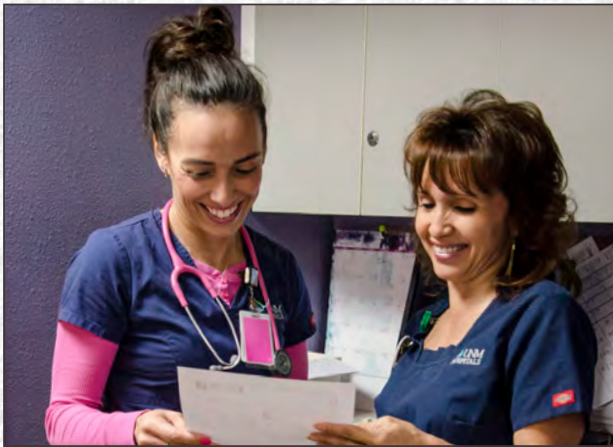


New Mexico Health Care Workforce Committee

2017 Annual Report



OCTOBER 1, 2017

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New Mexico Health Care Workforce Committee 2017 Annual Report

October 1, 2017

This publication was developed as a white paper to report on the status of the New Mexico health care workforce during the period 1 January 2016 – 31 December 2016. For the purposes of attribution and authorship, the New Mexico Health Care Workforce Committee suggests the following citation:

Farnbach Pearson AW, Reno JR, New Mexico Health Care Workforce Committee. 2017 Annual Report. Albuquerque NM: University of New Mexico Health Sciences Center, 2017.

From the Chair of the New Mexico Health Care Workforce Committee

The New Mexico Health Care Workforce Committee conducts an annual study of the supply and distribution of the state's health care providers in order to provide its report to the Legislature by 1 October.

New Mexico is a national leader in its ability to identify and offer in-depth analysis of provider shortages. Throughout the year, staff members collate and analyze data gathered by the health professions licensing boards, which serves as the basis for the Committee's recommendations for improving the recruitment and retention of providers in New Mexico's rural and underserved areas.

This year's report for the first time includes data from certified nurse midwives, licensed midwives and emergency medical technicians. It also provides an updated analysis of the registered nurse workforce, the first since the 2013 report.

Most of the analysis and writing for this year's report was performed by Amy W. Farnbach Pearson, PhD, from the Office of Research at the University of New Mexico Health Sciences Center. Jessica Reno, MPH, an epidemiologist in the UNM Department of Psychiatry & Behavioral Sciences, conducted the behavioral health analysis. We all owe them a debt of gratitude.

As in the past, we offer recommendations for building the provider workforce. While it might not be possible to act on all of these recommendations, given the state's funding limitations, we believe they lay out a roadmap for future initiatives.

We hope this study will inform and help guide policymakers and legislators as they work to meet the ongoing challenge of ensuring high-quality health care for all New Mexicans.

Sincerely,

A handwritten signature in black ink, appearing to read 'R. Larson', with a large, sweeping flourish at the end.

Richard S. Larson, MD, PhD
Chair, New Mexico Health Care Workforce Committee
Executive Vice Chancellor, UNM Health Sciences Center

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Summary of the 2017 Recommendations of the New Mexico Health Care Workforce Committee

2017 Recommendations for All Health Professions

For detailed descriptions of these recommendations, please see Section II.G on page 73.

- Rec. 2017.1.* Identify funding for efforts to support the New Mexico Nursing Education Consortium (NMNEC).
- Rec. 2017.2.* Continue funding for expanded primary and secondary care residencies in New Mexico.
- Rec. 2017.3.* Support further exploration of Medicaid as an avenue for expanding residencies in New Mexico.
- Rec. 2017.4.* Position the Higher Education Department to take full advantage of the next opportunity to reinstate the U.S. Department of Health and Human Services matching grant to support New Mexico's state loan repayment program.
- Rec. 2017.5.* Increase funding for state loan-for-service and loan repayment programs, and consider restructuring them to target the professions most needed in rural and underserved areas, rather than prioritizing those with higher debt.
- Rec. 2017.6.* Request that the Department of Health add pharmacists, social workers and counselors to the health care professions eligible for New Mexico's Rural Healthcare Practitioner Tax Credit program.
- Rec. 2017.7.* Remedy the pharmacists' survey.
- Rec. 2017.8.* Provide funding for the New Mexico Health Care Workforce Committee.

2017 Behavioral Health Recommendations

For detailed descriptions of these recommendations, please see Section III.D on page 93.

- Rec. 2017.9.* Require that licensed behavioral health professionals receive three hours of continuing education credits each licensure cycle in the treatment of substance use disorders
- Rec. 2017.10.* Develop reimbursement mechanisms through Medicaid for services delivered by behavioral health interns in community settings
- Rec. 2017.11.* Create a state Behavioral Health Workforce Center of Excellence
- Rec. 2017.12.* Expedite direct services via telehealth by participating in interstate licensing compacts when available

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Section I

Introduction

I.A. Background

New Mexico is a national leader in health workforce data collection, analysis and planning. Beginning with passage of the New Mexico Health Care Work Force Data Collection, Analysis and Policy Act of 2011, the New Mexico Legislature established mandatory practices for collecting a core essential data set across all health care licensure boards at the time of license issue and/or renewal, and tasked a broad stakeholder committee – the New Mexico Health Care Workforce Committee – with analyzing data and making recommendations.¹

In 2012, the Legislature amended the statute to designate the University of New Mexico Health Sciences Center as the steward for data storage and committee governance, providing a centralized infrastructure and opportunity to leverage the unique resources of an academic health center to develop a statewide planning effort. This report is the fifth annual report from the committee, and the information collected to date through the Legislature’s enactment of health workforce data collection forms both a robust time series, allowing analyses of changes in our state’s health professions, and an expanding roster of professions analyzed.

In addition to the annual report, the New Mexico Health Care Workforce Committee conducts research on a range of narrower topics of interest to the Committee and to the nationwide health workforce research community. This research is disseminated through research publications and conference presentations. This year, New Mexico health care workforce data formed the basis of a conference presentation on the general pediatrics workforce as a subset of the primary care physician workforce and a conference poster on the state’s obstetrics and gynecology physicians.^{2,3} Such research offers deeper insights into the state’s health care workforce needs, as well as increasing awareness of New Mexico as a national leader in this area of research. The results of these studies are included in the discussions of the relevant sectors of the New Mexico health care workforce in Section II.

Each year, we gain access to an expanded data set as more professionals come up for license renewal, and better refine our data collection and analysis methods. In 2017, the Committee is pleased to include: new analysis of Certified Nurse-Midwives (Section II.B.2), Licensed Midwives (Section II.B.3), and Emergency Medical Technicians (Section II.D.4); additional detail on Primary Care Physicians (Section II.A.1) and Obstetrics and Gynecology Physicians (Section II.B.1); and an update of 2016’s in-depth analysis of the state’s behavioral health workforce (Section III). As the data increase each year in both breadth and time-depth, the committee will be able to more broadly examine health care professional distribution and trends in recruitment and retention, as well as plans for future need and changes in the health care system.

I.B. Methodology

This year’s report is the result of six full years of data collection and committee activities. Surveys are required at license renewal for all health care professionals licensed through the state, including medical, dental, nursing, behavioral and allied health professions. The surveys, administered by each profession’s licensing board, may include questions tailored to each profession and must include questions on

demographics, practice status, education and training, practice activities, hours and weeks worked, acceptance of Medicare/Medicaid, near-future practice plans and the effects of professional liability insurance on planned practice change.

This year's report includes estimates of the number of professionals practicing in New Mexico during any part of calendar year 2016 in the following professions:

1. **Primary Care Physicians:** Includes all medical doctors (MDs) and doctors of osteopathy (DOs) who specialize in family practice, family medicine, general practice, general pediatrics or general internal medicine.
2. **Certified Nurse Practitioners (CNPs) and Clinical Nurse Specialists (CNSs):** Includes CNPs and CNSs in the practice areas of community/public health, geriatrics, medical/surgical, obstetrics/gynecology, pediatric/child maternal, special care units and other. Certified registered nurse anesthetists (CRNAs) and certified nurse midwives (CNMs) who are not also CNPs are not included in this count.
3. **Physician Assistants (PAs):** Includes all providers licensed as physician assistants by the Board of Medicine or Board of Osteopathy.
4. **Obstetrics and Gynecology Physicians (OB-GYNs):** Includes all MDs and DOs who specialize in obstetrics and/or gynecology.
5. **Certified Nurse Midwives (CNMs):** Includes all individuals licensed as CNMs by the Department of Health, whether CNM only or CNM and CNP.
6. **Licensed Midwives (LMs):** Includes all individuals licensed as LMs by the Department of Health.
7. **General Surgeons:** Includes all MDs and DOs who specialize in general surgery.
8. **Psychiatrists:** Includes all MDs and DOs who list psychiatry as their primary specialty.
9. **Dentists:** Includes all licensed dentists.
10. **Pharmacists:** Includes all licensed registered pharmacists.
11. **Emergency Medical Technicians (EMTs):** Includes all individuals licensed as EMT-Basic, EMT-Intermediate or EMT-Paramedic.

I.B.1. Practitioner Estimates

Estimates of the number of practitioners working in each county were generated by linking licensure data and license renewal survey responses. This combined analysis remedies many of the limitations of relying on either type of data alone in order to provide a more accurate and complete understanding of New Mexico's health care workforce.

Licensure data alone do not allow accurate estimates of state- and county-level practice locations. Practitioners may maintain licensure in more than one state, and may register their license at residential or

mailing addresses other than their practice locations. For example, of the 9,457 physicians with active New Mexico licenses, only 5,438 (57.5 percent) practice in New Mexico, according to their self-reported practice addresses provided in response to the license renewal survey (Table 1.1).

Table 1.1. Number of Health Professionals with New Mexico Licenses Practicing in the State, 2016

Profession	Percent Practicing in NM, 2015	Total Licensed in NM	Estimated Total Practicing in NM	Percent Practicing in NM, 2016
All MDs/DOs	57.2%	9,457	5,438	57.5%
Primary Care Physicians	64.3%	3,206	2,076	64.8%
CNPs/CNSs	64.8%	2,017	1,379	68.4%
Physician Assistants	74.7%	986	746	75.7%
OB-GYN Physicians	65.0%	421	274	65.1%
CNMs	ND ^a	184	156	84.8%
Licensed Midwives	ND ^a	80	48	60.0%
General Surgeons	63.2%	314	188	59.9%
Psychiatrists	59.8%	571	332	58.1%
Dentists	72.7%	1,566	1,171	74.8%
Pharmacists	59.3%	3,204	2,013	62.8%
RNs	NA ^b	26,920	17,219	64.0%
EMTs	ND ^a	6,340	6,101	96.2%

^a ND indicates survey data were not yet available.

^b NA indicates this profession was not analyzed in the year indicated.

Furthermore, estimating practitioner counts using licensure data alone may result in systematic double-counting based on multiple licensure. A practitioner with more than one license, such as a CNP who is also an RN, is only counted once at his or her highest level of licensure. CNPs who are also CNMs are an exception; as these levels of licensure are considered equal, these individuals are counted as both CNPs and CNMs.

Double-counting is also a concern with respect to primary care physician specialties, but is corrected by the distinction between specialty and subspecialty in the physician survey. For example, pediatric or general internal medicine physicians often subspecialize in areas such as cardiology or endocrinology, and thus do not practice as primary care physicians. These individuals are thus excluded from the total number of primary care physicians.

Our estimates correct for practitioners who have been licensed but not surveyed. While some licensing boards require survey completion at initial licensure and license renewal, others are required to complete surveys only upon license renewal. Physicians (MDs and DOs), for example, are not surveyed upon licensure, but are required to complete a survey upon license renewal. After the initial renewal, they are required to renew their licenses with surveys every three years. As a result, a full three-year cycle is necessary to collect surveys across all physicians. As of 31 December 2016, 86.4 percent of physicians in New Mexico had completed a survey. The remaining 13.6 percent primarily comprises physicians who have not yet renewed their New Mexico licenses, and thus have not yet had opportunities to complete the survey.

Estimates of practitioners were adjusted to account for those who have not been surveyed. Surveyed practitioners were allocated to New Mexico counties by ZIP codes for self-reported practice location; practitioners who reported out-of-state or unknown ZIP codes for practice location were excluded from the New Mexico practice counts. For most health professions, there is a high correlation between mailing and practice counties, particularly in rural areas. Thus, for those practitioners who have not yet completed license renewal surveys, practice locations were estimated from license mailing address ZIP codes.

Methodology specific to professions can be found in individual subsections by profession in Sections II and III. See also Appendix C for a table of progress in obtaining survey data for all licensed health professionals.

I.B.2. Comparison to National Practitioner Benchmarks

Estimates of the number of health care practitioners working in each county are compared with benchmarks based on national averages and/or recommendations of practitioners per population. This analysis allows comparison of New Mexico to national workforce levels, assessment of counties that may have exceptionally low numbers of practitioners compared to others, and examination of the distribution of workforce at the county level in order to better understand the need for recruitment and retention activities. Maps are provided for each profession showing how each county's workforce compares to these national benchmarks, allowing county-to-county comparison of health care workforce levels.

The national benchmarks used to calculate health care professional needs by county are shown in Table 1.2. To calculate New Mexico's practitioner-to-population ratios in each county, county-level population estimates from the U.S. Census Bureau were used.⁴

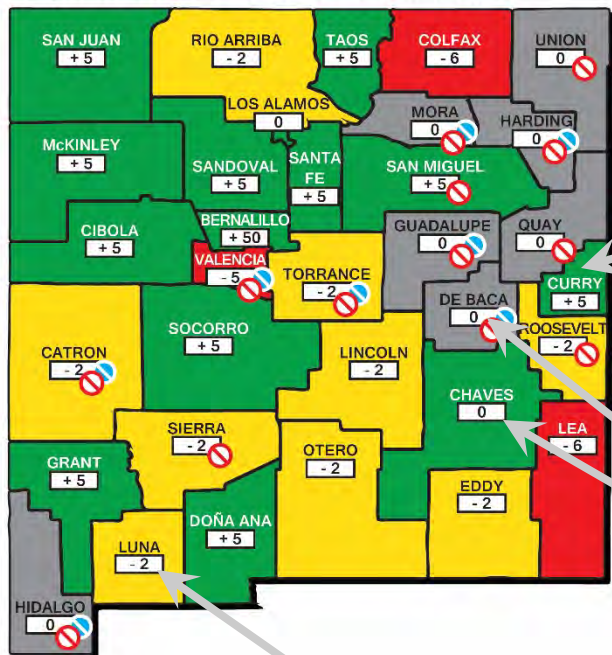
Table 1.2. Practitioner-to-Population Benchmarks Used to Assess the New Mexico Health Care Workforce

Profession	National Benchmark	Benchmark per 10,000 Population
Primary Care Physicians	0.79 per 1,000 population ⁵	7.9 per 10,000 population
Certified Nurse Practitioners and Clinical Nurse Specialists	0.59 per 1,000 population ⁶	5.9 per 10,000 population
Physician Assistants	0.303 per 1,000 population ⁷	3.03 per 10,000 population
Obstetrics and Gynecology Physicians	2.1 per 10,000 female population ⁸	2.1 per 10,000 female population
Certified Nurse Midwives	7.05 per 100,000 female population ⁹	0.705 per 10,000 female population
Licensed Midwives	1.7 per 100,000 female population ¹⁰	0.17 per 10,000 female population
General Surgeons		
Critical Need	3.0 per 100,000 population ¹¹	0.3 per 10,000 population
Minimum Need	6.0 per 100,000 population	0.6 per 10,000 population
Optimal Ratio	9.2 per 100,000 population	0.92 per 10,000 population
Psychiatrists	1 per 6,500 population ¹²	1.54 per 10,000 population
Dentists	1 per 2,500 population ¹³	4 per 10,000 population
Pharmacists	0.78 per 1,000 population ¹⁴	7.8 per 10,000 population
Emergency Medical Technicians	28.7 per 10,000 population ¹⁵	28.7 per 10,000 population

I.B.3. Understanding the Data

Throughout Section II, the reader will encounter maps similar to the one shown in Figure 1.1. This figure offers an illustrated guide to what each element of the maps means.

Interpretation of the Benchmark Maps



The **BENCHMARK VALUE** is provided in the legend of each map for easy reference.

Comparison to Benchmark (X per 10,000 Population)

- At or Above Benchmark
- 1 - 5 Providers Below Benchmark
- > 5 Providers Below Benchmark
- At Benchmark With 0 Providers
- ⊗ No Surgical Facility in County
- ⊗ No Inpatient Maternity Service in County
- 0 Number Above (+) or Below (-) Benchmark

The **COLOR** of each county corresponds to its providers above or below the national benchmark. Green counties are at or above benchmark, yellow counties are moderately below benchmark, and red counties are severely below benchmark.

Additional **SYMBOLS** like these may be included for additional information pertinent to the profession. Look in the legend for their definitions.

The **NUMBER** in each county shows the number of providers above or below benchmark. In this example, Luna County would need to add two providers in order to meet the national benchmark.

What's the difference between counties with the number **ZERO** and colored **GREEN** or **GRAY**? In both cases, the number zero indicates that the number of providers is the same as the benchmark value. Those with a benchmark of zero and no providers are **GRAY**, while those with a benchmark of one or more that is met by the number of providers identified for the county are **GREEN**.

Figure 1.1. Maps similar to this one are included for each profession analyzed in Section II. The text boxes here highlight the key points to be taken from these benchmark maps. For maps with different coloration or format, keys to interpretation can be found in the figure captions.

It is important to keep in mind that *the number of health professionals above or below benchmark is not a direct measure of health care accessibility, or whether the workforce is adequate to meet the health care needs of the population*. A county-level provider-to-population ratio assumes homogeneity of provider practice and population need, and so does not account for differences in practice work hours, patient utilization, patients' severity of illness, distance to the nearest provider and other factors.

In summary, the provider-to-population ratio, selected as the best available metric to allow national workforce comparisons, should be regarded as an indicator of counties and regions that may require additional resources, not a direct measure of workforce adequacy.

I.B.4. Limitations of the Data

While New Mexico is unique in the thorough and robust nature of its workforce data, the practitioner surveys cannot capture certain aspects of the health professional workforce. *First, it has become clear that the current method for administering the registered pharmacist survey is untenable.* It is our understanding that upon license renewal, New Mexico registered pharmacists are asked to proceed to their survey, currently conducted via the online survey and questionnaire tool Survey Monkey. However, they do not need to register their completion of the survey in order to complete license renewal, in effect rendering the survey voluntary: by the end of 2015, only 34.1 percent of registered pharmacists had completed the survey since its implementation. Survey data for 2016 were not received by the New Mexico Health Care Workforce Committee. Furthermore, this survey is anonymous, preventing us from linking license information with survey data. This linkage is key to our analysis, as it allows us to identify providers by practice location rather than license mailing address. As a result, the county-level analysis of pharmacists to date has used mailing addresses rather than practice location. *It will be critically important for the Board of Pharmacy to bring their survey in line with statutory requirements in order to ensure complete, high-quality data and an accurate analysis of the state's pharmacist workforce.*

Second, we noted last year that the item asking for physicians' specialties had been omitted in 2015. We are grateful to the Regulation and Licensing Division for their prompt action in restoring this item to the physician survey in 2016.

Third, there is some inherent uncertainty due to variability among respondents in all survey data, and the New Mexico health professional licensure survey data is no exception. Providers' responses may be affected by their individual interpretation of a survey question. For example, New Mexico health professionals are asked about the proportion of time they spend in direct patient care; one respondent might interpret this as only face-to-face time with patients, while another might include time spent on interpreting laboratory results, writing up notes and other patient care activities in addition to time in the exam room.

In addition, the health professions' surveys vary slightly both within and beyond the required core data set. For example, physicians are asked their race separately from their Hispanic or non-Hispanic ethnic identity, while nurses are asked their race and ethnicity in a single survey item. Where it was not possible to align data from the professions' differing surveys, as with race and ethnicity for nurses and other professions, we have noted this in the text and presented the data separately.

Fourth, as has been noted, national benchmarks are not measures of workforce adequacy, surplus or shortage. For most professions analyzed, an optimal provider-to-population ratio is not available; indeed, given the great variation both within and beyond New Mexico in population density, health care needs, insurance coverage and other factors, there is unlikely to be a single optimal provider-to-population ratio. Additionally, the available benchmarks combine specialties in ways that may obscure details of the need for care among New Mexico's population. For example, a count above benchmark in primary care physicians may comprise a large number of adult primary care physicians and few pediatricians. This example is explored further in the section on primary care physicians, Section II.A.1.

As a result, provider counts above benchmarks throughout Section II should not be taken as areas with surplus, or even adequate numbers of providers. Patients in these areas may still experience long wait times to see providers, have difficulty finding providers accepting Medicaid or another insurance and otherwise experience difficulty in accessing medical treatment.

Finally, there are aspects of health care that our data cannot measure. These include the adequacy of facilities in which to practice, employer demand for the various health professions and patient satisfaction with the providers accessible to them.

Despite these necessary limitations, New Mexico's health care workforce survey data remain a national exemplar, and represent a powerful source of information to understand the distribution of health professionals statewide and formulate solutions to the health care challenges faced by many of our state's population.

I.C. Summary of New Mexico's Health Care Workforce

The New Mexico Health Care Workforce Committee estimates that practicing in the state are 2,076 primary care physicians (PCPs), 1,379 certified nurse practitioners and certified nurse specialists (CNP/CNSs), 746 physician assistants (PAs), 273 obstetrics and gynecology physicians (OB-GYNs), 156 certified nurse-midwives (CNMs), 48 licensed midwives (LMs), 188 general surgeons, 332 psychiatrists, 1,171 dentists, 2,013 pharmacists, 17,219 registered nurses (RNs) and 6,101 emergency medical technicians (EMTs) (Table 1.3). These providers' locations reveal workforce below benchmarks in many areas of the state. Our analysis indicates that without redistributing the current workforce, New Mexico is below national benchmarks by 139 PCPs, 142 CNPs/CNSs, 119 PAs, 31 OB-GYNs, 12 CNMs, 4 LMs, 14 general surgeons, 106 psychiatrists, 55 dentists, 257 pharmacists, 3,361 RNs and 475 EMTs.

Our continued analysis of these professions over multiple years allows us to track improvements or declines for each profession. Since the last year analyzed (2015 for all professions except RNs, which were last analyzed for 2012), the state has gained providers in all of the nine categories of health professionals examined: three PCPs (0.1% increase), 86 CNPs/CNSs (6.7%), 29 PAs (4.0%), 20 OB-GYNs (7.9%), 11 general surgeons (6.2%), 30 psychiatrists (9.9%), 40 dentists (3.5%), 102 pharmacists (5.3%), and 1,506 RNs (9.6%).

Table 1.3. Summary of Statewide Health Care Professionals, 2013 – 2016

Profession Metric	2013	2014	2015	2016	Net Change 2013 - 2016
PCP					
# in New Mexico	1,957	1,908	2,073	2,076 ^b	119
Total Below Benchmark ^a	153	145	125	139	-14
Counties Below Benchmark	23	22	17	22	-1
CNP/CNS					
# in New Mexico	1,089	1,228	1,293	1,379	290
Total Below Benchmark ^a	271	197	201	142	-129
Counties Below Benchmark	25	20	19	18	-7
PA					
# in New Mexico	ND ^c	694	717	746	52
Total Below Benchmark ^a		136	136	119	-17
Counties Below Benchmark		21	22	22	1
OB-GYN					
# in New Mexico	256	236	253	273 ^b	17
Total Below Benchmark ^a	40	43	36	31	-9
Counties Below Benchmark	14	14	12	9	-5
CNM					
# in New Mexico	ND	ND	ND	156	-
Total Below Benchmark ^a				12	-
Counties Below Benchmark				9	-
LM					
# in New Mexico	ND	ND	ND	48	-
Total Below Benchmark ^a				4	-
Counties Below Benchmark				4	-
General Surgeons					
# in New Mexico	179	162	177	188 ^b	9
Total Below Benchmark ^a	21	18	16	14	-7
Counties Below Benchmark	12	8	8	7	-5
Psychiatrists					
# in New Mexico	321	289	302	332 ^b	11
Total Below Benchmark ^a	104	109	111	106	2
Counties Below Benchmark	25	26	26	26	1
Dentists					
# in New Mexico	ND	1,081	1,131	1,171	90
Total Below Benchmark ^a		73	67	55	-18
Counties Below Benchmark		18	20	18	0
Pharmacists					
# in New Mexico	ND	1,928	1,911	2,013	85
Total Below Benchmark ^a		293	292	257	-36
Counties Below Benchmark		26	28	26	0
RNs					
# in New Mexico	15,713 ^d	NA ^e	NA ^e	17,219	1,506
Total Below Benchmark ^a	4,269 ^d			3,361	-908
Counties Below Benchmark	30 ^d			30	0
EMTs					
# in New Mexico	ND	ND	ND	6,101	-
Total Below Benchmark ^a				475	-
Counties Below Benchmark				12	-

^a Total below benchmark reflects the number of providers needed to bring all counties below benchmarks to national provider-to-population values.

^b This is the first year for which DO specialties were analyzed, correcting prior years' overestimation of DOs in primary care and underestimation in OB-GYN, general surgery, and psychiatry.

^c ND indicates survey data were not yet available.

^d RNs were last analyzed for 2012; these data are from that year.

^e NA indicates this profession was not analyzed in the years indicated.

I.C.1. Uneven Distribution of Providers

New Mexico faces significant challenges in access to health care due to its large rural and frontier areas. Thirty-four percent of the state’s 2.1 million residents live in rural and frontier counties (Figure 1.2), which tend to have health care workforce below national benchmark values.

Population Density of New Mexico Counties

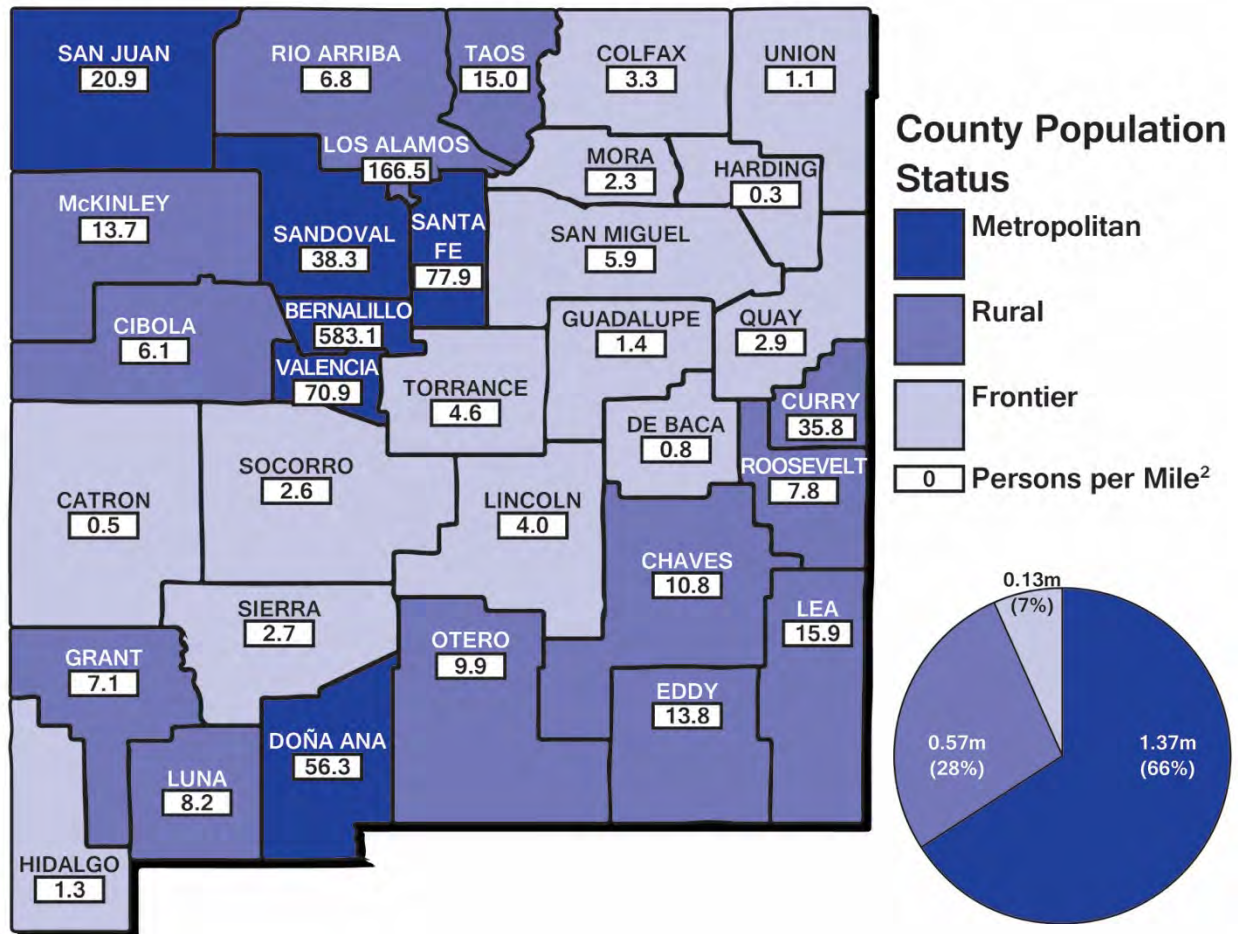


Figure 1.2. Each county’s color indicates its classification as frontier (light), rural (medium) or metropolitan (dark); the white boxes show the population density (persons per square mile). The pie chart shows the proportion of the state’s population residing in metropolitan, rural or frontier counties.

In reviewing Section II of this report, readers will note that many counties have provider counts far below benchmarks, while others have providers equal to or exceeding benchmark values. This uneven distribution – or maldistribution – of providers across the state underscores the need to evaluate workforce distribution. Counties that meet or exceed benchmarks tend to be those with urban areas and/or close proximity to training and major health care facilities. Because we do not anticipate substantial relocation of providers from better-served to poorer-served counties, we state for each profession the

number of providers that would allow New Mexico counties to meet national benchmarks *assuming no redistribution of practitioners from counties with above-benchmark numbers to those with fewer.*

In addition, New Mexico faces substantial health disparities related to income inequality and other social determinants of health. Meeting or exceeding benchmarks for providers does not indicate that all county residents have adequate access to health care and health professionals.

Section II

State Workforce Distribution by Profession

II.A. The Primary Care Workforce

An adequate primary care workforce is essential to promote overall health and prevent disease and disability through access to comprehensive, high-quality health care services.¹⁶ Physicians, advanced practice registered nurses and physician assistants all contribute greatly to this key sector of the health care workforce. In this section, we review New Mexico's physicians working in primary care specialties (Section II.A.1). In addition, there is the analysis of the state's entire complement of certified nurse practitioners and clinical nurse specialists (Section II.A.2) and physician assistants (Section II.A.3), regardless of specialty. Finally, in Section II.A.4, we discuss the estimated CNP/CNS and PA workforce in primary care alongside primary care physicians.

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II.A.1. Primary Care Physicians

II.A.1.a. Executive Summary

There were an estimated 2,076 PCPs in New Mexico in 2016, one more than in 2015 and 432 more than the benchmark based on national averages (Figure 2.1, Appendix A.1). Table 2.1 shows how each county's PCP count has changed since 2013. Of the total, 45.6 percent are concentrated in Bernalillo County, which has 411 more PCPs than the national average (Table 2.2). Other counties with above-average PCP-to-population ratios include Santa Fe (+86), Grant and Los Alamos (+17 each) and Doña Ana (+16). The counties most below benchmark include Eddy and Torrance (-10 each), Luna (-11), Otero (-18), Lea (-19) and Valencia (-33) (Table 2.2). *Assuming no redistribution of the current workforce, an additional 139 PCPs would enable New Mexico to meet the national benchmark (0.79 per 1,000 population) in all counties.*

Primary Care Physicians Compared to Benchmark, 2016

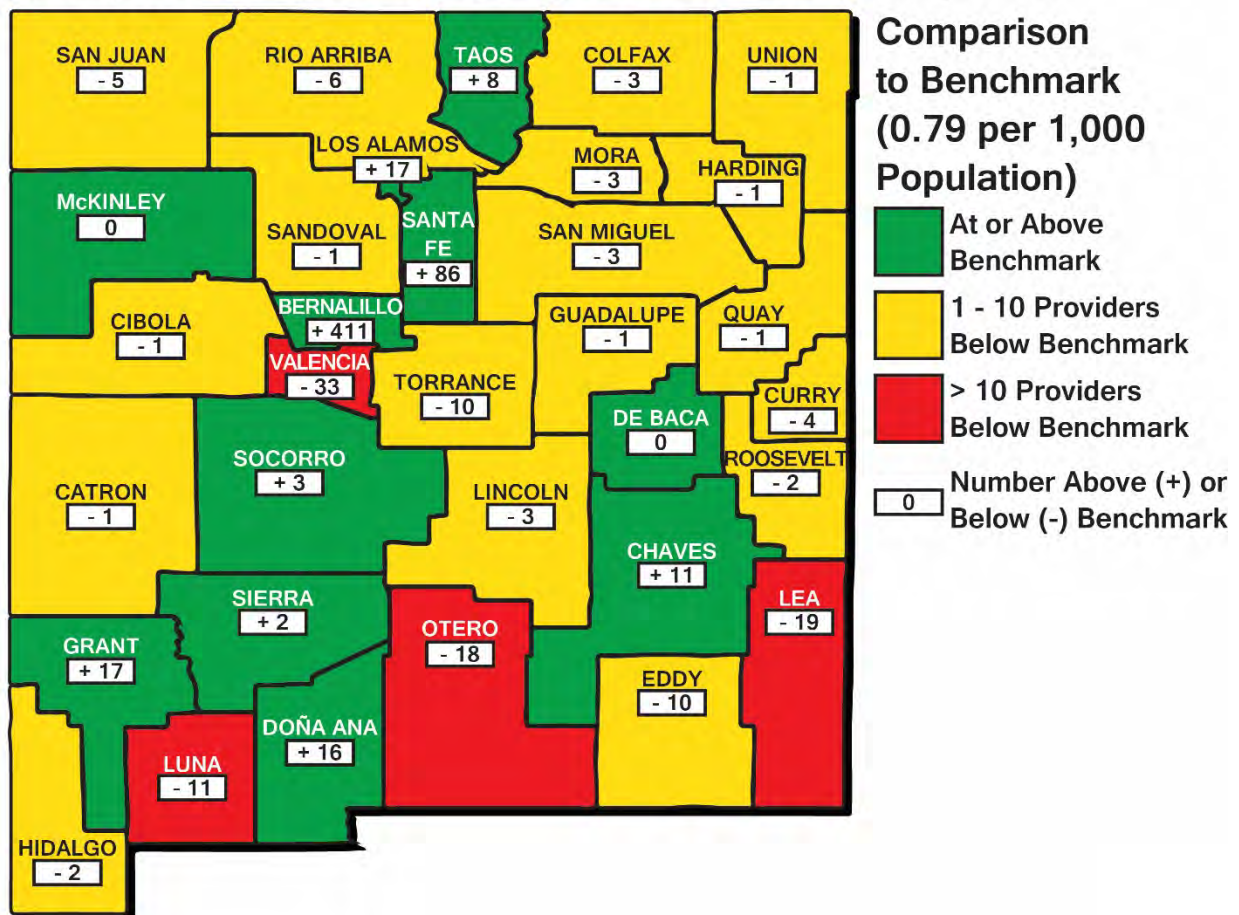


Figure 2.1. Primary care physician workforce relative to the national benchmark of 0.79 PCPs per 1,000 population is shown in the white boxes. Each county's color indicates whether it is at or above benchmark (green), below benchmark by 10 or fewer providers (yellow), or below benchmark by more than 10 providers (red).

