and, due to this timeliness, are highly demanded and heavily used in the private and public sectors. Data are published monthly at https://jobs.state.nm.us/LAUS.

[13] The most recent surveys and reports can be found at http://www.nmprevention.org/NM-Community-Survey.html

[14] The most recent NMPS can be found at http://www.nmprevention.org/SPF-Rx-Data-Collection-Instruments.html

Qualitative Data

Qualitative methods are useful for eliciting the perspectives of stakeholders at multiple levels of the health system. They yield descriptive data on the range and nuances of community and service delivery contexts and are well-suited to elucidating the experiences of service users, providers, and other health system stakeholders; assessing strengths and vulnerabilities of communities and service systems; prioritizing areas for interpretation and analysis; deepening our understanding of quantitative research findings; and providing direction for future assessment and planning.

In this needs assessment, we conducted in-depth qualitative interviews and focus groups with a variety of stakeholders in OUD prevention, treatment, and recovery in Southern NM. These included individuals primarily identifying as having lived experience with OUD and OUD services in Southern NM (two focus groups, n=8), behavioral health professionals with at least one year of experience providing direct services in the prevention or treatment of OUD (three focus groups n=10 participants), first responders (two focus groups, n=4), and key service system stakeholders, such as administrators of health facilities (e.g., chief medical officers) and state-level policymakers (six individual interviews, n=6). Interviews and focus groups adhered to a semi-structured interview guide that was tailored to each stakeholder group (service users/families, providers, administrators). Interview guides covered personal experiences with OUD and OUD services in Southern NM, perspectives on community-, organizational-, and system-level facilitators and barriers to OUD services, and recommendations for resources and strategies to improve the prevention and treatment of OUD in Southern NM. See Appendix 1 for sample guides. These formal data collection events were supplemented by a number of informal conversations with other service users, providers, and decision makers in OUD services, such as directors of professional associations, as well as via structured data presentations with the members of our RCORP-SNM consortium and CAG.

Interviews and focus groups were documented by researchers with handwritten notes as well as digitally recorded (with one exception when an interviewee declined recording). We analyzed these data using a rapid qualitative assessment process, an iterative approach that facilitates summarizing and analyzing textual information quickly. After each qualitative data collection event, researchers filled out a structured template detailing the content of each interview or focus group pertaining to domains of interest (e.g., Needs/Concerns of People with OUD, Workforce Issues, etc.). A sample template is included in Appendix 2. The qualitative descriptions in this needs assessments are drawn primarily from these templates with supplementary material from the digital recordings as needed.

Notably, due to the highly constrained timeline for this Assessment Report, it was not possible for us to collect an exhaustive qualitative representation of the wide range of OUD services or stakeholders throughout our sizable target region. Qualitative findings throughout this needs assessment should thus be interpreted as rich snapshots of issues, experiences, and perspectives that are characteristic of, if not universally applicable to, the OUD problem in Southern NM. Gaps in data as well as planned means to address them will be noted throughout this assessment report.

D. Overview of Results/Findings

The following sections detail the findings of our needs assessment process. First, we describe the prevalence and severity of OUD in Southern NM, including quantitative data on opioid use, drug overdoses, and prescribing practices. This section also features a discussion of the needs and concerns of people with OUD, including data on well-known comorbidities and social determinants of OUD, which are prevalent in our target population. These data are supplemented with qualitative findings illuminating the substantial challenges that individuals with OUD encounter in their daily lives. We conclude this section by sketching some of the positive characteristics of Southern NM communities and the behavioral health system that will contribute to improvements in OUD prevention, treatment, and recovery in the future.

Second, we outline the current status of OUD services in Southern NM, including 1) prevention and harm reduction, and 2) treatment and recovery services. *We grouped these services in this way as this is how our qualitative data collection participants perceived them. Throughout the discussion we remain mindful of how this grouping can be problematic.* For example, prevention and harm reduction can often find themselves at practical odds (e.g., prevention of misuse messaging can collide with that of prevention of overdose), and the oft-mentioned absence of strong recovery resources jeopardizes the longevity of treatment success. Even though few community-level participants articulated this notion, this also acknowledges that relapse is frequently part of the recovery experience, such that a return to treatment will be part of many individuals' recovery journey.

In each section, we summarize the gaps that contribute to the OUD problem in Southern NM, as well as opportunities and resources that can be leveraged to improve it.

Third, we discuss the behavioral health workforce in Southern NM, including a summary of workforce gaps, as well as opportunities and resources for improvements.

Prevalence and Severity of OUD in Southern NM

For the past two decades, NM's drug overdose death rate has been among the highest in the nation. From 2012 to 2016, the state drug overdose death rate was 24.6 deaths per 100,000 people, compared to the national rate of 16.3 per 100,000 people.[15] The state overdose death rate increased in 2018 and NM continues to have the highest overdose death rate west of the Mississippi[16] .

[15] "NM-IBIS - Health Indicator Report - Drug Overdose Deaths," accessed January 12, 2019, https://ibis.health.state.nm.us/indicator/view/DrugOverdoseDth.Cnty.html; "NM-IBIS - Substance Abuse Epidemiology Profile Report - Executive Summary," accessed January 12, 2019, https://ibis.health.state.nm.us/report/saepi/ExecutiveSummary.html.

[16] Drug Overdose Mortality by State (2017) accessed 11/23/19, https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm

Drug Overdose Rates

Most recent NM DOH reporting for the state[17] reveal the shape of the drug overdose problem in NM. About 2 of 3 drug overdoses in NM in 2018 involved an opioid. While NM has decreased in state rankings for opioid-related overdose from first or second to 17th in 2017, what appears to be a positive shift is sadly in large part is due to increases in overdose rates in other states (see Figure 8). Overdose prevention specialists in the state attribute the plateauing of NM's rate to increases to a strong harm reduction and OD prevention system already in place in response to a longstanding northern NM opioid crisis. This existing capacity supported the ability to quickly train and distribute Narcan/Naloxone throughout the state.

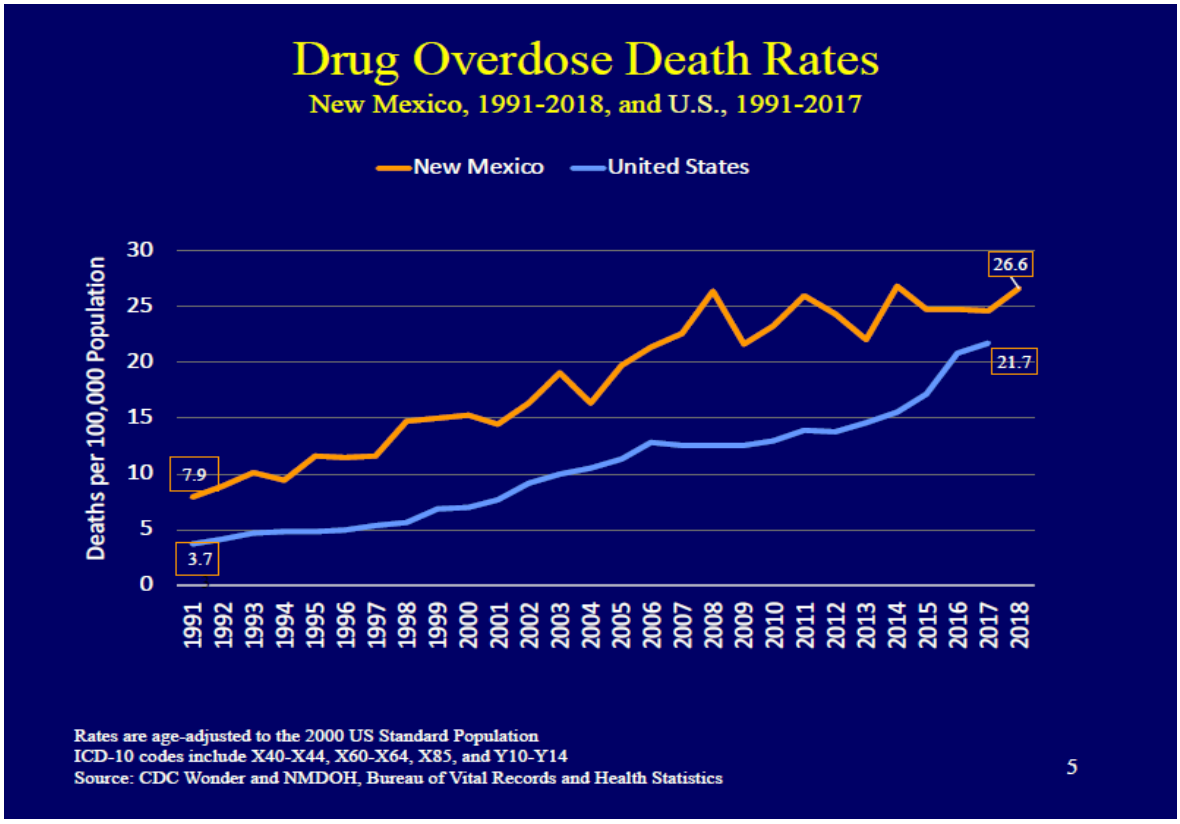


Figure 8 Slide source Prevention of Drug Overdose Death New Mexico, Michael Landon NMDOH 10-09-19

Figure 9 and Figure 10 show RCORP county Drug Overdose death rates by county. In Figure 9, we were able to access 2013-2017 actual rates per 100, 000 population, and compare to New Mexico and urban and Northern Bernalillo County. Here, overdose deaths include all licit and illicit drugs, which may include for example, Benzodiazepines and methamphetamine, with the predominant drug being opioids

[17] Drug Overdose in NM Factsheet September 2019. Draft shared by Consortium partner NMDOH in order to inform assessment report.

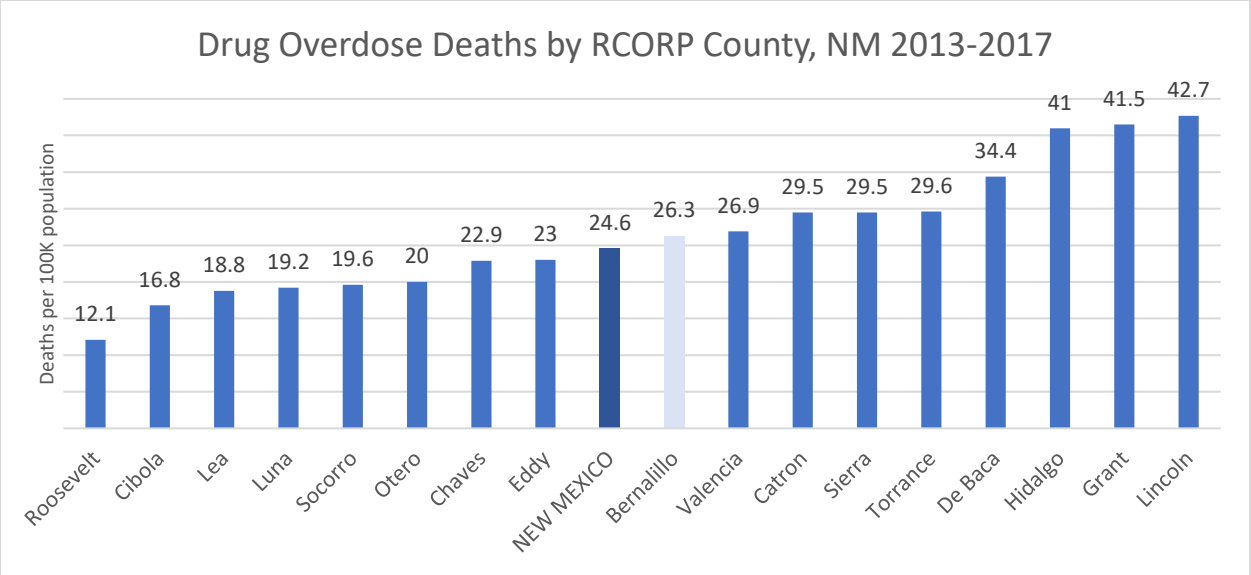


Figure 9 Source: https://nmhealth.org/about/erd/ibeb/sap/dod/

Figure 10 represents the most up to date data available from the NM DOH. Green highlighted counties below represent the Southern NM counties with rates over that of the state. It is important to note that Rio Arriba and San Miguel Counties, in the northern part of the state, have carried a decades old burden of opioid overdose deaths. Several participants in the assessment process noted that attribution of the opioid problem in NM to these northern counties may have led state policy makers to overlook the very different needs of the southern part of the state.

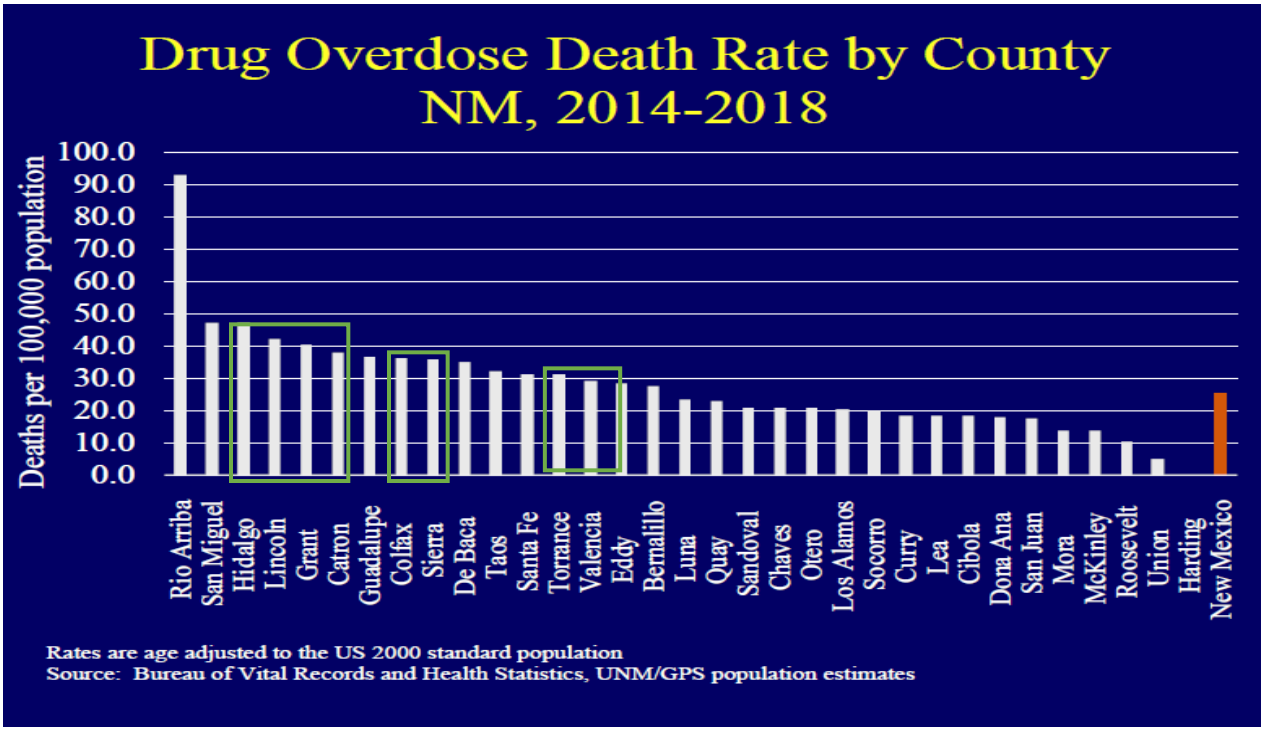


Figure 10: Slide source Prevention of Drug Overdose Death New Mexico, Michael Landon NMDOH 10-09-19

Recent reports from NMDOH show that the rural drug overdose death rates in New Mexico are highest in the state, as shown in Figure 11.

