NEW MEXICO STATE HEALTH ASSESSMENT

2014 - 2016

New Mexico Department of Health

"Promote health and wellness, improve health outcomes, and assure safety net services for all people in New Mexico."

New Mexico Department of Health Mission Statement

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New Mexico State Health Assessment
EXECUTIVE SUMMARY

INTRODUCTION

The New Mexico Department of Health (NMDOH), under the leadership of Cabinet Secretary Retta Ward, is pursuing Public Health Accreditation to measure NMDOH performance using the Public Health Accreditation Board (PHAB) Standards and Measures. The statement of intent was submitted on May 17, 2012.

This document summarizes information and processes used by the NMDOH to assess the heath of the state's population and how the information is used in work with communities to develop priorities and plans of action to improve health. This document has been prepared to obtain advice and consultation from national partner organizations involved in the accreditation process to identify what further actions may be required to meet the community health assessment prerequisite requirement. NMDOH understands the importance of this prerequisite and its relationship to PHAB Domain 1: Conduct assessments focused on population health status and health issues facing the community, Standard 1.1. Participate in or conduct a collaborative process resulting in a comprehensive health assessment, and Measures 1.1.1 Participate in or conduct a state partnership that develops a comprehensive state community health assessment of the population of the state, and 1.1.2 Complete a state level community health assessment.

> **"A process of collecting, analyzing, and using data to educate and mobilize communities, develop priorities, garner resources, and plan actions to improve the public's health."**
>
> Association of State and Territorial Health Officers

NEW MEXICO DEMOGRAPHICS

With an area of 121,593 sq mi (314,926 sq km), New Mexico ranks as the 5th largest of the 50 U.S. states. The state is roughly bisected by the Rio Grande River. Mountain ranges which are a part of the Rocky Mountains run in broken groups north to south through central New Mexico on either side of the Rio Grande.

New Mexico's climate ranges from arid to semiarid with a wide range of temperatures. Average January temperatures vary from about 35°F (2°C) in the north to about 55°F (13°C) in the southern and central regions. July temperatures range from about 78°F (26°C) at high elevations to around 92°F (33°C) at lower elevations.

Average annual precipitation (1971–2000) was 9.5 in (24 cm) in Albuquerque; at higher elevations, annual precipitation averaged over 20 in (50 cm). Nearly one-half the annual rainfall comes during July and August, and thunderstorms are common in the summer. Snow is much more frequent in the north than in the south. The Rio Grande provides most of the irrigation water for New Mexico's area of most intensive agriculture.

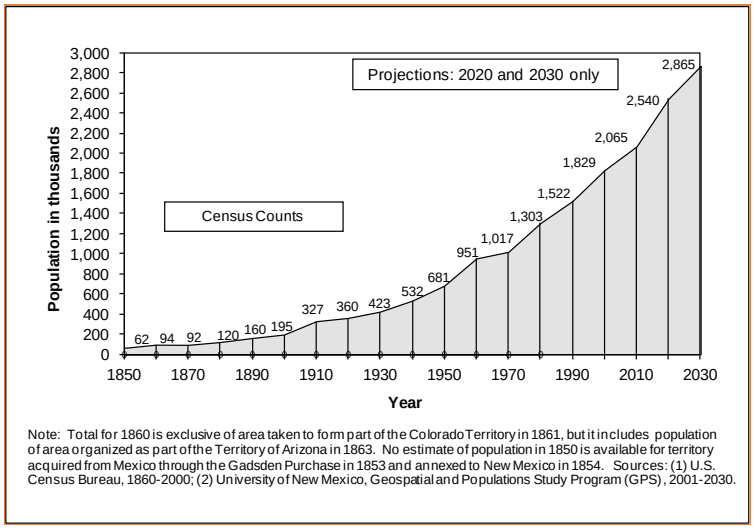
Due to the lack of water resources, most of New Mexico's arable land is devoted to grazing. Much of the state's income comes from its considerable mineral wealth which includes uranium ore, potash, salt, perlite, copper ore, natural gas, beryllium and tin concentrates, coal and petroleum.

The federal government is the largest employer in the state, accounting for over 25% of New Mexico's jobs. A large percentage of these jobs are related to the military.

New Mexico's 2011 estimated population was 2,075,056, which is a 0.5% increase from 2010. This is also an increase of 13.5% since 2000.