Table 2.1. Primary Care Physician Distribution by New Mexico County, 2013 – 2016

County	2013	2014	2015	2016	Net Change 2013 - 2016
Bernalillo	855	807	936	946	91
Catron	2	3	3	2	0
Chaves	73	71	75	63	-10
Cibola	20	19	19	21	1
Colfax	9	9	11	7	-2
Curry	36	36	39	36	0
De Baca	1	2	1	1	0
Doña Ana	168	162	182	185	17
Eddy	35	37	39	36	1
Grant	32	34	38	39	7
Guadalupe	3	3	3	2	-1
Harding	1	0	0	0	-1
Hidalgo	2	2	1	1	-1
Lea	30	29	35	36	6
Lincoln	13	13	14	12	-1
Los Alamos	33	33	32	31	-2
Luna	10	10	9	8	-2
McKinley	50	50	62	59	9
Mora	1	2	2	1	0
Otero	37	42	37	34	-3
Quay	7	7	5	6	-1
Rio Arriba	27	29	28	26	-1
Roosevelt	14	13	14	13	-1
San Juan	96	93	95	86	-10
San Miguel	26	24	22	19	-7
Sandoval	103	104	101	111	8
Santa Fe	188	183	185	203	15
Sierra	11	12	11	11	0
Socorro	12	13	16	16	4
Taos	37	36	33	34	-3
Torrance	1	2	2	2	1
Union	0	0	1	2	2
Valencia	24	28	24	27	3
STATE TOTAL	1,957	1,908	2,075	2,076	119

Table 2.2. Counties with the Greatest PCP Differences from National Benchmark

County	Practitioners Above Benchmark	County	Practitioners Needed to Meet Benchmark
Bernalillo	411	Valencia	33
Santa Fe	86	Lea	19
Grant	17	Otero	18
Los Alamos	17	Luna	11
Doña Ana	16	Eddy, Torrance	10 each

II.A.1.b. Methodological Notes

Our estimates of the New Mexico PCP workforce include MDs and DOs who specialize in family medicine, general practice, general internal medicine and general pediatrics. General internal medicine providers who subspecialize (e.g., cardiology, immunology) and pediatric subspecialists are not counted among the state’s PCPs.

Although several state and national organizations include physicians specializing in obstetrics and gynecology (OB-GYNs) in their primary care estimates, such as the Health Resources and Services Administration when designating primary care Health Professional Shortage Areas, we report OB-GYNs as a separate health workforce category. We analyze OB-GYNs independently in order to examine features unique to this specialty, including their serving a specific segment of the population and their need for specialized facilities, such as access to a surgical suite to perform Caesarian sections. Our benchmark for assessing PCPs, from the Kaiser Family Foundation, also excludes OB-GYNs from the national PCP-per-population ratio (0.79 per 1,000 population).

PCPs who are employed strictly in acute care (i.e., hospital emergency department and inpatient services) are included in our primary care estimate, which aligns with the Kaiser Family Foundation methodology used to establish our PCP benchmark. A national study suggests that approximately 30 percent of general internal medicine physicians work as hospitalists and 7 percent of family medicine physicians work in emergency departments.¹⁷ In prior years, we have found a comparable proportion of New Mexico’s PCP workforce practicing as hospitalists.¹⁸

The estimated counts of PCPs are based on 9,457 MDs and DOs with active licenses in New Mexico, comprising 7,572 surveyed MDs, 1,190 MDs who have an active license but no survey (those newly licensed in the state), 602 surveyed DOs and 93 unsurveyed DOs. For both MDs and DOs, primary care specialty (family practice, general practice, general pediatrics or general internal medicine) was determined first by self-reported specialty on the individual’s most recent survey. For unsurveyed physicians and those for whom the only survey available was 2015 (the year for which the specialty item was omitted from the survey), specialty was identified through licensure and/or board certification. *This is the first year for which DOs were allocated to specialty in this manner; in prior years, it was assumed based on the literature that 70 percent practice in primary care.* PCPs were allocated to counties first by the five-digit ZIP code of their self-reported primary practice location. Where this information was not available, the county was identified by the licensure address ZIP code.

II.A.1.c. Discussion

Figure 2.1 shows the county-level comparison of New Mexico's PCPs to the national benchmark of 0.79 PCPs per 1,000 population. Although the estimated 2,076 PCPs in New Mexico in 2016 represent a statewide PCP-to-population ratio of 1.0, or 432 above the national benchmark, only 11 counties (33 percent) were at or above benchmark. Table 2.2 shows the counties with the greatest numbers of PCPs above and below benchmark. The five counties with the most practitioners above benchmark – Bernalillo, Santa Fe, Grant, Los Alamos and Doña Ana – together account for two-thirds (67.6 percent) of the state's PCPs (see PCP counts reported in Table 2.1). The five counties most below benchmark were Valencia, Lea, Otero, Luna, Eddy and Torrance, which together would require 101 PCPs to achieve benchmark PCP-to-population ratios. As a whole, and assuming no redistribution of the current workforce, an additional 139 PCPs would be required to meet the national benchmark in all counties.

Having collected survey data for multiple years, we are now able to report on year-to-year changes in provider counts. Table 2.1 shows the county-level changes in PCP counts between 2013 and 2016. Large PCP gains have been observed in Bernalillo, Doña Ana and Santa Fe counties, with more modest gains in several other counties. Of note in 2016 are the losses of 10 providers each in Chaves and San Juan counties. While losses of similar magnitude have observed to rebound relatively rapidly (see, for example, the decline and recovery of Bernalillo County PCPs between 2013 and 2015), it will be important to monitor the workforce in these counties in future years.

As mentioned in the discussion of data limitations in Section I.B.4, it is important to remember that counties shown in Figure 2.1 as having PCPs above benchmark are not necessarily free of health access issues. Health systems factors such as wait times to see physicians, insurance restrictions and the distribution of PCP specialties within a county (i.e., having many adult PCPs but few pediatricians), may seriously hamper the population's access to care.

PCP counts overall may mask shortages of workforce relative to special populations, such as children and the elderly. Following submission of last year's annual report, Farnbach Pearson et al. examined the 2015 PCP workforce available to treat the state's adult and pediatric populations.² The state's PCPs were allocated as adult or pediatric PCPs according to specialty: physicians specializing in general internal medicine were classified as adult PCPs, general pediatrics physicians were classified as pediatric PCPs, and family medicine, general practice and DOs classified as primary care were allocated as 85 percent adult and 15 percent pediatric, following the proportion reported by Shipman, et al. for family medicine physicians.¹⁹

The county-level adult and pediatric PCP counts were compared to county populations of adults and individuals under 18 years of age. In initial analysis, Bernalillo and Los Alamos counties were found to be outliers: Bernalillo due to its large counts of both adult and pediatric PCPs, and Los Alamos due to its unusually high proportion of pediatric PCPs to 1,000 population under 18 (2.61, 67 percent greater than the next highest county: Bernalillo, at 1.56 pediatric PCPs to 1,000 population under 18).²

Farnbach Pearson et al. found the pediatric PCP percentage to be highly consistent with the proportion of the state's population under 18 years of age (both 24 percent); however, as has been found across health professions, pediatric PCPs were maldistributed. County-level counts of pediatric and adult PCPs were found to be highly correlated ($r^2 = 0.95$), while their ratios per population were poorly correlated ($r^2 = 0.37$). That is, the *count* of pediatric PCPs in a county was tightly linked to the count of adult PCPs in the same county; however, the *ratio* of PCPs per 1,000 population was likely to be different for adults and children in the same county. As a result, it is possible for a county to be above benchmark for adult PCPs

while below benchmark for pediatric PCPs (Catron, Cibola, Colfax, Curry, Doña Ana, Guadalupe and McKinley counties) or vice versa (Quay, San Miguel and Sandoval counties).²

While all of these counties have family medicine physicians who might take on a greater proportion of pediatric or adult patients, this would tend to shift the shortfall between segments of the population rather than mitigate these departures from benchmark. Because of this, it may be beneficial for recruitment and retention efforts to evaluate PCP sub-categories relative to the populations they serve and target PCP specialties for any underserved age groups. This will be worth further consideration with respect to the geriatric population, which experiences an increased need for health services; it is predicted that by 2030, approximately half of the state's population will be over 65 or under 18.²⁰

Beyond these details, it is important to note that health care providers are not distributed evenly within counties. Whether a county is above or below benchmark, its providers may be concentrated within metropolitan areas, leaving large rural areas short of providers. It is furthermore likely that residents of counties short of providers travel to better-served counties or out of state to receive health care services; as a result, the population served by health professionals in a given county may be larger than just that county's residents. This is particularly true for counties with large medical systems and hospital complexes, such as Bernalillo and Chaves.

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II.A.2. Certified Nurse Practitioners and Clinical Nurse Specialists

II.A.2.a. Executive Summary

There were an estimated 1,379 CNPs/CNSs in New Mexico in 2016, 86 more than in 2015 and 175 more than the benchmark based on national averages (Figure 2.2, Appendix A.2). Table 2.3 shows how each county's NP/CNS count has changed since 2013. Of the total, 46.6 percent are concentrated in Bernalillo County, which has 250 more CNPs/CNSs than the national average (Table 2.4). Other counties with above-average NP/CNS-to-population ratios include Santa Fe (+26), Eddy (+12), Quay and Taos (+8 each). The counties most below benchmark include Otero (-10), McKinley (-17), San Juan (-24), Valencia (-25) and Sandoval (-26) (Table 2.4). *Assuming no redistribution of the current workforce, an additional 142 CNPs and CNSs would enable New Mexico to meet the national benchmark (0.59 per 1,000 population) in all counties.*

CNPs and CNSs Compared to Benchmark, 2016

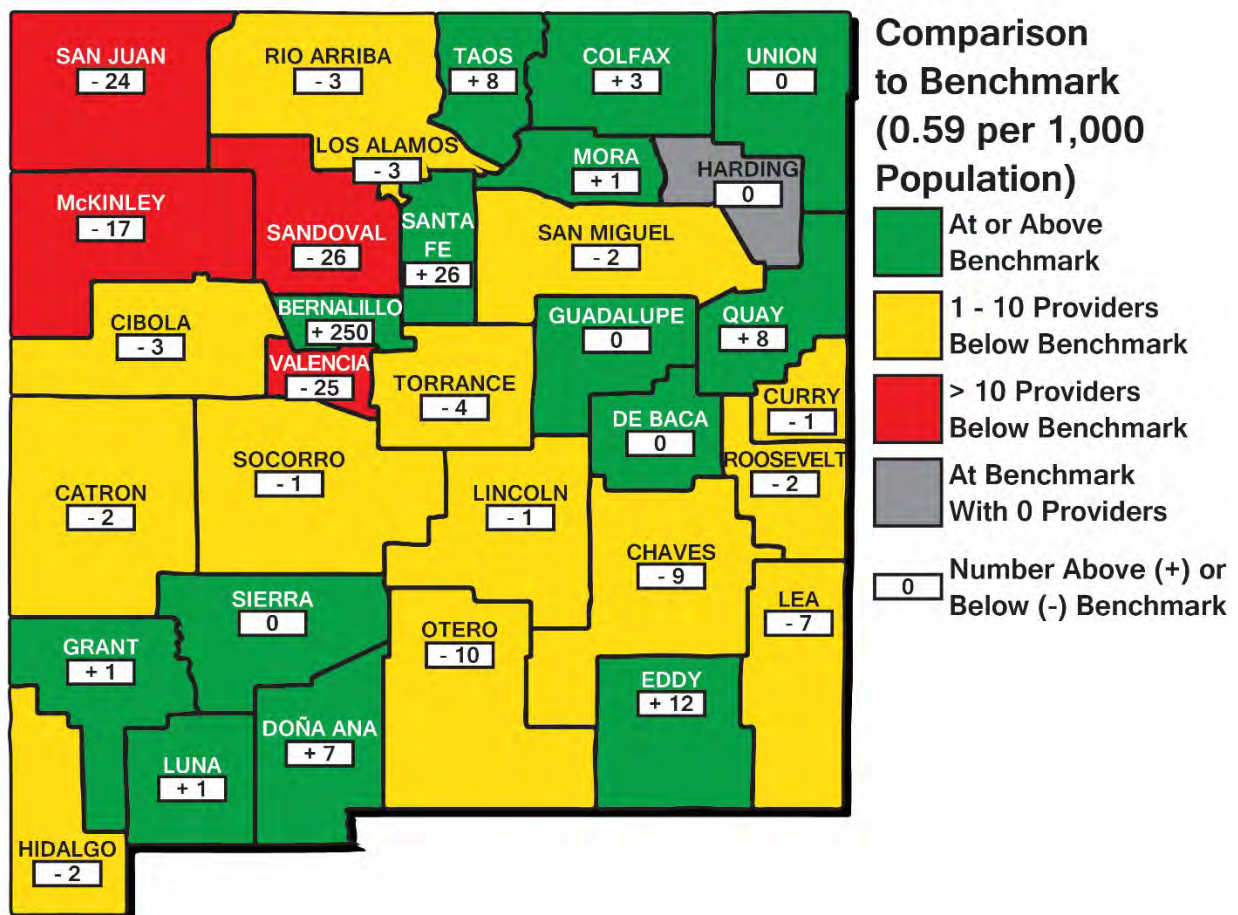


Figure 2.2. Certified nurse practitioner and clinical nurse specialist workforce relative to the national benchmark of 0.59 CNPs/CNSs per 1,000 population is shown in the white boxes. Each county's color indicates whether it is at or above benchmark (green), below benchmark by 10 or fewer providers (yellow), or below benchmark by more than 10 providers (red). Gray counties have no providers and benchmark values of zero. A benchmark of zero occurs when the county population multiplied by the benchmark results in a value less than 0.50.

Table 2.3. CNP/CNS Distribution by New Mexico County, 2013 – 2016

County	2013	2014	2015	2016	Net Change 2013 - 2016
Bernalillo	533	595	636	643	110
Catron	0	0	0	0	0
Chaves	25	31	27	29	4
Cibola	9	9	12	13	4
Colfax	5	7	7	10	5
Curry	19	23	22	28	9
De Baca	1	2	2	1	0
Doña Ana	112	125	130	131	19
Eddy	36	33	44	45	9
Grant	12	14	14	17	5
Guadalupe	3	3	3	3	0
Harding	0	1	0	0	0
Hidalgo	0	0	0	0	0
Lea	26	24	28	33	7
Lincoln	9	6	7	10	1
Los Alamos	6	8	9	8	2
Luna	13	14	16	15	2
McKinley	16	21	25	26	10
Mora	4	3	4	4	0
Otero	12	18	22	28	16
Quay	8	7	11	13	5
Rio Arriba	23	21	24	20	-3
Roosevelt	7	8	10	9	2
San Juan	28	33	28	43	15
San Miguel	13	15	15	14	1
Sandoval	29	54	37	56	27
Santa Fe	85	91	96	112	27
Sierra	2	1	5	6	4
Socorro	7	9	8	9	2
Taos	18	18	23	27	9
Torrance	5	10	5	5	0
Union	2	3	3	2	0
Valencia	21	21	20	19	-2
STATE TOTAL	1,089	1,228	1,293	1,379	290

Table 2.4. Counties with the Greatest CNP/CNS Differences from National Benchmark

County	Practitioners Above Benchmark	County	Practitioners Needed to Meet Benchmark
Bernalillo	250	Sandoval	26
Santa Fe	26	Valencia	25
Eddy	12	San Juan	24
Quay, Taos	8 each	McKinley	17
		Otero	10

II.A.2.b. Methodological Notes

The breadth and depth of data available for New Mexico’s nurses is exceptional, due to the efficiency with which New Mexico’s Board of Nursing instituted their required survey following the New Mexico Health Care Work Force Data Collection, Analysis and Policy Act of 2011. Data from the survey of New Mexico’s nurses were the first to be made available to the New Mexico Health Care Workforce Committee, and remain an exemplar for professions developing or updating their surveys.

Certified nurse practitioners (CNPs) and clinical nurse specialists (CNSs) are advanced practice registered nurses with independent authority to diagnose and prescribe within their scope of practice. Advanced practice registered nurses include certified registered nurse anesthetists (CRNAs) and certified nurse-midwives (CNMs) in addition to CNPs and CNSs. However, it was necessary to adjust the advanced practice registered nurse count in order to evaluate this sector of the health care workforce consistently with our national benchmark.

The national benchmark excludes CRNAs and CNMs who are not also CNPs, as well as CNPs/CNSs practicing in behavioral health. Thus, it was necessary to reduce the total of 2,781 advanced practice registered nurses with active New Mexico licensure by 484 CRNAs, 153 CNMs, and 127 CNPs/CNSs reporting a practice area of behavioral health. Our analysis in this section includes the remaining 2,017 CNPs/CNSs; the contributions of CNMs are discussed in Section II.B.2, while those of behavioral health CNPs/CNSs are included in Section III.

As for PCPs, CNPs/CNSs were allocated to counties first by their self-reported practice five-digit ZIP code; where this information was not available, the county was identified by the licensure address ZIP code. Of the 2,017 CNPs/CNSs consistent with the national benchmark criteria, 1,379 identified a New Mexico practice location in the survey.

The New Mexico Board of Nursing survey asks area of specialty. CNPs/CNSs were grouped by self-reported practice areas as follows: obstetrics and gynecology (responses of obstetrics/gynecology), behavioral health (responses of psychiatric/mental health), primary care (responses of other, other-position, nurse-practitioner or pediatric/child maternal) and other (responses of community/public health, consultant, geriatric, medical/surgical, N/A or special care unit and those without responses to the practice area item). However, with the exception of behavioral health – excluded from the benchmark counts as discussed above – these practice areas are not reflected in our benchmark calculations because the national benchmark does not distinguish among advanced practice nursing specialties.

II.A.2.c. Discussion

Figure 2.2 shows the county-level comparison of New Mexico's CNPs/CNSs to the national benchmark of 0.59 CNPs/CNSs per 1,000 population. The state as a whole has 175 providers above the national benchmark, with 15 counties (45.5 percent) at or above benchmark (including Harding County, which has a benchmark value of zero). Table 2.4 shows the counties with the greatest numbers of CNPs/CNSs above and below benchmark. The counties with the most practitioners above benchmark – Bernalillo, Santa Fe, Eddy, Quay and Taos – together account for 60.9 percent of the state's CNPs/CNSs. The counties most below benchmark were Sandoval, Valencia, San Juan, McKinley and Otero, which together would require 102 CNPs/CNSs to achieve benchmark CNP/CNS-to-population ratios. As a whole, and assuming no redistribution of the current workforce, an additional 142 CNPs/CNSs would be required to meet the national benchmark in all counties.

Table 2.3 shows the county-level changes in CNP/CNS counts between 2013 and 2016. Net decreases have been observed in only two counties (Rio Arriba and Valencia). All other counties have remained stable (eight counties) or increased (23 counties). The most substantial increases since 2013 have been observed in Bernalillo, Doña Ana, Otero, Sandoval and Santa Fe counties.

As discussed above, New Mexico's CNPs/CNSs report area of specialty on the licensure survey. By self-reported practice areas, there are 619 CNPs/CNSs practicing in primary care, 88 practicing in obstetrics and gynecology – excluding those who are CNMs but not also CNPs – and 672 in other practice areas. In addition, 111 behavioral health CNPs/CNSs are practicing in the state.

II.A.3. Physician Assistants

II.A.3.a. Executive Summary

There were an estimated 746 PAs in New Mexico in 2016, 48 more than in 2015 and 117 more than the benchmark based on national averages (Figure 2.3, Appendix A.3). Table 2.5 shows how each county's PA count has changed since 2014. Of the total, 52.4 percent are concentrated in Bernalillo County, which has 186 more PAs than the national average (Table 2.6). Other counties with above-average PA-to-population ratios include Santa Fe (+16), Sandoval (+10), Taos (+9), Los Alamos and Grant (+6 each). The counties most below benchmark include Eddy (-7), McKinley (-11), Lea (-12), Valencia (-15) and Doña Ana (-27) (Table 2.6). *Assuming no redistribution of the current workforce, an additional 119 PAs would enable New Mexico to meet the national benchmark (0.303 per 1,000 population) in all counties.*

Physician Assistants Compared to Benchmark, 2016

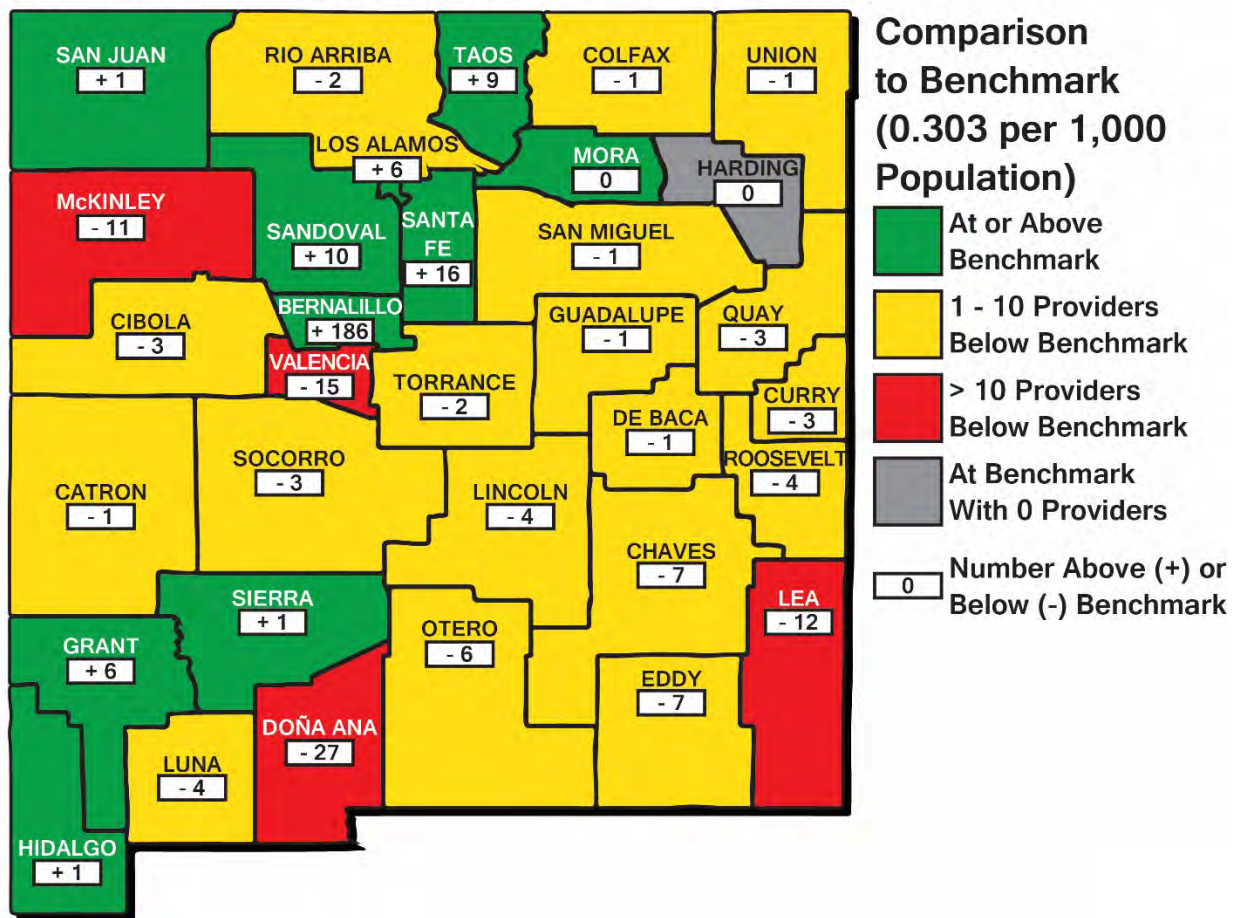


Figure 2.3. Physician assistant workforce relative to the national benchmark of 0.303 PAs per 1,000 population is shown in the white boxes. Each county's color indicates whether it is at or above benchmark (green), below benchmark by 10 or fewer providers (yellow), or below benchmark by more than 10 providers (red). Gray counties have no providers and benchmark values of zero.

Table 2.5. Physician Assistant Distribution by New Mexico County, 2014 – 2016

County	2014	2015	2016	Net Change 2014 - 2016
Bernalillo	351	358	391	40
Catron	0	0	0	0
Chaves	14	12	13	-1
Cibola	0	4	5	5
Colfax	4	4	3	-1
Curry	6	9	12	6
De Baca	0	0	0	0
Doña Ana	33	35	38	5
Eddy	6	10	10	4
Grant	18	18	15	-3
Guadalupe	1	0	0	-1
Harding	0	0	0	0
Hidalgo	1	2	2	1
Lea	10	9	9	-1
Lincoln	1	1	2	1
Los Alamos	6	11	11	5
Luna	3	3	3	0
McKinley	12	13	12	0
Mora	0	1	1	1
Otero	11	14	14	3
Quay	0	0	0	0
Rio Arriba	8	10	10	2
Roosevelt	3	3	2	-1
San Juan	38	35	36	-2
San Miguel	8	7	7	-1
Sandoval	54	45	53	-1
Santa Fe	66	58	61	-5
Sierra	4	5	4	0
Socorro	3	2	2	-1
Taos	19	19	19	0
Torrance	0	2	3	3
Union	0	0	0	0
Valencia	14	8	8	-6
STATE TOTAL	694	698	746	52

Table 2.6. Counties with the Greatest PA Differences from National Benchmark

County	Practitioners Above Benchmark	County	Practitioners Needed to Meet Benchmark
Bernalillo	186	Doña Ana	27
Santa Fe	16	Valencia	15
Sandoval	10	Lea	12
Taos	9	McKinley	11
Los Alamos, Grant	6 each	Eddy	7

II.A.3.b. Methodological Notes

The estimated counts of PAs are based on 986 PAs with active license in New Mexico, comprising 644 surveyed PAs and 342 PAs who have an active license but no survey. In 2016, PAs did not report specialties on their survey; as a result, county-level counts include all PAs, consistent with our national benchmark metric. As for PCPs, PAs were allocated to counties first by the five-digit ZIP code of their self-reported primary practice location; where this information was not available, the county was identified by the licensure address ZIP code.

II.A.3.c. Discussion

Figure 2.3 shows the county-level comparison of New Mexico’s PAs to the national benchmark of 0.303 PAs per 1,000 population. Although the state as a whole has 117 providers above the national benchmark, only 11 counties (33.3 percent) were at or above benchmark (including Harding County, which has a benchmark value of zero). Table 2.6 shows the counties with the greatest numbers of PAs above and below benchmark. The counties with the most practitioners above benchmark – Bernalillo, Santa Fe, Sandoval, Taos, Los Alamos and Grant – together account for 73.7 percent of the state’s PAs. The five counties most below benchmark were Doña Ana, Valencia, Lea, McKinley and Eddy, which together would require 72 PAs to achieve benchmark PA-to-population ratios. As a whole, and assuming no redistribution of the current workforce, an additional 119 PAs would be required to meet the national benchmark in all counties.

Table 2.5 shows the county-level changes in PA counts between 2014 and 2016. Overall, the state has gained 52 PAs since 2014. During that time, 12 counties have lost PAs, 12 have gained PAs, and 10 have remained stable.

As for CNPs/CNSs, PA specialties are not reflected in the estimated counts to match the inclusion criteria of our benchmark metric. According to the National Commission on Certification of Physician Assistants, approximately 40 percent of PAs work in primary care fields; this indicates that there could be 298 New Mexico PAs working in primary care practice areas. We have learned that the PA survey includes an item asking provider’s specialty as of 2017; as a result, we anticipate being able to report more in-depth information on PAs’ specialties beginning in the 2018 annual report.

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II.A.4. Discussion of the Primary Care Workforce

II.A.4.a. Executive Summary

Of New Mexico's estimated 2,993 primary care providers in 2016, 2,076 were physicians, 619 were CNPs/CNSs and 298 were PAs. This represents an increase of 32 from 2015, when there were an estimated 2,961 primary care providers in the state. Figure 2.4 shows how primary care provider-to-population ratios compare among New Mexico's 33 counties.

Primary Care Workforce, 2016

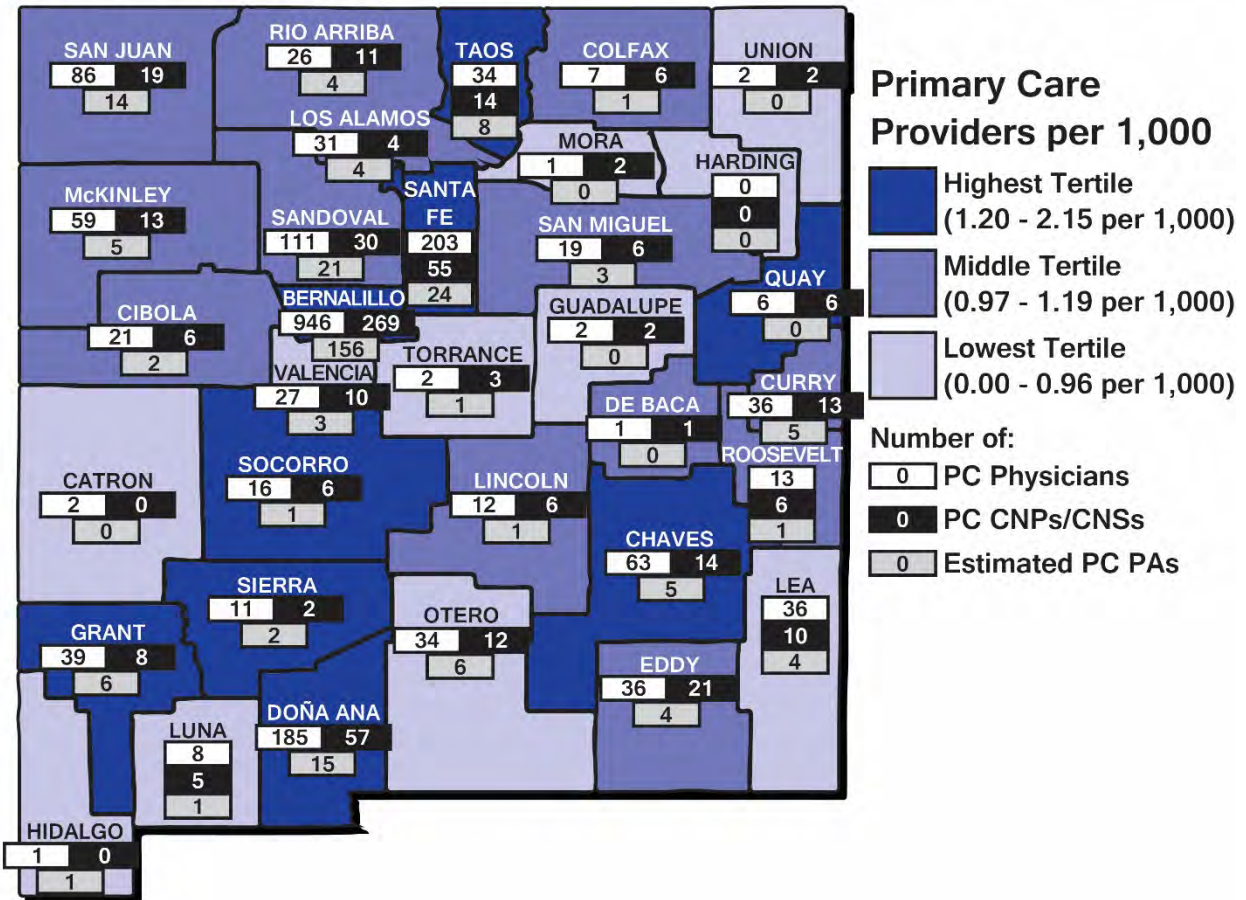


Figure 2.4. Shown in each county's boxes are the number of primary care physicians (white), primary care CNP/CNS (black) and estimated primary care PAs (gray). Each county's color indicates whether it falls in the top (dark), middle (medium), or bottom (light) third of counties for total primary care providers per 1,000 population.