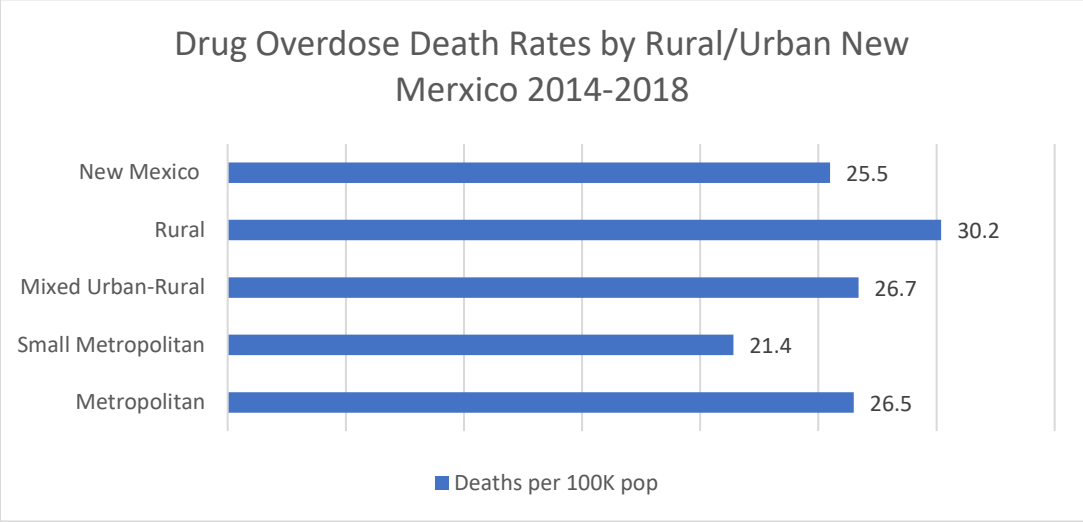


Figure 11. Data Sources: NMDOH VVRHS and IBEB SAE: Rates are age-adjusted to the 2000 US standard population.

Roughly half of the drug overdoses in NM involve a prescription drug, according to Peter Ryba, PMP Director. Starting in 2013, changes in prescribing regulations have been linked to encouraging decreases in prescription-drug, especially opioid related death rates. These changes include mandatory PMP registration and use, data entry within 24 hours for both prescribers and pharmacies, and monitoring of prescribing by NMDOH and licensing boards so that dangerous prescribing practices can be curtailed. Figure 12 shows encouraging decreases in the opioid overdose rate in response to decreases in prescribing of opioids overall. According to a September 2019 draft report from NMDOH using DEA sales data, there was a 36% decrease in prescription opioid sales between 2011 and 2017.

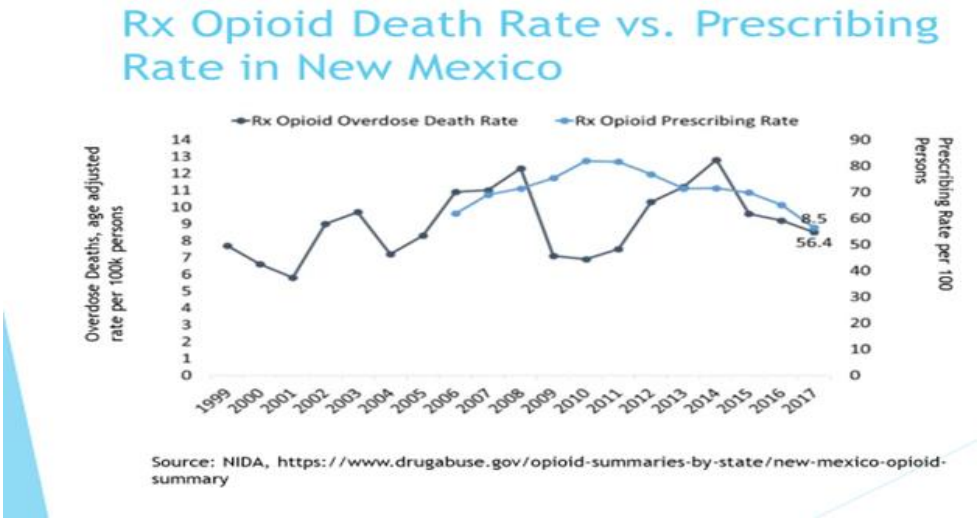


Figure 12, Slide source: Prevention of Drug Overdose Death NM, Michael Landon NMDOH 10-09-19

Other drug use in New Mexico

State policymakers have demonstrated concern for the return of methamphetamine use in NM, and increases in meth-involved deaths (see Figure 13). The methamphetamine involved death rate nearly tripled between 2013 and 2018 (NMDOH September 2019). We also know that in 2018, 83% of benzodiazepine-related overdoses also involved opioids. PMP monitoring and education of prescribers regarding the dangers of co-prescribing these respiratory depressants. See Figure 13 for NMDOH's latest trends in drugs. involved in overdoses.

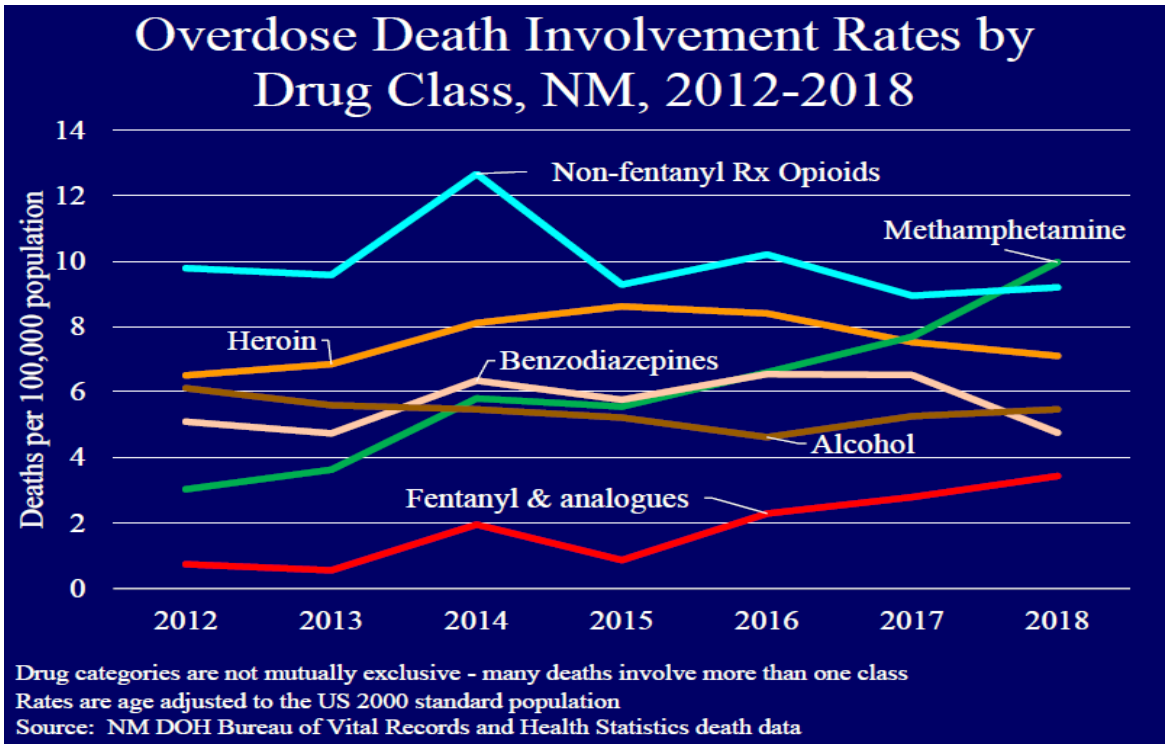


Figure 13, Slide source: Prevention of Drug Overdose Death NM, Michael Landon NMDOH 10-09-19

This concerning rise in methamphetamine-related overdoses has been tracked by NM DOH, and was noted to some degree by data collection participants. It is important to note that in the counties of our coverage, methamphetamine use is highly variable, and its consumption has proven to be difficult to track as prevalence is so low. In the south, meth use appears to be related to temporal manual labor, such as in the southeast oil fields or in chile harvesting. Because younger adult males are more likely to experience a meth-related overdose in NM (usually in combination with opioids), a theory of heavy masculine-associated labor (supported by stimulant and painkiller use) may bear out (see Figure 14).

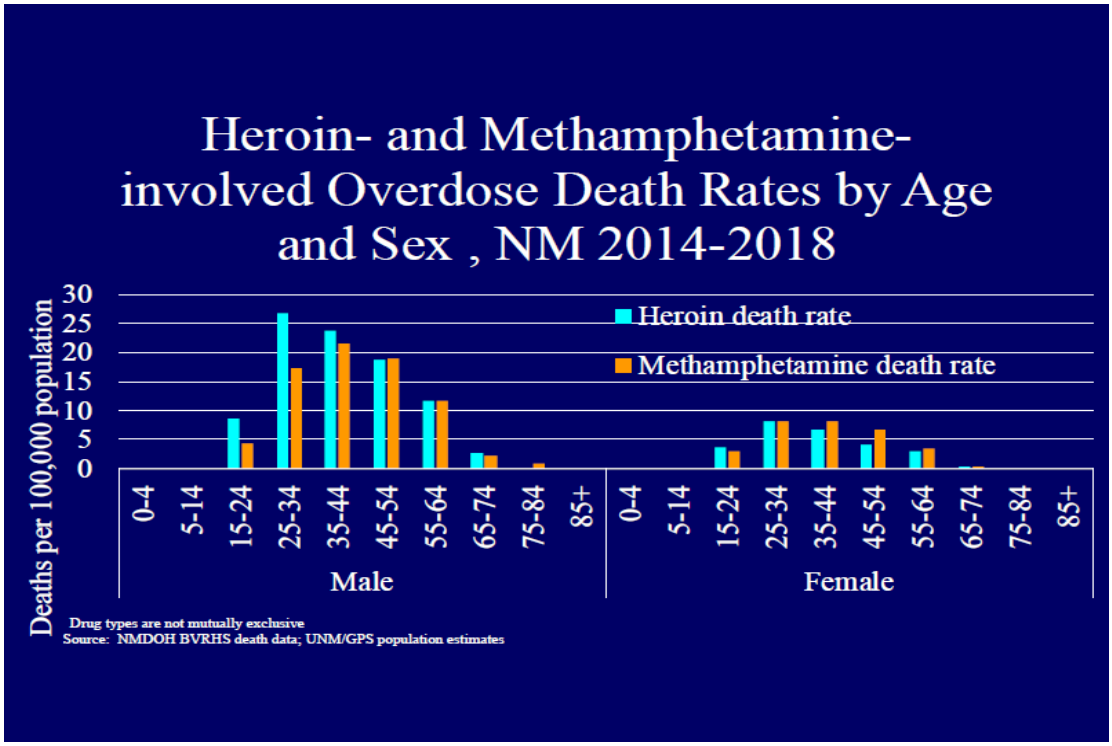


Figure 14, Slide source: Prevention of Drug Overdose Death NM, Michael Landon NMDOH 10-09-19

Consumption, access to and use of prescription opioids

Youth: The NM Youth Risk and Resiliency Survey (YRRS)

Data gathered bi-annually with NM students in the state's version of the YRBS reveal again the burden of opioid misuse in Southern NM. Bernalillo County, which houses Albuquerque, the largest city in the state and situated in North Central NM, is included for urban comparison. In Figure 15 below, observe how heroin and painkiller use map very similarly for these counties.

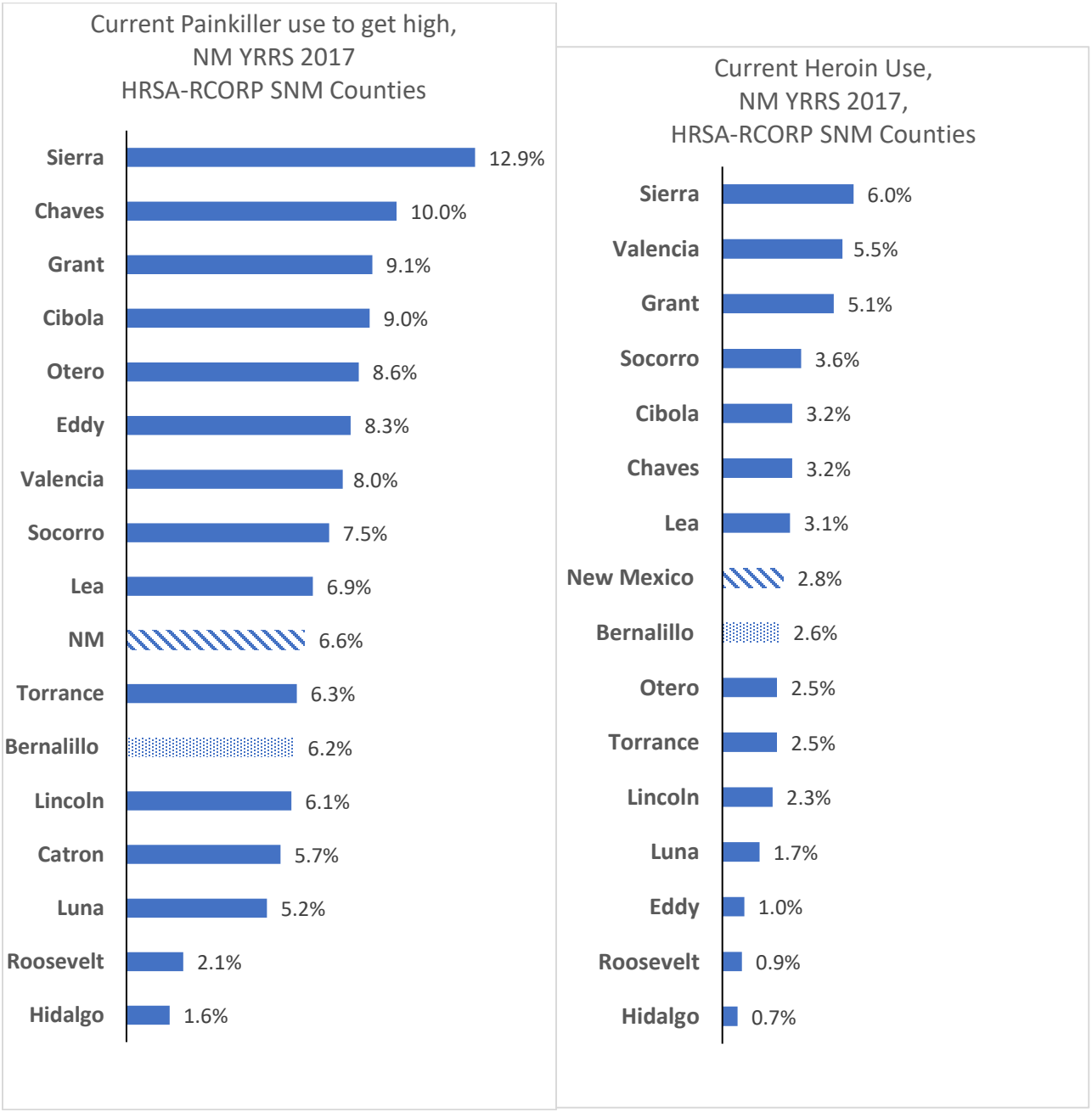


Figure 15: NM Youth Risk and Resiliency Survey http://youthrisk.org/

Adults: New Mexico Community Survey

The adult NM Community survey (methodology described above), provides us annual, up to date data on prescription opioid attunes and behaviors by county[18]. As we are able to conduct additional analysis, we can identify unique characteristics as based upon demographics and geography. Urban and northern Bernalillo County is added for comparison.

Table 3 NMCS 2019: Use and access to opioid painkillers HRSA SNM Counties, by gender

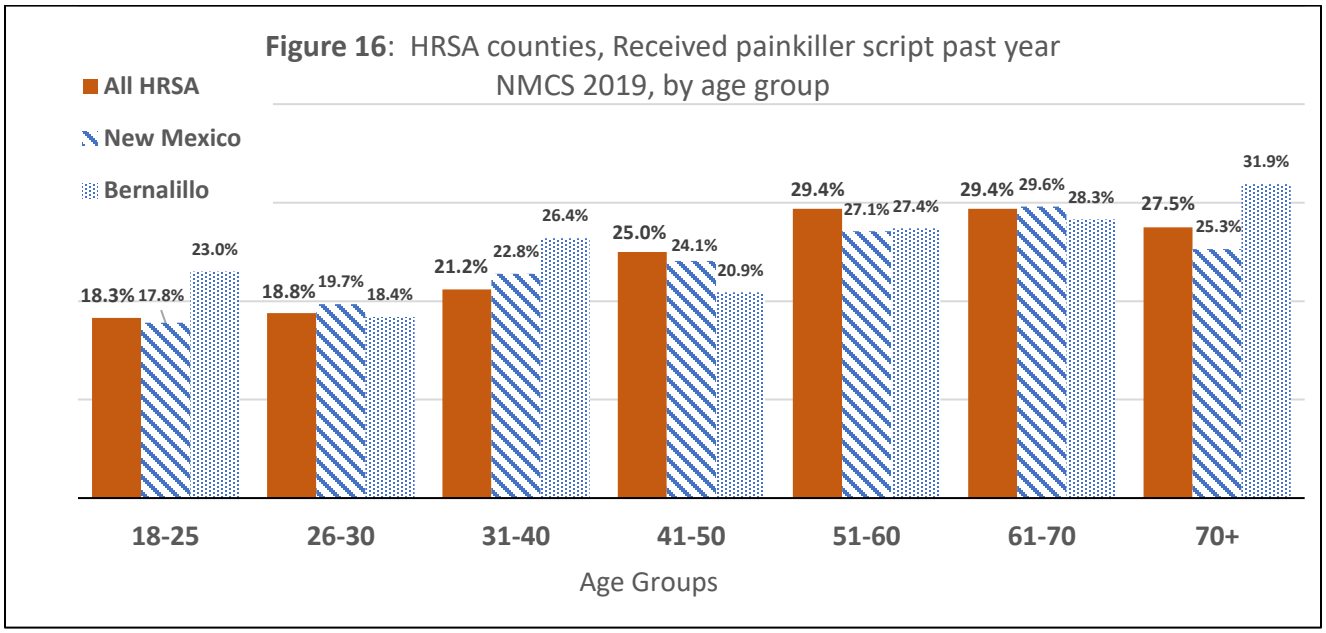
	Self- reported receiving painkillers in the past year		30 day painkiller use		Rx painkiller use to get high among current users	
	Males	**Females**	**Males**	**Females**	**Males**	**Females**
Chaves	16.5%	27.0%	7.1%	11.7%	40.0%	15.6%
Cibola	19.3%	26.4%	0.7%	2.7%	*	*
Eddy	25.6%	28.9%	15.8%	13.3%	23.8%	21.9%
Grant	19.3%	28.2%	5.8%	10.9%	20.0%	15.8%
Luna	29.2%	25.7%	15.9%	12.5%	35.3%	25.7%
Roosevelt	24.4%	27.1%	15.3%	15.4%	52.2%	17.1%
Sierra	31.2%	21.8%	17.1%	9.4%	42.1%	11.1%
Socorro	17.7%	13.6%	5.2%	5.3%	23.1%	42.9%
Torrance	28.5%	27.7%	14.8%	15.0%	11.8%	34.1%
Valencia	24.7%	25.6%	6.0%	16.7%	20.0%	20.0%
All HRSA	**23.9%**	**25.6%**	**10.5%**	**12.1%**	**27.8%**	**16.5%**
Bernalillo	*23.3%*	*27.1%*	*10.3%*	*11.1%*	*26.2%*	*24.2%*
New Mexico	*22.8%*	*25.5%*	*10.3%*	*12.0%*	*27.1%*	*16.8%*

**n was too low to report*

For example, Table 3 shows that more women in select rural communities of Southern NM and across the state report receiving a painkiller script in the past year and report using a painkiller for any reason in the past 30 days. These results bear out with the higher prescription painkiller overdose rates women experience in the state. However, when looking at those current users who reported using painkillers to get high, the gender differences flip. In nearly every community surveyed, men were more likely to use their painkillers to get high. According to the 2019 NMCS, in the SNM counties, as much as 1 in 3 adults (Roosevelt) and 1 in 5 (Cibola) adults who used painkillers in the last 30 days reported using them to get high. That they used them to get high does not mean that they may also have been using them to treat medically-identified pain.

Figure 16 below also reveals that older adults in the Southern NM HRSA counties are more likely to receive painkillers in the past year. Not only does this reflect a potential for misuse or overdose, but also for intentional and unintentional diversion to others.

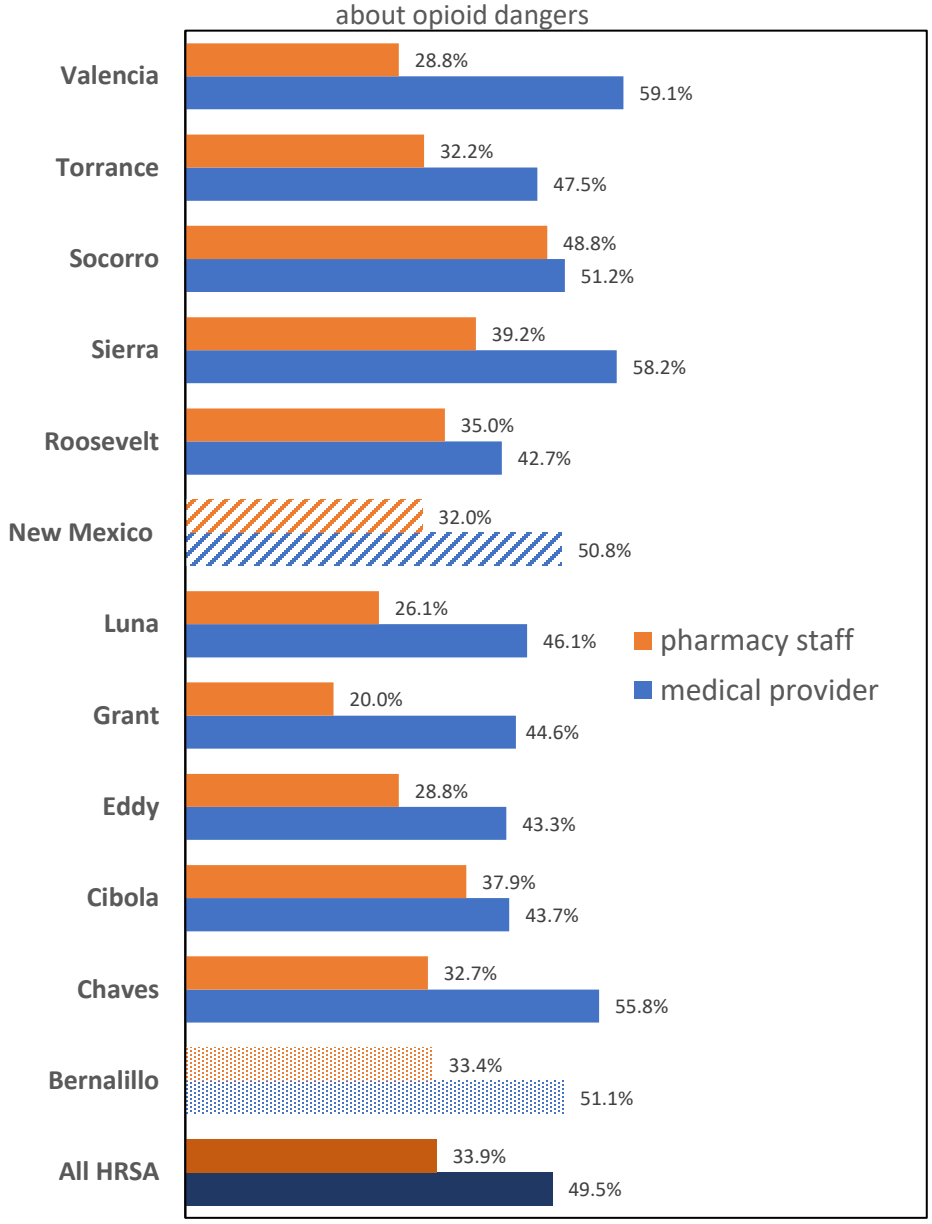
[18] Recall that only counties fully participating in the NMCS are represented. Insufficient n's would exclude a county from representation in these county level reports.



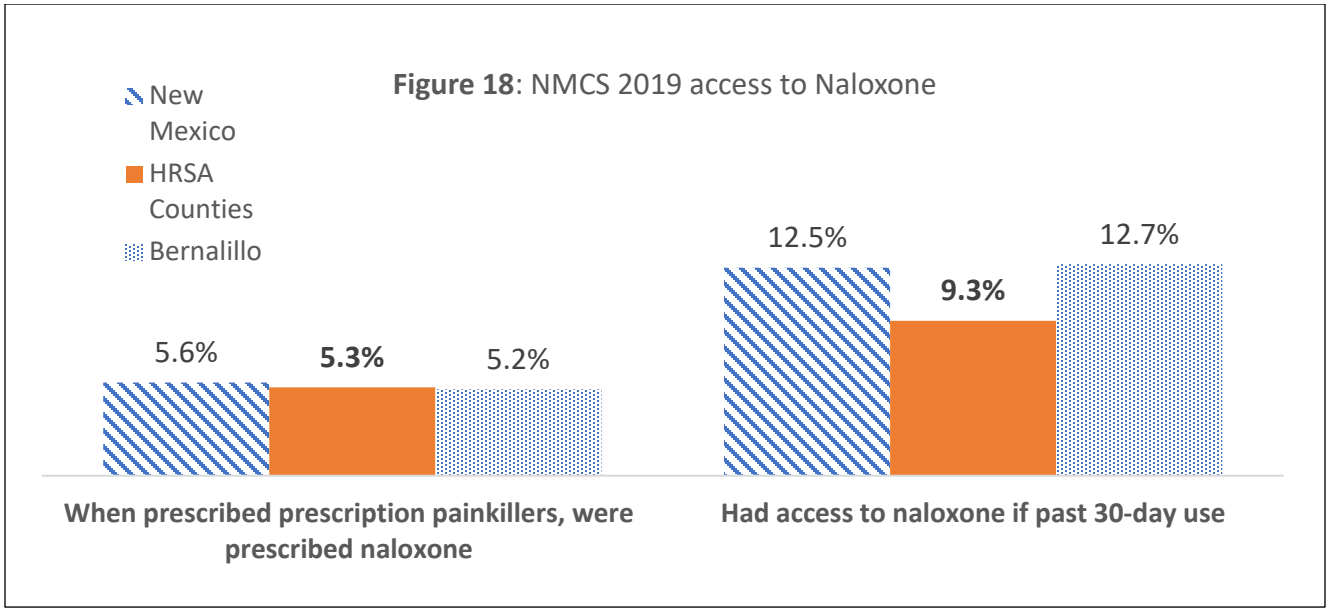
Provider attitudes and behaviors

A question on the NMCS asks if a patient recalls whether their prescriber or pharmacist provided vital information about the harms of opioids. Figure 17 shows that in our HRSA counties, pharmacies and providers are less likely to educate their clients about this very important issue. This disparity is likely due to the rural nature of these communities where providers are few; and turn-over is high. As every patient should report that they were informed about the dangers of this class of drugs, clearly, there is an important need to be filled by pharmacists and medical providers.