Table 2.7. Primary Care Practitioners by County, 2016

County	Physicians	CNP/CNS	PA	TOTAL	Net Change, 2015 - 2016
Bernalillo	946	269	156	1,371	16
Catron	2	0	0	2	-1
Chaves	63	14	5	82	-13
Cibola	21	6	2	29	2
Colfax	7	6	1	14	-3
Curry	36	13	5	54	0
De Baca	1	1	0	2	-1
Doña Ana	185	57	15	257	13
Eddy	36	21	4	61	-3
Grant	39	8	6	53	1
Guadalupe	2	2	0	4	-1
Harding	0	0	0	0	0
Hidalgo	1	0	1	2	0
Lea	36	10	4	50	0
Lincoln	12	6	1	19	-1
Los Alamos	31	4	4	39	-1
Luna	8	5	1	14	-1
McKinley	59	13	5	77	-4
Mora	1	2	0	3	-1
Otero	34	12	6	52	-1
Quay	6	6	0	12	2
Rio Arriba	26	11	4	41	-6
Roosevelt	13	6	1	20	-1
San Juan	86	19	14	119	-9
San Miguel	19	6	3	28	-2
Sandoval	111	30	21	162	19
Santa Fe	203	55	24	282	23
Sierra	11	2	2	15	0
Socorro	16	6	1	23	0
Taos	34	14	8	56	0
Torrance	2	3	1	6	1
Union	2	2	0	4	1
Valencia	27	10	3	40	2
STATE TOTAL	2,076	619	298	2,993	32

II.A.4.b. Methodological Notes

Physicians, certified nurse practitioners and physician assistants all contribute greatly to New Mexico's primary care workforce. To analyze this sector of the health care workforce, we identified 1) primary care physicians, that is, MDs and DOs with specialties of family medicine, general practice, general internal medicine and general pediatrics; 2) primary care advanced practice registered nurses, that is, CNPs/CNSs who self-reported a practice area of nurse-practitioner, pediatric/child-maternal, other, or other position; and 3) an estimated 40 percent of PAs. We anticipate refining the primary care PA estimate next year, when specialty data for these providers will begin to be available.

It is important to note that the estimates do not account for the number of estimated primary care providers who may be working in settings outside of primary care, such as hospitalists. See Sections II.A.1 – II.A.3 above for discussion of the individual professions and additional detail regarding how counts are determined.

County comparisons for primary care workforce were made using the total of physicians, CNPs/CNSs and PAs estimated to be specializing in primary care per 1,000 population. The counties were then ranked to determine whether each fell in the top, middle or bottom third of counties for primary care practitioners per population. Note, as for all the maps included in this report, that a county falling in the top category does not necessarily have adequate numbers of practitioners. In this case, the county has a large number of primary care practitioners *relative to other counties in the state*.

II.A.4.c. Discussion

We estimated that New Mexico had 2,993 primary care providers in 2016. Of this total, 2,076 were physicians, 619 were CNP/CNS and 298 were PAs. The 2016 primary care workforce has increased by 32 above 2015 numbers. The most substantial increases were observed for Sandoval, Santa Fe and Bernalillo counties. Overall, 15 counties showed increases in the primary care workforce, 16 counties showed decreases and two counties did not change.

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II.B. The Women's Health and Birth Attendant Workforce

This year, we have updated our analysis of obstetrics and gynecology physicians (OB-GYNs); in addition, we have included our first analyses of certified nurse midwives (CNMs) and licensed midwives (LMs). All three types of provider contribute substantially to women's health in New Mexico.

What do each of these practitioners do? OB-GYNs are physicians specially trained to treat obstetric (pregnancy- and birth-related) and/or gynecological (related to the female reproductive system) health issues. OB-GYNs are physicians who provide prenatal care and attend births at hospitals for both normal and high-risk pregnancies, perform Caesarian sections if the need arises, and provide the full spectrum of women's health care.

Certified nurse midwives have undergone training in both nursing and midwifery; they are educated at a master's degree level in both nursing and midwifery and certified by the American College of Nurse Midwives. The care CNMs provide includes prenatal care and birth attendance in hospitals, birthing centers and homes, as well as routine well-woman care and treatment for minor gynecological conditions.

Licensed midwives are also sometimes called direct-entry midwives. Direct-entry midwives may be trained through self-study, apprenticeship or a school of midwifery. New Mexico is one of 27 states that license direct-entry midwives. In New Mexico, all LMs are required to be certified professional midwives – a certification overseen by the North American Registry of Midwives. This certification requires training and education (through apprenticeship or an accredited program such as the National College of Midwifery in Taos), supervised clinical experience and a written exam. LMs provide prenatal care and birth attendance in homes and birthing centers. They may not prescribe medications, but they do have limited authority to administer them.

New Mexico has the highest proportion of midwife-attended births in the United States. CNMs attend 8 percent of births in the nation as a whole, while in New Mexico, 26 percent of births are attended by CNMs.²¹ This is thought to be due to the autonomy of practice allowed CNMs in the state, the official recognition and licensure of direct-entry midwives (LMs) and our history as a frontier state.

In addition to the above practitioners, it is important to note that physicians specializing in family medicine also provide obstetric and gynecological care to New Mexico's women. These providers are included among the primary care physicians discussed in Section II.A.1; we have not included them here due to the difficulty of quantifying their relative contributions to primary care (for both children and adults) and obstetrics and gynecology.

In this section, there is analysis of all three types of providers exclusively practicing in women's health and birth attendance. OB-GYNs are discussed in Section II.B.1, CNMs in Section II.B.2, and LMs in Section II.B.3. Finally, in Section II.B.4, we discuss what the distribution of all three provider types indicates for the health care of New Mexican women.

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II.B.1. Obstetrics and Gynecology Physicians

II.B.1.a. Executive Summary

There were an estimated 273 OB-GYNs in New Mexico in 2016, 20 more than in 2015 and 54 more than the benchmark based on national averages (Figure 2.5, Appendix A.4). Table 2.8 shows how each county's OB-GYN count has changed since 2013. Of the total, 52.7 percent are concentrated in Bernalillo County, which has 72 more OB-GYNs than the national average (Table 2.9). Other counties with above-average OB-GYN-to-female population ratios include Colfax (+3), Doña Ana (+3), Eddy, Los Alamos, McKinley, Rio Arriba, Otero, Socorro and Taos (+1 each). The counties most below benchmark include Torrance (-2), Santa Fe (-3), San Juan (-6), Valencia and Sandoval (-8 each) (Table 2.9). **Assuming no redistribution of the current workforce, an additional 31 OB-GYNs would enable New Mexico to meet the national benchmark (2.1 per 10,000 female population) in all counties.**

OB-GYNs Compared to Benchmark, 2016

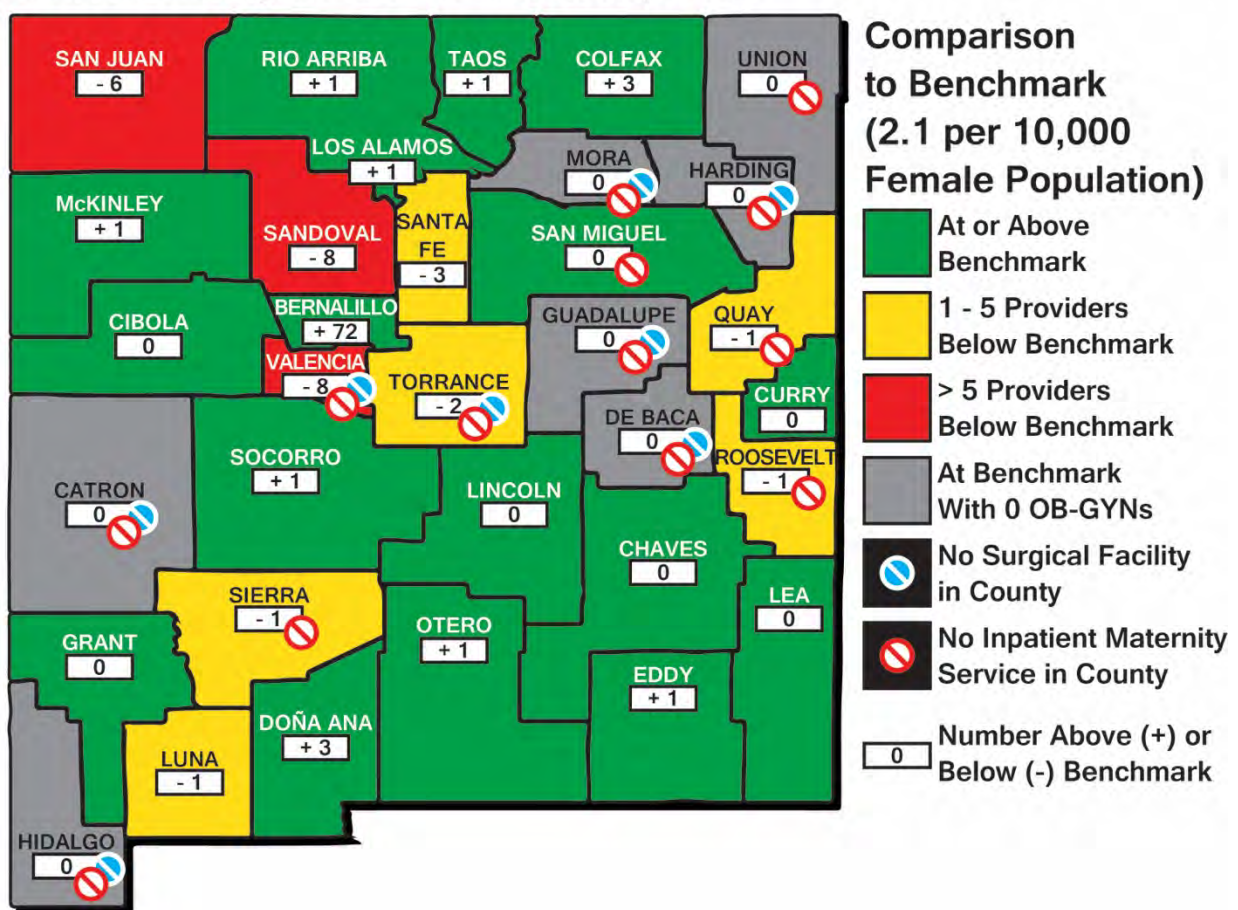


Figure 2.5. OB-GYN workforce relative to the national benchmark of 2.1 OB-GYNs per 10,000 female population is shown in the white boxes. Each county's color indicates whether it is at or above benchmark (green), below benchmark by five or fewer providers (yellow), or below benchmark by more than five providers (red). Gray counties have no providers and benchmark values of zero. Red "no" symbols denote counties without inpatient labor and delivery facilities; blue "no" symbols denote counties without surgical facilities.

Table 2.8. OB-GYN Physician Distribution by New Mexico County, 2013 – 2016

County	2013	2014	2015	2016	Net Change 2013 - 2016
Bernalillo	133	119	133	144	11
Catron	0	0	0	0	0
Chaves	9	7	7	7	-2
Cibola	2	2	2	3	1
Colfax	2	2	2	4	2
Curry	2	2	3	5	3
De Baca	0	0	0	0	0
Doña Ana	21	20	23	26	5
Eddy	9	7	9	7	-2
Grant	3	3	3	3	0
Guadalupe	0	0	0	0	0
Harding	0	0	0	0	0
Hidalgo	0	0	0	0	0
Lea	3	3	6	7	4
Lincoln	3	2	2	2	-1
Los Alamos	2	3	2	3	1
Luna	4	4	3	2	-2
McKinley	8	10	9	9	1
Mora	0	0	0	0	0
Otero	11	10	8	8	-3
Quay	0	0	0	0	0
Rio Arriba	3	3	3	5	2
Roosevelt	1	1	1	1	0
San Juan	9	9	7	6	-3
San Miguel	4	4	3	3	-1
Sandoval	7	7	6	7	0
Santa Fe	12	11	13	13	1
Sierra	0	0	0	0	0
Socorro	4	4	4	3	-1
Taos	3	3	4	5	2
Torrance	0	0	0	0	0
Union	0	0	0	0	0
Valencia	1	0	0	0	-1
STATE TOTAL	256	236	253	273	17

Table 2.9. Counties with the Greatest OB-GYN Differences from National Benchmark

County	Practitioners Above Benchmark	County	Practitioners Needed to Meet Benchmark
Bernalillo	73	Sandoval, Valencia	8 each
Colfax	3	San Juan	6
Doña Ana	3	Santa Fe	3
Eddy, Los Alamos, McKinley, Otero, Rio Arriba, Socorro, Taos	1 each	Torrance	2

II.B.1.b. Methodological Notes

Our estimates of the New Mexico OB-GYN workforce include MDs and DOs who specialize in obstetrics and/or gynecology. As for PCPs, the estimated counts of OB-GYNs are based on 9,457 MDs and DOs with active license in New Mexico, comprising 7,572 surveyed MDs, 1,190 MDs who have an active license but no survey, 602 surveyed DOs and 93 unsurveyed DOs. For both MDs and DOs, obstetrics and/or gynecology specialty was determined first by self-reported specialty on the individual’s most recent survey. For unsurveyed physicians and those for whom the only survey available was 2015 (the year for which the specialty item was omitted from the survey), specialty was identified through licensure and/or board certification. As mentioned previously, *this is the first year for which DOs were allocated to specialty in this manner. In prior years, it was assumed based on the literature that 70 percent practice in primary care; the remaining 30 percent were not allocated to specialties.* OB-GYNs were allocated to counties first by the five-digit ZIP code of their self-reported primary practice location; where this information was not available, the county was identified by the licensure address ZIP code.

Using this methodology, we identified a total of 421 actively licensed physicians specializing in obstetrics and/or gynecology. Of these, 345 MDs (85.4 percent) and 15 DOs (88.2 percent) were surveyed.

II.B.1.c. Discussion

Figure 2.5 shows the county-level comparison of New Mexico’s OB-GYNs to the national benchmark of 2.1 OB-GYNs per 10,000 female population. The state as a whole has 54 providers above the national benchmark, with 24 counties (72.7 percent) at or above benchmark; however, this includes seven counties (Catron, De Baca, Guadalupe, Harding, Hidalgo, Mora and Union) that have no OB-GYNs and a benchmark value of zero. Table 2.9 shows the counties with the greatest numbers of OB-GYNs above and below benchmark. The counties with the most practitioners above benchmark – Bernalillo, Colfax, Doña Ana, Eddy, Los Alamos, McKinley, Otero, Rio Arriba, Socorro and Taos – together account for 78.4 percent of the state’s OB-GYNs. The five counties most below benchmark were Sandoval, Valencia, San Juan, Santa Fe and Torrance, which together would require 27 OB-GYNs to achieve benchmark OB-GYN-to-female-population ratios. As a whole, and assuming no redistribution of the current workforce, an additional 31 OB-GYNs would be required to meet the national benchmark in all counties.

The changes in OB-GYN counts by county over the period 2013 to 2016 are shown in Table 2.8. Since 2013, the state has gained 18 OB-GYNs, chiefly in Bernalillo County but also through modest increases in Doña Ana, Lea and other counties. Overall, 11 counties have gained OB-GYNs, 13 have maintained their 2013 workforce levels, and nine have lost OB-GYNs.

Late in 2016, Moffett et al. performed additional analysis of New Mexico’s 2015 OB-GYN workforce.³ This research highlighted the necessity of practice facilities and infrastructure to recruit and retain

workforce, as the 10 counties without OB-GYNs were also without inpatient labor and delivery facilities; the only counties with practicing OB-GYNs and hospitals providing maternity care were Roosevelt, at which an OB-GYN provides prenatal care at a family health center, and San Miguel. In San Miguel County, the labor and delivery facilities at Alta Vista Regional Hospital in Las Vegas were closed in 2016 due to a shortage of staff; they are currently working to recruit the necessary workforce to reopen. As physicians are surveyed only every three years, the closure has occurred too recently for the loss of providers in this county to be fully reflected in workforce counts.

Moffett et al. further found a number of demographic and practice differences between OB-GYNs working in metropolitan and rural counties. New Mexico's rural OB-GYNs were significantly more likely to be male, work 40 or more hours weekly, work in a hospital outpatient setting and work with four or fewer physicians in the same setting. Rural OB-GYNs were significantly less likely to identify as Hispanic and to be employed by a large group practice. They were furthermore 4.3 years older than metropolitan OB-GYNs on average. Together, these differences are suggestive of the types of individuals working in rural settings (non-Hispanic, older males) and the practice conditions they encounter there (long hours, smaller practices and hospital settings), which may be informative in shaping future recruitment and retention efforts.

II.B.2. Certified Nurse Midwives

II.B.2.a. Executive Summary

There were an estimated 156 CNMs in New Mexico in 2016 (Figure 2.6, Appendix A.5). Of the total, 57.1 percent are concentrated in Bernalillo County, which has 65 more CNMs than the national average (Table 2.10). Other counties with above-average CNM-to-female population ratios include Santa Fe (+11), Sandoval (+4), Grant, San Juan and Taos (+3 each). The counties most below benchmark include Valencia (-3), Lea (-2), Eddy, Lincoln, Luna, Otero, Rio Arriba, Roosevelt and Torrance (-1 each) (Table 2.10). *Assuming no redistribution of the current workforce, an additional 12 CNMs would enable New Mexico to meet the national benchmark (7.05 per 100,000 female population) in all counties.*

CNMs Compared to Benchmark, 2016

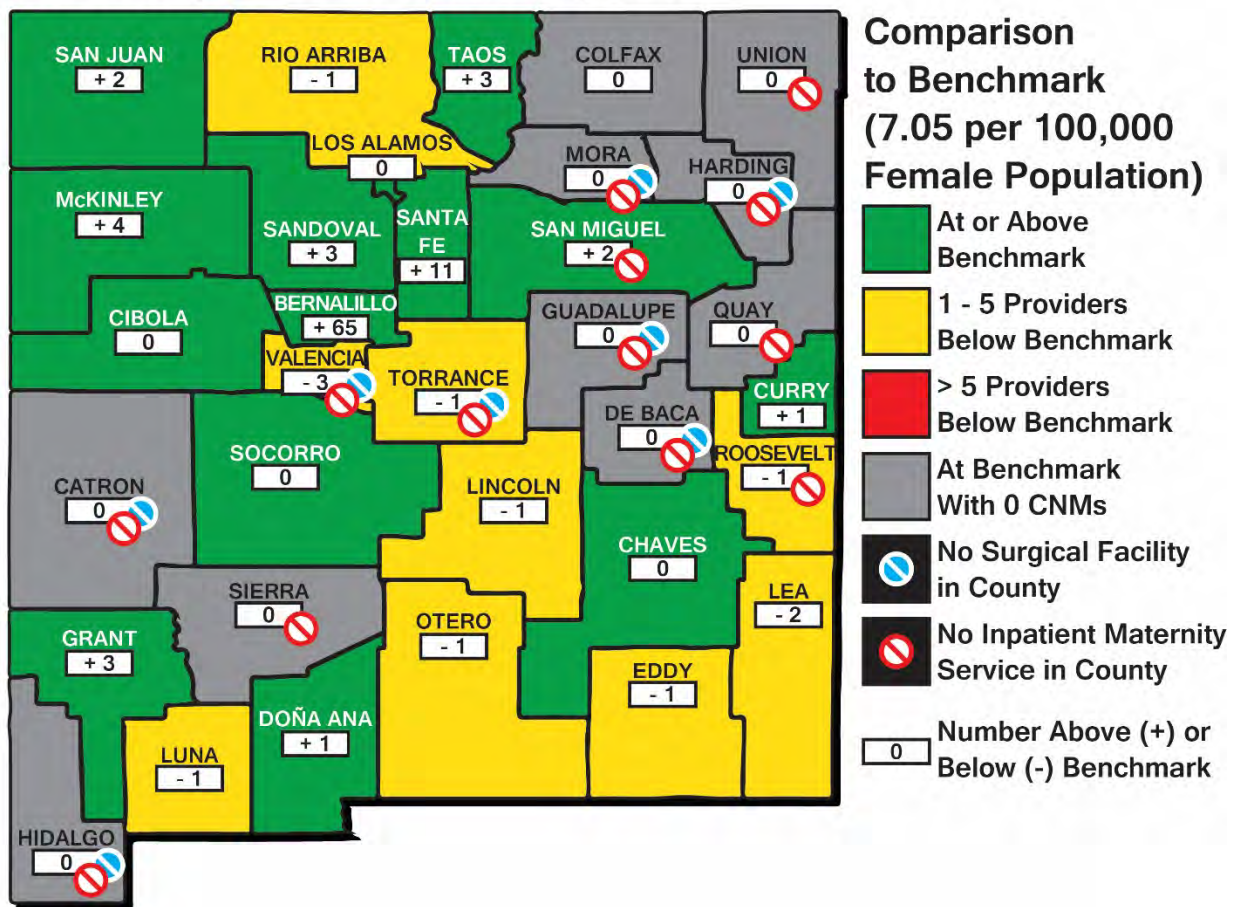


Figure 2.6. CNM workforce relative to the national benchmark of 7.05 CNMs per 100,000 female population is shown in the white boxes. Each county's color indicates whether it is at or above benchmark (green), below benchmark by five or fewer providers (yellow), or below benchmark by more than five providers (red). Gray counties have no providers and benchmark values of zero. Red "no" symbols denote counties without inpatient labor and delivery facilities; blue "no" symbols denote counties without surgical facilities.

Table 2.10. Counties with the Greatest CNM Differences from National Benchmark

County	Practitioners Above Benchmark	County	Practitioners Needed to Meet Benchmark
Bernalillo	65	Valencia	3
Santa Fe	11	Lea	2
Sandoval	4	Eddy, Lincoln, Luna, Otero, Rio Arriba, Roosevelt, Torrance	1 each
Grant, San Juan, Taos	3 each		

II.B.2.b. Methodological Notes

This is the first year we have been able to analyze data for CNMs. As a result, it was necessary to identify a national benchmark metric. The American Midwifery Certification Board has published their count of United States CNMs and certified midwives (a similar certification that is not relevant to New Mexico), reporting a total of 11,475 active CNMs and certified midwives. Subtracting the 30 individuals practicing in United States territories and the 103 certified midwives leaves 11,342 CNMs nationwide. Dividing this number by the U.S. Census estimate of 160,780,741 female population yields a national average of 7.05 CNMs per 100,000 female population.⁹

CNM licensure and survey data from the New Mexico Department of Health were merged with Board of Nursing licensure and survey data for analysis of CNMs. The estimated counts of CNMs are based on New Mexico’s 184 actively licensed CNMs, of whom 156 were found to practice in New Mexico. As for CNPs/CNSs, CNMs were allocated to counties first by their self-reported practice five-digit ZIP code from the Board of Nursing survey; where this information was not available, the county was identified by the licensure address ZIP code.

II.B.2.c. Discussion

Figure 2.6 shows the county-level comparison of New Mexico’s CNMs to the national benchmark of 7.05 CNMs per 100,000 female population. The state as a whole has 83 providers above the national benchmark, with 24 counties (72.7 percent) at or above benchmark; however, this includes 10 counties (Catron, Colfax, De Baca, Guadalupe, Harding, Hidalgo, Mora, Quay, Sierra and Union) that have no CNMs and a benchmark value of zero. Table 2.10 shows the counties with the greatest numbers of CNMs above and below benchmark. The counties with the most practitioners above benchmark – Bernalillo, Santa Fe, Sandoval, Grant, San Juan and Taos – together account for 81.4 percent of the state’s CNMs. The counties most below benchmark were Valencia, Lea, Eddy, Lincoln, Luna, Otero, Roosevelt and Torrance, which together account for all 12 of the CNMs needed to achieve benchmark CNM-to-female population ratios without redistributing the current workforce.

The absence of red counties in Figure 2.6 highlights the substantial contributions made by CNMs to women’s health in New Mexico. It is to be expected that larger than average CNM-to-female population ratios would be found in a state where more than one in four births are attended by midwives, compared to 8 percent nationwide. This is reflected in an overall ratio of 14.9 CNMs per 100,000 female population in the state, more than twice the national benchmark.

Despite these dramatic departures from national birth attendance norms, however, there remain nine counties with fewer CNMs than the national average, again highlighting the maldistribution of New Mexico’s health care providers and the difficulty accessing health care providers faced by individuals

living in rural and frontier counties. In addition, as observed for OB-GYNs, CNMs tend to practice in counties with hospital maternity services, underscoring the importance of facilities and infrastructure to successful recruitment and retention of health care workforce.

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II.B.3. Licensed Midwives

II.B.3.a. Executive Summary

There were an estimated 48 LMs in New Mexico in 2016 (Figure 2.7, Appendix A.6). Of the total, 25 percent are concentrated in Bernalillo County, which has six more LMs than the national average (Table 2.11). Other counties with above-average LM-to-female population ratios include Santa Fe (+7), Taos (+6), Rio Arriba (+4), Doña Ana, Grant and Sandoval (+3 each). The counties below benchmark include Chaves, Lea, McKinley and San Juan (-1 each) (Table 2.11). *Assuming no redistribution of the current workforce, an additional four LMs would enable New Mexico to meet the national benchmark (7.05 per 100,000 female population) in all counties.*

LMs Compared to Benchmark, 2016

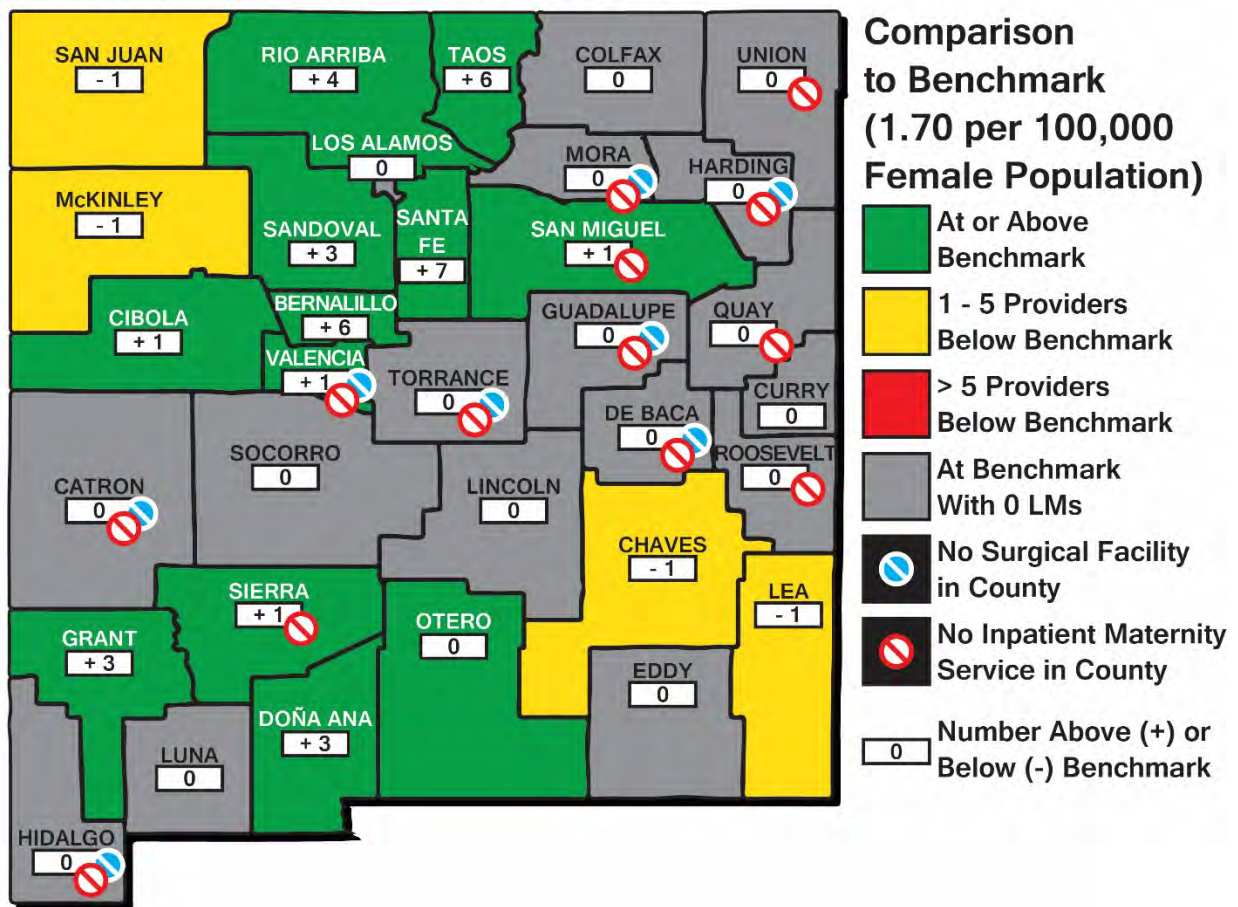


Figure 2.7. LM workforce relative to the national benchmark of 1.7 LMs per 100,000 female population is shown in the white boxes. Each county's color indicates whether it is at or above benchmark (green), below benchmark by five or fewer providers (yellow), or below benchmark by more than five providers (red). Gray counties have no providers and benchmark values of zero. Red "no" symbols denote counties without inpatient labor and delivery facilities; blue "no" symbols denote counties without surgical facilities.

Table 2.11. Counties with the Greatest LM Differences from National Benchmark

County	Practitioners Above Benchmark	County	Practitioners Needed to Meet Benchmark
Santa Fe	7	Chaves, Lea, McKinley, San Juan	1 each
Bernalillo, Taos	6 each	No other counties are below benchmark for LMs.	
Rio Arriba	4		
Doña Ana, Grant, Sandoval	3 each		

II.B.3.b. Methodological Notes

This is the first year we have been able to analyze data for LMs. As a result, it was necessary to identify a national benchmark metric. As discussed in Section II.B above, direct-entry midwives are not licensed in every state; in New Mexico, licensure requires CPM (certified professional midwife) certification by the North American Registry of Midwives. Comparison of the states allowing CPM practice and licensure²² with CPM counts by state¹⁰ found significantly higher CPM-to-female population ratios in states allowing licensure and practice. Thus, our national metric uses only those states for comparison. Anton et al. report 1,546 CPMs in states allowing their practice and licensure.¹⁰ Dividing this number by the estimated female population in those states of 91,082,355 yields a national benchmark of 1.70 per 100,000 female population.¹⁰

The estimated counts of LMs are based on New Mexico’s 80 actively licensed LMs, of whom 48 were found to practice in New Mexico. LMs were allocated to counties by their city and state as reported on the Department of Health LMs roster.

II.B.3.c. Discussion

Figure 2.7 shows the county-level comparison of New Mexico’s LMs to the national benchmark of 1.7 LMs per 100,000 female population. The state as a whole has 32 providers above the national benchmark, with 29 counties (87.9 percent) at or above benchmark; however, this includes 17 counties (51.5 percent) that have no LMs and a benchmark value of zero. Table 2.11 shows the counties with the greatest numbers of LMs above and below benchmark. The counties with the most practitioners above benchmark – Santa Fe, Bernalillo, Taos, Rio Arriba, Doña Ana, Grant and Sandoval – together account for 87.5 percent of the state’s LMs. The only counties below benchmark – Chaves, Lea, McKinley and San Juan – were lacking only one LM each to achieve benchmark.

The large number of gray counties shown in Figure 2.7 highlights both the relative scarcity of LMs in the state and nationwide. However, it is important to note that in two of the counties without OB-GYNs or CNMs – Sierra and Valencia – LMs practice as the only birth attendants. These counties are also without hospital maternity services, a reflection of LMs’ predominately home-birthing attendance.

II.B.4. Discussion of the Women’s Health and Birth Attendant Workforce

Table 2.12 shows the counts of all three types of women’s health providers and birth attendants by county. Notable is the absence of all three types of providers from nine counties: Catron, De Baca, Guadalupe, Harding, Hidalgo, Mora, Quay, Torrance and Union. That is, 27.3 percent of New Mexico counties have no women’s health specialists at all.

Table 2.12. Women’s Health Providers and Birth Attendants by County, 2016

County	OB-GYN Physicians	CNMs	LMs	TOTAL
Bernalillo	144	89	12	245
Catron	0	0	0	0
Chaves	7	2	0	9
Cibola	3	1	1	5
Colfax	4	0	0	4
Curry	5	3	0	8
De Baca	0	0	0	0
Doña Ana	26	9	5	40
Eddy	7	1	0	8
Grant	3	4	3	10
Guadalupe	0	0	0	0
Harding	0	0	0	0
Hidalgo	0	0	0	0
Lea	7	0	0	7
Lincoln	2	0	0	2
Los Alamos	3	1	0	4
Luna	2	0	0	2
McKinley	9	7	0	16
Mora	0	0	0	0
Otero	8	1	1	10
Quay	0	0	0	0
Rio Arriba	5	0	4	9
Roosevelt	1	0	0	1
San Juan	6	6	0	12
San Miguel	3	3	1	7
Sandoval	7	8	4	19
Santa Fe	13	16	8	37
Sierra	0	0	1	1
Socorro	3	1	0	4
Taos	5	4	6	15
Torrance	0	0	0	0
Union	0	0	0	0
Valencia	0	0	2	2
STATE TOTAL	273	156	48	477

Twelve counties have no hospital maternity services, although, as noted above, San Miguel county's Alta Vista Regional Hospital is working to reopen their labor and delivery service. Eight counties lack surgical facilities in which to perform Cesarean sections. The closure of labor and delivery in San Miguel was particularly damaging for access, as it left the entire northeast quadrant of the state without hospital maternity services.