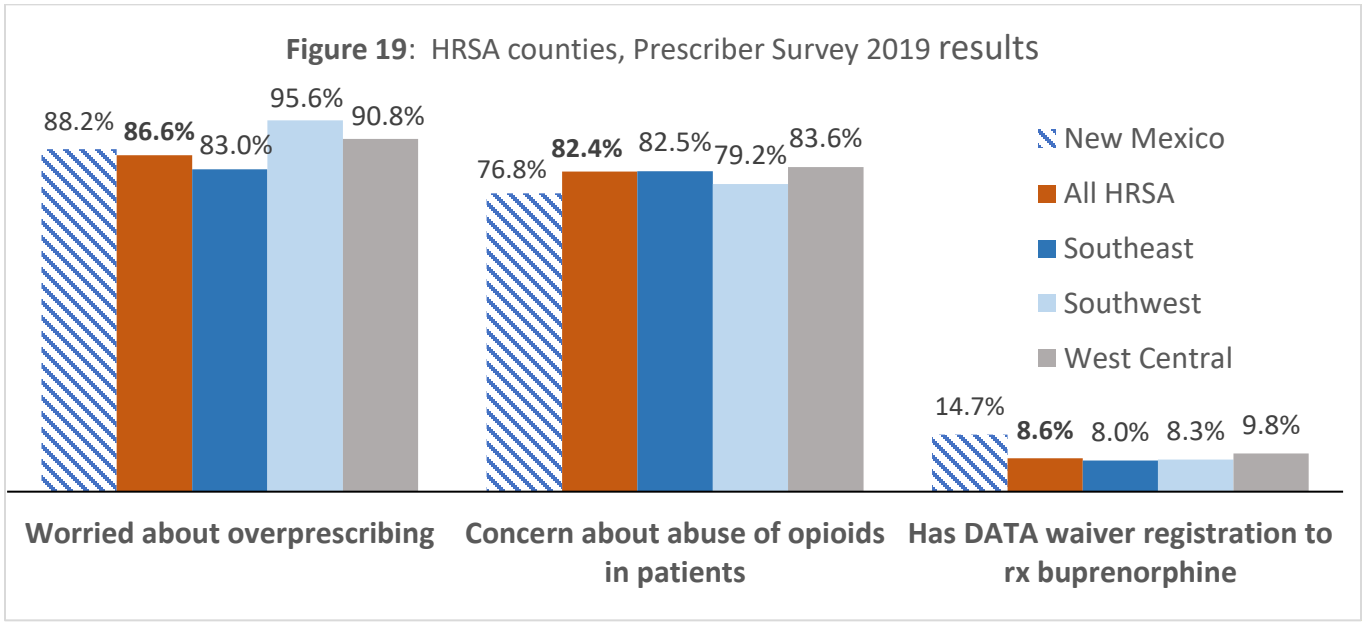
Figure 17: NMCS 2019, medical and pharmacy providers informing about opioid dangers



Knowing about Naloxone and having access to it is essential for prevention of overdose for any opioid user. In the SNM counties, we see fewer participants who use opioids reporting that they had access to Naloxone in the 2019 NMCS (Figure 18).



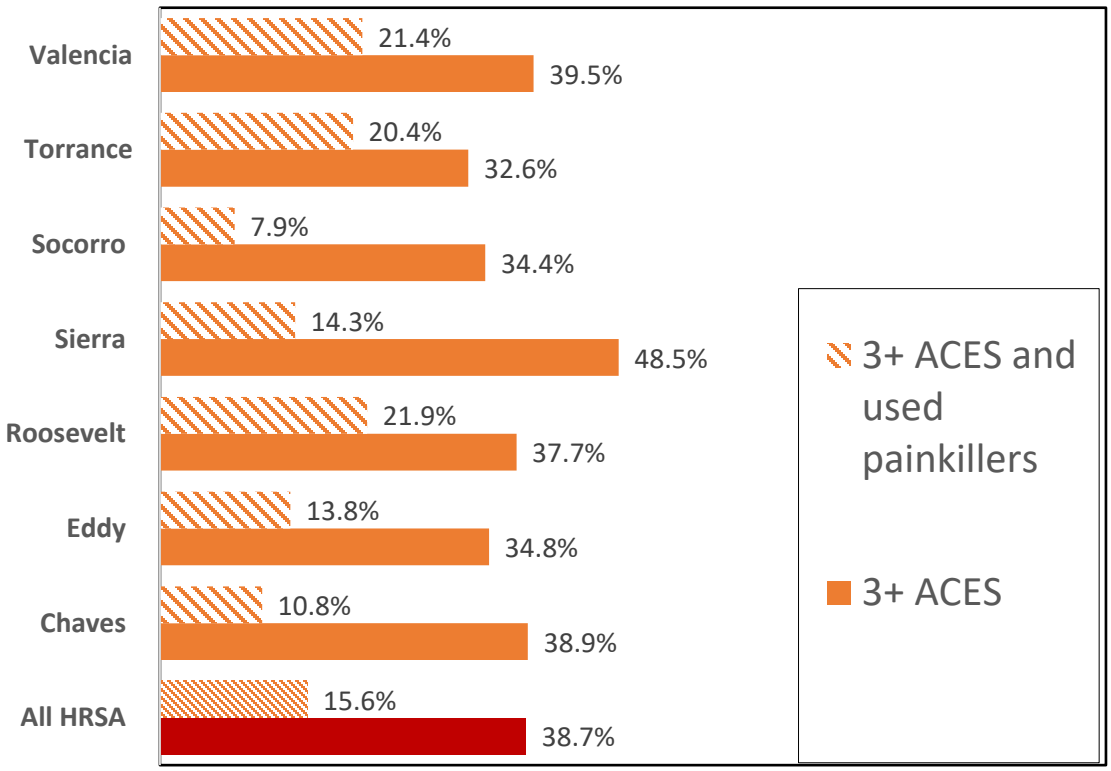
New data from the 2019 New Mexico medical provider survey (NMPS, methodology described above) analyzed for the HRSA communities reveals a high **degree of concern about** overprescribing and about potential abuse among patients. In Figure 19 below, providers participating in the survey are revealed to be very concerned about opioids across the board. Each SNM HRSA region even shows higher concern about abuse of opioids among their patients than the statewide results. However, as the right cluster of columns reveal, very few providers surveyed reported having the DATA waiver required to prescribe MAT, especially in the HRSA regions. Among those survey participants who reported possessing the DATA waiver, only 18 serving in the entire HRSA region actively prescribe buprenorphine: 10 in the Southeast, 2 in the Southwest and 6 in West Central. These numbers might be duplicated.



Needs and concerns of individuals with OUD in Southern NM

Along with the need for providers to communicate appropriately with patients and to be able to provide the medicine they need for their well being, there are many needs and concerns for those who use opioids in NM. While we describe many of these concerns in the following qualitative section, it is also important to highlight some of the precursors to opioid misuse in NM. In 2019, some communities participating in the NMCS also chose to ask about ACEs (Adverse Childhood Events) adults had experienced. High ACEs is defined as three or more events, such as physical and emotional neglect or abuse, or experiencing an adult in the home with mental illness or SUD. High ACEs are associated with health problems in adulthood, such as with behavioral health, and in a separate study not yet published, we have shown with these data that there is a correlation between high ACEs and painkiller misuse. In Figure 20 below, we observe how in select HRSA counties, the percentage of respondents from each county with high ACEs alongside those with high ACEs who also used painkillers for any reason. It is alarming to see that between 1/3 and ½ of the population has experienced high ACEs.

Figure 20: High ACEs and painkiller use HRSA counties, NMCS 2019



Social determinants of health

Our qualitative data underscore the central role of structural factors, i.e., "upstream" factors originating in the physical and sociopolitical environment—in shaping the needs and experiences of individuals with OUD in Southern NM.

Pervasive structural vulnerabilities: In our interviews and focus groups, participants described a number of structural vulnerabilities—meaning increased risks for mental and physical ill-health that result from an individual's physical and sociopolitical environment—that compounded the challenges of OUD for many Southern New Mexicans. Chronic shortages in housing and housing assistance affected individuals who were insecurely housed or who needed to find a new living situation to distance themselves from negative social influences. Financial insecurity and difficulty finding stable employment was common and contributed to difficulties accessing healthy food and remaining enrolled in health insurance. For racial and ethnic minorities, discrimination from law enforcement and healthcare and social service providers deepened experiences of stigma associated with their OUD.

Severe and prevalent comorbidities: Both quantitative and qualitative data indicate that people who struggle with opioid misuse are commonly also dealing with other severe mental and physical health issues, which in turn aggravate and are aggravated by their opioid misuse. One experienced behavioral healthcare provider estimated that the majority of her/his clients with OUD had at least two additional diagnoses: often a trauma-related mental health condition, such as depression or anxiety, and a chronic medical condition that was usually caused or worsened by concerns in their physical or socioeconomic environment, such as lack of housing or healthy food.

Challenges and barriers to preventing and treating OUD in Southern NM

Over the course of our qualitative interviews and focus groups, we encountered a number of themes pertaining to common and persistent factors that facilitated the misuse of opioids and challenged the ability of individuals with OUD to find, access, and utilize effective treatment services.

Likelihood of diversion to use of other drugs as a result of more stringent opioid prescribing practices: Although opioid prescribing practices throughout NM have improved as a result of more stringent monitoring, individuals with lived experience of OUD noted that many people who had already become addicted to prescription opioids were compelled to start using other drugs, like meth or heroin, after it became more difficult to obtain prescriptions. When prescribing practices changed, one individual described, "At that point, we were already addicted without even realizing it. . . . Heroin was the next best thing and the easiest thing."

Pervasive structural and administrative barriers to entering treatment: Focus group participants who had experienced OUD commonly praised the treatment services they had received. However, numerous individuals emphasized that even for those who wanted treatment for OUD, the biggest barriers to treatment and recovery is simply being able to effectively find and initiate treatment, especially MAT. One person who was in recovery from OUD opined that, "The only way to get help is if you get in trouble" with the law. Echoing others, this individual was prescribed MAT via a drug court.

Others recounted the good fortune to find a healthcare or social service provider who was active and persistent in getting them a referral to treatment. For example, one person recalled struggling to find a MAT provider when she discovered she was pregnant, commenting, "I was in limbo and wanted to get clean." After failing to find a provider in multiple towns and encountering rude and unhelpful healthcare staff, she attributed her ultimate recovery to an OB/GYN who, "did whatever she could to get me referrals." To address this gap, one state policy maker opined that legislation should be implemented mandating that every medical provider obtain the DEA waiver for prescribing MAT. One provider and administrator described numerous structural barriers faced in running a rural MAT clinic; a longstanding methadone provider, they were still waiting to complete the requirements to add buprenorphine to its treatment schedule. Staffing and the absence of peer support were noted as key barriers.

Stigma toward MAT: A common theme across the interviews and focus groups was the persistence of stigmatized attitudes toward MAT as a treatment modality for OUD. The participant quoted above recalled that one healthcare provider she encountered claimed that s/he "didn't believe in MAT," a common theme that arose in multiple interviews and focus groups. Similarly, several individuals in recovery recalled being initially suspicious of MAT because they felt that being on Suboxone "wasn't really getting clean." This opinion was reportedly widely shared among friends and family members, who worried that MAT was just another way to get high.

Stigmatized attitudes toward OUD: One health system administrator emphasized the pervasiveness of stigma around OUD, commenting that it is nearly impossible to be raised in our society without developing the belief that SUD is essentially a character failing. Such beliefs, s/he noted, take a long time to overcome for everyone, regardless of good intentions. Addressing stigma involves patience and time to develop new understandings, as well as modeling treating patients with respect. Several participants in interviews and focus groups mentioned that members of law enforcement in particular took a primarily punitive approach toward OUD, treating it like a crime rather than a reason to offer help. However, participants also emphasized that stigma remained common among healthcare providers, even those trained in behavioral health. For example, one hospital administrator regularly found it necessary to remind providers that just like, "we don't stop treating a diabetic because they're not eating right," it was inappropriate to stop treating someone with OUD because s/he relapsed or missed appointments. A state-level administrator observed a reluctance among more rural healthcare providers in the Southern part of the state to take on MAT because of fears that their practices might become overwhelmed with "those kinds of patients."

Delays in funding and best practices for Southern NM: Many participants noted that despite the spread of promising harm reduction and treatment practices (e.g., Narcan) in other parts of the state, it was often hard to get resources and training to put such practices into regular use in Southern NM. One individual in recovery commented, "If you live south of the line you are just screwed."

Limitations in transportation: As in rural areas elsewhere, transportation presented a barrier for individuals trying to access and utilize OUD treatment. This was particularly challenging in places where patients had to make multiple in-person visits to receive MAT from providers that were often 30-40 miles from their home. Where public transportation exists in Southern NM communities, it is often available only a few times a day, necessitating hours of waiting and traveling. Many individuals

receiving treatment for OUD relied on transportation from Medicaid, although the need to make and confirm appointments was sometimes burdensome. Additionally, one hospital administrator noted that an expansion to HIPAA meant to protect the privacy of individuals receiving behavioral health treatment made it difficult to provide transportation to more than one individual at a time.

Facilitators and protective factors associated with preventing and treating OUD in Southern NM

Recognition of SUD as a serious mental illness: As individuals, healthcare providers, and state and federal policymakers increasingly recognize SUD as a serious mental illness, opportunities are growing to support individuals with OUD as they seek and engage in treatment. For example, through Medicaid, individuals with OUD are eligible to receive comprehensive community support services that help them learn how to navigate complex healthcare and social services systems, as well as care coordination for those who need it. Promising programs are also being developed and tested to help people who are not eligible for Medicaid, such as the Bridges 2 Wellness program at Hidalgo Medical Services in the far southwest region of the state, which provides care coordination, personalized education, and community outreach through a multiyear grant from the Substance Abuse and Mental Health Services Administration (SAMHSA).

Diversity of community context: Although the racial/ethnic, socioeconomic, and linguistic diversity of Southern NM can present challenges to the equitable provision of comprehensive OUD services, participants in interviews and focus groups also emphasized that diversity is a major strength in Southern NM. Multiple healthcare providers cited diversity as an asset of their community and one of the reasons that they were committed to serving in those communities. One healthcare administrator asserted that in her/his substantial experience, a diverse environment increases flexibility of thinking among healthcare and social services providers, making it less likely that providers will feel that they can project their opinions on others. S/he commented that when discussing cultural competence with her/his staff, s/he liked to suggest that staff members let visible differences be a reminder to them to be aware of and sympathetic to non-visible differences, such as challenging beliefs and experiences.

Family cohesion and support: Although the social density and isolation of small towns and rural areas can be challenging for individuals who need to escape negative influences as part of their recovery from OUD, multiple participants in focus groups and interviews also highlighted the benefits of the close families and intergenerational households that are common in Southern NM. For example, one healthcare provider estimated that nearly half of her/his clients lived with a grandparent who was an indispensable “partner” in supporting her/his grandchild. Even the fact that OUD sometimes affects multiple generations of a family can be a supportive factor when it results in family members understanding, having compassion, and providing knowledgeable support to those currently experiencing OUD.

Prevention, Treatment, and Recovery Service Systems for OUD in Southern NM

OUD prevention and harm reduction in Southern NM

Like other states across the nation, NM has been the recipient of several OUD federal grants, primarily administered through the NMDOH and NM Human Services Department-Behavioral Health Services Division (BHSD). For over five years the Office of Substance Use Disorder (OSAP at BHSD) has supported prevention efforts of community coalitions, emphasizing environmental and policy approaches to prevent OUD. Other federal funding has supported naloxone education and dissemination, promoting use of the PMP, MAT training and support on best practices for opioid prescribing. Over the past few years the state has invested in expanding education, employment and billing opportunities for peer support specialists, community health workers, community support workers and care coordinators. Most recently, there has been more growing interest and investment in first responders and incarcerated populations.

Primary prevention programs that include addressing diversion, education and awareness

New Mexico Opioid State Targeted Response Grant (STR) initiative is overseen by the New Mexico's Human Services Department's Behavioral Health Services Division (HSD/BHSD). The goals of the grant are to 1) increase the number of people who receive treatment for OUD, 2) increase the number of people who receive OUD recovery services, 3) increase the number of providers implementing MAT, 4) increase the number of trained OUD prevention and treatment providers, and 5) decrease the rate of opioid misuse, opioid overdoses, and opioid-related deaths. The STR grant funds the training and distribution of Narcan (naloxone) to first responders across the state to use to reverse opioid overdoses as well as training of health care providers to provide MAT to people with OUD.

Academic Detailing is outreach education for health care professionals. This one-on-one approach offers providers the opportunity to access the most up-to-date, evidence-based guidelines and recommendations, without having to do the research themselves. A trained professional delivers a synthesis of the newest information, while listening and responding to the provider's needs to best care for their patients.

Others: The following population based strategies limit social and regulated access to prescription opioids and increase awareness of harms. These programs face funding cuts from state and federal sources http://www.nmprevention.org/Service-Providers.html#.

- PFS 15 ends in 2020: Cibola, Chaves, Roosevelt, NMT in Socorro
  - SAPT block grant funds support programs *(subject to RFP in 2020) in Socorro, Sierra, Grant, Cibola, Luna, Eddy, Mescalero Apache nation, Torrance, Valencia
  - DFC: Hidalgo County (ends 2020)
  - PFS 19 (5-year underage drinking that includes opioid misuse prevention) Mescalero Apache Nation, Chaves only in target area.

PDMP, including diversion from regulated sources

NM has undergone a number of improvements to the PDMP/PMP system in recent years, making it one of the states with the strongest PMP system.

- Required checks for both prescribers and pharmacists, required data entry w/in 24 hours.
- DOH reports to boards and prescribers possible dangerous prescribing,
- DOH shares data on quarterly basis with community programs and state
- Diversion of prescription opioids through regulated sources is less of an issue in NM than in other states.

Overdose Prevention

- The STR/SOR grant in this geography supports overdose prevention training by funding Naloxone distribution, coupled with access to MAT. Capacity was built through the PDO grant in overdose prevention but not allowed to distribute in rural areas.
- Comprehensive Addiction and Recovery Act (CARA) grant

Consortium and CAG members were surveyed to identify the degree to which state initiatives are available in Southern NM counties. At the time of this report, we had received feedback from 12 of the 16 counties.

Figure 21: Prevention and harm reduction initiatives identified per county

		Catron	Chaves	Cibola	De Baca	Eddy	Grant	Hidalgo	Lea	Lincoln	Luna	Otero	Roosevelt	Sierra	Socorro	Torrance	Valencia
Prevention	Detention Center Staff training – Naloxone & OD training			X							X	X		X			X
	A Dose of RxEality - Statewide Media Campaign	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	There's Another Way (CDC/Pizer)																
	ASAP (Army Substance Abuse Program-National Guard)																
	RALI NM Rx Statewide																
	Pax Good Behavior Game in primary schools																
	# providers receiving Academic Detailing – Safer prescribing											X				X	
	Prevention Coalitions (OSAP & DFC)		X	X			X	X		X**	X	X*	X	X	X	X	
	Pharmacists Training on CDC regulations offered (DOH)													X		X	
	Other (please specify)											X					

		Catron	Chaves	Cibola	De Baca	Eddy	Grant	Hidalgo	Lea	Lincoln	Luna	Otero	Roosevelt	Sierra	Socorro	Torrance	Valencia
Harm Reduction & Intervention	Narcan training offered (BHSD)											X*			X	X	X
	Narcan distributed to first responders (BHSD)											X*		X	X		X
	Law Enforcement Training Institute trainings offered (DOH)											X		X	X	X	X
	Training on PMP Central Registry															X	
	Training on Opioid Prescribing Standards to Prescribers (DOH/UNM)											X					
	Drug Courts																
	Drug Courts - Adult			X			X	X			X	X	X	X	X	X	X
	Drug Court – Youth and/or Family			X							X	X				X	X
	BHSD Sequential Intercept model											X					X
	Jail to Community Transition Programs (Step Up, JTC, Intercept, etc.)						X							X	X	X	X
	Other (please specify)											X				X	X

* Source: Lindstrom, Wayne. LHHS Committee Report Update on Substance Abuse Treatment Centers XX5. https://www.nmlegis.gov/handouts/LHHS%XX5X5%XItem%XX%X%XHSD%XUpdate%Xon%XSubstance%XAbuse%XTreatment%XCenters%Xin%XNM.pdf

** Mescalero Tribe

Gaps in OUD prevention and harm reduction in Southern NM

State and Federal Funding: Federal funding for discretionary grants is waning in NM**.** Funding currently only exists for environmental strategies targeting adults; little prevention education messaging focusing on children or resiliency in area. There is no parent education programs through OSAP funding and little community funding for primary prevention (FG). State funding through BHSD/OSAP focuses on higher population counties and, to a limited degree, tribes. The only tribal program currently funded is with the Mescalero Apache Nation.

Inconsistent focused work on Disparities: No known disparities focus of prevention programs in spite of documented risks for heroin use in YRRS for foreign born, housing unstable, SGM youth.

Lack of Spanish language prevention services in spite of known disparities for foreign born children (FG), Low & erratic density of Spanish speakers in area of coverage could result of this gap.

Stigma in Prevention: Community based coalitions derive from a base that often lacks education in stigma prevention, reproducing stigma in their messaging to the public. Law enforcement and first responders in particular can express stigmatizing ideology (FG)

Lack of prevention education in schools: We spoke with multiple individuals—including people in recovery, first responders, and behavioral health providers—who worried that prevention education was no longer a part of school curricula, in contrast to their memories of the past. Some individuals in recovery from OUD commented that they had not known about the potential for dependency and negative physical and mental consequences of OUD. This lack of awareness included both participants who had obtained opioids indirectly (e.g., from friends) to use recreationally as well as those who had received them directly from a doctor.

Lack of prevention education and support for parents: Interview and focus group participants commented that parents needed additional support to prevent and/or address opioid misuse with their children. Individuals who were in recovery from OUD suggested that parents need to be able to recognize the signs of opioid misuse and would benefit from education in how to positively support their children in getting treatment.

Lack of education around Narcan use: Multiple individuals who had been prescribed Narcan noted that they had not received any information from their doctors or pharmacists about how to use it safely and effectively.

Concerns about privacy and confidentiality around harm reduction resources: While many Southern NM communities had implemented harm reduction efforts, such as needle exchanges, interview and focus group participants noted that the small size and dense networks of acquaintanceship in rural communities presented a barrier to their use. In many cases, despite efforts to de-stigmatize needle exchanges by publicizing their usefulness to individuals with diabetes and other less stigmatized concerns, community members were still reluctant to visit exchanges for fear of being seen by neighbors and acquaintances. This concern was aggravated by the fact that many towns only had one needle exchange that was close to other community resources, making it impossible to go elsewhere. For example, on individual explained, “I wouldn’t go ‘cause I was kind of embarrassed. I’m related to a lot of law enforcement and things get around really quick. . . . In a small town you care a lot about what people think about you. You have a lot of pride.”

Stigma around harm reduction among law enforcement and first responders: A common concern voiced by interview and focus group participants is the pervasiveness of stigma toward harm reduction practices among police and other first responders. For example, one individual recounted the experience of a relative who provided Narcan training to first responders. One officer commented, “If I ever see a heroin user overdosing, I’m just going to let them die.”

Opportunities and resources for OUD prevention and harm reduction in Southern NM

Possible partners: BHSD/OSAP programs have learned to collaborate across Southern NM and statewide. With new funding opportunities local prevention programs may provide skilled preventionists familiar with community. Additional funding is necessary to reach all Southern NM counties and to sustain prevention staff. OSAP and DWI community level partnerships exist to some degree where both funding sources exist. Efforts to collaborate and leverage prevention resources and strategies can be explored and strengthened where needed. Collaboration and communication among state agencies that receive prevention funds is critical for planning and efficient use of resources. It also eliminates confusion at the local level as multiple initiatives are deployed. There are several existing state level forums for state agencies to plan, implement, evaluate and fund prevention initiatives. Having senior level agency decision makers involved in multi-agency planning efforts is necessary for effective collaboration.

Grants/funding streams: State block grant funds for prevention, federal PFS funds recently awarded to local communities, state DWI funds and DFC funding to local communities may offer opportunities for multi-year funding.

Promising practices: Community and prescriber partnerships through academic detailing that disseminates evidence-based practices for managing chronic pain. One-on-one sessions with healthcare providers allow the educator to assess and meet individual needs around pain management. There is also an opportunity to use academic detailing with Medication Assisted Treatment. Opioid education and naloxone distribution to reduce opioid overdose deaths are being provided throughout the state to law enforcement, first responders, prescribers, pharmacists and community members. Medicaid billing for patient support services (determinants of health)

Leveraging the experiences of individuals in recovery: Many of the individuals in recovery that we interviewed voiced a desire to use their experiences and stories to help others in their community to avoid OUD. For example, one person described her/his dream of opening a hair salon that would also function as a safe space for young people struggling with addiction where s/he could "talk to kids about not to go down the same road I went down."

Effectiveness of harm reduction strategies: Although we heard many stories and expressions of stigmatized attitudes toward harm reduction, interview and focus group participants also praised the progress that had been made in many communities to spread awareness and use of harm reduction strategies, such as Narcan. Individuals in recovery from OUD were often on the frontline of educating others about the importance of carrying Narcan and knowing how to use it. One individual told us that s/he had become known for always carrying a supply of Narcan in her/his backpack so that others could come to her/him in case of an emergency. Healthcare providers and administrators recounted their efforts to fight stigmatized attitudes with counter-messaging that likened Narcan to other well-accepted medical treatments. For example, one health system administrator noted that calling harm reduction "enabling" of opioid misuse is like refusing to stock antibiotics to avoid "enabling" infections.

OUD treatment and recovery in Southern NM

Consortium and CAG members were surveyed to identify the degree to which state initiatives are available in Southern NM counties. At the time of this report, we had received feedback from 12 of the 16 counties. Results are shown in Figure 22.

Figure 22: Treatment and recovery initiatives identified per county

		Catron	Chaves	Cibola	De Baca	Eddy	Grant	Hidalgo	Lea	Lincoln	Luna	Otero	Roosevelt	Sierra	Socorro	Torrance	Valencia
Treatment & Treatment Support Services	Hospitals		X	X	X	X	X		X	X	X	X	X	X	X		
	Community Health Centers/FQHC locations	X		X			X	X	X		X	4	X	X	X	X	X
	School Based Health Centers	X		X			X	X	X		X		X	X	X		
	Detox Services (Social, Medical, Residential)						X										X
	Adult Residential Treatment Centers		X			X											
	Adolescent Residential Treatment Centers		X	X					X								X
	Methadone Treatment Centers		X														X
	Adult Intensive Outpatient Programs		X	X		X	X							X	X		X
	Adolescent Intensive Outpatient Programs						X		X		X						X
	Participation in Project ECHO for MAT			X								X		X			
	Training provided on SUD specific therapies																X
	Community Reinforcement Approach																
	Motivational Interviewing													X	X		X
	Seeking Safety													X	X		
	CRAFT																X
	Assisted Community Treatment								X								X
	Sandoval/Valencia counties pilot								X								X
	Rx Monitoring Program Support																
	Program Management Support through ECHO								X								
Recovery	Recovery Support Groups								X			X		X	X		X
	NA Programs	X		X			X		X		X	X	X	X	X		X
	AA Programs	X		X			X		X		X	X	X	X	X		X
	Youth Peer to Peer Program								X		X			X	X		X
	Suicide prevention groups – eg Recovery Night - targeting stigma								X			X		X	X		
	Promotora /CHW, Navigator, CCSS or Care Coord Services						X	X	X		X	X		X	X		X

Gaps in OUD treatment and recovery in Southern NM

Limitations of telehealth: Although the behavioral health providers we spoke to largely touted advances in telehealth as promising developments in treating OUD, some individuals in recovery expressed dissatisfaction with the potential lack of privacy or a personal touch. One person complained, "Who wants to talk about the most intimate parts like that?" Healthcare providers described some additional limitations of telehealth, including fluctuating bandwidth capabilities, stringent requirements for HIPAA compliance, and the need for specialized training so that providers could replicate the intimacy of an in-person encounter remotely. One administrator of an FQHC also noted that because telehealth is considered an in-home service by Medicaid, s/he was not able to offer telehealth from her/his facility, as FQHCs are prohibited from providing in-home services.

"Missing links" in the continuum of care: While Southern NM communities often had some valuable treatment and recovery resources, they often suffered from gaps along the continuum of care. For example, one community had lost an inpatient residential treatment facility that had moved to the other side of the state. In its absence, one hospital administrator complained, there was no choice but to send struggling individuals "back into a triggering environment." Another potentially missing link noted by an interview participant was a space for safe sobering that would prevent police from treating health facilities "like a drunk tank."