The needs of rural hospitals to balance costly facilities and services with their relatively low demand due to low population density make it challenging to maintain maternity services, and some degree of regionalization of care is perhaps unavoidable due to these economic pressures. Nonetheless, it will be important to explore ways to ease access to maternity and particularly prenatal care for women in these underserved counties.

II.C. Other Physician Specialties

II.C.1. General Surgeons

II.C.1.a. Executive Summary

There were an estimated 188 general surgeons in New Mexico in 2016 (Figure 2.8, Appendix A.7). Table 2.13 shows how the county-level counts have changed since 2013. Of the 2016 total, 39.9 percent are concentrated in Bernalillo County, which has 34 more general surgeons than adequate (Table 2.14). Other counties with above-adequate general surgeon counts include Santa Fe (+8), Curry (+6), Eddy and McKinley (+5 each). The counties most below benchmark include Valencia (-5), Sandoval (-3), Lea, Otero (-2 each), Lincoln and Torrance (-1 each) (Table 2.14). *Assuming no redistribution of the current workforce, an additional 14 general surgeons would enable New Mexico to meet the national benchmark (six per 100,000 population) in all counties.*

General Surgeons Compared to Benchmark, 2016

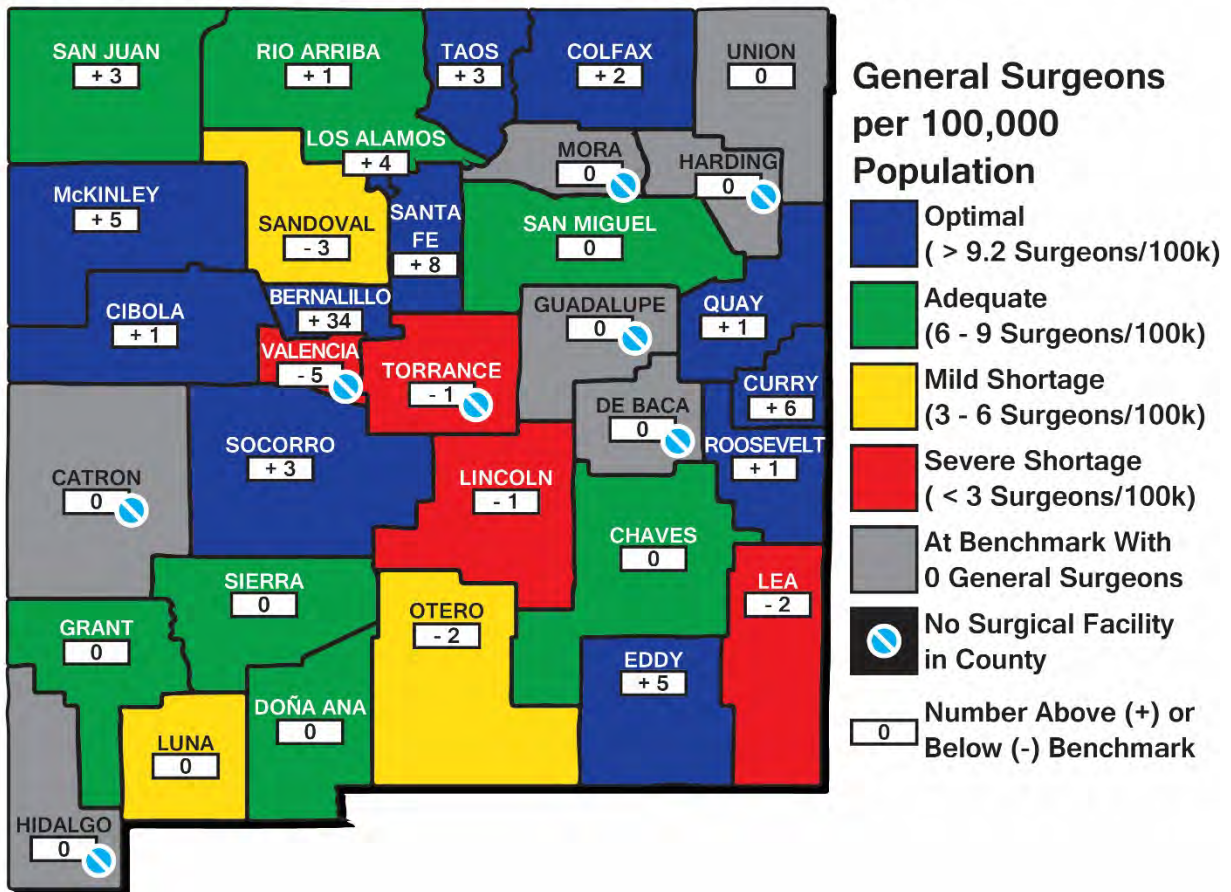


Figure 2.8. General surgeon workforce relative to the national benchmark of more than six general surgeons per 100,000 population is shown in the white boxes. Each county's color indicates whether the count of general surgeons per 100,000 population is considered optimal (blue), adequate (green), a mild shortage (yellow) or a severe shortage (red). Gray counties have no providers and benchmark values of zero. Blue "no" symbols denote counties without surgical facilities.

Table 2.13. General Surgeon Distribution by New Mexico County, 2013 – 2016

County	2013	2014	2015	2016	Net Change 2013 - 2016
Bernalillo	68	60	74	75	7
Catron	0	0	0	0	0
Chaves	3	4	4	4	1
Cibola	1	2	2	3	2
Colfax	5	4	4	3	-2
Curry	9	9	9	9	0
De Baca	0	0	0	0	0
Doña Ana	12	11	13	13	1
Eddy	7	5	8	8	1
Grant	4	5	3	2	-2
Guadalupe	0	0	0	0	0
Harding	0	0	0	0	0
Hidalgo	0	0	0	0	0
Lea	2	2	2	2	0
Lincoln	0	0	0	0	0
Los Alamos	6	5	4	5	-1
Luna	1	1	1	1	0
McKinley	7	8	8	9	2
Mora	0	0	0	0	0
Otero	2	2	2	2	0
Quay	1	1	2	2	1
Rio Arriba	1	2	3	3	2
Roosevelt	1	1	1	2	1
San Juan	7	7	6	10	3
San Miguel	3	3	2	2	-1
Sandoval	4	4	5	6	2
Santa Fe	12	15	17	17	5
Sierra	0	0	0	1	1
Socorro	2	3	2	4	2
Taos	7	7	4	5	-2
Torrance	0	0	0	0	0
Union	2	1	1	0	-2
Valencia	0	0	0	0	0
STATE TOTAL	179	162	177	188	9

Table 2.14. Counties with the Greatest General Surgeon Differences from National Benchmark

County	Practitioners Above Benchmark	County	Practitioners Needed to Meet Benchmark
Bernalillo	34	Valencia	5
Santa Fe	8	Sandoval	3
Curry	6	Lea, Otero	2 each
Eddy, McKinley	5 each	Lincoln, Torrance	1 each

II.C.1.b. Methodological Notes

Our estimates of the New Mexico general surgeon workforce include MDs and DOs who specialize in general surgery. Thresholds for optimal, adequate, mild shortage and severe shortage are taken from Ricketts et al.¹¹

The estimated counts of general surgeons are based on 9,457 MDs and DOs with active license in New Mexico, comprising 7,572 surveyed MDs, 1,190 MDs who have an active license but no survey, 602 surveyed DOs and 93 unsurveyed DOs. For both MDs and DOs, general surgery specialty was determined first by self-reported specialty on the individual’s most recent survey. For unsurveyed physicians and those for whom the only survey available was 2015 (the year for which the specialty item was omitted from the survey), specialty was identified through licensure and/or board certification. As mentioned previously, *this is the first year for which DOs were allocated to specialty in this manner. In prior years, it was assumed based on the literature that 70 percent practice in primary care; the remaining 30 percent were not allocated to specialties.* General surgeons were allocated to counties first by the five-digit ZIP code of their self-reported primary practice location; where this information was not available, the county was identified by the licensure address ZIP code.

A total of 314 general surgeons with active New Mexico licensure were identified. Of these, 243 MDs (83.2 percent) and 19 DOs (86.4 percent) were surveyed.

II.C.1.c. Discussion

Figure 2.8 shows the county-level comparison of New Mexico’s general surgeons to the national benchmark of six per 100,000 population. The state as a whole has 63 providers above the national benchmark, with 26 counties (78.8 percent) at or above benchmark (including seven counties with benchmark values of zero). Table 2.14 shows the counties with the greatest numbers of general surgeons above and below benchmark. The counties with the most practitioners above benchmark – Bernalillo, Santa Fe, Curry, Eddy and McKinley – together account for 62.8 percent of the state’s general surgeons. The counties most below benchmark were Valencia, Sandoval, Lea, Otero, Lincoln and Torrance, which together would require 14 general surgeons to achieve benchmark general surgeon-to-population ratios. As a whole, and assuming no redistribution of the current workforce, an additional 14 general surgeons would be required to meet the national benchmark in all counties.

Table 2.13 shows the county-level changes in general surgeon counts between 2013 and 2016. Overall, the state has gained nine general surgeons since 2013. During that time, six counties have lost general surgeons, 14 have gained general surgeons, and 13 have remained stable. As noted in Section II.B.1 regarding OB-GYNs, the eight counties without surgical facilities will remain unstaffed by general surgeons.

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II.C.2. Psychiatrists

II.C.2.a. Executive Summary

There were an estimated 332 psychiatrists in New Mexico in 2016 (Figure 2.9, Appendix A.8). Table 2.15 shows how the county-level counts have changed since 2013. Of the 2016 total, 55.1 percent are concentrated in Bernalillo County, which is 79 psychiatrists above benchmark (Table 2.16). Other counties with psychiatrist counts above benchmark include Santa Fe (+30) and San Miguel (+6). The counties most below benchmark include Sandoval (-12), Doña Ana (-11), Lea, Otero and San Juan (-7 each) (Table 2.16). *Assuming no redistribution of the current workforce, an additional 106 psychiatrists would enable New Mexico to meet the national benchmark (one per 6,500 population) in all counties.*

Psychiatrists Compared to Benchmark, 2016

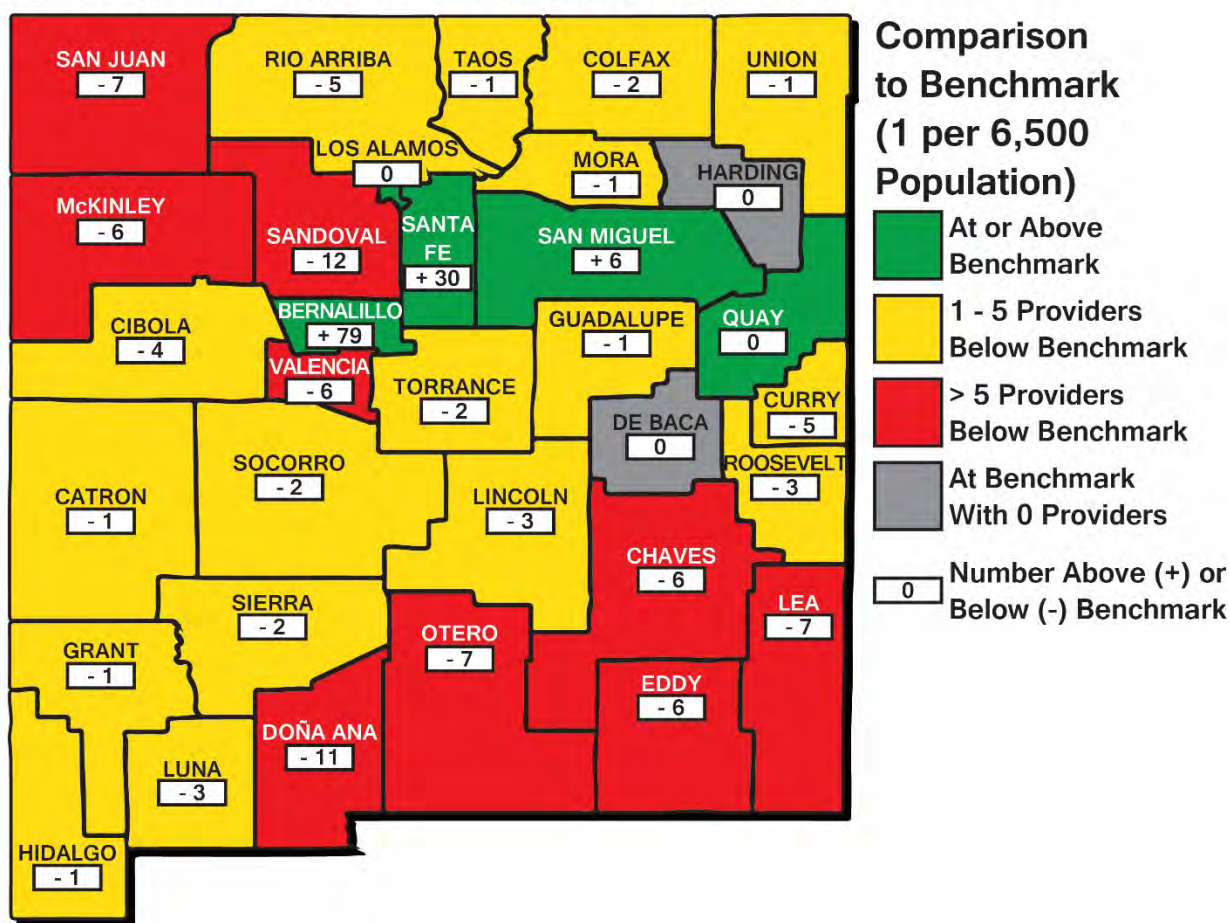


Figure 2.9. Psychiatrist workforce relative to the national benchmark of one psychiatrist per 6,500 population is shown in the white boxes. Each county's color indicates whether it is at or above benchmark (green), below benchmark by five or fewer providers (yellow), or below benchmark by more than five providers (red). Gray counties have no providers and benchmark values of zero.

Table 2.15. Psychiatrist Distribution by New Mexico County, 2013 – 2016

County	2013	2014	2015	2016	Net Change 2013 - 2016
Bernalillo	174	150	167	183	9
Catron	0	0	0	0	0
Chaves	6	6	5	4	-2
Cibola	1	1	1	0	-1
Colfax	0	0	0	0	0
Curry	4	4	4	3	-1
De Baca	0	0	0	0	0
Doña Ana	23	25	21	22	-1
Eddy	2	2	4	3	1
Grant	5	4	3	3	-2
Guadalupe	0	0	0	0	0
Harding	0	0	0	0	0
Hidalgo	0	0	0	0	0
Lea	3	3	4	4	1
Lincoln	0	0	0	0	0
Los Alamos	1	1	3	3	2
Luna	1	1	1	1	0
McKinley	7	7	5	6	-1
Mora	0	0	0	0	0
Otero	2	2	2	3	1
Quay	1	1	1	1	0
Rio Arriba	0	0	1	1	1
Roosevelt	0	0	0	0	0
San Juan	8	6	8	11	3
San Miguel	9	9	9	10	1
Sandoval	8	6	8	10	2
Santa Fe	51	48	51	53	2
Sierra	0	0	0	0	0
Socorro	3	2	1	1	-2
Taos	4	4	3	4	0
Torrance	0	0	0	0	0
Union	0	0	0	0	0
Valencia	8	7	7	6	-2
STATE TOTAL	321	289	309	332	11

Table 2.16. Counties with the Greatest Psychiatrist Differences from National Benchmark

County	Practitioners Above Benchmark	County	Practitioners Needed to Meet Benchmark
Bernalillo	79	Sandoval	12
Santa Fe	30	Doña Ana	11
San Miguel	6	Lea, Otero, San Juan	7 each
Los Alamos, Quay	0		

II.C.2.b. Methodological Notes

Our estimates of the New Mexico psychiatrist workforce include MDs and DOs who specialize in psychiatry. The estimated counts of psychiatrists are based on 9,457 MDs and DOs with active license in New Mexico, comprising 7,572 surveyed MDs, 1,190 MDs who have an active license but no survey, 602 surveyed DOs and 93 unsurveyed DOs. For both MDs and DOs, psychiatry specialty was determined first by self-reported specialty on the individual’s most recent survey. For unsurveyed physicians and those for whom the only survey available was 2015 (the year for which the specialty item was omitted from the survey), specialty was identified through licensure and/or board certification. As mentioned previously, *this is the first year for which DOs were allocated to specialty in this manner. In prior years, it was assumed based on the literature that 70 percent practice in primary care; the remaining 30 percent were not allocated to specialties.* Psychiatrists were allocated to counties first by the five-digit ZIP code of their self-reported primary practice location; where this information was not available, the county was identified by the licensure address ZIP code.

A total of 571 psychiatrists with active New Mexico licensure were identified. Of these, 461 MDs (85.8 percent) and 32 DOs (94.1 percent) were surveyed.

II.C.2.c. Discussion

Figure 2.9 shows the county-level comparison of New Mexico’s psychiatrists to the national benchmark of one per 6,500 population. The state as a whole has nine providers above the national benchmark, with only seven counties (21.1 percent) at or above benchmark (including two counties with benchmark values of zero). Table 2.16 shows the counties with the greatest numbers of psychiatrists above and below benchmark. The counties with the most practitioners at or above benchmark – Bernalillo, Santa Fe, San Miguel, Los Alamos and Quay – together account for 75.3 percent of the state’s psychiatrists. The counties most below benchmark were Sandoval, Doña Ana, Lea, Otero and San Juan, which together would require 30 psychiatrists to achieve benchmark psychiatrist-to-population ratios. As a whole, and assuming no redistribution of the current workforce, an additional 106 psychiatrists would be required to meet the national benchmark in all counties.

Table 2.15 shows the county-level changes in psychiatrist counts between 2013 and 2016. Overall, the state has gained 11 psychiatrists since 2013. During that time, eight counties have lost psychiatrists, 10 have gained psychiatrists, and 15 have remained stable. Psychiatrists, and the behavioral health workforce more broadly, are discussed in greater depth in Section III.

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II.D. Other Health Professions

II.D.1. Dentists

II.D.1.a. Executive Summary

There were an estimated 1,171 dentists in New Mexico in 2016 (Figure 2.10, Appendix A.9). Table 2.17 shows how the county-level counts have changed since 2014. Of the 2016 total, 43.4 percent are concentrated in Bernalillo County, which is 237 dentists above benchmark (Table 2.18). Other counties with dentist counts above benchmark include Santa Fe (+62), San Juan (+42), Doña Ana (+20) and Sandoval (+12). The counties most below benchmark include Otero, Valencia (-9 each), Lea (-5), Eddy and Torrance (-4 each) (Table 2.18). *Assuming no redistribution of the current workforce, an additional 55 dentists would enable New Mexico to meet the national benchmark (one per 2,500 population) in all counties.*

Dentists Compared to Benchmark, 2016

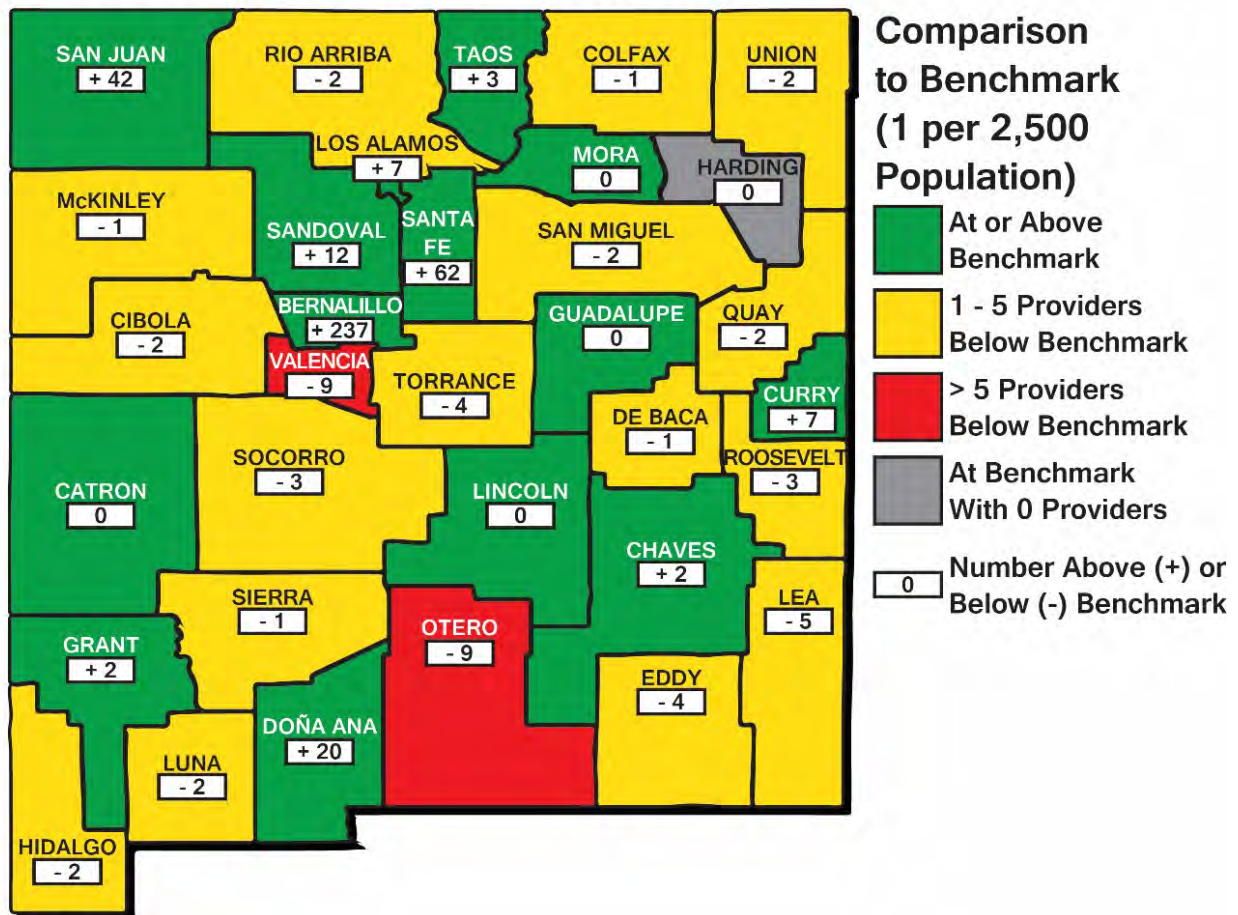


Figure 2.10. Dentist workforce relative to the national benchmark of one dentist per 2,500 population is shown in the white boxes. Each county's color indicates whether it is at or above benchmark (green), below benchmark by five or fewer providers (yellow), or below benchmark by more than five providers (red). Gray counties have no providers and benchmark values of zero.

Table 2.17. Dentist Distribution by New Mexico County, 2013 – 2016

County	2014	2015	2016	Net Change 2014 - 2016
Bernalillo	480	504	508	28
Catron	1	1	1	0
Chaves	21	24	28	7
Cibola	8	8	9	1
Colfax	4	4	4	0
Curry	25	29	27	2
De Baca	0	0	0	0
Doña Ana	95	104	106	11
Eddy	15	19	19	4
Grant	13	11	13	0
Guadalupe	1	1	2	1
Harding	0	0	0	0
Hidalgo	0	0	0	0
Lea	19	17	23	4
Lincoln	8	10	8	0
Los Alamos	16	15	14	-2
Luna	7	7	8	1
McKinley	32	31	29	-3
Mora	1	1	2	1
Otero	19	18	17	-2
Quay	1	1	1	0
Rio Arriba	10	11	14	4
Roosevelt	3	3	5	2
San Juan	71	78	88	17
San Miguel	12	10	9	-3
Sandoval	60	60	69	9
Santa Fe	112	114	121	9
Sierra	6	4	3	-3
Socorro	4	4	4	0
Taos	15	17	16	1
Torrance	2	2	2	0
Union	0	0	0	0
Valencia	20	23	21	1
STATE TOTAL	1,081	1,131	1,171	90

Table 2.18. Counties with the Greatest Dentist Differences from National Benchmark

County	Practitioners Above Benchmark	County	Practitioners Needed to Meet Benchmark
Bernalillo	237	Otero, Valencia	9 each
Santa Fe	62	Lea	5
San Juan	42	Eddy, Torrance	4 each
Doña Ana	20		
Sandoval	12		

II.D.1.b. Methodological Notes

New Mexico has 1,566 actively licensed dentists, of whom 879 (56.1 percent) have completed a license renewal survey. Dentists were allocated to counties first by the five-digit ZIP code of their self-reported primary practice location; where this information was not available, the county was identified by the licensure address ZIP code.

II.D.1.c. Discussion

Figure 2.10 shows the county-level comparison of New Mexico’s dentists to the national benchmark of one per 2,500 population. The state as a whole has 339 providers above the national benchmark, with only 15 counties (45.5 percent) at or above benchmark (including one county with a benchmark value of zero). Table 2.18 shows the counties with the greatest numbers of dentists above and below benchmark. The counties with the most practitioners at or above benchmark – Bernalillo, Santa Fe, San Juan, Doña Ana and Sandoval – together account for 76.2 percent of the state’s dentists. The counties most below benchmark were Otero, Valencia, Lea, Eddy and Torrance, which together would require 31 dentists to achieve benchmark dentist-to-population ratios. As a whole, and assuming no redistribution of the current workforce, an additional 55 dentists would be required to meet the national benchmark in all counties.

Table 2.17 shows the county-level changes in dentist counts between 2014 and 2016. Overall, the state has gained 90 dentists since 2014. During that time, five counties have lost dentists, 17 have gained dentists and 11 have remained stable.

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II.D.2. Pharmacists

II.D.2.a. Executive Summary

There were an estimated 2,013 pharmacists in New Mexico in 2016 (Figure 2.11, Appendix A.10). Table 2.19 shows how the county-level counts have changed since 2014. Of the 2016 total, 56.5 percent are concentrated in Bernalillo County, which is 609 pharmacists above benchmark (Table 2.20). Other counties with pharmacist counts above benchmark include Sandoval (+35), De Baca, Los Alamos and Taos (+1 each). The counties most below benchmark include Doña Ana (-35), McKinley (-32), San Juan (-25), Otero (-24) and Rio Arriba (-23) (Table 2.20). *Assuming no redistribution of the current workforce, an additional 257 pharmacists would enable New Mexico to meet the national benchmark (0.78 per 1,000 population) in all counties.*

Pharmacists Compared to Benchmark, 2016

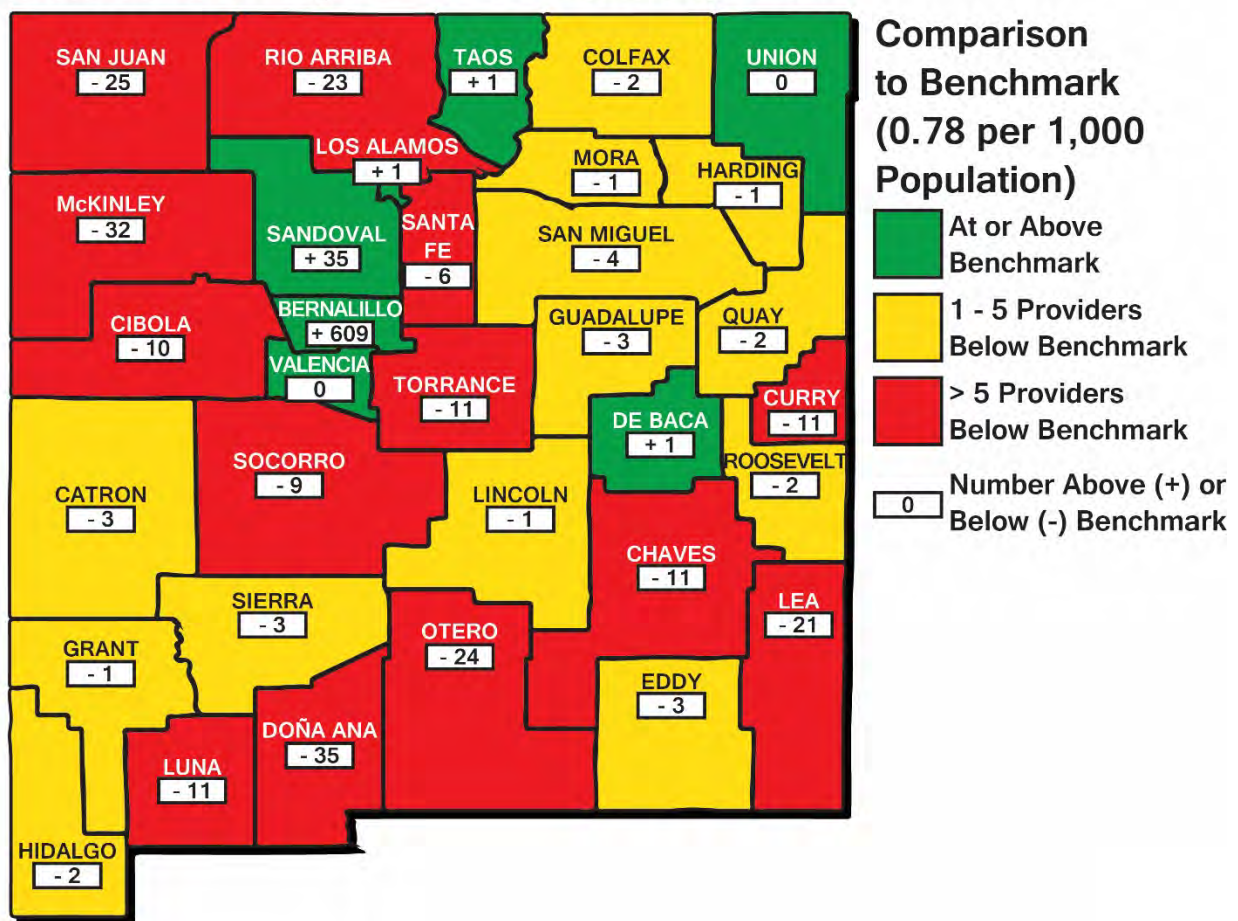


Figure 2.11. Pharmacist workforce relative to the national benchmark of 0.78 pharmacists per 1,000 population is shown in the white boxes. Each county's color indicates whether it is at or above benchmark (green), below benchmark by five or fewer providers (yellow), or below benchmark by more than five providers (red). Please note that pharmacists are allocated to counties by mailing address due to the issues with the pharmacists' survey discussed in Section I.B.4.

Table 2.19. Pharmacist Distribution by New Mexico County, 2013 – 2016

County	2014	2015	2016	Net Change 2014 - 2016
Bernalillo	1,079	1,070	1,137	58
Catron	0	0	0	0
Chaves	40	40	40	0
Cibola	13	13	11	-2
Colfax	10	9	8	-2
Curry	25	26	28	3
De Baca	2	2	2	0
Doña Ana	123	121	132	9
Eddy	38	40	42	4
Grant	20	21	21	1
Guadalupe	0	0	0	0
Harding	0	0	0	0
Hidalgo	1	1	1	0
Lea	27	26	33	6
Lincoln	18	15	14	-4
Los Alamos	12	13	15	3
Luna	6	6	8	2
McKinley	25	23	26	1
Mora	3	3	3	0
Otero	22	24	27	5
Quay	6	6	5	-1
Rio Arriba	9	9	8	-1
Roosevelt	14	14	13	-1
San Juan	65	66	65	0
San Miguel	19	18	18	-1
Sandoval	143	142	146	3
Santa Fe	112	108	110	-2
Sierra	6	6	6	0
Socorro	2	2	4	2
Taos	26	24	27	1
Torrance	2	2	1	-1
Union	3	3	3	0
Valencia	57	58	59	2
STATE TOTAL	1,928	1,911	2,013	85

Table 2.20. Counties with the Greatest Pharmacist Differences from National Benchmark

County	Practitioners Above Benchmark	County	Practitioners Needed to Meet Benchmark
Bernalillo	609	Doña Ana	35
Sandoval	35	McKinley	32
De Baca, Los Alamos, Taos	1 each	San Juan	25
		Otero	24
		Rio Arriba	23

New Mexico Pharmacies

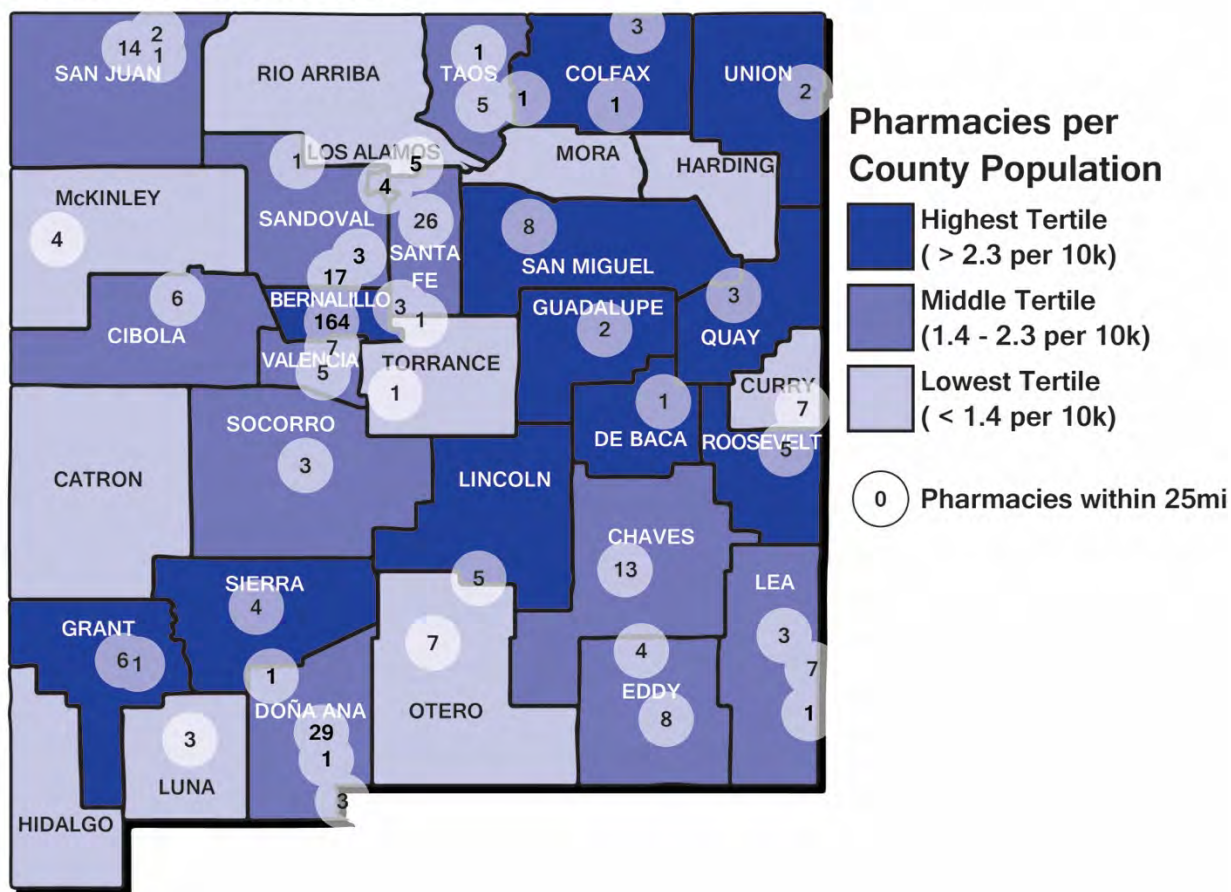


Figure 2.12. The number of pharmacies within a 25-mile radius is shown in the white dots, which are 25 miles in diameter. Each county's color indicates whether it is among the third of counties with the highest pharmacy-per-population ratio (dark), middle third (medium) or lowest third (light).

II.D.2.b. Methodological Notes

New Mexico has 3,204 actively licensed pharmacists, of whom an unknown proportion have completed a license renewal survey. As discussed previously, the registered pharmacists' survey is voluntary and administered through an anonymous web portal, reducing the number of responses and preventing linkage of license and survey data. As a result, pharmacists were allocated to counties by the five-digit ZIP code of their licensure address.

In order to analyze pharmacy locations (Figure 2.12), a list of licensed New Mexico pharmacies was obtained from the University of New Mexico College of Pharmacy. They were allocated to counties and location by street address. Each location containing pharmacies was mapped using the number of pharmacies at that location and a circle equal to 25 miles in diameter surrounding the city's pin location in Google Maps.

II.D.2.c. Discussion

Figure 2.11 shows the county-level comparison of New Mexico's pharmacists to the national benchmark of 0.78 per 1,000 population. The state as a whole has 390 providers above the national benchmark, with only seven counties (21.2 percent) at or above benchmark. Table 2.20 shows the counties with the greatest numbers of pharmacists above and below benchmark. The counties with the most practitioners at or above benchmark – Bernalillo, Sandoval, De Baca, Los Alamos and Taos – together account for 65.9 percent of the state's pharmacists. The counties most below benchmark were Doña Ana, McKinley, San Juan, Otero and Rio Arriba, which together would require 139 pharmacists to achieve benchmark pharmacist-to-population ratios. As a whole, and assuming no redistribution of the current workforce, an additional 257 pharmacists would be required to meet the national benchmark in all counties.

Table 2.19 shows the county-level changes in pharmacist counts between 2014 and 2016. Overall, the state has gained 85 pharmacists since 2014. During that time, nine counties have lost pharmacists, 14 have gained pharmacists and 10 have remained stable.

This year, we also mapped the locations of New Mexico's pharmacies; as discussed for other health care providers above, a lack of facilities and infrastructure may form a barrier to practice. We found that pharmacies are generally grouped within larger population centers (Figure 2.12). As a result, counties such as Lincoln may fall within the highest tertile for pharmacies per population, while residents of the county outside of Ruidoso and Ruidoso Downs must travel more than 25 miles in each direction to see a pharmacist. As shown in Figure 2.12, large swaths of the state are greater than 25 miles from the nearest pharmacy, including all of Catron County – an area 25 percent larger than the state of Connecticut. While individuals in these areas are likely able to use mail order and internet pharmacies, as well as clinic-based dispensaries, they may have considerable difficulty consulting a pharmacist face-to-face. New Mexico pharmacy companies have begun to establish remote telepharmacy services in order to address this issue.

II.D.3. Registered Nurses

II.D.3.a. Executive Summary

There were an estimated 17,219 RNs in New Mexico in 2016, 1,506 more than in 2012, the last year for which this profession was analyzed. There were 759 fewer than the benchmark based on national averages (Figure 2.13, Appendix A.11). Table 2.21 shows how each county's RN count has changed since 2012. Of the total, 48.5 percent are concentrated in Bernalillo County, which has 2,495 more RNs than the national average (Table 2.22). Other counties with above-average RN-to-population ratios include Grant (+18) and San Miguel (+26). The counties most below benchmark include Valencia (-459), Sandoval (-427), Doña Ana (-361), Lea (-244) and McKinley (-190) (Table 2.22). *Assuming no redistribution of the current workforce, an additional 3,361 RNs would enable New Mexico to meet the national benchmark (8.64 per 1,000 population) in all counties.*

Registered Nurses Compared to Benchmark, 2016

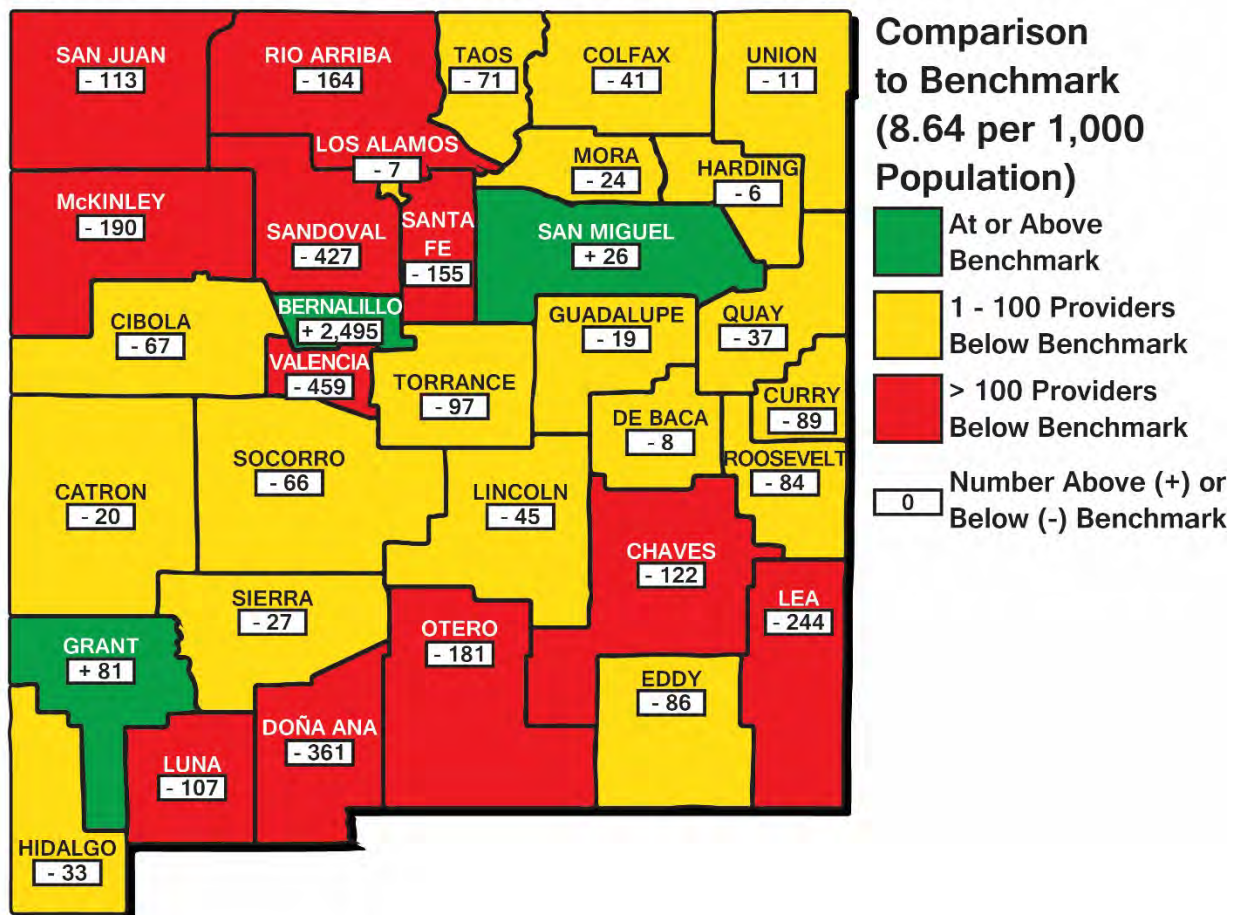


Figure 2.13. Registered nurse workforce relative to the national benchmark of 8.64 RNs per 1,000 population is shown in the white boxes. Each county's color indicates whether it is at or above benchmark (green), below benchmark by 100 or fewer providers (yellow), or below benchmark by more than 100 providers (red).

Table 2.21. RN Distribution by New Mexico County, 2012 – 2016

County	2012 ^a	2016	Net Change 2012 - 2016
Bernalillo	7,725	8,344	619
Catron	9	10	-1
Chaves	422	442	20
Cibola	125	170	45
Colfax	69	65	-4
Curry	312	345	33
De Baca	6	7	1
Doña Ana	1,403	1,490	87
Eddy	390	412	22
Grant	304	325	21
Guadalupe	17	19	2
Harding	1	0	-1
Hidalgo	7	4	-3
Lea	344	359	15
Lincoln	120	123	3
Los Alamos	152	150	-2
Luna	81	104	23
McKinley	428	457	29
Mora	8	15	7
Otero	388	384	-4
Quay	34	35	1
Rio Arriba	176	182	6
Roosevelt	70	81	11
San Juan	845	881	36
San Miguel	259	266	7
Sandoval	379	800	421
Santa Fe	1,087	1,129	42
Sierra	66	70	4
Socorro	82	81	-1
Taos	192	215	23
Torrance	22	35	13
Union	37	25	-12
Valencia	153	194	41
STATE TOTAL	15,713	17,219	1,506

^a Registered nurse data were not analyzed for 2013 – 2015.

Table 2.22. Counties with the Greatest Registered Nurse Differences from National Benchmark

County	Practitioners Above Benchmark	County	Practitioners Needed to Meet Benchmark
Bernalillo	2,495	Valencia	459
Grant	81	Sandoval	427
San Miguel	26	Doña Ana	361
No additional counties are above benchmark for RNs.		Lea	244
		McKinley	190

II.D.3.b. Methodological Notes

As discussed in Section II.A.2.b above, the New Mexico Board of Nursing is to be commended on the quality of the nurses’ survey and the efficiency with which it was instituted. The estimated counts of RNs are based on New Mexico’s 26,920 RNs *who were not also licensed at a higher level*. That is, RNs who were also CNPs, CNSs, CRNAs, or CNMs were excluded from the RN count. Of these 26,920 RNs, 17,219 identified a New Mexico practice location in the survey. As for CNPs/CNSs, RNs were allocated to counties first by their self-reported practice five-digit ZIP code; where this information was not available, the county was identified by the licensure address ZIP code.

II.D.3.c. Discussion

Figure 2.13 shows the county-level comparison of New Mexico’s RNs to the national benchmark of 8.64 RNs per 1,000 population. Unlike the other professions analyzed, the state suffers from an overall shortage of RNs, not just maldistribution. The state as a whole is 759 RNs below the national benchmark; only three counties (9.1 percent) were at or above benchmark. Table 2.22 shows the counties above benchmark – Bernalillo, Grant and San Miguel – which together account for 51.9 percent of the state’s RNs. The five counties most below benchmark were Valencia, Sandoval, Doña Ana, Lea and McKinley, which together would require 1,681 RNs to achieve benchmark RN-to-population ratios. As a whole, and assuming no redistribution of the current workforce, an additional 3,361 RNs would be required to meet the national benchmark in all counties, 908 fewer than were needed in 2012.

Table 2.21 shows the county-level changes in RN counts between 2012, when the profession was last analyzed, and 2016. Overall, the state has gained 1,506 RNs since 2012. During that time, 25 counties have gained RNs and eight have lost RNs. Substantial increases were observed for Bernalillo, Doña Ana and Sandoval counties; however, both Doña Ana and Sandoval remain below benchmark for RNs.

Given the large number of counties falling below the national benchmark for RNs, it will be necessary to identify effective recruitment and retention strategies for this sector of the health care workforce. One avenue we encourage the Legislature to consider is the Enhanced Nurse Licensure Compact (eNLC). The eNLC allows nurses to hold multistate licenses allowing them to practice in other member states, subject to each state’s practice laws. Already adopted by 26 states, the eNLC will replace the current compact at the end of 2018. If New Mexico does not adopt the eNLC, it will remain bound by the terms of the original NLC with any other participating states that do not adopt the eNLC – currently only Colorado, Rhode Island and Wisconsin. In contrast, upon entering into the eNLC, New Mexico would allow multistate licensure of nurses among many other states, including the neighboring states of Arizona, Oklahoma, Texas and Utah.

The eNLC has many benefits. Nurses would be able to practice in multiple states with a single license, without the regulatory burden of obtaining licenses in each state separately. At the same time, nurses are required to hold their “home” state’s license, so that a nurse moving to New Mexico could begin work immediately with her multistate license, but must apply for a New Mexico license within 90 days. The eNLC clarifies nurses’ authority to practice in multiple states via telemedicine, an increasingly popular form of health care delivery. In addition, discipline cases, complaints and investigative information are able to be shared across state lines under the compact, enhancing patient safety.

At the same time, this compact is not without its detractors. Critics argue that practice location should remain rooted to the physical place of work, whereas the eNLC holds that practice occurs where the patient is located. With the increasing role of telemedicine, proponents are in favor of this change in the concept of practice location from the original NLC. In addition, oversight of the eNLC is by an interstate commission that can make binding decisions on member states; critics express concern that too much of member states’ practice authority is surrendered by this structure. Finally, it is assumed that scope of practice in all states is the same and that the practicing nurse is familiar with her scope in every state in which she is practicing. This may be problematic for cross-border telemedicine delivery.

The New Mexico Health Care Workforce Committee discussed the eNLC without coming to consensus on the subject. The complexity of this decision is such that it should be carefully considered by New Mexico’s state government. We encourage the Legislature to examine the matter and take action based upon their findings.

II.D.4. Emergency Medical Technicians

II.D.4.a. Executive Summary

There were an estimated 6,101 EMTs in New Mexico in 2016 (Figure 2.14, Appendix A.12). Of the total, 33.3 percent are concentrated in Bernalillo County, which has 88 more EMTs than the national average (Table 2.23). Other counties with above-average EMT-to-population ratios include Sandoval (+145), Lincoln (+53), San Juan (+34) and Los Alamos (+33). The counties most below benchmark include Doña Ana (-146), Otero (-61), Lea (-58), San Miguel (-41) and Cibola (-34) (Table 2.23). *Assuming no redistribution of the current workforce, an additional 475 EMTs would enable New Mexico to meet the national benchmark (2.87 per 1,000 population) in all counties.*

Emergency Medical Technicians Compared to Benchmark, 2016

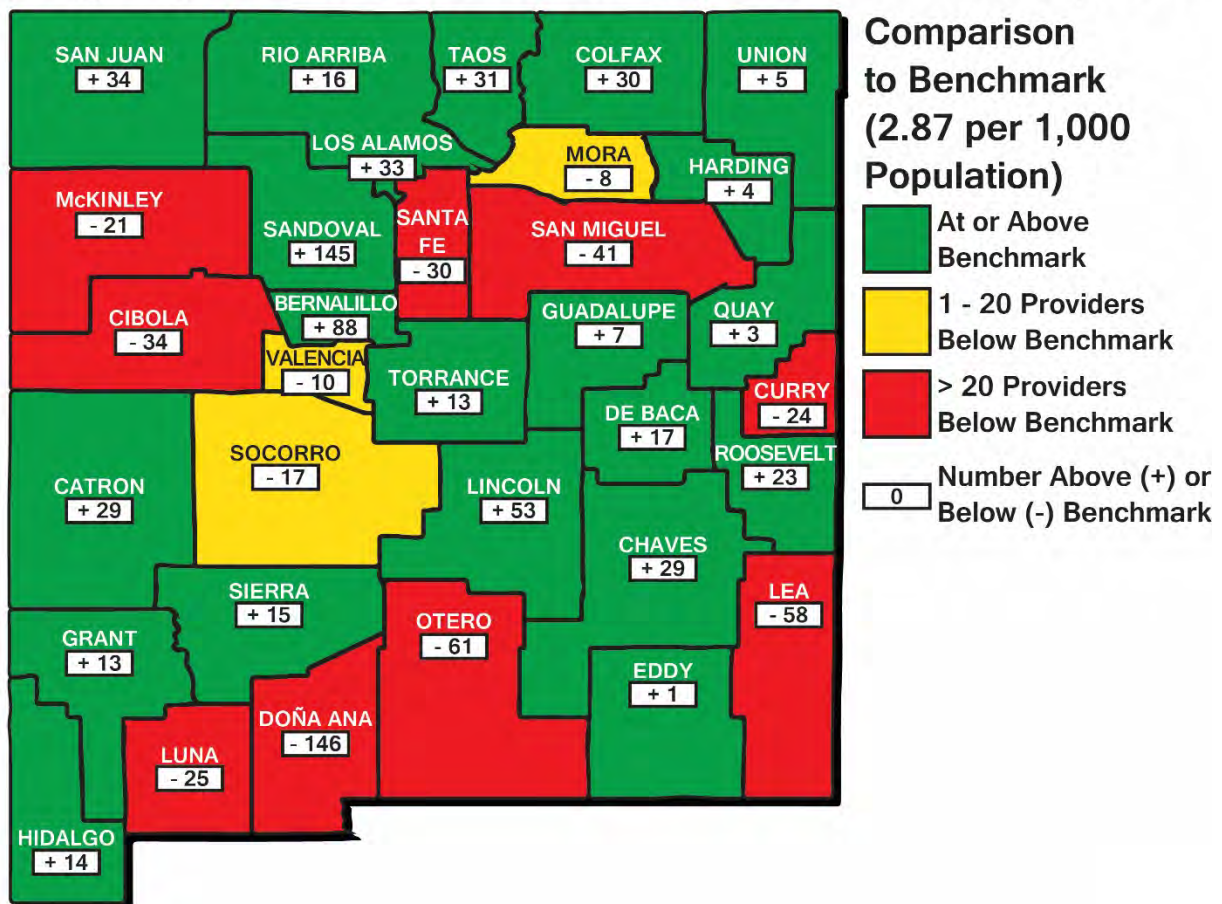


Figure 2.14. EMT workforce relative to the national benchmark of 2.87 EMTs per 1,000 population is shown in the white boxes. Each county's color indicates whether it is at or above benchmark (green), below benchmark by 20 or fewer providers (yellow), or below benchmark by more than 20 providers (red).

Table 2.23. Counties with the Greatest EMT Differences from National Benchmark

County	Practitioners Above Benchmark	County	Practitioners Needed to Meet Benchmark
Sandoval	145	Doña Ana	146
Bernalillo	88	Otero	61
Lincoln	53	Lea	58
San Juan	34	San Miguel	41
Los Alamos	33	Cibola	34

II.D.4.b. Methodological Notes

This is the first year we have been able to analyze data for EMTs. As a result, it was necessary to identify a national benchmark metric. The Federal Interagency Committee on Emergency Medical Services reports a national average of 2.87 EMTs of license type basic, intermediate and paramedic (EMT-B, EMT-I and EMT-P) per 1,000 population.¹⁵ New Mexico also issues dispatcher and first responder licenses. Because we have not identified a national metric that includes these license types, these individuals were excluded from the EMT counts.

The estimated counts of EMTs are based on New Mexico’s 7,102 actively licensed EMTs, of whom 6,340 (89.3 percent) are of license types EMT-B, EMT-I and EMT-P. EMTs complete surveys at initial licensure and license renewal; as a result, survey responses are available for 99.5 percent of licensees. EMTs were allocated to counties first by self-reported employment county; where this information was not available, the county was identified by the licensure address ZIP code.

II.D.4.c. Discussion

Figure 2.14 shows the county-level comparison of New Mexico’s EMTs to the national benchmark of 2.87 EMTs per 1,000 population. The state as a whole has 128 providers above the national benchmark, with 21 counties (63.6 percent) at or above benchmark. Table 2.23 shows the counties with the greatest numbers of EMTs above and below benchmark. The counties with the most practitioners above benchmark – Sandoval, Bernalillo, Lincoln, San Juan and Los Alamos – together account for only 51.5 percent of the state’s EMTs, suggesting that this profession is more equitably distributed than many of the others we analyze. Nonetheless, substantial shortfalls below benchmark do exist. The counties most below benchmark – Doña Ana, Otero, Lea, San Miguel and Cibola – would require a total of 340 EMTs to achieve benchmark.

EMTs showed a markedly bimodal distribution relative to benchmark, with the majority of counties either above benchmark (21 counties, 63.6 percent) or falling more than 20 EMTs below benchmark (nine counties, 27.3 percent). Only three counties (9.1 percent) were 20 or fewer EMTs below benchmark. It is important to remember that across all of the professions analyzed, the practitioner counts are based upon active licenses to match the national benchmarks used; the proportion of these individuals’ time spent on health care activities is not examined. With respect to EMTs, it is thought that many maintain certification to practice on a volunteer rather than full-time professional basis. Alternatively, it may be that more EMTs are needed in New Mexico than in the average state; with our scant and maldistributed workforce for many other health professions, these individuals may serve a larger role in New Mexico communities than in states better-supplied with health workforce. In future years, we will explore this phenomenon in greater depth.

II.E. Other Features of the Health Care Workforce

II.E.1. Executive Summary

The demographic data collection required under the Work Force Data Collection, Analysis and Policy Act is a tremendous resource for workforce analysis and planning. In this section, we present for New Mexico's physicians (MDs and DOs), CNPs/CNSs and PAs three demographic categories important for state workforce planning efforts: gender, race/ethnicity and age.

In each table, the total practitioner counts indicate the number of practitioners who completed a survey; as a result, these counts may differ from the counts presented earlier in Section II. In comparison to New Mexico's population, the physician workforce is more likely to be male, Asian or (to a lesser extent) Black and non-Hispanic. While New Mexico's physicians remain older than the national average, their median age (53.5) has remained stable relative to last year. In contrast, New Mexico's CNPs/CNSs and PAs are more likely than the state's population as a whole to be female; they are also more likely than the state's population to be non-Hispanic and Asian or (for PAs) white. CNPs/CNSs and PAs are both younger than the state's physicians: CNPs/CNSs by approximately eight months (median age 52.8) and PAs by a full eight years (median age 45.5).

II.E.2. Gender

Survey data show that 35.2 percent of New Mexico’s physicians (MDs and DOs) are female and 64.8 percent are male (Table 2.24). These proportions do not reflect the state’s population as a whole, but compare favorably to the national median of 32.4 percent female and 67.6 percent male.²³ Female physicians represent 43.8 percent of primary care physicians, 55.5 percent of OB-GYNs and 39.0 percent of psychiatrists, but only 22.0 percent of general surgeons. The gender proportions of New Mexico’s physicians continue to remain stable: in 2012, MDs were 35.1 percent female and 64.8 percent male.

Table 2.24. Gender of Surveyed New Mexico Physicians, 2016

Gender	NM Pop.	All MDs and DOs		Primary Care		OB-GYN		Psychiatrists		General Surgeons	
	%	Count	%	Count	%	Count	%	Count	%	Count	%
Female	50.4%	1,893	35.2%	898	43.8%	151	55.5%	128	39.0%	41	22.0%
Male	49.6%	3,487	64.8%	1,153	56.2%	121	44.5%	200	61.0%	145	78.0%
TOTAL		5,380		2,051		272		328		186	

Table 2.25 shows the gender proportions of New Mexico’s CNPs/CNSs and PAs. Unlike physicians, these practitioners are more commonly female, with 88.0 percent of state CNPs/CNSs and 59.7 percent of state PAs reporting female gender.

Table 2.25. Gender of Surveyed New Mexico CNPs/CNSs and PAs, 2016

Gender	NM Pop. ²⁴	CNPs/CNSs		PAs	
	%	Count	%	Count	%
Female	50.5%	1,213	88.0%	428	59.7%
Male	49.5%	165	12.0%	289	40.3%
TOTAL		1,378		717	

II.E.3. Race and Ethnicity

Diversity of the health care workforce directly affects patient access to care, and is important for meeting the health care needs of New Mexico’s racially and ethnically diverse population, especially in rural and underserved communities.

Table 2.26 shows the racial diversity of New Mexico’s physicians compared to the state’s population as a whole. Compared to the state’s population, physicians practicing in-state are less likely to be American Indian or Alaska Native, White or two or more races. New Mexico’s physicians are more likely than the state population as a whole to be Asian or Pacific Islander, Black or African American or other races. Psychiatrists showed a slightly different racial makeup than either physicians as a whole or the other specialties analyzed: New Mexico’s psychiatrists were more frequently White or two or more races than the state as a whole, and less frequently Black or African American.

Table 2.27 shows the racial diversity of the state’s CNPs/CNSs and PAs compared to New Mexico’s population as a whole. Individuals reporting a race of American Indian or Alaskan Native or Black or African American were underrepresented among both CNPs/CNSs and PAs; PAs were more likely than the state as a whole to report being white.

Table 2.28 shows the self-reported ethnicity of New Mexico’s physicians, CNPs/CNSs and PAs compared to the state’s population as a whole. Hispanic individuals were underrepresented across all three professions relative to the state’s population; fewer than one in five of these health professionals self-classified as Hispanic, compared to nearly one in two in the New Mexico population.

Table 2.26. Race of Surveyed New Mexico Physicians Compared to New Mexico’s Population, 2016

	Total Count ^a	American Indian or Alaska Native	Asian or Pacific Islander	Black or African American	White	Other	Two or more
NM Population²⁴	2,084,117	190,528 (9.1%)	30,037 (1.4%)	43,738 (2.1%)	1,524,911 (73.2%)	226,850 (10.9%)	68,053 (3.3%)
All Physicians	4,251	44 (1.0%)	463 (10.9%)	139 (3.3%)	3,011 (70.8%)	500 (11.8%)	94 (2.2%)
Primary Care	1,416	21 (1.5%)	186 (13.1%)	60 (4.2%)	887 (62.6%)	229 (16.2%)	33 (2.3%)
OB-GYN	203	2 (1.0%)	15 (7.4%)	13 (6.4%)	143 (70.4%)	23 (11.3%)	7 (3.4%)
Psychiatrists	228	4 (1.8%)	14 (6.1%)	3 (1.3%)	172 (75.4%)	26 (11.4%)	9 (3.9%)
General Surgeons	131	1 (0.8%)	18 (13.7%)	4 (3.1%)	89 (67.9%)	15 (11.5%)	4 (3.1%)

^a For the rows pertaining to New Mexico’s health care workforce, the total count represents those who answered the survey item pertaining to race.

Table 2.27. Race of Surveyed New Mexico CNPs/CNSs and PAs Compared to New Mexico's Population, 2016

	Total Count	American Indian or Alaska Native	Asian or Pacific Islander	Black or African American	White	Other	Two or more ^b	Other or Unreported
NM Population²⁴	2,084,117	190,528 (9.1%)	30,037 (1.4%)	43,738 (2.1%)	1,524,911 (73.2%)	226,850 (10.9%)	68,053 (3.3%)	NA
CNPs/CNSs	1,230	16 (1.3%)	33 (2.7%)	20 (1.6%)	875 (71.1%)	215 ^a (17.5%)	^b	71 (5.8%)
PAs	399	19 (4.8%)	14 (3.5%)	4 (1.0%)	334 (83.7%)	19 (4.8%)	9 (2.3%)	NA

^a The nursing survey options for race and ethnicity are as follows: African American/Black, American Indian/Alaska Native, Asian/Pacific Islander, Caucasian/White, Hispanic and Other or Unreported. The "Other" column in this row represents responses of "Hispanic"

^b Per the note above, there is no "Two or More" option on the nursing survey.

Table 2.28. Ethnicity of Surveyed New Mexico Physicians, CNPs/CNSs, and PAs Compared to New Mexico's Population, 2016

	Total Count ^a	Hispanic or Latino
NM Population²⁴	2,084,117	986,972 (47.4%)
All Physicians	5,193	711 (13.7%)
Primary Care	1,796	333 (18.5%)
OB-GYN	247	31 (12.6%)
Psychiatrists	298	43 (14.4%)
General Surgeons	169	28 (16.6%)
CNPs/CNSs	1,230	215 (17.5%)
PAs	493	95 (19.3%)

^a For the rows pertaining to New Mexico's health care workforce, the total count represents those who answered the survey item pertaining to ethnicity.

II.E.4. Age

The age distribution of New Mexico physicians is shown in Table 2.29. The median age of New Mexico physicians was 53.5 in 2016, comparable to the median ages in 2015 (53.6) and 2012 (53.4). The state's average physician is more than two years older than the average for the nation as a whole: New Mexico physicians averaged 53.4 years of age, while the national average is 51.3.²⁵ Nationally, New Mexico also continues to have the highest percentage of physicians aged 60 or older (35.9 percent, compared to 28.4 percent nationally).²³

Table 2.29. Age of Surveyed New Mexico Physicians, 2016

Age	All Physicians		Primary Care		OB-GYN		Psychiatrists		General Surgeons	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
<25	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
25-34	383	7.0%	202	9.7%	18	6.6%	15	4.5%	10	5.3%
35-44	1,309	24.1%	515	24.8%	72	26.3%	59	17.7%	59	31.4%
45-54	1,229	22.6%	469	22.6%	55	20.1%	74	22.2%	38	20.2%
55-64	1,376	25.3%	506	24.4%	65	23.7%	91	27.3%	41	21.8%
65+	1,138	20.9%	384	18.5%	63	23.0%	93	27.9%	40	21.3%
Unknown	2	0.0%	0	0.0%	1	0.4%	1	0.3%	0	0.0%
TOTAL	5,347		2,076		274		333		188	
Median Age		53.5		51.9		53.2		57.3		53.3

The age distribution of the state's CNPs/CNSs and PAs is shown in Table 2.30. New Mexico's CNPs/CNSs are comparable in age to the state's physicians with a median age of 52.8. In contrast, PAs in the state are substantially younger (median age 45.5).

Table 2.30. Age of Surveyed New Mexico CNPs/CNSs and PAs, 2016

Age	CNPs/CNSs		PAs	
	Count	Percent	Count	Percent
<25	2	0.1%	0	0.0%
25-34	157	11.4%	169	22.7%
35-44	271	19.7%	194	26.0%
45-54	337	24.4%	166	22.3%
55-64	433	31.4%	152	20.4%
65+	179	13.0%	64	8.6%
Unknown	0	0.0%	1	0.1%
TOTAL	1,379		746	
Median Age		52.8		45.5

II.F. Discussion

Health workforce planning requires efforts to ensure that the right professionals – and combination of professionals for effective teams – are available when and where they are needed to meet a population’s health care needs.

We have been pleased this year to update the analysis of RNs, last published in our 2013 report. In this year’s report, CNMs, LMs and EMTs are also analyzed for the first time, underscoring the increasingly complete picture of New Mexico’s health care workforce made possible as each year more health professions implement their required surveys. In addition to the 12 professions analyzed this year, there are 24 licensed health professions in the state that have implemented survey requirements (see Appendix C). As more professions meet their survey goals, we anticipate the opportunity to conduct more nuanced analyses of specific professions – as for primary care and OB-GYN physicians this year – and develop recommendations for training, recruitment and system-wide innovations.

Knowing the number of professionals and where they are practicing is only the first step – though a very important one – in being able to plan for current and future health care workforce needs. The national averages and standard ratios that we are using as benchmarks are meant to be tools for comparison and for representing the distribution of professionals across the state. The analyses based on these metrics do not represent access to care, i.e., whether New Mexico’s residents are able to consult health professionals where and when the need arises.

Many factors influence access to care and the capacity of the workforce to meet the population’s needs. People living in an area with practitioner-to-population ratios above benchmark values may nevertheless lack access to care for a number of reasons. They might be unable to afford care, for example. Even with affordable health care, they might find that it takes a month or more to get an appointment with a new primary care physician or to see a specialist. Health system issues – including the time needed for preauthorization, to process billing, and for other scheduling matters – also greatly affect sufficiency in all areas of the state.