Challenges in referring patients among health systems: Health system administrators noted that referring patients between healthcare providers and facilities could be challenging when electronic medical records and tracking systems were not interoperable.

Administrative burdens for behavioral health providers and facilities: One hospital administrator noted that policies designed to protect patients could sometimes have the effect of complicating providers' ability to help. For example, policies stipulating the need to obtain specific consents to share information between providers and with health insurance companies sometimes made it difficult to providers to deliver and/or bill for services. Some health professionals also highlighted the administrative work associated with billing health insurance as a particular challenge, especially when health insurance providers denied or delayed payment, causing overworked behavioral health providers extra time and money to pursue it.

Variations in coverage and reimbursement rates for behavioral health services: The effect of health insurance coverage on patients' abilities to access behavioral health services varied widely by provider and facility. For example, FQHCs are mandated to provide services and have funding mechanisms in place so that they do not have to turn anyone away. However, at other facilities, some patients are deterred from utilizing behavioral health care by copays associated with Medicare or private health insurance that they cannot afford. One health system administrator particularly emphasized the potential for Medicare enrollees to miss out on vital services as the population of elderly people and individuals with disabilities (covered by Medicare) with SUD grows. In addition, fluctuations in or uncertainties surrounding reimbursement rates for behavioral health services negatively affecting behavioral health providers. For example, one provider noted that Medicare would not pay for multiple same-day services in behavioral health (e.g., a visit with a therapist and a MAT prescriber), a limitation that is especially nonsensical in a rural environment where asking

clients to return over the course of multiple days presents a substantial burden. Several providers complained of lower reimbursement rates for FQHCs compared to private practitioners, while another noted that rates had not been adjusted for inflation.

Shortage of bilingual treatment and recovery services: As in prevention, bilingual services are in short supply. One healthcare provider noted that although s/he and her/his colleagues were able to provide services in Spanish, they had a harder time accommodating a recent influx of Arabic-speaking families to the community.

Lack of education in OUD for first responders: Throughout our interviews and focus groups, participants underscored the point that first responders, such as police officers and EMTs, were often the frontline in encountering individuals with OUD. Yet, despite this commonly acknowledged truth, first responders were often expected to operate with little or no knowledge about how to effectively recognize and treat the symptoms of OUD, nor how to effectively refer individuals for treatment services. In one focus group with first responders, a volunteer firefighter marveled that s/he was often alone in trying to help people with complex needs that s/he was not able to understand. In the same group, an EMT recounted a story about police officers trying to administer Narcan to an individual who had been using methamphetamine and not understanding why it was not effective. A second EMT detailed how s/he would try to talk to individuals who had overdosed about their need for treatment as s/he drove them the emergency room but concluded that s/he never knew if those conversations were effective. These experiences, along with repeated comments about the prevalence of stigmatized attitudes toward OUD and harm reduction among first responders described elsewhere, underscore the urgent need for first responders to receive education and resources to support them in learning about OUD, gaining compassion for individuals with OUD, and referring people with OUD to other services and supports.

Opportunities and resources for OUD treatment and recovery in Southern NM

Effectiveness of MAT: Although stigma toward MAT on the part of individuals with OUD, friends and family members, law enforcement and first responders, and even treatment providers is a common barrier to its use, the effectiveness of MAT reportedly changes many minds as it helps people recover from OUD. One individual commented, “Having to live life and battle [OUD] is really tough. But I don’t have to battle anymore. I can just live my life. [Suboxone] gives you the ability to get your life back.”

Care coordination programs: Where healthcare facilities were able to offer dedicated and comprehensive care coordination to facilitate *referrals* to both healthcare and social services (e.g., health insurance enrollment counseling, food and housing assistance), behavioral health providers celebrated the successes of these programs. These facilities had an office or staff member dedicated exclusively to helping patients navigate complex bureaucracies and access needed resources, taking these tasks off the plates of already overworked providers.

Establishing relationships between behavioral health facilities and court systems: In at least one community, a well-developed relationship between law enforcement and the court system with a

local behavioral health facility helped to smooth the path of people with OUD into treatment services. A health system administrator noted that this relationship was also cost-effective as police were able to send people in need *of* treatment directly to their facility rather than the emergency room. Another administrator relayed a report from the local jail administrator that s/he was seeing fewer "revolving door" inmates. However, interview participants emphasized the need for pre-trial diversion programs in drug courts to try to help people understand their need for help rather than mandating treatment punitively. Overall, nearly all of our interview and focus group participants—including first responders—stressed the need for law enforcement personnel to receive ongoing education and support in best practices for individuals with OUD.

Spread of telehealth capabilities: Despite some of the potential downsides to telehealth, healthcare providers pointed to steady improvements in telehealth as an important part of any long-term solution to OUD in Southern NM.

Possible Partners: With current political climate and funding, there are opportunities for collaboration between the criminal justice system and prevention, harm reduction, treatment and recovery service providers. Project ECHO offers MAT training and support to interested rural providers. In October2019 a multi-agency behavioral health plan was presented to legislative interim committee.

Grants/funding streams: NM received $4.7 million through State Targeted Response (STR) for each of FY 2017 and 2018, and $5.3 million through State Opioid Response (SOR) in FY 2018. In FY 2019, New Mexico received a total of $8 million through SOR.

Promising practices and pathways: STR and SOR funding goals focused on:

- Expansion of MAT trainings focusing on prescribing, treatment, and recovery. Trainings include the DATA 2000 Waiver Training; Safer Opioid Prescribing Trainings; MAT ECHO, which provides weekly education, guidance, support and consultation, including prescribing, psychosocial supports, and community resources;
- NM Children, Youth and Families Dept. provides training on Motivational Interviewing, psychosocial supports, patient placement criteria and the Community Reinforcement Approach. CYFD also provides comprehensive training to all its staff in the Nurtured Heart Approach,
- Trainings to support MAT expansion with Seeking Safety, Historical Trauma and American Society of Addiction Medicine (ASAM) criteria.
- The Certified Peer Support Worker (CPSW) Training has included enhancement of the existing CPSW training to address OUD and MAT and offering trainings statewide through the Office of Peer Engagement and Recovery (OPRE). As of August 2019, there have been 100 trained but we do not know how many of these individuals are from the 16 targeted counties.
- Implementation of the evidence-based Collaborative Hubs model (also known as the Hub & Spoke model), where the ECHO and NMopioidhub.com website help link providers statewide. Regional Hubs include collaborating health and additions professionals who provide MAT, psychosocial interventions and recovery services.
- During the next few years the state plans to expand the Law Enforcement Assisted Diversion (LEAD) program to at least one new southern site and for new tribal sites.

Other: A 2019 Office of Inspector General Report recommended that NM-HSD should also improve access to services by reviewing its access to care standards and by increasing access to transportation, access to broadband, and the use of telehealth. [19]The report also stated HSD should improve the effectiveness of services by increasing adoption of electronic health records, identifying and sharing information about strategies to improve care coordination, expanding initiatives to integrate behavioral and primary healthcare, and sharing information about open-access scheduling and the Treat First Clinical Model.

OUD Workforce in Southern NM

All of NM is a HRSA designated as a behavioral health professional shortage area. In an effort to address the workforce shortages, a report is prepared and presented to the New Mexico Legislature annually regarding the status of the state's licensed health professionals and where they practice. Each year since 2011 data provided to the state's licensing boards are collated and analyzed to inform recommendations for recruiting and retaining providers in the state's rural and underserved areas. The report includes behavioral health workforce, along with primary and oral care professionals. The most recent report was published in October 2019, covering the period of January 1, 2018 through December 31, 2019.[20] The annual NM health care workforce reports from 2016 to the present were reviewed as part of this needs assessment along with other relevant state and federal reports, including community health needs assessments recently completed by community health centers and nonprofit hospitals serving the target area.

The New Mexico Health Care Workforce Committee 2019 Annual Report states that in 2018, there were a total of 473 prescribers, 4,723 independently licensed psychotherapy providers, 3,464 non-independently licensed psychotherapy providers and 771 substance abuse treatment providers practicing in New Mexico. Figure 23 shows how behavioral health provider-to-population ratios compare among New Mexico's 33 counties and the proportions of these providers made up by the four provider types. Eight of the 11 counties with the lowest per capita behavioral health workforce relative to other counties in the state are located in Southern NM.

Looking at independently and non-independently licensed behavioral health care providers is helpful for developing sustainable pathways to full licensure for all clinicians. Of the 16 southern NM counties, six (Hidalgo, Luna, Eddy, Lea, Chaves and De Baca) have especially high proportions of non-independently licensed clinicians, suggesting that non-independently licensed behavioral health clinicians may have difficulty obtaining the necessary supervision to reach independent licensure.

[19] Chiedi, J.A. , Provider Shortages and Limited Availability of Behavioral Health Services in New Mexico's Medicaid Managed Care. U.S. Department of Health and Human Services, Office of the Inspector General. September 2019

[20] Farnbach Pearson AW, Reno JR, New Mexico Health Care Workforce Committee. 2019 Annual Report. Albuquerque NM: University of New Mexico Health Sciences Center, 2019.

Figure 23: Composition of NM behavioral health workforce in 2018

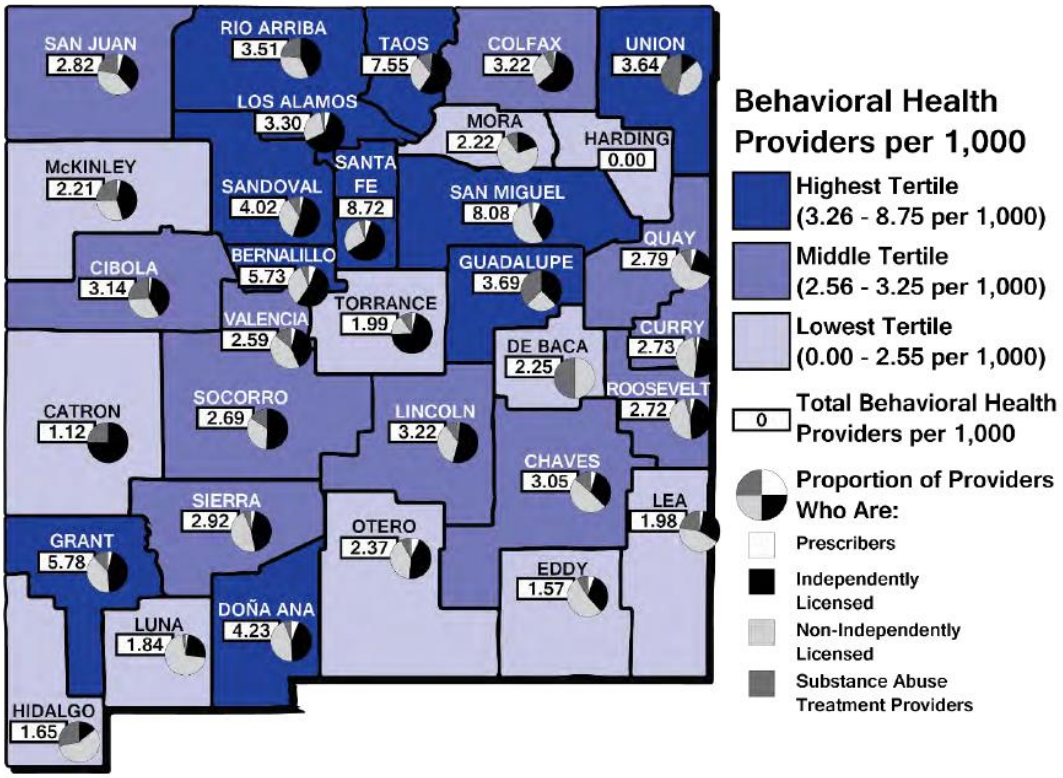


Figure 4.1. White boxes in each county show the total number of behavioral health providers per 1,000 population. County colors indicate whether each county ranks in the top (dark), middle (medium) or bottom (light) third of counties for this measure. Each county's pie chart shows the proportion of prescribers (white), independently-licensed clinicians (black), non-independently licensed clinicians (light gray), or substance use clinicians (dark gray).

Over the past three years there has been very little change in the demographics of the behavioral health workforce; it remains primarily female (statewide SUD providers are 66% female vs. 34% male) and white (statewide SUD providers are about 34% Hispanic or Latino compared to about 48% of the population).[21] As in many states across the nation, NM's behavioral health clinicians are approaching retirement age. Nearly one-third of NM's behavioral health prescribers are at least 65 years of age, making it important to continue to recruit new clinicians.

We were interested in learning where licensed providers are most likely to practice. According to the 2017 NM Health Care Workforce Report, less than 4% of substance use treatment providers surveyed reported that they practice in a Federally Qualified Health Center (FQHC). Less than 2% of all other licensed behavioral health providers were likely to practice in a FQHC. Independent practices, group practices or other locations is where they were most likely to practice.

[21] Farnbach Pearson AW, Reno JR, New Mexico Health Care Workforce Committee. 2019 Annual Report. Albuquerque NM: University of New Mexico Health Sciences Center, 2019.

Of 92 certified MAT providers, only 14 are located in Southern NM (see Figure 24).[22] This needs assessment revealed that access to real-time accurate data on the actual number of MAT certified providers within a region is difficult to obtain due to high turnover and the time lag in uploading data to resource sites such as NMopioidhub.com.

On a positive note, there are currently 89 National Health Service Corps sites in Southern NM that receive both primary and behavioral health providers. To incentivize clinicians to practice in rural areas, the state developed the NM Health Service Corps Stipend. Unfortunately, only six stipends were offered in 2019 and of those only 1 was a behavioral health professional (Nurse Practitioner-Psych)

Figure 24: Number of National Health Service Corp Sites and MAT Providers in Southern NM

	Catron	Chaves	Cibola	De Baca	Eddy	Grant	Hidalgo	Lea	Lincoln	Luna	Otero	Roosevelt	Sierra	Socorro	Torrance	Valencia
National Health Service Corp Site/ # individuals (Primary and BH)	2	6	7	2	6	14	4	11	3	7	8	4	2	5	3	5
# MAT Certified Providers	0	4	1	0	3	2	1	1	0	1	2	0	1	3	1	2

Access to training, internship and supervision opportunities create a pipeline for behavioral health providers from New Mexico, who are most likely to stay and practice in New Mexico. Figure 25 shows the behavioral health training opportunities available throughout the state. These training programs will be explored in more detail in the workforce development report.

Figure 25: Behavioral Health Training Opportunities in Southern New Mexico

Institution	EMS: EMTs & Paramedics	Social Work	Psychology	Community Health Worker / CHR	Alcohol & Substance Abuse Studies (or Counseling)	Prevention Specialist / Community Health Education Specialist	Peer Support Worker
ENMU Main (Portales)	X	X	X				
ENMU Roswell	X			X	X		
ENMU Ruidoso	X		X		X		
NM Institute of Mining & Technology (Socorro)			X				
NM Junior College (Hobbs)	Information unavailable						
NMSU Alamogordo	Information unavailable						
NMSU Carlsbad	X	X					
NMSU Grants	X	X					

[22] Retrieved 11/07/2019 from: https://doseofreality.com/locations/?fwp_category=mat-medication-assisted-treatment

UNM Valencia	X						
WNMU (Silver City)	X	X	X		X		
Dona Ana Community College	X			X			
NM ATODA Prevention Workforce Training System						X	
Central NM Community College (CNM)	X		X	X	X		
Santa Fe Community College	X		X	X	X		
Northern NM College (Española)			X		X		
San Juan College (Farmington)	X		X		X		
UNM Taos	X			X			
UNM Gallup	X				X		
NM Highlands University		X	X				
Office of Peer Recovery & Engagement (OPRE)							X

Gaps in OUD workforce in Southern NM

Persistent challenges in hiring: In some cases, administrators faced such severe difficulties in hiring a qualified workforce that they were unable to offer desperately needed services. For example, administrators at one hospital lamented that a planned and funded 24-hour detox facility remained unopened because nearly 20 necessary therapist and nurse positions remained unfilled after more than four months of hiring. Administrators also underscored the financial challenges of hiring a qualified workforce, noting that they were sometimes compelled to adjust their business model in order to offer salaries and benefits that would attract professionals to their community, especially as the costs of delivering care continued to rise.

Challenges in preventing burnout and fostering work-life balance: Healthcare providers commonly emphasized the persistent specter of burnout that threatened their long-term ability to help patients. Large caseloads and burdensome administrative procedures added to the substantial mental and emotional energy that their work required. Health system administrators also affirmed that caseloads could be "a painful issue" as they juggled the need to meet national productivity standards with the fear of making providers feel overworked and unhappy. Similarly, the need to document and bill for services was a common drag on job satisfaction for behavioral health providers. One health system administrator summed up these challenges as a fundamental disconnect between the "business model" that kept behavioral health facilities running, funded, and meeting standards on the one hand, and on the other, the "reasons that most people become providers," namely: an ethical commitment to helping people.

Administrative burdens associated with licensing and credentialing: Although healthcare providers and administrators underscored the importance of professionalization for behavioral healthcare providers, they noted that requirements (e.g., those associated with receiving waivers to

prescribe MAT) could also be burdensome and complex, sometimes slowing hiring processes in places where providers were badly needed.

Rurality-based barriers to effective and ongoing training: Multiple interview participants noted a need for ongoing training in rigorous, evidence-based practices for behavioral healthcare providers. However, due to the rurality and small size of Southern NM communities, health system administrators reported challenges finding qualified trainers who were willing to come to them or paying for staff to take time away from patients to travel to trainings elsewhere. One individual who was responsible for a small staff of behavioral health providers related that s/he and another staff member sometimes attended trainings alone and then attempted to re-create them for the staff back home. Moreover, another administrator emphasized the questionable effectiveness of one-time "spray and pray" trainings in fostering long-term improvements and voiced the need for ongoing coaching, monitoring, and train-the-trainer initiatives. This administrator also suggested that training should include discussions of ineffective treatments and practices in order to ensure that they were no longer being utilized.

Lack of racial and cultural representation in behavioral health workforce: In describing disparities in American Indian and Hispanic providers, one health administrator noted, "That's the problem with the behavioral health workforce in NM is that it doesn't look like NM."

Limitations in clinical supervision: Healthcare providers and administrators emphasized the importance of clinical supervision to ensure that providers were confident and effective, yet provider shortages limited the time that could be spent on supervision. Moreover, some seasoned providers suggested that new providers often experienced supervision as scary or punitive, rather than a supportive learning experience to improve their skills. A health system administrator lamented the lack of in vivo clinical supervision that would allow providers to receive immediate feedback, correction, and support from a supervisor in real time, a common practice in many other fields. This individual commented that, "we should at least bring behavioral health training up to the standards of cosmetology."

Opportunities and resources for OUD workforce in Southern NM

Local residency programs to create a behavioral health pipeline: Hospital and local college administrators noted the success of residency programs in creating a pipeline for other kinds of health professionals who were likely to come from local communities and/or be motivated to stay and serve the community after their residency was complete.

Policies and procedures to ease administrative burdens: Health system administrators noted that, rather than assuming that documentation and billing procedures are self-evident, providers need explicit training in how to complete them effectively. In one facility, administrators had success incorporating documentation and billing into clinical supervision for new providers. Moreover, building in time for providers to dedicate exclusively to administrative work not only helps providers get everything done during normal work hours (rather than on nights and weekends) in a timely fashion, it also improves patient satisfaction as many patients dislike having a provider who "is always

on the computer" as they try to document visits as they occur. Such practices support providers in incorporating administrative tasks into their daily work so that they feel less like an additional burden.

Policies and procedures to prevent burnout: Health system administrators described efforts to help providers maintain a healthy work-life balance, including offering holiday pay and making sure that providers took enough days off.

Rallying of cross-sector partners around workforce shortages: As NM's behavioral workforce shortage has become increasingly clear in recent years, multiple state organizations and government agencies have identified workforce development as an urgent need. In conversations with consortium and CAG members, as well as with healthcare administrators and providers, energy appears to be cohering around workforce-focused strategies, including developing new pipelines for providers, partnering with training institutions and potential employers, and expanding the opportunities for community health and peer support workers.

Experience and motivation of individuals in recovery to support others struggling with OUD: In our conversations with individuals in recovery, numerous participants voiced a passion to help others who were struggling with OUD. One individual described her/his practice of taking a backpack full of Narcan to neighborhoods where s/he knew people were likely to overdose, looking for people to help. Another returned to the room where we were packing up our focus group materials to tell us how s/he had just gotten a GED ten years after s/he dropped out of high school in order to pursue a LADAC certification. At the same time, healthcare providers and administrators commonly noted the importance of individuals like these in growing a workforce of knowledgeable, motivated, and community-connected peer supporters and providers.

Opportunities and resources for OUD Workforce in Southern NM

Possible Partners: Multiple state agencies, educational institutions and nonprofit organizations have the desire and resources to address the SUD/OUD workforce in Southern NM. Representatives from the NM DOH, HSD/BHSD, Workforce Solutions, Eastern NM University –Roswell, Western NM University and the University of NM are all members of the RCORP Consortium and will be key partners to develop strategies appropriate for workforce development in rural NM. The NM Association of Behavioral Health Professionals, also a Consortium member, is an association of behavioral health employers and an important resource for addressing workforce readiness, payment barriers, and other systemic issues related to workforce development.

Grants/funding streams: Both BHSD at NM-HSD and Workforce Solutions recently received new funding to focus on behavioral health workforce development. At the time of this writing, we are gathering information about the timeframe, goals, scope and funding amount for these projects.

Promising practices: Online classes, remote learning (e.g. Project ECHO) and remote supervision are promising practices to increase the behavioral health workforce in rural Southern NM. Training and employing paraprofessionals, such as peer support specialists, care coordinators,

community health workers, recovery support workers and certified prevention specialists are valued in rural communities. Clinical care is supported by services provided by these non-licensed professionals, such as: locating treatment and recovery services; navigating the healthcare system; providing insurance enrollment or information about sliding fee or medication assistance programs; locating or arranging for transportation; and linking individuals with SUD and their families to support services such as food, housing, education, childcare, etc.

Other: In October 2019, Cabinet Secretaries from New Mexico's HSD, DOH, CYFD and Aging and Long Term Services presented a proposal to the Legislative Health and Human Services Committee to rebuild the behavioral health provider network, with a focus on providers who serve Medicaid Managed Care enrollees.[23] The state agencies recommended the following behavioral health provider enhancement strategies related to workforce development:

- Simplify credentialing
- Expand and invest in telehealth models (Project ECHO, UNM Access, other ACCESS programs)
- Loan forgiveness expansion
- Medicaid fee schedule reform
- Provider input and active involvement will be critical to success at every level

E. Priority Setting for OUD in Southern NM

A myriad of factors contribute to OUD prevention, treatment, recovery and the related workforce. The needs assessment results demonstrate the complexity of OUD and the numerous and varied current and potential strategies to address it.

Our priority setting process to inform the strategic plan is in development. It may consist of some or all of the following steps with engagement from the Consortium and CAG members. First, identify values and principles to guide the decision making process. Values/principles may include items like importance, urgency, reach, collaboration, cultural relevancy, cost, etc. Less than 10 criteria will be identified. Second, identify one or two key issue statements to address. For example, the issue statement(s) may focus on topics such as cultural relevance, access, systems, policy, workforce, etc. Breaking down the complexity of OUD into more familiar issue statements will allow goals and strategies to be more easily identified. The issue statement(s) will also help to clarify the impact or outcomes of proposed strategies. Third, based on the need assessment results and primary issue statement(s), the stakeholders will identify potential strategies or solutions that are most appropriate for rural Southern New Mexicans. Fourth, using the values identified in step one, the consortium and CAG members will identify two additional criteria that can be qualified in a dichotomous way, such as effort and impact, or resources and cultural appropriateness. Finally, using a quadrant analysis approach, consortium and CAG members will determine which quadrant each solution or strategy would be placed using the two criteria and being qualified as high versus low along each axis.

[23] Scrase, D.R., Medrano, A., Pittenger, B., Behavioral Health Improving Access to Services In New Mexico. Presented to New Mexico Legislative Health and Human Services Committee October 10, 2019

The prioritization process described above will be facilitated by the CHI and PIRE team during a joint meeting with consortium and CAG members scheduled for December 18, 2019. If feasible, we will survey participants to get as much information ahead of time in order to complete all steps in the proposed process.

F. Discussion/Conclusion

The quantitative and qualitative findings in this needs assessment poignantly attest to the severity and prevalence of OUD in the rural counties of Southern NM. Although statewide improvements in opioid prescribing practices and the spread of harm reduction strategies do appear to be having an effect on NM's high rates of overdose deaths, the remote and underserved communities of Southern NM are slow to benefit from these changes despite the significant social, economic, and physical and mental health vulnerabilities that put them at increased risk for OUD.

Our findings also underscore the substantial multilevel barriers that stand in the way of effective prevention and treatment of OUD in Southern NM. These include challenges associated with rurality, including the difficulties of traveling long distances for services, unevenness of economic opportunity, and lack of access to a full complement of healthcare and social services. First responders who are tasked with acting as the frontline in recognizing and intervening on OUD are woefully underprepared and under resourced to do so. In addition, we document a number of limitations affecting the behavioral health workforce in Southern NM, such as chronic provider shortages, pervasive administrative burdens, and system-level shortcomings, including gaps in funding and missing links in the continuum of care.

However, we also found a number of promising trends and opportunities that point to improvements in the behavioral health system in Southern NM. Despite their sometimes-slow spread, evidence-based strategies for monitoring the prescription of opioids, reducing mortalities associated with opioid use, and treating OUD are making inroads in Southern NM. Moreover, although stigma toward such practices persists in many pockets—such as among first responders and some healthcare providers, behavioral health stakeholders in Southern NM largely support and champion these strategies, especially as they witness their effectiveness among their own clients and communities. Indeed, behavioral health providers in Southern NM remain deeply committed to making improvements in their services they provide. Finally, recognition of the OUD problem—including the behavioral health workforce shortage—at the state level is a promising indicator of future support.

At the same time, we also emphasize the importance of recognizing and leveraging the existing strengths of rural communities in Southern NM in efforts to address OUD. These strengths include the social and cultural diversity of Southern NM, as well as the prevalence of intergenerational support, local investment in the community, and the motivation of individuals in recovery to support their peers.

As these findings indicate, there is an urgent need to streamline and "connect the dots" between existing efforts and resources, as well as to spread promising strategies equitably among even the most remote communities of Southern NM. We look forward to further considering these challenges as we move forward with our strategic planning process.

Appendix 1: Qualitative interview guides

HRSA RCORP-SNM
Administrator Interview Guide

Thank you so much for taking part in today's interview about preventing and treating opioid use disorder in Southern New Mexico. The purpose of this interview is to help us understand the range of needs and challenges related to preventing and treating opioid use disorder in 16 Southern New Mexico counties, and to identify opportunities and resources that can be drawn on in efforts to improve services for New Mexicans in those counties. Do you have any questions before we begin? Okay, let's get started.

1. Can you tell me about your current work roles and responsibilities?

    a. In general, how much of your work is focused on clients with opioid use disorder? What kind of assistance do you provide to clients with opioid use disorder?

    b. In general, how much of your work is focused on prevention of opioid misuse?

    c. In general, how much of your work entails training or supporting others who are or will be working in this field?

2. In your experience, what needs and concerns related to opioid use are people most likely to have?

    a. Which of these questions and concerns do you feel most comfortable addressing? Why?

    b. Which of these questions and concerns do you feel least comfortable addressing? Why?

3. In general, what makes it easy or hard to work with individuals with opioid use disorder? Why do you feel this way?

    a. In general, what makes it easy or hard to prevent opioid use disorder? Why do you feel this way?

Now I'd like to ask you about a number of different factors **in your community** that might affect how easy or hard it is for people to get the services they need related to opioid use. You may not be able to comment on all of these factors, and that is okay.

4. How do the following factors affect the ability of people in your community to get opioid-related services? *[Skip or probe for items as appropriate]*

    a. Geographic issues, such as rurality, transportation, or Internet access?

    b. Proximity to the U.S.-Mexico border region?

    c. Stigma or fear related to opioid use? Stigma or fear related to treatment, such as medication-assisted treatment [MAT]?

    d. Availability of housing?

e. Availability of social services, such as housing assistance, domestic violence shelters, food assistance, etc.?

f. Employment issues, such as self-disclosure policies, availability of vocational rehabilitation, etc.?

g. Law enforcement and/or first responders?

h. Language or cultural differences?

i. Availability of qualified workforce in your agency and community?