The benchmarks themselves are also inadequate for examining the dynamic nature of the health care workforce under national health care reform and new team-based care models. These new variables underscore the need to know not just the number of professionals, but also what capabilities exist in the workforce, the interconnections between professional roles and potential reconfigurations to enhance quality and capacity.

The report serves as a snapshot of how many health care professionals are practicing in New Mexico and where they are concentrated or lacking – and as a launching point for asking more specific questions about the state’s health care workforce and what actions should be taken to enhance access to care for all residents.

II.G. Policy Recommendations

II.G.1. Health Care Workforce Training and Licensure

Rec. 2017.1. Identify funding for efforts to support the New Mexico Nursing Education Consortium (NMNEC).

Funding streams from the Robert Wood Johnson Foundation and the New Mexico Board of Nursing are no longer available for 2018. Therefore, we recommend at a minimum that in the interim legislative process, NMNEC testimony be provided to the Legislative Health & Human Services Committee (LHHS) and Legislative Education Study Committee.

We furthermore recommend that over the course of 2018 the New Mexico State Legislature explore adding an additional line item of \$380,000 to support the operations for sustained support of existing NMNEC programs, onboarding the remainder of state-supported nursing programs and preserving the NMNEC curriculum integrity. This funding would strengthen the New Mexico partnership model between universities and community colleges to increase the academic preparedness of the nursing workforce.

In 2010, the Institute of Medicine recommended an increase in the proportion of nurses with a baccalaureate degree to 80 percent by 2020.²⁶ According to the American Association of Colleges of Nursing (AACN), many hospitals and other medical facilities are following the IOM guidelines and strongly encourage associate degree in nursing (ADN)-prepared RNs to earn their bachelor of science in nursing (BSN) within five years of graduation.

For the last 10 years, AACN research has shown that higher education does make a difference in the quality of clinical practice. Evidence shows that nurses with a BSN give better care. The studies show that patients in the care of nurses with a BSN have better outcomes, including lower rates of mortality. Also, research shows that nurses who have a BSN or higher training are more proficient in making diagnoses and evaluating the results of interventions.²⁷

NMNEC has been successful in addressing the IOM reports recommendation of increasing nurses with BSN degrees for New Mexico's nursing workforce. Funding support for NMNEC is essential to continue to build partnerships between universities and community colleges to expand the BSN degree option, increase BSN prepared nurses for New Mexico, improve efficiency, quality and educational outcomes of nursing education through cooperation among community colleges and universities, increase nursing workforce diversity by improving nursing education for minorities, particularly in rural areas and maintain the NMNEC curriculum integrity.

Rec. 2017.2. Continue funding for expanded primary and secondary care residencies in New Mexico.

In 2014 and 2016, the Committee recommended that the state explore options for increasing the number of funded Graduate Medical Education (residency) positions. We reiterate our recommendation that the Legislature continue to fund expanded primary and secondary care residencies, particularly for practice in areas that are rural and/or underserved, as residency service in such areas can be a powerful recruitment tool.

Rec. 2017.3. Support further exploration of Medicaid as an avenue for expanding residencies in New Mexico.

We recommend the Legislature continue the work begun in 2014 to leverage state Medicaid funds to develop primary care residencies at Federally Qualified Health Centers and eligible rural hospitals in the state's shortage areas.²⁸

II.G.2. Financial Incentives for Health Professionals

Rec. 2017.4. Continue state funding of the former federal matching funds for New Mexico's state loan repayment program and position the Higher Education Department to take full advantage of the next opportunity to reinstate the U.S. Department of Health and Human Services matching grant to support this program.

The New Mexico Higher Education Department is prioritizing this upcoming opportunity. We reiterate our 2015 and 2016 recommendations endorsing their efforts to do so. Since the federal matching funds were lost, the state has funded this program fully; it is of paramount importance that funds continue to be allocated to maintain current funding levels for this program in order to maintain this valuable recruitment tool.

Rec. 2017.5. Increase funding for state loan-for-service and loan repayment programs, and consider restructuring them to target the professions most needed in rural and underserved areas rather than prioritizing those with higher debt.

Rural clinics and hospitals face tremendous challenges in recruiting and retaining medical staff sufficient to maintain standards of care; for example, see the discussion of the maternity service closure at Alta Vista in Section II.B. Eligibility of their employees for state loan repayment is a valuable recruitment tool for qualified sites. We recommend that these programs be expanded and restructured with an eye toward recognizing and ameliorating the existing dearth of health professionals in rural and frontier areas.

With respect to funding levels, we note that the primary barrier to effectiveness of these state programs is the small number of practitioners they are able to benefit given current funding levels; we encourage the Legislature to increase their funding.

We first recommended these programs' restructuring in our 2015 report. Shifting selection of practitioners for these programs from emphasizing providers' level of debt to prioritizing the professions most needed in rural areas would more effectively recruit necessary practitioners to shortage areas. In addition, there are a variety of methods to potentially expand the current loan repayment program that include increasing funding to individuals through the current system or passing increased loan repayment funds through hospitals and other health care organizations.

Rec. 2017.6. Request that the Department of Health add pharmacists, social workers and counselors to the health care professions eligible for New Mexico's Rural Healthcare Practitioner Tax Credit program.

The professions currently eligible include licensed dental hygienists, physician assistants, certified nurse midwives, certified registered nurse anesthetists, certified nurse practitioners and clinical nurse specialists. Pharmacists are urgently needed in many areas of the state, and counselors and social workers

make up nearly 80 percent of our state behavioral health workforce. They are not included in this program, which is an effective recruitment and retention tool to increase providers in rural settings.

II.G.3. Health Care Workforce Analysis

Rec. 2017.7. Remedy the pharmacists' survey.

As discussed above, the survey administered to New Mexico registered pharmacists 1) is, in effect, voluntary; 2) is anonymous, preventing linkage of license and survey data; and 3) was not provided to the New Mexico Health Care Workforce Committee for 2016. It will be critically important for the Board of Pharmacy to bring their survey in line with statutory requirements in order to ensure complete, high-quality data and an accurate analysis of the state's pharmacist workforce.

Rec. 2017.8. Provide funding for the New Mexico Health Care Workforce Committee.

As we recommended in 2014, 2015 and 2016, funding for this committee will allow for more in-depth analysis of the state's health care workforce and the efficacy of recruitment and retention programs.

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Section III

New Mexico's Behavioral Health Workforce

III.A. Behavioral Health Needs in New Mexico

New Mexico continues to have ongoing challenges in sustaining an adequate behavioral health workforce to assure timely access to mental health and substance use treatment throughout the state. These challenges are part of the larger national picture, in which there is increasing recognition that there is an insufficient behavioral workforce to deliver behavioral health care during a time of increasing demand for services.²⁹

III.A.1. Behavioral Health Outcomes in New Mexico

Unfortunately, New Mexico continues to have long-standing disparities in behavioral health outcomes when compared to national data.

As demonstrated in Figure 3.1, New Mexico's death rate from alcohol-related chronic disease has been *first or second in the nation for the past 15 years, and is 1.5 to 2 times the national rate*. It has also been increasing since 1990. The leading causes of alcohol-related chronic disease mortality include chronic liver disease, alcohol dependence, alcohol abuse, hypertension and stroke.

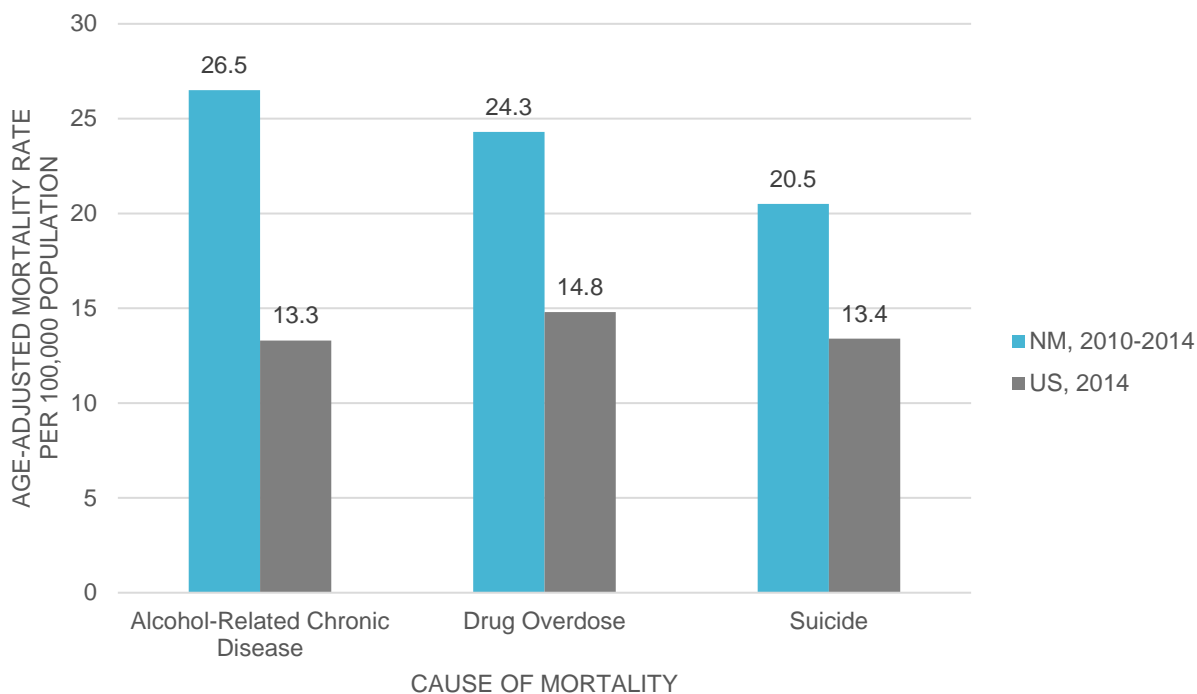


Figure 3.1. Mortality from select causes in New Mexico and the United States. Mortality by cause per 100,000 population is shown for New Mexico (blue) and the United States (gray).³⁰

New Mexico also continues to have high drug overdose mortality rates compared to the rest of the United States (Figure 3.1). These deaths include intentional drug overdose, but 80 to 85 percent are caused by unintentional drug overdoses. The recent increase in unintentional drug overdose deaths is largely attributed to the rise in prescription drug use, which accounts for 48 percent of drug overdose deaths in New Mexico.

Rates of suicide are another important behavioral health outcome. Approximately 61,000 New Mexico adults (4.0 percent) had serious thoughts of suicide each year from 2013 to 2014.³¹ According to the New Mexico Youth Risk and Resiliency Survey (YRRS), 8.6 percent of high school students attempted suicide in 2011, which is higher than the U.S. rate (7.8 percent).³² Figure 3.1 depicts suicide deaths identified using vital records data. New Mexico's suicide mortality rate has been 1.5 to 1.9 times the national rate since 1981. In addition, the national rate has been increasing since 2000, along with New Mexico's rate.

III.A.2. Access to Treatment

The National Survey on Drug Use and Health undertaken by the Substance Abuse and Mental Health Services Administration found that only 44.2 percent of New Mexico adults 18 years or older with a mental illness receive mental health treatment each year.³¹ This rate of treatment is similar to the national rates of treatment of any mental illness (42.9 percent).³¹ Similarly, only 37.2 percent of youth 12 to 17 years received treatment for their major depressive episode each year. Of those who do receive treatment in the public mental health system, the majority of adults report improved functioning from the treatment which is similar to the overall U.S. rates (70.3 percent vs. 70.9 percent). Encouragingly, among children and adolescents who receive treatment through New Mexico's public mental health system, a much higher percentage report improved functioning compared to the United States as a whole (80.3 percent vs. 69.5 percent).³³

Among adults who perceived a need for treatment but did not receive it, the top reason for not receiving treatment was cost (61.1 percent), followed by accessibility (31.6 percent) and personal reasons (32.2 percent, including not having felt the need for treatment at the time, thinking treatment wouldn't help, and being concerned about being committed or having to take medicine).³¹ In New Mexico, expansion of Medicaid with a robust package of behavioral health benefits has helped to address cost as a barrier for seeking treatment. However, as the workforce survey results show, it continues to be difficult to recruit behavioral health clinicians to work in public settings serving individuals with Medicaid.

III.B. Methodology

The data from the licensure survey allows us to answer the following specific questions for the following categories of behavioral health providers:

1. **Prescribers:** Includes psychiatrists, advanced nurse specialists with psychiatry specialty, and prescribing psychologists.
2. **Independently Licensed Psychotherapy Providers:** Includes providers of therapy and psychosocial interventions for mental illness and addictions treatment. They include non-prescribing psychologists, social workers, counselors and marriage and family therapists.
3. **Non-Independently Licensed Psychotherapy Providers:** Includes psychology associates, non-independently licensed social workers and non-independently licensed counselors. These

providers have a limited scope of practice to treat mental illness and addictions until they achieve full independent licensure.

4. **Substance Use Clinicians:** Includes providers of psychosocial interventions to treat addictions, and include licensed alcohol and drugs counselors and licensed substance use associates. This category includes dedicated substance use clinicians and does not overlap with the other categories regardless of independent licensure. Unlike other clinicians in the behavioral health workforce, their scope of practice does not include treatment of mental illness.

This section presents all data for behavioral health care providers actively licensed and practicing in New Mexico during the 2016 calendar year. The same data sources and methodology were used to identify behavioral health providers as for those providers described in Section II. Surveys are administered by the provider's licensing board upon license renewal only. Of the behavioral health providers with an active license in 2016, 9 percent of prescribers had not yet been surveyed, as well as 53 percent of independently licensed clinicians, 54 percent of non-independently licensed clinicians and 46 percent of substance use clinicians (Appendices B.1 and C.1). Several of the tables presented below were derived from survey data, including payment type, practice location type, future plans, health information technology, race/ethnicity and training location. Therefore, the total providers included in these tables are lower than the total licensed in the state. Additionally, because each licensing board administers a different license renewal survey, the nurse practitioners and nurse specialists are excluded from tables or separated due to differences in survey questions. In each case, only providers who responded to the survey question are included in the tables.

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III.C. Analysis of New Mexico's Behavioral Health Workforce

III.C.1. Behavioral Health Care Providers in New Mexico

In 2016, there were 484 prescribers, 4,734 independently licensed psychotherapy providers, 3,465 non-independently licensed psychotherapy providers and 845 substance use treatment providers practicing in New Mexico. Table 3.1 shows the number of behavioral health clinicians in each category in each county in 2016; please see Appendix B.2 for additional details on the smaller categories of practitioner comprising each license type. *Of note, eight counties do not have any access to behavioral health prescribers and two counties, Harding and De Baca, do not have any access to independently licensed clinicians.*

Composition of Behavioral Health Care Workforce, 2016

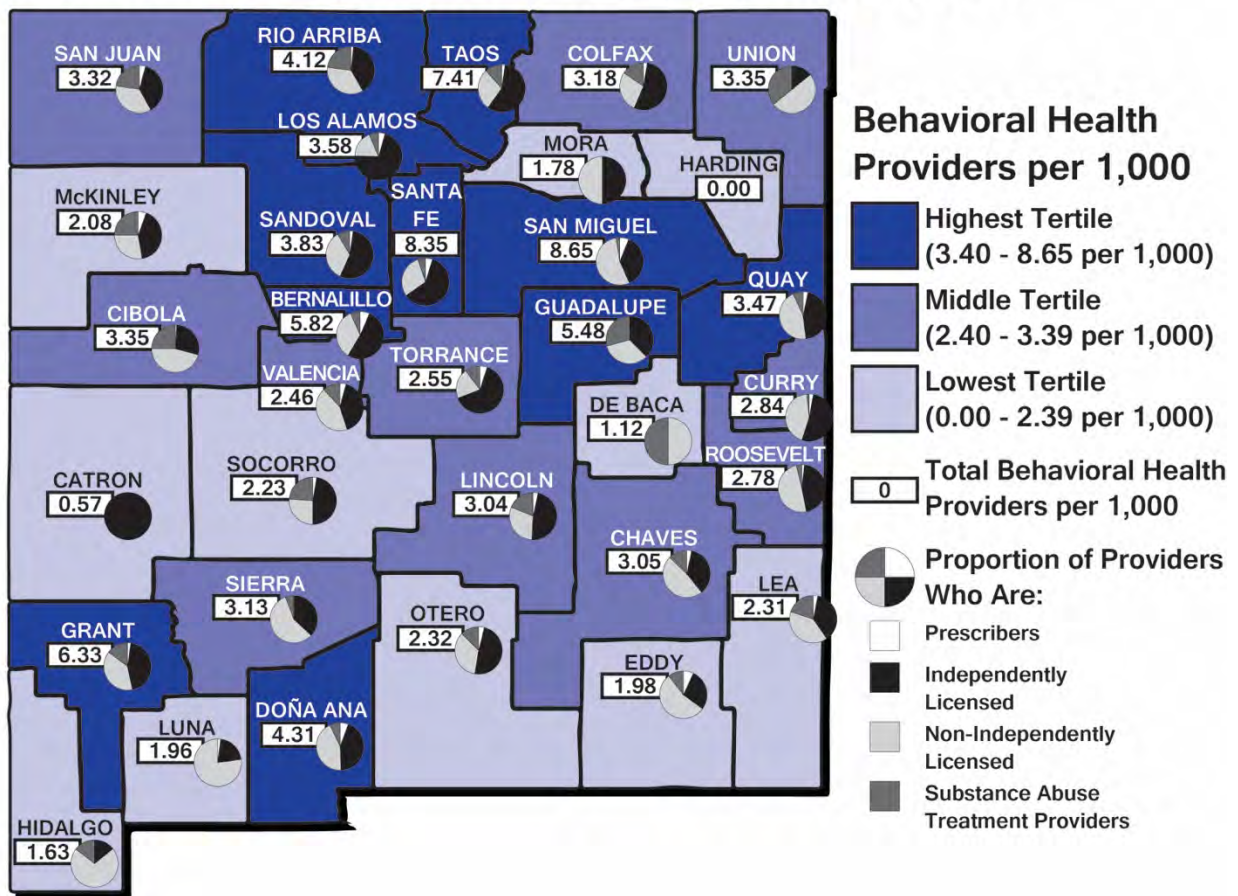


Figure 3.2. White boxes in each county show the total number of behavioral health providers per 1,000 population. County colors indicate whether each county ranks in the top (dark), middle (medium) or bottom (light) third of counties for this measure. Each county's pie chart shows the proportion of prescribers (white), independently-licensed psychotherapy providers (black), non-independently licensed psychotherapy providers (light gray), or substance use treatment providers (dark gray).

Table 3.1. Behavioral Health Care Providers by License Category, 2016

County	Prescribers ^a	Independently Licensed Psychotherapy Providers	Non-Independently Licensed Psychotherapy Providers	Substance Use Treatment Providers	County Total
Bernalillo	252	2,068	1,367	256	3,943
Catron	0	2	0	0	2
Chaves	7	71	96	25	199
Cibola	1	26	42	23	92
Colfax	1	21	11	6	39
Curry	4	75	62	2	143
De Baca	0	0	1	1	2
Doña Ana	53	404	401	66	924
Eddy	8	32	62	12	114
Grant	4	80	69	26	179
Guadalupe	0	9	8	7	24
Harding	0	0	0	0	0
Hidalgo	0	1	5	1	7
Lea	5	60	64	32	161
Lincoln	2	28	18	11	59
Los Alamos	3	46	12	4	65
Luna	1	10	37	0	48
McKinley	9	65	43	39	156
Mora	0	4	4	0	8
Otero	6	74	53	19	152
Quay	1	13	13	2	29
Rio Arriba	3	66	58	38	165
Roosevelt	1	24	26	2	53
San Juan	16	145	134	87	382
San Miguel	15	89	130	6	240
Sandoval	13	296	189	46	544
Santa Fe	62	750	365	64	1,241
Sierra	0	13	20	2	35
Socorro	1	18	10	9	38
Taos	6	141	70	28	245
Torrance	2	25	8	4	39
Union	0	2	7	5	14
Valencia	8	76	80	22	186
STATE TOTAL	484	4,734	3,465	845	9,528

^a This column includes 314 Medical Doctors and 18 Doctors of Osteopathy.

As discussed in Section I.B, using licensure data alone to determine practice location would result in over-counting providers, because professionals often use a residential address to obtain licensure rather than a practice address. Counts were determined using the practice address of surveyed providers and the mailing address of non-surveyed providers. Providers with out-of-state and unknown ZIP codes for practice location are excluded from the counts. In 2016, 9,528 of a total of 11,463 (83.1 percent) behavioral health providers with an active license in 2016 were practicing in New Mexico (Appendix B.3).

Figure 3.2 illustrates the behavioral health workforce per 1,000 population, graphically depicting the counties with the fewest behavioral health providers per population for each behavioral health provider category (see also Appendix B.4). The Northeast and Southwest regions of New Mexico tend to have the lowest ratios of providers to population, with the exception of non-independently licensed psychotherapy providers, who are scarcer in the southern part of the state.

Figure 3.3 compares the county-level ratio of substance use treatment providers to adult binge drinking prevalence. Binge drinking is a salient contributor to alcohol-related injury and mortality and is associated with social problems, such as interpersonal violence, crime and risky sexual behavior. It is defined as alcohol consumption at least once in the past 30 days that brings the blood alcohol concentration level to 0.08 percent or above – usually corresponding to five or more (for men) or four or more (for women) alcoholic drinks on a single occasion.³⁴ There is a moderate, negative correlation ($r = -0.31$) between the county-level ratio of substance use treatment providers and adult binge drinking prevalence, suggesting that the higher availability of substance use care is correlated with lower prevalence of adult binge drinking. The highest prevalence of adult binge drinking is in Mora County (26.2 percent), where there are no substance use treatment providers. The lowest prevalence of binge drinking is in De Baca County (3.8 percent), where there are 0.56 substance use treatment providers per 1,000 population: one of the top 10 highest ratios of substance use treatment providers in the state.

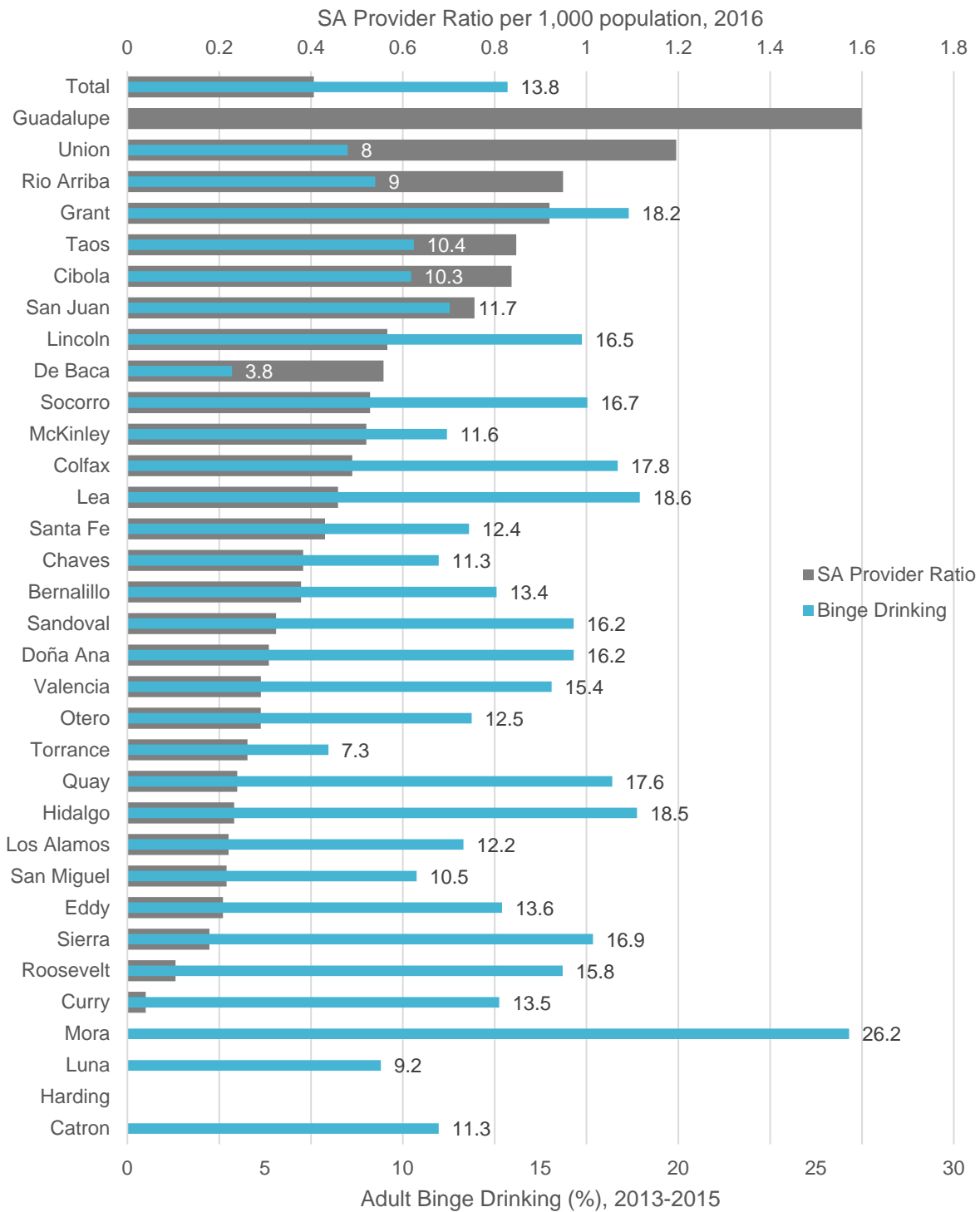


Figure 3.3. Ratio of substance use treatment providers in 2016 and prevalence of adult binge drinking 2013 – 2015 in New Mexico.³³

III.C.2. Independently and Non-Independently Licensed Providers

As non-independently licensed counselors and social workers progress towards full independent licensure, they are supervised by and must meet regularly with an independently licensed clinician. Figure 3.4 and Appendix B.5 describe the proportions of independently licensed clinicians in each county. This information is helpful for the development of sustainable pathways to full licensure for all clinicians. In communities with low proportions of independently licensed clinicians, it will be important to create structures for access to clinical supervision with independently licensed clinicians.

Percent of Psychotherapy Providers with Independent Licensure, 2016

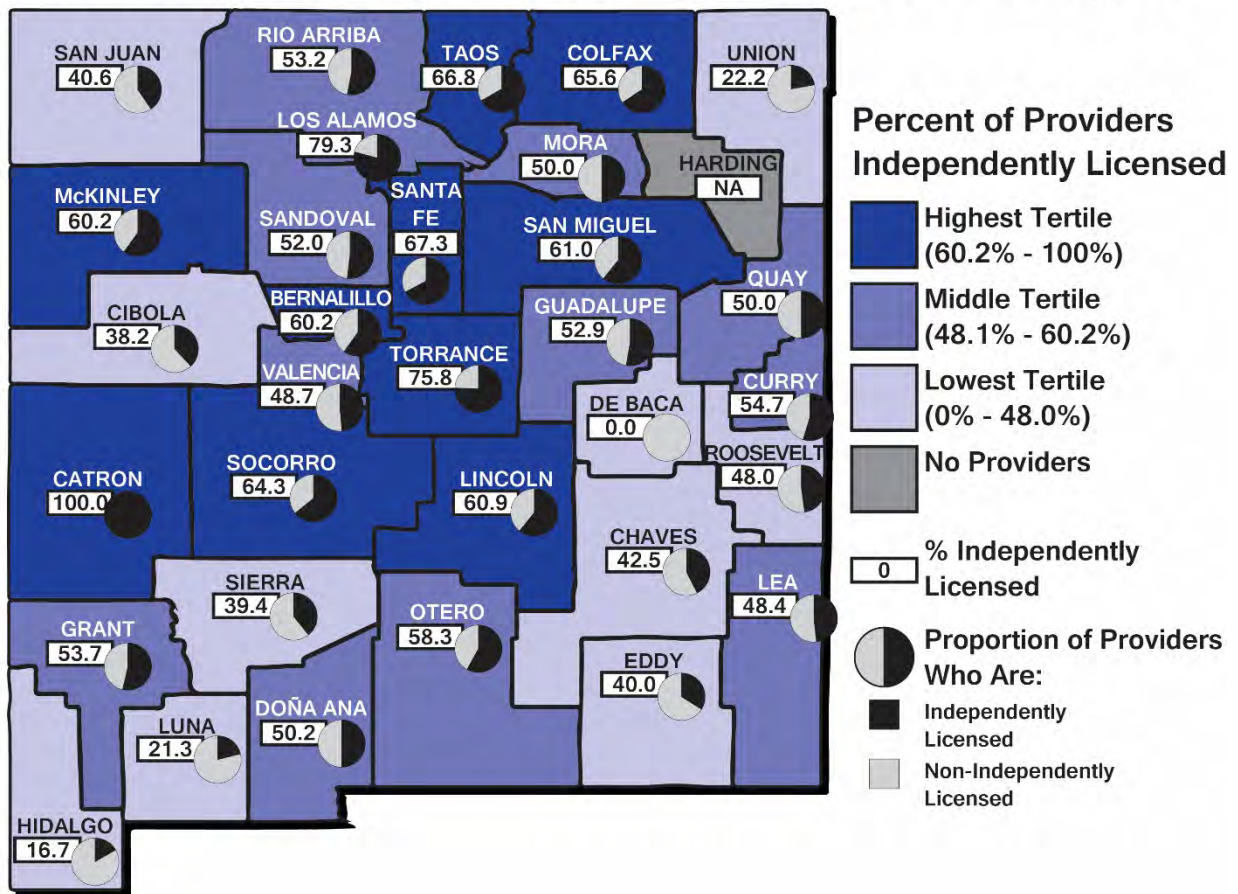


Figure 3.4. The white box for each county shows the percent of psychotherapy providers with independent licensure; colors indicate whether each county ranks in the top (dark), middle (medium) or bottom (light) third for this value. Harding County, which has no behavioral health providers, is colored gray. Pie charts show the proportion of independently (black) or non-independently (gray) licensed providers.

Some of New Mexico’s rural counties have especially low proportions of independently licensed clinicians. In order to strengthen our workforce, it is important to expand efforts to provide clinical supervision via telehealth. Two counties, De Baca and Harding, have no independently licensed psychotherapy providers. Thus, social workers and counselors working towards independent licensure in these counties will need to arrange supervision via telehealth or travel a distance for supervision to meet their licensure requirements.

III.C.3. Medicaid Acceptance by Behavioral Health Care Providers

Adults with serious mental illness and youths with serious emotional disturbances (the most severe forms of mental illness) are disproportionately more likely to have Medicaid coverage than other forms of insurance.³⁵ As we characterize New Mexico’s behavioral health workforce, it is important to identify how many clinicians accept Medicaid, as this is an important indicator of access for the most severely ill.

In New Mexico, 863,358 individuals are enrolled currently in Medicaid, which represents approximately 43 percent of the state’s population. Table 3.2 presents the distribution of providers in each category who reported that zero percent, 1 to 29 percent, 30 to 59 percent, and 60 to 100 percent of their patients have Medicaid as their primary payer. *It is of serious concern that more than one quarter of New Mexico behavioral health providers reported that none of their patients have Medicaid as a primary payer.* Appendices B.6 through B.8 include similar tables for Medicare, Tricare/VA/IHS and private insurance.

Table 3.2 includes the 3,137 behavioral health care providers who were surveyed and answered the question about patients with Medicaid as primary payer. It excludes nurse practitioners and nurse specialists, because this question is not on the nurse license renewal survey.

Table 3.2. Percentage of Behavioral Health Care Providers’ Patients Using Medicaid as Primary Payment, 2016

License Category	Total	% Patients with Medicaid as Primary Payment							
		0%		1 ^a – 29%		30 – 59%		60 – 100%	
		#	%	#	%	#	%	#	%
Prescribers^b	218	53	24.3%	38	17.4%	65	29.8%	62	28.4%
Independently Licensed Psychotherapy Providers	1,656	505	30.5%	262	15.8%	334	20.2%	555	33.5%
Non-Independently Licensed Psychotherapy Providers	977	288	29.5%	122	12.5%	126	12.9%	441	45.1%
Substance Use Treatment Providers	286	110	38.5%	33	11.5%	36	12.6%	107	37.4%

^a It is possible that some clinicians who entered “1” meant “100%.”

^b Excludes nurse practitioners and nurse specialists, who were not asked about payment.

III.C.4. Behavioral Health Care Practice Locations

In an ideal behavioral health system, the majority of treatment is delivered in community settings that provide early identification and prevention and have the capacity to provide evidence-based psychosocial interventions using a team-based approach. Nationally, there is a move toward integrating primary care and behavioral health in order to provide access to physical and mental health care in the same location. In response, many of the Federally Qualified Health Centers in New Mexico have enhanced their behavioral health programs and are an important source of behavioral health care in many rural counties.

Table 3.3 describes the practice location for psychiatrists, psychologists, social workers, and counselors. *The majority of prescribers and independently licensed behavioral health clinicians are working in independent practice locations rather than in public settings or larger group practices.* This pattern will be an important consideration if New Mexico moves towards health systems and accountable care organizations for the delivery of healthcare.

Table 3.4 describes the practice location for psychiatric nurse specialists. The majority of psychiatric nurses are employed in hospital settings. While there will always be a need for qualified nurses in acute care settings, there is increased recognition that psychiatric nurses provide important expertise in community settings, especially when addressing the intersections between behavioral and physical health.

Table 3.3. Practice Location for Behavioral Health Care Providers, 2016

Location Type	Prescribers ^a		Independently Licensed Psychotherapy Providers		Non-Independently Licensed Psychotherapy Providers		Substance Use Treatment Providers	
	n	%	n	%	n	%	n	%
Hospitals	38	13.9%	57	2.8%	102	6.7%	22	5.3%
Hospital Clinics	26	9.5%	96	4.7%	27	1.8%	8	1.9%
Independent Practice	83	30.4%	818	40.1%	108	7.1%	62	14.9%
Group Practice	43	15.8%	308	15.1%	302	19.9%	105	25.2%
Nursing Home	3	1.1%	19	0.9%	56	3.7%	1	0.2%
Private Clinic	1	0.4%	75	3.7%	63	4.2%	25	6.0%
Nonprofit Community Health Center	19	7.0%	170	8.3%	198	13.1%	48	11.5%
Military/ VA Clinic	24	8.8%	49	2.4%	12	0.8%	8	1.9%
IHS Clinic	3	1.1%	14	0.7%	21	1.4%	9	2.2%
Federally Qualified Health Center	1	0.4%	30	1.5%	27	1.8%	16	3.8%
Other	32	11.7%	402	19.7%	599	39.5%	113	27.1%
TOTAL	273		2,038		1,515		417	

^a Excludes nurse practitioners and nurse specialists; see Table 3.4.

Table 3.3 (above) includes the 4,243 behavioral health care providers who were surveyed and answered the question about type of practice location. It excludes nurse practitioners and nurse specialists, because the practice location question on the nurse licensing renewal survey included different categories. Therefore, Table 3.4 (below) describes the practice location for the 99 nurse practitioners and nurse specialists who were surveyed and answered the question about type of practice location.

Table 3.4. Practice Location for Psychiatric CNPs/CNSs, 2016

Location Type	n	%
Clinic	23	23.2%
Community/ Public Health	6	6.1%
Hospital	40	40.4%
Office Nurse	2	2.0%
School of Nursing	2	2.0%
Self-Employed	12	12.1%
Other	14	14.1%
TOTAL	99	

III.C.5. Age Distribution of Behavioral Health Care Providers

Table 3.5 provides information about the median and average age of the various behavioral health providers and the proportion of providers in each age category. Many of New Mexico’s behavioral health clinicians are approaching retirement age; therefore, it will be important to continue efforts in recruitment for new clinicians. *In fact, more than a quarter of prescribers are at least 65 years of age, as well as 24 percent of independently licensed psychotherapy providers.* The presence of experienced behavioral health clinicians is a strength in our system while also an important factor to consider when planning future needs.

Table 3.5. Age of Behavioral Health Care Providers, 2016

Age	Prescribers		Independently Licensed Psychotherapy Providers		Non-Independently Licensed Psychotherapy Providers		Substance Use Treatment Providers	
	n	%	n	%	n	%	n	%
<25	0	0.0%	4	0.1%	111	3.3%	12	1.4%
25-34	21	4.4%	421	9.1%	973	28.7%	102	12.2%
35-44	73	15.2%	858	18.6%	852	25.1%	135	16.2%
45-54	112	23.4%	931	20.2%	701	20.7%	219	26.3%
55-64	149	31.1%	1,309	28.4%	566	16.7%	244	29.3%
65+	124	25.9%	1,093	23.7%	188	5.5%	121	14.5%
TOTAL	479		4,616		3,391		833	
Median Age	57.6		55.9		41.6		53.2	
Average Age	56.6		54.1		43.5		51.2	

III.C.6. Future Plans of Behavioral Health Care Providers

Table 3.6 provides information about future practice changes among behavioral health providers. *The majority of respondents do not have plans to change practice, which is a reassuring sign for the stability of New Mexico's behavioral health system.* However, 6 percent of prescribers are planning to move their practice out of New Mexico within the next year, and 8 percent are planning to significantly reduce their hours.

Table 3.6 includes the 4,498 behavioral health care providers who were surveyed and answered the question about future practice plans. It excludes nurse practitioners and nurse specialists, because this question is not on the nurse license renewal survey.

Table 3.6. Future Practice Plans of Behavioral Health Care Providers, 2016

Near Future Practice Plans ^a	Prescribers ^b		Independently Licensed Psychotherapy Providers		Non-Independently Licensed Psychotherapy Providers		Substance Use Treatment Providers	
	#	%	#	%	#	%	#	%
Retire from patient care	10	3.6%	93	4.2%	33	2.1%	7	1.6%
Significantly reduce patient care hours	23	8.2%	128	5.8%	39	2.5%	15	3.4%
Move my practice out of New Mexico	17	6.1%	68	3.1%	32	2.0%	9	2.0%
None of the above	230	82.1%	1,917	86.9%	1,462	93.4%	415	93.0%
TOTAL	280		2,206		1,566		466	

^a Providers were asked whether they had plans for the next 12 months.

^b Nurse Practitioners and nurse specialists were excluded from this analysis, as no psychiatric nurse specialists responded to the future practice plans question.

III.C.7. Health Information Technology and Electronic Health Records

Table 3.7 provides information about the health information technology capacity of behavioral health providers. *Fewer than half of all behavioral health providers have access to electronic health records or have the capacity to use health information technology for population health management.* In contrast to physical health care providers, behavioral health providers were not eligible for incentives to effectively use health information technology. As the state further integrates behavioral and physical health and a population health perspective to promote wellness, it will be important to develop information technology infrastructure in the behavioral health system.

Table 3.7 includes the 1,440 behavioral health care providers who were surveyed and answered the question about health information technology capability. It excludes nurse practitioners and nurse specialists, because this question is not on the nurse licensing renewal survey.

Table 3.7. Health Information Technology Capabilities of Behavioral Health Care Providers, 2016

Health Information Technology Capability	Prescribers ^a		Independently Licensed Psychotherapy Providers		Non-Independently Licensed Psychotherapy Providers		Substance Use Treatment Providers	
	(n = 164)		(n = 644)		(n = 461)		(n = 171)	
	#	%	#	%	#	%	#	%
Computerized provider order entry	97	59.1%	208	32.3%	146	31.7%	51	29.8%
Patient access to electronic health records	70	42.7%	202	31.4%	120	26.0%	41	24.0%
E-labs	95	57.9%	108	16.8%	71	15.4%	27	15.8%
E-prescribing	35	21.3%	108	16.8%	66	14.3%	27	15.8%
Create registries	51	31.1%	102	15.8%	75	16.3%	21	12.3%
Patient timely access to labs	27	16.5%	83	12.9%	69	15.0%	17	9.9%
Quality reporting	65	39.6%	256	39.8%	199	43.2%	81	47.4%
Record vital signs	99	60.4%	117	18.2%	107	23.2%	32	18.7%
Record Demographics	98	59.8%	351	54.5%	231	50.1%	93	54.4%
None of the above	8	4.9%	40	6.2%	22	4.8%	10	5.8%

^a Excludes nurse practitioners and nurse specialists, who were not asked about health information technology access.

III.C.8. Race and Ethnicity of Behavioral Health Care Providers

Table 3.8 provides information about the race of New Mexico behavioral health providers, while Table 3.9 provides ethnicity information; this information for psychiatric CNPs/CNSs is shown in Table 3.10. *Unfortunately, the behavioral health care workforce is less diverse than the state's population.* To address health disparities and to provide culturally and linguistically competent care, it will continue to be important to actively recruit and retain healthcare professionals from diverse backgrounds. Notably, 46 percent of non-independently licensed psychotherapy providers are of Hispanic ethnicity and 13 percent of substance use treatment providers are American Indian in race, which reflects the general population in the state.

Tables 3.8 and 3.9 include the 4,242 behavioral health care providers who were surveyed and answered the questions about race or ethnicity. It excludes nurse practitioners and nurse specialists, because the race and ethnicity questions on the nurse licensing renewal survey included different categories. Therefore, Table 3.10 describes the race and ethnicity of the 103 nurse practitioners and nurse specialists who were answered the question about race/ethnicity.

Table 3.8. Race of Surveyed New Mexico Behavioral Health Care Providers Compared to New Mexico's Population, 2016

	Total Count	American Indian or Alaska Native	Asian or Pacific Islander	Black or African American	White	Other	Two or More
NM Population²⁴	2,084,117	190,528 (9.1%)	30,037 (1.4%)	43,738 (2.1%)	1,524,911 (73.2%)	226,850 (10.9%)	68,053 (3.3%)
Prescribers^a	275	6 (2.2%)	17 (6.2%)	3 (1.1%)	220 (80.0%)	21 (7.6%)	8 (2.9%)
Ind. License	2,058	38 (1.8%)	23 (1.1%)	33 (1.6%)	1,783 (86.6%)	125 (6.1%)	56 (2.7%)
Non-Ind. License	1,498	77 (5.1%)	12 (0.8%)	37 (2.5%)	1,171 (78.2%)	151 (10.1%)	50 (3.3%)
Substance Use	411	54 (13.1%)	1 (0.2%)	24 (5.8%)	274 (66.7%)	43 (10.5%)	15 (3.6%)

^a Excludes nurse practitioners and nurse specialists; see table 3.10.

Table 3.9. Ethnicity of Surveyed New Mexico Behavioral Health Care Providers Compared to New Mexico's Population, 2016

	Total Count	Hispanic or Latino
NM Population²⁴	2,084,117	986,972 (47.4%)
Prescribers	258	45 (17.4%)
Ind. License	1,952	391 (20.0%)
Non-Ind. License	1,476	676 (45.8%)
Substance Use	402	139 (34.6%)

Table 3.10. Race of Surveyed New Mexico Psychiatric CNPs/CNSs, 2016

	Total Count	American Indian or Alaska Native	Asian or Pacific Islander	Black or African American	Hispanic	White, Non-Hispanic	Other
Psychiatric CNPs/CNSs	103	1 (1.0%)	2 (1.9%)	0 (0.0%)	16 (15.5%)	79 (76.7%)	5 (4.9%)

III.C.9. Gender of Behavioral Health Care Providers

Table 3.11 provides the gender demographics of the behavioral health workforce and shows that the majority of clinicians are female, in all license categories. This table includes the 8,181 behavioral health care providers who indicated their gender on their licensing form.

Table 3.11. Gender of New Mexico Behavioral Health Care Providers, 2016

Gender	NM Pop.	Prescribers		Independently Licensed Psychotherapy Providers		Non-Independently Licensed Psychotherapy Providers		Substance Use Treatment Providers	
	%	Count	%	Count	%	Count	%	Count	%
Female	50.4%	222	51.3%	3,270	77.0%	2,311	84.1%	507	67.1%
Male	49.6%	211	48.7%	974	23.0%	437	15.9%	249	32.9%
TOTAL		433		4,244		2,748		756	

III.C.10. Behavioral Health Care Providers Trained in New Mexico

Table 3.12 describes the percentage of behavioral health providers across categories who trained in New Mexico. This table includes the 4,139 behavioral health care providers who were surveyed and answered the question about training. *The majority of counselors and therapists received their training in New Mexico, whereas less than 40 percent of prescribers trained in the state.* As we build recruitment efforts, it will be helpful to track these trends across provider categories.

Table 3.12. Behavioral Health Care Providers Practicing in New Mexico who were Trained in the State, 2016

License Category	Total	Trained in New Mexico	
		Count	%
Prescribers	383	151	39.4%
Independently Licensed Psychotherapy Providers	1,999	1,227	61.4%
Non-Independently Licensed Psychotherapy Providers	1,358	1,192	87.8%
Substance Use Treatment Providers	399	337	84.5%
TOTAL	4,139	2,907	70.2%

III.D. Policy Recommendations Related to Behavioral Health

Rec. 2017.9. Require that licensed behavioral health professionals receive three hours of continuing education credits each licensure cycle in the treatment of substance use disorders
This continuing education requirement brings behavioral health professionals on par with prescribers in New Mexico, who are mandated to receive five hours of continuing education in the treatment of addictions and safer opioid prescribing. This mechanism would increase the capacity of our entire workforce to treat substance use disorders.

Rec. 2017.10. Develop reimbursement mechanisms through Medicaid for services delivered by behavioral health interns in community settings

A student intern is an individual who is currently enrolled in a health profession training program for counseling, psychology or social work that has been approved by the appropriate board, is performing the duties assigned in the course of training, and is appropriately supervised according to the standards set by the appropriate board and the training program. Many states have developed Medicaid reimbursement codes that allow community agencies to receive reimbursement for health care services delivered by trainees such as social work students, counseling students, psychology interns and psychology post-doctoral students who are receiving proper supervision. Eighteen states have adopted this practice for psychology interns and psychology post-doctoral fellows. Additionally, Michigan, Vermont and Wisconsin have expanded this practice to allow Medicaid billing through the supervisor's National Provider Identifier for counseling and social work interns. This change requires three components:

1. The internship or clinical program must be an accredited educational program;
2. The clinical supervision of the interns must be approved by the relevant board; and
3. The clinical supervisor is an approved New Mexico Medicaid provider.

Since site of clinical training is a predictor of ultimate practice location,³⁶ adoption of this practice in New Mexico could facilitate the development of sustainable internship sites in underserved communities that would enhance recruitment to these practice settings. Additionally, this change would increase access to care. The estimated annual cost of enacting this recommendation is \$1,765,072.

Rec. 2017.11. Create a State Behavioral Health Workforce Center of Excellence

In order to address the behavioral health workforce challenges in Nebraska, the state legislature created the Behavioral Health Education Center of Nebraska, which is located at the University of Nebraska's Medical Center. Nebraska's initiative provides workforce training and education across the state via on-site and telehealth initiatives and takes responsibility for ongoing workforce analyses and reports. New Mexico could develop a similar initiative to meet its behavioral health needs. New Mexico's center would include educational leadership from the five fields of behavioral health disciplines: counseling, social work, psychiatric nursing, psychology and psychiatry. By locating this center at a clinical site, this center of excellence could provide ongoing opportunities for clinical placements that allow interns across the five disciplines to work and learn together. Another key component would be the co-ordination and expansion of telehealth supervision of non-independently licensed clinicians in rural communities to support their trajectory toward full independent licensure. Finally, this center of excellence would host and deliver ongoing trainings in best practices for behavioral health through webinars, workshops and an annual conference. The total annual cost for this center – which includes staff, telehealth equipment and an annual educational conference – is \$563,893.30.

Rec. 2017.12. Expedite direct services via telehealth by participating in interstate licensing compacts when available

It is anticipated that interstate licensure compacts might be available for psychology, medicine and nursing for licensed clinicians in these specialties who are interested in providing direct telehealth services in participating compact states. These compacts promote the mobility of health professionals and decrease barriers and obstacles for licensure in order to increase access to care to underserved populations and in rural areas. As a pilot, the Health Care Workforce Committee recommends adopting the Psychology Interjurisdictional Compact (PSYPACT). PSYPACT allows for the ethical and legal psychological practice across state boundaries. PSYPACT authorizes psychologists from a compact state to provide electronic (HIPAA-compliant) psychological services to patients in another compact state without having to get licensed in that remote jurisdiction. It also enables psychologists from a compact state to provide temporary in-person, face-to-face psychological service across state boundaries for up to 30 days within a calendar year. Arizona, Utah and Nevada have enacted PSYPACT legislation, and it is strongly being considered by Texas and several other Western states. Both the New Mexico Psychological Association and the New Mexico Board of Psychologist Examiners strongly support PSYPACT for New Mexico. The approximate annual cost of participating in this compact is \$6,000.

Section IV

Recommendations of the New Mexico Health Care Workforce Committee

IV.A. Introduction

Beginning with its 2014 report, the New Mexico Health Care Workforce Committee has made recommendations for solutions to the issues highlighted in its annual analysis of the state's health care providers. These recommendations have included both items actionable by the Legislature and more general recommendations for communities and health professional training programs. Here, we review prior years' recommendations and their status and provide our 2016 recommendations.

IV.B. Status of 2014 Recommendations

IV.B.1. 2014 Education and Training Recommendations

Rec. 2014.1

Health professions training programs should be enhanced, including strong support for the UNM School of Medicine, advanced practice registered nurse programs at UNM and NMSU, New Mexico Nursing Education Consortium programs to increase the BSN-prepared workforce and development of a BA/DDS program similar to UNM's BA/MD program. As the state invests in these programs, the New Mexico Health Care Workforce Committee will need expanded tracking to analyze how many graduates practice in New Mexico.

ACTION: Supplemental appropriations to institutions for nursing program expansion increased from \$1.81 million in FY 2014 to \$8.39 million in FY 2016, with a decrease to \$7.70 million in FY 2018. The Legislative Finance Committee reported that the number of nursing degrees awarded has increased from 932 in 2011 to 1,062 in 2014. It notes that "additional evaluation work is needed ... to fully assess whether investments in expanding nurse education is working as intended."³⁷

The first graduates from UNM HSC's expanded pediatric nurse practitioner, family nurse practitioner and certified nurse midwife programs have joined the workforce in 2017. These graduates' entry into the workforce will provide an opportunity to analyze the impact of training program expansion on the state's need for advanced practice registered nurses.

Rec. 2014.2

The state should fully support Graduate Medical Education (GME) by continuing funding for nine current GME positions and explore options for increasing the number of funded positions, particularly for practice in rural areas and underserved areas. This would entail developing additional primary care training locations throughout New Mexico.

ACTION: The Legislature fully funded nine residency slots each year in FY 2015 and FY 2016, with an emphasis on internal medicine, family medicine, general surgery and psychiatry. For these 18 slots, \$1.65 million was appropriated to UNM HSC in FY 2018. Additional slots were not funded in either FY 2017 or FY 2018.

The Legislature also appropriated \$399,500 in FY 2015 and FY 2016 to support primary care residencies at Hidalgo Medical Services, a Federally Qualified Health Center in southwestern New Mexico.

The 2014 Legislature also advanced the creation of primary care residency slots by leveraging state Medicaid funds.²⁸ This program is still in development; if successful, primary care residency development under this program could be supported through the base Medicaid funding budget for residency slots at Federally Qualified Health Centers in New Mexico primary care shortage areas.

Rec. 2014.3

The Community Health Worker certificate should be fully implemented.

ACTION: We have reiterated this recommendation (Rec. 2016.17).

IV.B.2. 2014 Financial Incentives for Addressing Shortages

Rec. 2014.4

Financial incentives for recruiting health care professionals should be maintained and expanded on the basis of their demonstrated efficacy. The New Mexico Health Care Workforce committee should be funded in order to collect data, conduct analyses and develop appropriate outcome measures of these programs.

ACTION: In 2015, the LFC reported several state investments in health care workforce financial aid.³⁷ The Legislature appropriated \$3.9 million for loan-for-service or loan repayment programs in FY 2016, an increase over FY 2014 levels. This included \$200,000 to compensate for funds previously received from a U.S. Department of Health and Human Services matching grant that was not renewed for FY 2014 – 2015. The amount allocated to loan-for-service or loan repayment programs in FY 2018 has been reduced to \$2.9 million.

In addition, the state expanded funding for Western Interstate Commission for Higher Education positions, which allow students from New Mexico to pay in-state tuition at affiliated dental and veterinary schools in exchange for three years of service in New Mexico. Funding was expanded from \$1.15 million in FY 2015 to \$2.27 million in FY 2016, but as of FY 2018 stands at \$0.75 million.

Rec. 2014.5

The state tax incentive program should be evaluated for its impact on recruiting and retaining New Mexico's rural health care workforce.

ACTION: We have reiterated this recommendation (Rec. 2015.13).

IV.B.3. 2014 Recruitment for Retention in New Mexico Communities

Rec. 2014.6

Recruitment efforts should address social and environmental barriers to successful recruitment.

ACTION: The non-profit New Mexico Health Resources has continued to support recruitment of health professionals to underserved areas. In 2015 – 2016, this organization placed 62 health professionals and 30 physicians with Conrad J-1 Visa Waivers in the state.

Rec. 2014.7

Explore strategies to help manage workloads for health care practitioners and create professional support networks, particularly in health professional shortage areas.

ACTION: Several successful New Mexico programs that foster health professions career development in rural areas – including Hidalgo Medical Services, UNM Locum Tenens, the UNM Physician Access Line and Health Extension Rural Offices – continue to help manage workloads and create professional support networks, as we reported in 2014 and 2015.

Rec. 2014.8

Enhance linkages between rural practitioners and the UNM Health Sciences Center to improve health care workforce retention.

ACTION: As we reported in 2015, telehealth technologies and virtual clinic platforms such as Project ECHO have continued to enhance primary care practice in rural New Mexico.

IV.B.4 2014 New Mexico Health Care Workforce Committee

Rec. 2014.9

The New Mexico Health Care Workforce Committee should be funded in order to conduct its analyses. Funding for this committee will allow it to assess the efficacy of health care workforce programs and study in depth the mental health service environment, as well as expand tracking of health care workforce recruitment and retention.

ACTION: We have reiterated this recommendation (Rec. 2015.14, 2016.18 and 2017.9).

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IV.C. Status of 2015 Recommendations

IV.C.1. 2015 Behavioral Health Recommendations

Rec. 2015.1

With additional funding, UNM HSC can expand statewide access to telehealth consultation with behavioral health clinicians.

ACTION: We recognize the ongoing need to expand telehealth access to direct clinical services and real-time consultation. Given the tight fiscal environment, we will defer this recommendation for the future. In 2016, we instead recommended commencing planning for a statewide telehealth infrastructure to expand behavioral health access.

Rec. 2015.2

Request that the New Mexico Counseling and Therapy Practice Board and the Board of Psychologist Examiners re-examine their requirements for face-to-face mentoring (to be replaced by tele-mentoring) in order to minimize the barriers to rural practice.

ACTION: As of 2015, the New Mexico Counseling and Therapy Practice Board, the Board of Psychologist Examiners and the Board of Social Work Examiners have agreed to expand or examine expanding the definition of supervised practice toward independent licensure to include tele-mentoring.

Rec. 2015.3

Request that the New Mexico Counseling and Therapy Practice Board, the Board of Social Work Examiners and the Board of Psychologist Examiners eliminate barriers in reciprocity (e.g., eliminate requirements for time practiced in a particular state) to make New Mexico more competitive in recruiting new practitioners.

ACTION: As above, these boards have agreed to examine ways to lessen or eliminate reciprocity barriers to improve practitioner recruitment.

Rec. 2015.4

Request that the New Mexico Behavioral Health Collaborative develop reimbursement mechanisms for services delivered by psychology interns, social work interns and counseling interns when participating in electives in the public behavioral health system.

ACTION: We have since reiterated this recommendation (Rec. 2016.17).

Rec. 2015.5

Request that all publicly funded higher education institutions release their licensure board pass rates to the New Mexico Behavioral Health Collaborative and the respective professional licensing boards so that the state can identify areas of continuous quality improvement to ensure that graduates are adequately prepared for licensing board examinations.

ACTION: In 2016, the New Mexico Behavioral Health Collaborative commenced discussions with Higher Education Department to facilitate this action.

Rec. 2015.6

The New Mexico Behavioral Health Collaborative should establish financing systems that promote sustainability and employee retention. Request that the Behavioral Health Collaborative disseminate a strategic plan on this topic by the end of FY 2016.

ACTION: The New Mexico Behavioral Health Collaborative developed and disseminated a strategic plan on sustainable financing systems (see link at endnote).³⁸

Rec. 2015.7

Request that the Department of Health add social workers and counselors to the list of health care professions who are eligible for New Mexico's Rural Healthcare Practitioner Tax Credit program.

ACTION: See update below at Rec. 2015.15.

Rec. 2015.8

Support recruitment mechanisms by expanding the Rural Primary Health Care Act to include behavioral health and contracting with a non-profit entity for recruitment services.

ACTION: We continue to recognize the ongoing need to support recruitment of behavioral health clinicians. A centralized job board has been created for all New Mexico agencies to recruit for behavioral health clinicians (see link at endnote).³⁹

The Rural Primary Care Act needs to be expanded to include a specialized behavioral health entity to support recruitment and contracting. Given the tight fiscal environment, we will defer this recommendation for the future.

IV.C.2. 2015 Recommendations for Other Health Professions

Rec. 2015.9

We strongly recommend that the Higher Education Department take full advantage of the next opportunity to reinstate the U.S. Department of Health and Human Services matching grant to support New Mexico's loan repayment program.

ACTION: The Higher Education Department is prioritizing this upcoming opportunity. We have reiterated this recommendation (Rec. 2016.14 and 2017.4).

Rec. 2015.10

We strongly recommend that the Legislative Health and Human Services and Legislative Finance Committees (LHHS and LFC) support funding for loan-for-service and loan repayment programs and consider increasing funding levels to enhance rural health care practice.

ACTION: LHHS supported this recommendation in 2015. We have reiterated this recommendation (Rec. 2016.12 and 2017.5)

Rec. 2015.11

We recommend that loan-for-service and loan repayment programs be structured to target the professions most needed in rural areas, rather than prioritizing practitioners with the highest levels of debt.

ACTION: We have reiterated this recommendation (Rec. 2016.13 and 2017.5).

Rec. 2015.12

We recommend that telehealth services be encouraged and funded to assist rural physicians in managing workload and treating complex cases.

ACTION: In 2015, the Legislative Health and Human Services Committee endorsed \$3 million in appropriations for Project ECHO. However, no additional funding was provided in the 2016 legislative session due to budgetary constraints. An additional \$50,000 appropriation was made to Project ECHO in FY 2018; however, due to the across the board cuts, Project ECHO's FY 2018 appropriation is less than the FY 2017 appropriation.

Rec. 2015.13

We recommend that the Department of Health cooperate with the Taxation and Revenue Department so that the New Mexico Health Care Workforce Committee can analyze the impact of the Rural Health Care Tax Credit on retention.

ACTION: LHHS requested the LFC update the 2011 study of the tax credit. As of August 2016, the Department of Health and Taxation and Revenue Department have initiated analysis of the retention impact of the Rural Health Care Tax Credit.

Rec. 2015.14

We recommend that the Legislature support funding the New Mexico Health Care Workforce Committee to study whether residents have adequate access to the various types of providers.

ACTION: The LFC has recommended supporting the committee's workforce analysis initiatives. LHHS endorsed the 2016 SB 150 to provide \$300,000 to support the work of the New Mexico Health Care Workforce Committee. However, this bill did not pass. We have reiterated this recommendation (Rec 2016.18 and 2017.9).

Rec. 2015.15

We recommend that pharmacists, counselors and social workers be added to the list of health care practitioners eligible for the Rural Health Care Tax Credit.

ACTION: 2017 HB 68 would have equalized the tax credit among all practitioners at the \$5,000 level and added licensed counselors, pharmacists and social workers. However, this bill did not pass. We have reiterated this recommendation (Rec. 2016.5 and 2017.6).

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IV.D. Status of 2016 Recommendations

IV.D.1. 2016 Behavioral Health Recommendations

Rec. 2016.1

In compliance with Chapter 61 of NMSA 1978, expedite implementation of professional licensure by endorsement for social workers, counselors and therapists.

ACTION: We defer this recommendation to a future year.

Rec. 2016.2

Develop reimbursement mechanisms through Medicaid for services delivered by trainees in community settings.

ACTION: We have reiterated this recommendation (Rec. 2017.11).

Rec. 2016.3

Identify funding for efforts to support and prepare candidates from diverse backgrounds to complete graduate degrees in behavioral health fields.

ACTION: This recommendation is deferred given current fiscal constraints.

Rec. 2016.4

Support Medicaid funding for community-based psychiatry residency programs in Federally Qualified Health Centers.

ACTION: The 2014 Legislature also advanced the creation of psychiatry residency slots by leveraging state Medicaid funds.²⁸ Through this program, psychiatry residency development will be supported through the base Medicaid funding budget for residency slots at Federally Qualified Health Centers in New Mexico primary care shortage areas.

Rec. 2016.5

Request that the Department of Health add social workers and counselors to the list of health care professions who are eligible for New Mexico's Rural Healthcare Practitioner Tax Credit program.

ACTION: As noted for Rec. 2015.15, 2017 HB 68 would have equalized the tax credit among all practitioners at the \$5,000 level and added licensed counselors, pharmacists and social workers. However, this bill did not pass. We have reiterated this recommendation (Rec. 2017.6).

Rec. 2016.6

Explore opportunities to leverage federal funding for the Health Information Exchange and adoption of electronic health records for behavioral health providers.

ACTION: This recommendation is deferred as the New Mexico Human Services Department focuses on the update of Centennial Care 2.0.

Rec. 2016.7

Bring licensing boards together to create a unified survey and dataset for behavioral health care providers.

ACTION: The Psychology Board is piloting an updated behavioral health survey with expanded fields to better understand the needs of behavioral health providers.

Rec. 2016.8

Convene a planning group to develop statewide telehealth infrastructure to deliver behavioral health services via telehealth to rural communities.

ACTION: The New Mexico Hospital Association has convened a planning group to explore the financing and sustainability of a statewide emergency telepsychiatry network to provide emergency consultations to patients in emergency departments.

Rec. 2016.9

Support the Collaborative Advanced Psychiatric-Education Exchange Program.

ACTION: The UNM College of Nursing was successful in receiving Health Resources and Services Administration funding to develop a post-master's certificate in psychiatric and mental health through the Collaborative Advanced Psychiatric – Education Exchange initiative.

IV.D.2. 2016 Recommendations for Other Health Professions

Rec. 2016.10

Correct the recent omission by the Regulation and Licensing Department of the practice specialty item from the physicians' online license renewal survey platform.

ACTION: We commend the New Mexico Regulation and Licensing Department for their prompt and effective response to this recommendation. The omission was resolved in January 2017.

Rec. 2016.11

Enhance the Physician Assistants' survey with an added practice specialty item.

ACTION: The practice specialty item has been incorporated into the Physician Assistants' license renewal survey in 2017, allowing initial analysis of PAs' specialties in 2018.

Rec. 2016.12

Maintain funding for the loan-for-service and loan repayment programs at their current levels.

ACTION: The state's coverage of the former federal matching funds is approaching its end date, but the opportunity for the Higher Education Department to reinstate federal funds has been delayed by the U.S. Department of Health and Human Services. As a result, we reiterate our recommendation that funding for these programs be maintained or expanded (Rec. 2017.4 and 2017.5).

Rec. 2016.13

Restructure loan-for-service and loan repayment programs to target the professions most needed in rural areas, rather than prioritizing practitioners with the highest levels of debt.

ACTION: We have reiterated this recommendation (Rec. 2017.5).

Rec. 2016.14

Position the Higher Education Department to take full advantage of the 2017 opportunity to reinstate the U.S. Department of Health and Human Services matching grant to support New Mexico's loan repayment program.

ACTION: The U.S. Department of Health and Human Services did not release the expected funding opportunity announcement for this program in 2017. As in 2015, the Higher Education Department is prioritizing their efforts to reinstate federal matching funds for the state loan repayment program when such an opportunity should be announced. We have reiterated this recommendation (Rec. 2017.4).

Rec. 2016.15

Continue funding for expanded primary and secondary care residencies in New Mexico.

ACTION: No further action has occurred since that described above for Rec. 2014.2. We have reiterated this recommendation (Rec. 2017.2).

Rec. 2016.16

Support further exploration of Medicaid as an avenue for expanding residencies in New Mexico.

ACTION: See update above at Rec. 2014.2. We have reiterated this recommendation (Rec. 2017.3).

Rec. 2016.17

Continue support for the Community Health Workers certification program to promote consistency among training programs for these health professionals.

ACTION: This support continues to be needed.

Rec. 2016.18

Provide funding for the New Mexico Health Care Workforce Committee.

ACTION: We have reiterated this recommendation (Rec. 2017.9).

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IV.E. 2017 Recommendations

IV.E.1. 2017 Recommendations for All Health Professions

For detailed descriptions of these recommendations, please see Section II.G.

Rec. 2017.1.

Identify funding for efforts to support the New Mexico Nursing Education Consortium (NMNEC).

Rec. 2017.2.

Continue funding for expanded primary and secondary care residencies in New Mexico.

Rec. 2017.3.

Support further exploration of Medicaid as an avenue for expanding residencies in New Mexico.

Rec. 2017.4.

Position the Higher Education Department to take full advantage of the next opportunity to reinstate the U.S. Department of Health and Human Services matching grant to support New Mexico's state loan repayment program.

Rec. 2017.5.

Increase funding for state loan-for-service and loan repayment programs, and consider restructuring them to target the professions most needed in rural and underserved areas rather than prioritizing those with higher debt.

Rec. 2017.6.

Request that the Department of Health add pharmacists, social workers and counselors to the health care professions eligible for New Mexico's Rural Healthcare Practitioner Tax Credit program.

Rec. 2017.7.

Remedy the pharmacists' survey.

Rec. 2017.8.

Provide funding for the New Mexico Health Care Workforce Committee.

IV.E.2. 2017 Behavioral Health Recommendations

For detailed descriptions of these recommendations, please see Section III.D.

Rec. 2017.9.

Require that licensed behavioral health professionals receive three hours of continuing education credits each licensure cycle in the treatment of substance use disorders

Rec. 2017.10.

Develop reimbursement mechanisms through Medicaid for services delivered by behavioral health interns in community settings

Rec. 2017.11.

Create a state Behavioral Health Workforce Center of Excellence

Rec. 2017.12.