5. In your community, what other challenges make it difficult for clients with opioid use disorder to get treatment services? Harm reduction? Recovery services? Social services and social/community support? *[Probe for topics not covered in #4]*

    a. In your community, what other challenges make it difficult to **prevent** opioid use disorder?

6. In your community, what opportunities do you see to prevent opioid use disorder? To improve treatment, harm reduction, or recovery services?

7. What makes it easy or hard for health and mental health providers to refer clients with opioid use disorder to other services in the community along the continuum of care, such as primary care or recovery services?

Now I'd like to ask you about a few different factors might affect how easy or hard it is for **healthcare providers** to serve clients with opioid use disorder. You may not be able to comment on all of these factors, and that is okay.

8. How do the following factors affect the ability of healthcare providers to deliver opioid-related services?

    a. How caseloads are managed?

    b. Policies and procedures related to documenting and billing for services?

    c. Whether or not clients are covered by health insurance? State or federal policies related to health insurance? Health insurance company policies?

    d. Policies and procedures related to clinical supervision and/or licensing?

    e. Support for evidence-based strategies, like medication-assisted treatment?

9. In general, what kind of training do **primary care providers** have to work with clients with opioid use disorder? From your perspective, how adequate is this training?

a. What kind of training do **mental and behavioral health** providers have to work with clients with opioid use disorder? From your perspective, how adequate is this training?

b. What kind of training do **law enforcement and first responders** have to work with clients with opioid use disorder? From your perspective, how adequate is this training?

c. What kind of training do **preventionists and harm reductionists** have to work with clients with opioid use disorder? From your perspective, how adequate is this training?

d. What kind of training is needed to improve services in relation to opioid use disorder?

10. In your workplace, how are you and your coworkers supported in your efforts to improve services related to opioid use disorder?

    a. How supportive are leaders at your workplace of new strategies and practices to improve opioid use disorder-related services?

    b. What factors affect whether or not such strategies are adopted in your workplace?

11. What kinds of strategies could be adopted to improve care for people in your community with opioid use disorder?

    a. What kinds of strategies could be adopted to make people with opioid use disorder more comfortable asking for help? What about their friends and family?

    b. What kinds of strategies could be adopted to improve referrals for those with opioid use disorder to get the other services across the spectrum of care?

    c. What kinds of strategies could be adopted to improve support for friends and family members of those living with OUD?

    d. What factors affect whether or not such strategies are adopted?

12. How easy or hard is it to recruit and retain new providers in this community? Why do you think this is?

    a. How easy or hard is it to recruit and retain providers <u>from</u> the local community? Why do you think this is? (Probe: How easy or hard is it to recruit and retain non-English speaking providers?)

    b. What efforts have you or other leaders made to recruit new providers?

        i. How effective are these efforts? Why or why not?

c. What state or federal programs have you or other leaders used to recruit new providers (e.g., local pipeline programs, rural residencies)?

    i. How effective are these efforts? Why or why not?

d. What state or federal programs have you or other leaders used to fund workforce development efforts (e.g., Medicaid reimbursement)?

    i. How effective are these efforts? Why or why not?

e. What kinds of new strategies could be adopted to improve recruitment of new providers? In the region? The state?

    i. What do you need to implement these strategies?

13. What kinds of public health, state or federal policy changes could improve the services and supports that are provided address opioid related issues?

14. Is there anything else you would like to share about your work or about the needs of clients with opioid use disorder in this community?

HRSA RCORP-SNM
Service User/Family Focus Group Guide

Thank you all so much for taking part in today's focus group about preventing and treating opioid use disorder in Southern New Mexico. The purpose of this focus group is to help us understand the range of needs and challenges related to preventing and treating opioid use disorder in 16 Southern New Mexico counties, and to identify opportunities and resources that can be drawn on in efforts to improve services for New Mexicans living in those counties.

Before we begin, I'd like to share some guidelines for this focus group:

- We would like everyone to participate. We really want to hear what everyone thinks, so if it seems like someone has not said anything, we may ask them what they think about a topic. If you prefer not to answer a question, you can say so and we will move on to someone else.
- Please do not interrupt others who are speaking. I apologize in advance if I seem to cut you off.
- All ideas are equally valid, and each person's views should be respected. There are no right or wrong answers.
- Please respect the confidentiality of what is said here today. While it is ok to talk about this focus group in general, please avoid telling others about what specific people say today.
- We will not ask you any questions about your personal information or health today. Please avoid revealing any personal information that you would not want others to know.
- We will take notes so that we can remember what we talked about today, but we will not write down the name of anyone here. Please try not to use names during our discussion. If a name gets recorded, we'll make sure to erase it from the transcript.

Does anyone have any questions before we begin? Okay, let's get started.

1. In this community, what makes it easy or hard to prevent opioid misuse?

    a. What makes it easy or hard for people to get treatment for opioid use disorder in this community?

    b. What makes it easy or hard for people to get Narcan or Naloxone and/or clean needles in this community? How about training to use Naloxone or Narcan?

    c. What makes it easy or hard for people to get recovery services in this community?

    d. In this community, what makes it easy or hard for people with opioid use disorder to connect with social support (meaning support from friends, family, and other non-professionals)?

    e. In this community, what opportunities do you see to prevent and treat opioid misuse? (Probe for different modalities including MAT)

2. What factors do you think influence a person's decision to use opioids vs. other kinds of pain treatment (e.g., over-the-counter medication)?

    a. How does health insurance coverage influence a person's decision to use opioids vs. other kinds of pain treatment (e.g., over-the-counter medication)?

3. What messages have you heard about the risks of opioid use and misuse? Where do these messages come from? How effective do you think these messages are in preventing opioid misuse?

    a. Do doctors or pharmacy staff talk to patients about the risks of opioid use and misuse? How effective are these conversations?

    b. What suggestions do you have for how doctors or pharmacy staff could do a better job talking to patients about the risks of opioid use and misuse?

4. How helpful are healthcare providers, like general practice doctors and nurses, in supporting people with opioid use disorder?

    a. What do they do well? What do they not do well?

    b. What could they do better?

5. How helpful are mental health or behavioral health providers, like psychologists or recovery counselors, in supporting people with opioid use disorder?

    a. What do they do well? What do they not do well?

b. What could they do better?

6. How helpful are law enforcement personnel in supporting people with opioid use disorder?

    a. What do they do well? What do they not do well?

    b. What could they do better?

    c. How about first responders, like EMTs?

7. What do people who are using or misusing opioids need to be better supported in this community?

    a. What kinds of professionals (e.g., doctors, recovery counselors) are needed to support people who are using or misusing opioids in this community?

8. Is there anything else that you would like to share about preventing and/or treating opioid misuse in this community?

HRSA RCORP-SNM
Provider Focus Group Guide

Thank you all so much for taking part in today's focus group about preventing and treating opioid use disorder in Southern New Mexico. The purpose of this focus group is to help us understand the range of needs and challenges related to preventing and treating opioid use disorder in 16 Southern New Mexico counties, and to identify opportunities and resources that can be drawn on in efforts to improve services for New Mexicans living in those counties.

Before we begin, I'd like to share some guidelines for this focus group:

- We would like everyone to participate. We really want to hear what everyone thinks, so if it seems like someone has not said anything, we may ask them what they think about a topic. If you prefer not to answer a question, you can say so and we will move on to someone else.
- Please do not interrupt others who may be speaking. I apologize in advance if I seem to cut you off.
- All ideas are equally valid, and each person's views should be respected. There are no right or wrong answers.
- Please respect the confidentiality of what is said here today. While it is ok to talk about this focus group in general, please avoid telling others about what specific people say today.
- We will not ask you any questions about your personal information or health today. Please avoid revealing any personal information that you would not want others to know.
- We will take notes so that we can remember what we talked about today, but we will not write down the name of anyone here. Please try not to use names during our discussion. If a name gets recorded, we'll make sure to erase it from the transcript.

Does anyone have any questions before we begin? Okay, let's get started.

15. Can we go around and each tell me a little bit about your current work roles and responsibilities?

a. In general, how much of your work focuses on opioid use disorder? What kind of assistance do you provide to clients with opioid use disorder?

16. What needs and concerns related to opioid use are your clients or people in your community most likely to have?

    a. Which of these questions and concerns do you feel most comfortable addressing? Why?

    b. Which of these questions and concerns do you feel least comfortable addressing? Why?

17. In general, what makes it easy or hard to work in the prevention of opioid use disorder or with those affected by it? Why do you feel this way?

Now I'd like to ask you about a number of different factors **in your community** that might affect how easy or hard it is for people to get the services they need related to opioid use. You may not be able to comment on all of these factors, and that is okay.

18. How do the following factors affect the ability of people in your community to get opioid-related services? *[Skip or probe for items as appropriate]*

    a. Geographic issues, such as rurality, transportation, or Internet access?

    b. Proximity to the U.S.-Mexico border region?

    c. Stigma or fear related to opioid use? Stigma or fear related to treatment, such as medication-assisted treatment [MAT]?

    d. Availability of housing?

    e. Availability of social services, such as housing assistance, domestic violence shelters, food assistance, etc.?

    f. Employment issues, such as self-disclosure policies, availability of vocational rehabilitation, etc.?

    g. Law enforcement and/or first responders?

    h. Language or cultural differences?

    i. Availability of qualified workforce in your agency and community?

19. In your community, what other challenges make it difficult for those with opioid use disorder to get treatment services? Harm reduction? Recovery services? Social services and social/community support? *[Probe for topics not covered in #4]*

    a. In your community, what other challenges make it difficult to **prevent** opioid use disorder?

20. In your community, what **opportunities** do you see to prevent opioid use disorder? To improve treatment, harm reduction, or recovery services?

21. How confident do you feel communicating with clients, their friends and family members, or the community about the following? *[Skip or probe for items as appropriate]*

    a. Physical health issues related to opioid misuse disorder?

    b. Harm reduction (e.g., Naloxone/Narcan use)?

    c. Medication-assisted treatment?

    d. Recovery services for opioid misuse disorder?

    e. How comfortable do you feel communicating with different kinds of providers about these issues?

22. In your work, how often do you refer clients with opioid use disorder to other services in the community along the continuum of care, such as primary care or recovery services?

    a. How often do you receive referrals from other providers along the continuum of care?

Now I'd like to ask you about a few different factors **in your work** that might affect how easy or hard it is for you to serve clients with opioid use disorder. You may not be able to comment on all of these factors, and that is okay.

23. How do the following factors affect your ability to provide opioid-related services?

    a. How caseloads are managed?

    b. Policies and procedures related to documenting and billing for services?

    c. Whether or not clients are covered by health insurance? State or federal policies related to health insurance? Health insurance company policies?

    d. Policies and procedures related to clinical supervision and/or licensing?

    e. Support for evidence-based strategies, like medication-assisted treatment?

    f. Community awareness, knowledge and attitudes toward opioid use?

24. What kind of training have you had in relation to opioid use disorder?

    a. In what ways was this training helpful?

    b. In what ways was it not so helpful?

c. What kind of training do you and your colleagues need to feel confident working with clients with opioid use disorder?

25. In your workplace, how are you and your coworkers supported in your efforts to improve services for clients with opioid use disorder?

    c. How supportive are leaders at your workplace of new strategies and practices to improve services for clients with opioid use disorder?

26. What kinds of strategies could be adopted to improve care for clients with opioid use disorder? In your workplace specifically?

    e. What kinds of strategies could be adopted to make people with opioid use disorder more comfortable asking for help? In your workplace specifically?

    f. What kinds of strategies could be adopted to improve referrals for clients with opioid use disorder to get the other services across the spectrum of care? In your workplace specifically?

    a. How easy or hard would it be to implement these strategies? Why?

27. How easy or hard is it to recruit and retain new providers in your community and workplace? Why do you think this is?

    a. How easy or hard is it to recruit and retain providers from the local community? Why do you think this is? (Probe: How easy or hard is it to recruit and retain non-English speaking providers?)

    b. What kinds of new strategies could be adopted in your workplace to improve recruitment of new providers? In the region? The state?

28. What kinds of public health, state or federal policy changes could improve the services and supports you provide around the use and misuse opioids?

29. What do you need to be better supported as a provider…

    a. …in your workplace?

    b. …in your community?

    c. …in the state?

30. Is there anything else you would like to share about your work as a provider or about the needs of clients with opioid use disorder in this community?

Appendix 2: Qualitative Interview/Focus Group Summary

PREPARED BY:
SITE/REGION:
PARTICIPANT ROLE:

NEEDS/CONCERNS OF PEOPLE WITH OUD

CHALLENGES/BARRIERS TO PREVENTING/TREATING OUD

FACILITATORS/OPPORTUNITIES TO PREVENT/TREAT OUD

GEOGRAPHIC/LANGUAGE/CULTURAL ISSUES

STIGMA

HOUSING/SOCIAL SERVICES/EMPLOYMENT

LAW ENFORCEMENT

WORKFORCE (INCLUDING TRAINING, RECRUITMENT)

PREVENTION

HARM REDUCTION

MAT

RECOVERY

REFERRAL/NETWORKING WITH OTHER SECTORS/PROVIDERS

WORKPLACE FACTORS (CASELOADS, BILLING, ETC.)

FACILITATORS/BARRERS TO IMPLEMENTATION OF NEW STRATEGIES

RECOMMENDATIONS FOR NEW PRACTICES/STRATEGIES/POLICIES

OTHER OBSERVATIONS & IMPORTANT QUOTATIONS

Appendix 1: Qualitative Interview/Focus Group Summary

PREPARED BY:
SITE/REGION:
PARTICIPANT ROLE:

NEEDS/CONCERNS OF PEOPLE WITH OUD

CHALLENGES/BARRIERS TO PREVENTING/TREATING OUD

FACILITATORS/OPPORTUNITIES TO PREVENT/TREAT OUD

GEOGRAPHIC/LANGUAGE/CULTURAL ISSUES

STIGMA

HOUSING/SOCIAL SERVICES/EMPLOYMENT

LAW ENFORCEMENT

WORKFORCE (INCLUDING TRAINING, RECRUITMENT)

PREVENTION

HARM REDUCTION

MAT

RECOVERY

REFERRAL/NETWORKING WITH OTHER SECTORS/PROVIDERS

WORKPLACE FACTORS (CASELOADS, BILLING, ETC.)

FACILITATORS/BARRERS TO IMPLEMENTATION OF NEW STRATEGIES

RECOMMENDATIONS FOR NEW PRACTICES/STRATEGIES/POLICIES

OTHER OBSERVATIONS & IMPORTANT QUOTATIONS