Expedite direct services via telehealth by participating in interstate licensing compacts when available

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Appendix A

Benchmark Gap Analyses for New Mexico Health Professions

Table A.1. Benchmark Gap Analysis of New Mexico PCPs, 2016

County	Population	Estimated Primary Care Physicians	Above (+) / Below (-) Benchmark
Bernalillo	676,953	946	411
Catron	3,508	2	-1
Chaves	65,282	63	11
Cibola	27,487	21	-1
Colfax	12,253	7	-3
Curry	50,280	36	-4
De Baca	1,793	1	0
Doña Ana	214,207	185	16
Eddy	57,621	36	-10
Grant	28,280	39	17
Guadalupe	4,376	2	-1
Harding	665	0	-1
Hidalgo	4,302	1	-2
Lea	69,749	36	-19
Lincoln	19,429	12	-3
Los Alamos	18,147	31	17
Luna	24,450	8	-11
McKinley	74,923	59	0
Mora	4,504	1	-3
Otero	65,410	34	-18
Quay	8,365	6	-1
Rio Arriba	40,040	26	-6
Roosevelt	19,082	13	-2
San Juan	115,079	86	-5
San Miguel	27,760	19	-3
Sandoval	142,025	111	-1
Santa Fe	148,651	203	86
Sierra	11,191	11	2
Socorro	17,027	16	3
Taos	33,065	34	8
Torrance	15,302	2	-10
Union	4,183	2	-1
Valencia	75,626	27	-33
STATE TOTAL	2,081,015	2,076	432

Table A.2. Benchmark Gap Analysis of New Mexico CNPs/CNSs, 2016

County	Population	Estimated CNPs and CNSs	Above (+) / Below (-) Benchmark
Bernalillo	676,953	645	252
Catron	3,508	0	-2
Chaves	65,282	27	-11
Cibola	27,487	12	-4
Colfax	12,253	7	0
Curry	50,280	24	-5
De Baca	1,793	1	0
Doña Ana	214,207	135	11
Eddy	57,621	45	12
Grant	28,280	15	-1
Guadalupe	4,376	3	0
Harding	665	0	0
Hidalgo	4,302	0	-2
Lea	69,749	25	-15
Lincoln	19,429	7	-4
Los Alamos	18,147	7	-4
Luna	24,450	14	0
McKinley	74,923	22	-21
Mora	4,504	4	1
Otero	65,410	23	-15
Quay	8,365	12	7
Rio Arriba	40,040	20	-3
Roosevelt	19,082	9	-2
San Juan	115,079	32	-35
San Miguel	27,760	14	-2
Sandoval	142,025	40	-42
Santa Fe	148,651	101	15
Sierra	11,191	5	-1
Socorro	17,027	8	-2
Taos	33,065	20	1
Torrance	15,302	5	-4
Union	4,183	2	0
Valencia	75,626	19	-25
STATE TOTAL	2,081,015	1,303	99

Table A.3. Benchmark Gap Analysis of New Mexico Physician Assistants, 2016

County	Population	Estimated PAs	Above (+) / Below (-) Benchmark
Bernalillo	676,953	391	186
Catron	3,508	0	-1
Chaves	65,282	13	-7
Cibola	27,487	5	-3
Colfax	12,253	3	-1
Curry	50,280	12	-3
De Baca	1,793	0	-1
Doña Ana	214,207	38	-27
Eddy	57,621	10	-7
Grant	28,280	15	6
Guadalupe	4,376	0	-1
Harding	665	0	0
Hidalgo	4,302	2	1
Lea	69,749	9	-12
Lincoln	19,429	2	-4
Los Alamos	18,147	11	6
Luna	24,450	3	-4
McKinley	74,923	12	-11
Mora	4,504	1	0
Otero	65,410	14	-6
Quay	8,365	0	-3
Rio Arriba	40,040	10	-2
Roosevelt	19,082	2	-4
San Juan	115,079	36	1
San Miguel	27,760	7	-1
Sandoval	142,025	53	10
Santa Fe	148,651	61	16
Sierra	11,191	4	1
Socorro	17,027	2	-3
Taos	33,065	19	9
Torrance	15,302	3	-2
Union	4,183	0	-1
Valencia	75,626	8	-15
STATE TOTAL	2,081,015	746	117

Table A.4. Benchmark Gap Analysis of New Mexico Obstetricians and Gynecologists, 2016

County	Population	Female Population	Estimated Obstetricians and Gynecologists	Above (+) / Below (-) Benchmark
Bernalillo	676,953	344,569	144	72
Catron	3,508	1,694	0	0
Chaves	65,282	32,706	7	0
Cibola	27,487	13,414	3	0
Colfax	12,253	6,053	4	3
Curry	50,280	24,134	5	0
De Baca	1,793	900	0	0
Doña Ana	214,207	108,603	26	3
Eddy	57,621	28,407	7	1
Grant	28,280	14,338	3	0
Guadalupe	4,376	1,886	0	0
Harding	665	313	0	0
Hidalgo	4,302	2,134	0	0
Lea	69,749	33,828	7	0
Lincoln	19,429	9,773	2	0
Los Alamos	18,147	8,946	3	1
Luna	24,450	12,201	2	-1
McKinley	74,923	38,960	9	1
Mora	4,504	2,153	0	0
Otero	65,410	31,855	8	1
Quay	8,365	4,291	0	-1
Rio Arriba	40,040	20,340	5	1
Roosevelt	19,082	9,484	1	-1
San Juan	115,079	58,000	6	-6
San Miguel	27,760	14,102	3	0
Sandoval	142,025	72,291	7	-8
Santa Fe	148,651	76,407	13	-3
Sierra	11,191	5,607	0	-1
Socorro	17,027	8,360	3	1
Taos	33,065	16,929	5	1
Torrance	15,302	7,238	0	-2
Union	4,183	1,815	0	0
Valencia	75,626	37,586	0	-8
STATE TOTAL	2,081,015	1,049,317	273	54

Table A.5. Benchmark Gap Analysis of New Mexico Certified Nurse-Midwives, 2016

County	Population	Female Population	Estimated CNMs	Above (+) / Below (-) Benchmark
Bernalillo	676,953	344,569	89	65
Catron	3,508	1,694	0	0
Chaves	65,282	32,706	2	0
Cibola	27,487	13,414	1	0
Colfax	12,253	6,053	0	0
Curry	50,280	24,134	3	1
De Baca	1,793	900	0	0
Doña Ana	214,207	108,603	9	1
Eddy	57,621	28,407	1	-1
Grant	28,280	14,338	4	3
Guadalupe	4,376	1,886	0	0
Harding	665	313	0	0
Hidalgo	4,302	2,134	0	0
Lea	69,749	33,828	0	-2
Lincoln	19,429	9,773	0	-1
Los Alamos	18,147	8,946	1	0
Luna	24,450	12,201	0	-1
McKinley	74,923	38,960	7	4
Mora	4,504	2,153	0	0
Otero	65,410	31,855	1	-1
Quay	8,365	4,291	0	0
Rio Arriba	40,040	20,340	0	-1
Roosevelt	19,082	9,484	0	-1
San Juan	115,079	58,000	6	2
San Miguel	27,760	14,102	3	2
Sandoval	142,025	72,291	8	3
Santa Fe	148,651	76,407	16	11
Sierra	11,191	5,607	0	0
Socorro	17,027	8,360	1	0
Taos	33,065	16,929	4	3
Torrance	15,302	7,238	0	-1
Union	4,183	1,815	0	0
Valencia	75,626	37,586	0	-3
STATE TOTAL	2,081,015	1,049,317	156	83

Table A.6. Benchmark Gap Analysis of New Mexico Licensed Midwives, 2016

County	Population	Female Population	Estimated LMs	Above (+) / Below (-) Benchmark
Bernalillo	676,953	344,569	12	6
Catron	3,508	1,694	0	0
Chaves	65,282	32,706	0	-1
Cibola	27,487	13,414	1	1
Colfax	12,253	6,053	0	0
Curry	50,280	24,134	0	0
De Baca	1,793	900	0	0
Doña Ana	214,207	108,603	5	3
Eddy	57,621	28,407	0	0
Grant	28,280	14,338	3	3
Guadalupe	4,376	1,886	0	0
Harding	665	313	0	0
Hidalgo	4,302	2,134	0	0
Lea	69,749	33,828	0	-1
Lincoln	19,429	9,773	0	0
Los Alamos	18,147	8,946	0	0
Luna	24,450	12,201	0	0
McKinley	74,923	38,960	0	-1
Mora	4,504	2,153	0	0
Otero	65,410	31,855	1	0
Quay	8,365	4,291	0	0
Rio Arriba	40,040	20,340	4	4
Roosevelt	19,082	9,484	0	0
San Juan	115,079	58,000	0	-1
San Miguel	27,760	14,102	1	1
Sandoval	142,025	72,291	4	3
Santa Fe	148,651	76,407	8	7
Sierra	11,191	5,607	1	1
Socorro	17,027	8,360	0	0
Taos	33,065	16,929	6	6
Torrance	15,302	7,238	0	0
Union	4,183	1,815	0	0
Valencia	75,626	37,586	2	1
STATE TOTAL	2,081,015	1,049,317	48	32

Table A.7. Benchmark Gap Analysis of New Mexico General Surgeons, 2016

County	Population	Estimated General Surgeons	Above (+) / Below (-) Benchmark
Bernalillo	676,953	75	34
Catron	3,508	0	0
Chaves	65,282	4	0
Cibola	27,487	3	1
Colfax	12,253	3	2
Curry	50,280	9	6
De Baca	1,793	0	0
Doña Ana	214,207	13	0
Eddy	57,621	8	5
Grant	28,280	2	0
Guadalupe	4,376	0	0
Harding	665	0	0
Hidalgo	4,302	0	0
Lea	69,749	2	-2
Lincoln	19,429	0	-1
Los Alamos	18,147	5	4
Luna	24,450	1	0
McKinley	74,923	9	5
Mora	4,504	0	0
Otero	65,410	2	-2
Quay	8,365	2	1
Rio Arriba	40,040	3	1
Roosevelt	19,082	2	1
San Juan	115,079	10	3
San Miguel	27,760	2	0
Sandoval	142,025	6	-3
Santa Fe	148,651	17	8
Sierra	11,191	1	0
Socorro	17,027	4	3
Taos	33,065	5	3
Torrance	15,302	0	-1
Union	4,183	0	0
Valencia	75,626	0	-5
STATE TOTAL	2,081,015	188	63

Table A.8. Benchmark Gap Analysis of New Mexico Psychiatrists, 2016

County	Population	Estimated Psychiatrists	Above (+) / Below (-) Benchmark
Bernalillo	676,953	183	79
Catron	3,508	0	-1
Chaves	65,282	4	-6
Cibola	27,487	0	-4
Colfax	12,253	0	-2
Curry	50,280	3	-5
De Baca	1,793	0	0
Doña Ana	214,207	22	-11
Eddy	57,621	3	-6
Grant	28,280	3	-1
Guadalupe	4,376	0	-1
Harding	665	0	0
Hidalgo	4,302	0	-1
Lea	69,749	4	-7
Lincoln	19,429	0	-3
Los Alamos	18,147	3	0
Luna	24,450	1	-3
McKinley	74,923	6	-6
Mora	4,504	0	-1
Otero	65,410	3	-7
Quay	8,365	1	0
Rio Arriba	40,040	1	-5
Roosevelt	19,082	0	-3
San Juan	115,079	11	-7
San Miguel	27,760	10	6
Sandoval	142,025	10	-12
Santa Fe	148,651	53	30
Sierra	11,191	0	-2
Socorro	17,027	1	-2
Taos	33,065	4	-1
Torrance	15,302	0	-2
Union	4,183	0	-1
Valencia	75,626	6	-6
STATE TOTAL	2,081,015	332	9

Table A.9. Benchmark Gap Analysis of New Mexico Dentists, 2016

County	Population	Estimated Dentists	Above (+) / Below (-) Benchmark
Bernalillo	676,953	508	237
Catron	3,508	1	0
Chaves	65,282	28	2
Cibola	27,487	9	-2
Colfax	12,253	4	-1
Curry	50,280	27	7
De Baca	1,793	0	-1
Doña Ana	214,207	106	20
Eddy	57,621	19	-4
Grant	28,280	13	2
Guadalupe	4,376	2	0
Harding	665	0	0
Hidalgo	4,302	0	-2
Lea	69,749	23	-5
Lincoln	19,429	8	0
Los Alamos	18,147	14	7
Luna	24,450	8	-2
McKinley	74,923	29	-1
Mora	4,504	2	0
Otero	65,410	17	-9
Quay	8,365	1	-2
Rio Arriba	40,040	14	-2
Roosevelt	19,082	5	-3
San Juan	115,079	88	42
San Miguel	27,760	9	-2
Sandoval	142,025	69	12
Santa Fe	148,651	121	62
Sierra	11,191	3	-1
Socorro	17,027	4	-3
Taos	33,065	16	3
Torrance	15,302	2	-4
Union	4,183	0	-2
Valencia	75,626	21	-9
STATE TOTAL	2,081,015	1,171	339

Table A.10. Benchmark Gap Analysis of New Mexico Pharmacists, 2016

County ^a	Population	Estimated Pharmacists	Above (+) / Below (-) Benchmark
Bernalillo	676,953	1,137	609
Catron	3,508	0	-3
Chaves	65,282	40	-11
Cibola	27,487	11	-10
Colfax	12,253	8	-2
Curry	50,280	28	-11
De Baca	1,793	2	1
Doña Ana	214,207	132	-35
Eddy	57,621	42	-3
Grant	28,280	21	-1
Guadalupe	4,376	0	-3
Harding	665	0	-1
Hidalgo	4,302	1	-2
Lea	69,749	33	-21
Lincoln	19,429	14	-1
Los Alamos	18,147	15	1
Luna	24,450	8	-11
McKinley	74,923	26	-32
Mora	4,504	3	-1
Otero	65,410	27	-24
Quay	8,365	5	-2
Rio Arriba	40,040	8	-23
Roosevelt	19,082	13	-2
San Juan	115,079	65	-25
San Miguel	27,760	18	-4
Sandoval	142,025	146	35
Santa Fe	148,651	110	-6
Sierra	11,191	6	-3
Socorro	17,027	4	-9
Taos	33,065	27	1
Torrance	15,302	1	-11
Union	4,183	3	0
Valencia	75,626	59	0
STATE TOTAL	2,081,015	2,013	390

^a As noted in Section II.D.2, county allocation for pharmacists is made using license mailing address due to the known issues with the survey (see Rec. 2017.8).

Table A.11. Benchmark Gap Analysis of New Mexico RNs, 2016

County	Population	Estimated RNs	Above (+) / Below (-) Benchmark
Bernalillo	676,953	8,344	2,495
Catron	3,508	10	-20
Chaves	65,282	442	-122
Cibola	27,487	170	-67
Colfax	12,253	65	-41
Curry	50,280	345	-89
De Baca	1,793	7	-8
Doña Ana	214,207	1,490	-361
Eddy	57,621	412	-86
Grant	28,280	325	81
Guadalupe	4,376	19	-19
Harding	665	0	-6
Hidalgo	4,302	4	-33
Lea	69,749	359	-244
Lincoln	19,429	123	-45
Los Alamos	18,147	150	-7
Luna	24,450	104	-107
McKinley	74,923	457	-190
Mora	4,504	15	-24
Otero	65,410	384	-181
Quay	8,365	35	-37
Rio Arriba	40,040	182	-164
Roosevelt	19,082	81	-84
San Juan	115,079	881	-113
San Miguel	27,760	266	26
Sandoval	142,025	800	-427
Santa Fe	148,651	1,129	-155
Sierra	11,191	70	-27
Socorro	17,027	81	-66
Taos	33,065	215	-71
Torrance	15,302	35	-97
Union	4,183	25	-11
Valencia	75,626	194	-459
STATE TOTAL	2,081,015	17,219	-759

Table A.12. Benchmark Gap Analysis of New Mexico EMTs, 2016

County	Population	Estimated EMTs	Above (+) / Below (-) Benchmark
Bernalillo	676,953	2,031	88
Catron	3,508	39	29
Chaves	65,282	216	29
Cibola	27,487	45	-34
Colfax	12,253	65	30
Curry	50,280	120	-24
De Baca	1,793	22	17
Doña Ana	214,207	469	-146
Eddy	57,621	166	1
Grant	28,280	94	13
Guadalupe	4,376	20	7
Harding	665	6	4
Hidalgo	4,302	26	14
Lea	69,749	142	-58
Lincoln	19,429	109	53
Los Alamos	18,147	85	33
Luna	24,450	45	-25
McKinley	74,923	194	-21
Mora	4,504	5	-8
Otero	65,410	127	-61
Quay	8,365	27	3
Rio Arriba	40,040	131	16
Roosevelt	19,082	78	23
San Juan	115,079	364	34
San Miguel	27,760	39	-41
Sandoval	142,025	553	145
Santa Fe	148,651	397	-30
Sierra	11,191	47	15
Socorro	17,027	32	-17
Taos	33,065	126	31
Torrance	15,302	57	13
Union	4,183	17	5
Valencia	75,626	207	-10
STATE TOTAL	2,081,015	17,219	128

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Appendix B. Additional Practice Details for New Mexico Behavioral Health Providers

Table B.1. Proportion of Behavioral Health Care Providers Surveyed by Large License Category and License Type, 2016

License Type	Surveyed	Not Surveyed	Total
Prescribers			
Prescribing Psychologist	35 (85.4%)	6 (14.6%)	41
CNP/CNS	111 (100.0%)	0 (0.0%)	111
All Psychiatrists ^a	296 (89.2%)	36 (10.8%)	332
Child & Adolescent Psychiatrist ^b	58 (89.2%)	7 (10.8%)	65
TOTAL	442 (91.3%)	42 (8.7%)	484
Independently Licensed Psychotherapy Providers			
Non-Prescribing Psychologist	523 (88.3%)	69 (11.7%)	592
Counselor	1,534 (70.4%)	645 (29.6%)	2,179
Social Worker	182 (9.3%)	1,781 (90.7%)	1,963
TOTAL	2,239 (47.3%)	2,495 (52.7%)	4,734
Non-Independently Licensed Psychotherapy Providers			
Psychologist	4 (57.1%)	3 (42.9%)	7
Counselor	528 (53.4%)	460 (46.6%)	988
Social Worker	1,075 (43.5%)	1,395 (56.5%)	2,470
TOTAL	1,607 (46.4%)	1,858 (53.6%)	3,465
Substance Use Clinicians			
Independent License	312 (59.5%)	212 (40.5%)	524
Non-Independent License	141 (43.9%)	180 (56.1%)	321
TOTAL	453 (53.6%)	392 (46.4%)	845
TOTAL	4,741 (49.8%)	4,787 (50.2%)	9,528

^a This row includes 314 MDs and 18 DOs.

^b This row is included in the "All Psychiatrists" row.

Table B.2. New Mexico Behavioral Health Providers, 2016

County	Prescribers				Independently Licensed Psychotherapy Providers				Non-Independently Licensed Psychotherapy Providers				Substance Use Clinicians			County Total
	Prescribing Psychologist	CNP/CNS	Psychiatrist ^a (Child & Adolescent)	TOTAL	Non-Prescribing Psychologist	Counselor	Social Worker	TOTAL	Psychologist	Counselor	Social Worker	TOTAL	Independent License	Non-Independent License	TOTAL	
Bernalillo	16	53	183(40)	252	326	907	835	2,068	1	423	943	1,367	160	96	256	3,943
Catron	0	0	0 (0)	0	0	1	1	2	0	0	0	0	0	0	0	2
Chaves	1	2	4 (0)	7	10	30	31	71	0	6	90	96	13	12	25	199
Cibola	1	0	0 (0)	1	4	14	8	26	1	17	24	42	15	8	23	92
Colfax	0	1	0 (0)	1	1	11	9	21	0	3	8	11	4	2	6	38
Curry	0	1	3 (1)	4	5	41	29	75	0	16	46	62	2	0	2	143
De Baca	0	0	0 (0)	0	0	0	0	0	0	0	1	1	1	0	1	2
Doña Ana	8	23	22 (3)	53	55	162	187	404	1	82	318	401	48	18	66	924
Eddy	0	5	3 (0)	8	1	14	17	32	0	11	51	62	7	5	12	114
Grant	1	0	3 (0)	4	8	44	28	80	1	18	50	69	18	8	26	179
Guadalupe	0	0	0 (0)	0	1	4	4	9	0	2	6	8	2	5	7	24
Harding	0	0	0 (0)	0	0	0	0	0	0	0	0	0	0	0	0	0
Hidalgo	0	0	0 (0)	0	0	1	0	1	0	1	4	5	0	1	1	7
Lea	1	0	4 (0)	5	8	32	20	60	0	14	50	64	15	17	32	161
Lincoln	2	0	0 (0)	2	3	17	8	28	0	2	16	18	5	6	11	59
Los Alamos	0	0	3 (1)	3	14	19	13	46	1	6	5	12	2	2	4	65
Luna	0	0	1 (1)	1	1	6	3	10	0	4	33	37	0	0	0	48
McKinley	0	3	6 (2)	9	4	29	29	65	0	11	32	43	29	10	39	156
Mora	0	0	0 (0)	0	0	0	4	4	0	0	4	4	0	0	0	8
Otero	1	2	3 (0)	6	8	46	20	74	0	8	45	53	14	5	19	152
Quay	0	0	1 (1)	1	1	6	6	13	0	3	10	13	1	1	2	29
Rio Arriba	1	1	1 (0)	3	2	32	32	66	0	13	45	58	17	21	38	165
Roosevelt	0	1	0 (0)	1	1	15	8	24	0	13	13	26	1	1	2	53
San Juan	2	3	11 (2)	16	9	55	81	145	0	15	119	134	56	31	87	382
San Miguel	0	5	10 (1)	15	17	37	35	89	0	20	110	130	6	0	6	240
Sandoval	0	3	10 (1)	13	27	124	145	296	0	56	133	189	26	20	46	544
Santa Fe	3	6	53 (9)	62	61	403	286	750	2	184	179	365	43	21	64	1,241
Sierra	0	0	0 (0)	0	0	5	8	13	0	3	17	20	2	0	2	35
Socorro	0	0	1 (1)	1	3	9	6	18	0	3	7	10	7	2	9	38
Taos	2	0	4 (0)	6	13	60	68	141	0	19	51	70	15	13	28	245
Torrance	1	1	0 (0)	2	1	13	11	25	0	4	4	8	2	2	4	39
Union	0	0	0 (0)	0	0	1	1	2	0	3	4	7	3	2	5	14
Valencia	1	1	6 (2)	8	5	41	30	76	0	28	52	80	10	12	22	186
TOTAL	41	111	332(65)	484	592	2,179	1,963	4,734	7	988	2,470	3,465	524	321	845	9,528

^a This column includes 314 MDs and 18 DOs.

Table B.3. Number of Behavioral Health Providers with New Mexico Licenses Practicing in the State, 2016

License Category	Total Licensed in NM	Estimated Total Practicing in NM	Percent Practicing in NM
Prescribers	744	484	65.1%
Independently Licensed Psychotherapy Providers	5,646	4,734	83.8%
Non-Independently Licensed Psychotherapy Providers	4,131	3,465	83.9%
Substance Abuse Treatment Providers	942	845	89.7%
TOTAL	11,463	9,528	83.1%

Table B.4. Ratio of Behavioral Health Care Providers to Population by Large License Category and County, 2016

County	Prescribers	Independently Licensed Psychotherapy Providers	Non-Independently Licensed Psychotherapy Providers	Substance Use Clinicians
Bernalillo	0.37	3.05	2.02	0.38
Catron	0.00	0.57	0.00	0.00
Chaves	0.11	1.09	1.47	0.38
Cibola	0.04	0.95	1.53	0.84
Colfax	0.08	1.71	0.90	0.49
Curry	0.08	1.49	1.23	0.04
De Baca	0.00	0.00	0.56	0.56
Doña Ana	0.25	1.89	1.87	0.31
Eddy	0.14	0.56	1.08	0.21
Grant	0.14	2.83	2.44	0.92
Guadalupe	0.00	2.06	1.83	1.60
Harding	0.00	0.00	0.00	0.00
Hidalgo	0.00	0.23	1.16	0.23
Lea	0.07	0.86	0.92	0.46
Lincoln	0.10	1.44	0.93	0.57
Los Alamos	0.17	2.53	.066	0.22
Luna	0.04	0.41	1.51	0.00
McKinley	0.12	0.87	0.57	0.52
Mora	0.00	0.89	0.89	0.00
Otero	0.09	1.13	0.81	0.29
Quay	0.12	1.55	1.55	0.24
Rio Arriba	0.07	1.65	1.45	0.95
Roosevelt	0.05	1.26	1.36	0.10
San Juan	0.14	1.26	1.16	0.76
San Miguel	0.54	3.21	4.68	0.22
Sandoval	0.09	2.08	1.33	0.32
Santa Fe	0.42	5.05	2.46	0.43
Sierra	0.00	1.16	1.79	0.18
Socorro	0.06	1.06	0.59	0.53
Taos	0.18	4.26	2.12	0.85
Torrance	0.13	1.63	0.52	0.26
Union	0.00	0.48	1.67	1.20
Valencia	0.11	1.00	1.06	0.29
TOTAL	0.23	2.27	1.67	0.41

Table B.5. Proportion of Independently Licensed Psychotherapy Providers, 2016^a

County	Independently Licensed	Non-Independently Licensed	Percent Independently Licensed
Bernalillo	2,068	1,367	60.2%
Catron	2	0	100.0%
Chaves	71	96	42.5%
Cibola	26	42	38.2%
Colfax	21	11	65.6%
Curry	75	62	54.7%
De Baca	0	1	0.0%
Doña Ana	404	401	50.2%
Eddy	32	62	34.0%
Grant	80	69	53.7%
Guadalupe	9	8	52.9%
Harding	0	0	NA
Hidalgo	1	5	16.7%
Lea	60	64	48.4%
Lincoln	28	18	60.9%
Los Alamos	46	12	79.3%
Luna	10	37	21.3%
McKinley	65	43	60.2%
Mora	4	4	50.0%
Otero	74	53	58.3%
Quay	13	13	50.5%
Rio Arriba	66	58	53.2%
Roosevelt	24	26	48.0%
San Juan	89	130	40.6%
San Miguel	296	189	61.0%
Sandoval	145	134	52.0%
Santa Fe	750	365	67.3%
Sierra	13	20	39.4%
Socorro	18	10	64.3%
Taos	141	70	66.8%
Torrance	25	8	75.8%
Union	2	7	22.2%
Valencia	76	80	48.7%
TOTAL	4,734	3,465	57.7%

^a Prescribers and substance use treatment providers were not included in this analysis.

Table B.6. Percentage of Behavioral Health Care Providers' Patients Using Medicare as Primary Payment, 2016

License Category	Total	% Patients with Medicare as Primary Payment							
		0%		1 ^a – 29%		30 – 59%		60 – 100%	
		#	%	#	%	#	%	#	%
Prescribers^b	214	68	31.8%	83	38.8%	54	25.2%	9	4.2%
Independently Licensed Psychotherapy Providers	1,470	1,030	70.1%	255	17.3%	107	7.3%	78	5.3%
Non-Independently Licensed Psychotherapy Providers	851	511	60.0%	116	13.6%	85	10.0%	239	16.3%
Substance Use Clinicians	262	185	70.6%	50	19.1%	14	5.3%	13	5.0%

^a It is possible that some clinicians responding "1" meant "100%."

^b Excludes CNP/CNS, who were not surveyed regarding payment.

Table B.7. Percentage of Behavioral Health Care Providers' Patients Using Tricare/VA/IHS as Primary Payment, 2016

License Category	Total	% Patients with Tricare/VA/IHS as Primary Payment							
		0%		1 ^a – 29%		30 – 59%		60 – 100%	
		#	%	#	%	#	%	#	%
Prescribers^b	188	90	47.9%	84	44.7%	3	1.6%	11	5.9%
Independently Licensed Psychotherapy Providers	1,353	942	69.6%	352	26.0%	24	1.8%	35	2.6%
Non-Independently Licensed Psychotherapy Providers	717	543	75.7%	153	21.3%	9	1.3%	12	1.7%
Substance Use Clinicians	240	190	79.2%	39	16.3%	3	1.3%	8	2.2%

^a It is possible that some clinicians responding "1" meant "100%."

^b Excludes CNP/CNS, who were not surveyed regarding payment.

Table B.8. Percentage of Behavioral Health Care Providers' Patients Using Private Insurance as Primary Payment, 2016

License Category	Total	% Patients with Private Insurance as Primary Payment							
		0%		1 ^a – 29%		30 – 59%		60 – 100%	
		#	%	#	%	#	%	#	%
Prescribers^b	207	41	19.8%	106	51.2%	44	21.3%	16	7.7%
Independently Licensed Psychotherapy Providers	1,619	445	27.5%	585	36.1%	332	20.5%	257	15.9%
Non-Independently Licensed Psychotherapy Providers	840	387	46.1%	363	43.2%	63	7.5%	27	3.2%
Substance Use Clinicians	266	136	51.1%	93	35.0%	22	8.3%	15	5.6%

^a It is possible that some clinicians responding "1" meant "100%."

^b Excludes CNP/CNS, who were not surveyed regarding payment.

Appendix C. Survey Collection Progress, 2010 – 2016

Table C.1 depicts the state’s progress in obtaining survey data for licensed health professionals. Survey data for physicians is not collected up to a year after they obtain their license. The New Mexico Medical Board requires physicians to renew their license in the following renewal cycle after a license is issued, at which time they are required to submit a survey. After the initial renewal, they are required to renew every three years.

The New Mexico Nursing Board was the first board to implement survey collection upon licensure, and the board requires completion of a survey at the time of initial licensure in order to collect demographic data. As a result, all licensed nursing professionals in the state have completed a licensure survey and are not included in Table C.1.

Table C.1. Percentage of Health Care Professionals' License Renewal Surveys Obtained, 2010 – 2016

License Type	License Count	Survey Count	Percent
Alcohol Abuse Counselor	3	0	0.0%
Alcohol and Drug Counselor	590	356	60.3%
Anesthesiologist Assistant	38	0	0.0%
Art Therapist	99	80	80.8%
Associate Marriage & Family Therapist	32	0	0.0%
Audiologist	168	132	78.6%
Clinical Mental Health Counselor (LPCC)	2,025	1,436	70.9%
Dental Assistant	2,861	1,920	67.1%
Dental Hygienist	1,360	949	69.8%
Dentist	1,566	879	56.1%
Doctor of Chiropractic	600	186	31.0%
Doctor of Chiropractic APC	122	99	81.1%
Doctor of Naprapathy	26	0	0.0%
Doctor of Osteopathy	695	602	86.6%
Licensed Baccalaureate Social Worker	583	378	64.8%
Licensed Clinical Social Worker	1,794	82	4.6%
Licensed Independent Social Worker	242	170	70.3%
Licensed Masters Social Worker	1,774	1,107	62.4%
Licensed Mental Health Counselor	1,108	632	57.0%
Licensed Midwife	80	33	41.3%
Marriage and Family Therapist	318	228	71.7%
Medical Doctor	8,762	7,572	86.4%
Occupational Therapist	942	505	53.6%
Occupational Therapy Assistant	467	299	64.0%
Physical Therapist	1,911	1,454	76.1%
Physical Therapist Assistant	755	456	60.4%
Physician Assistant	986	644	65.3%
Podiatrist	140	88	62.9%
Professional Mental Health Counselor	209	145	69.4%
Psychologist	810	709	87.5%
Psychologist Associate	9	5	55.6%
Registered Independent Counselor	7	1	14.3%
Registered Pharmacist	3,204	1,097	34.2%
Speech-Language Pathologist	1,692	1,568	92.7%
Substance Abuse Associate	348	161	46.3%
Telemedicine	704	0	0.0%
TOTAL	37,030	23,973	64.7%

Appendix D. Members of the New Mexico Health Care Workforce Committee, 1 October 2017

Name	Organization
Richard Larson, Chair	University of New Mexico Health Sciences Center
Charlie Alfero	Center for Health Innovation, Hidalgo Medical Center
Caroline Bonham	UNM HSC, Representing the Behavioral Health Subcommittee
Albert Bourbon	NM Medical Board <i>and</i> NM Academy of Physician Assistants
Robert Chavez	NM Board of Nursing
Travis Dulany	NM Legislative Finance Committee
Doris Fields	NM NAACP
Joie Glen	NM Association for Home and Hospice Care
Tomas Granados	NM Board of Psychologist Examiners
Jerry Harrison	NM Health Resources
Michael Hely	NM Legislative Council Service
Ellen Interlandi	NM Organization of Nurse Leaders
Annie Jung	NM Medical Society
Ben Kesner	NM Board of Pharmacy
Beth Landon	NM Hospital Association
Wayne Lindstrom	NM Division of Behavioral Services
Timothy Lopez	NM Department of Health
Steve Lucero	NM Hispanic Medical Association
Michael Moxey	NM Dental Association
Matthew Probst	NM Academy of Physician Assistants
Dorothy Romo	Presbyterian Medical Services
Joseph Sanchez	UNM College of Nursing
Sandy Stewart	NM Center for Nursing Excellence
Eugene Sun	Blue Cross Blue Shield of NM
Leonard Thomas	Indian Health Service
Dale Tinker	NM Pharmacists Association
Donna Wagner	NMSU College of Health and Social Services
Deborah Walker	NM Nurses Association
Barbara Webber	Health Action NM

Staff

Carlotta Abeyta	UNM Health Sciences Center
Erica Brown	UNM Health Sciences Center
Amy Farnbach Pearson	UNM Health Sciences Center
Michael Haederle	UNM Health Sciences Center
Vanessa Hawker	UNM Health Sciences Center
Maurice (Mark) Moffett	UNM Health Sciences Center
Jessica Reno	UNM Health Sciences Center

Suggested citation: Farnbach Pearson AW, Reno JR, New Mexico Health Care Workforce Committee. 2017 Annual Report. Albuquerque NM: University of New Mexico Health Sciences Center, 2017.