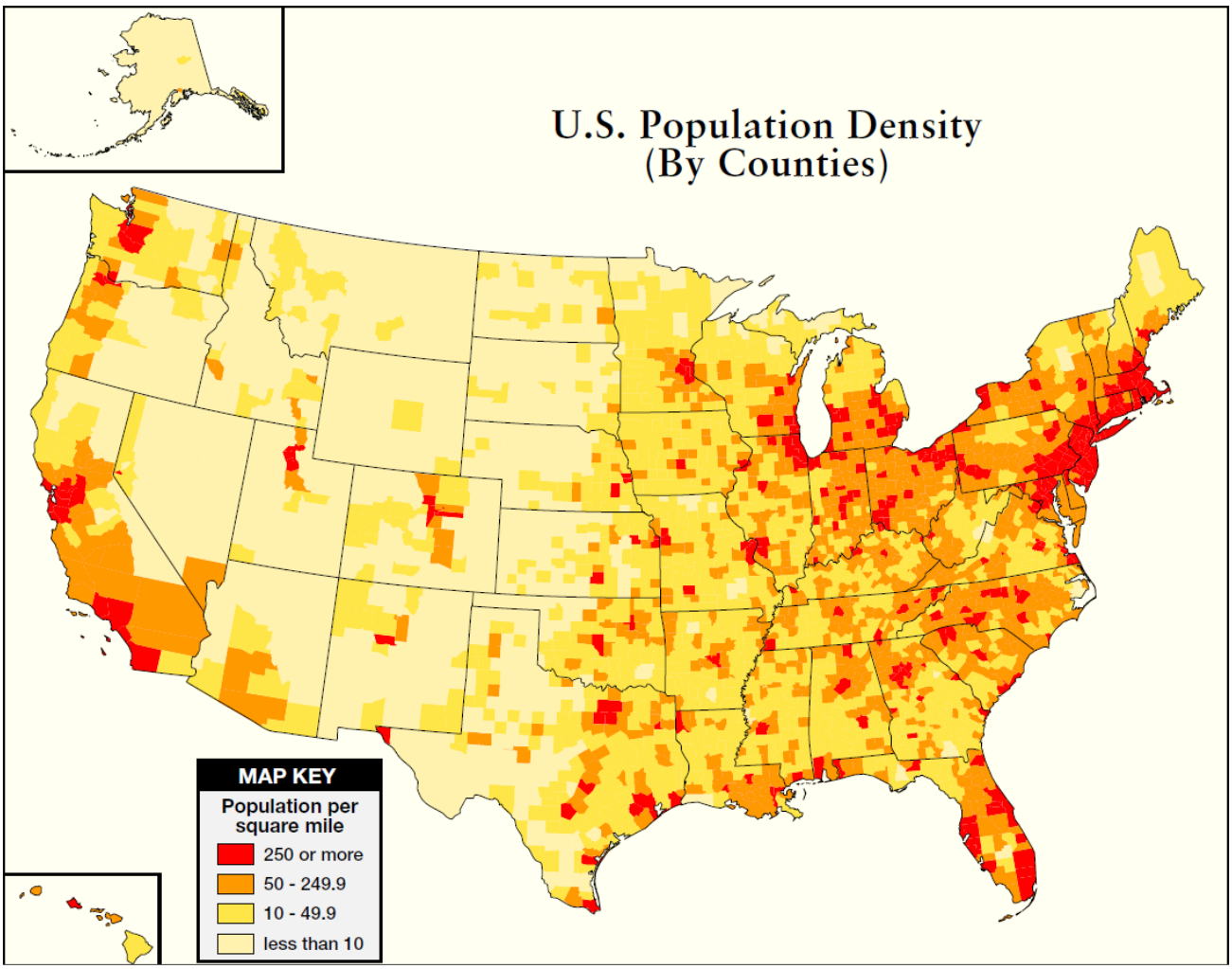
New Mexico's population is projected to reach 2,540,145 in 2020 and 2,864,796 in 2030. These are projected increases from 2011 of 22.4% and 38.1%, respectively (Figure P-1).

Figure 1, Population: Counts and Projections, New Mexico, 1850 to 2030



Note: Total for 1860 is exclusive of area taken to form part of the Colorado Territory in 1861, but it includes population of area organized as part of the Territory of Arizona in 1863. No estimate of population in 1850 is available for territory acquired from Mexico through the Gadsden Purchase in 1853 and annexed to New Mexico in 1854. Sources: (1) U.S. Census Bureau, 1860-2000; (2) University of New Mexico, Geospatial and Populations Study Program (GPS), 2001-2030.

With a population density of 17 people per square mile, New Mexico comes in 46th out of the 50 states. As the following population density map illustrates, population density is greatest in Bernalillo County which had a 2010 population density of 571 persons per square mile.

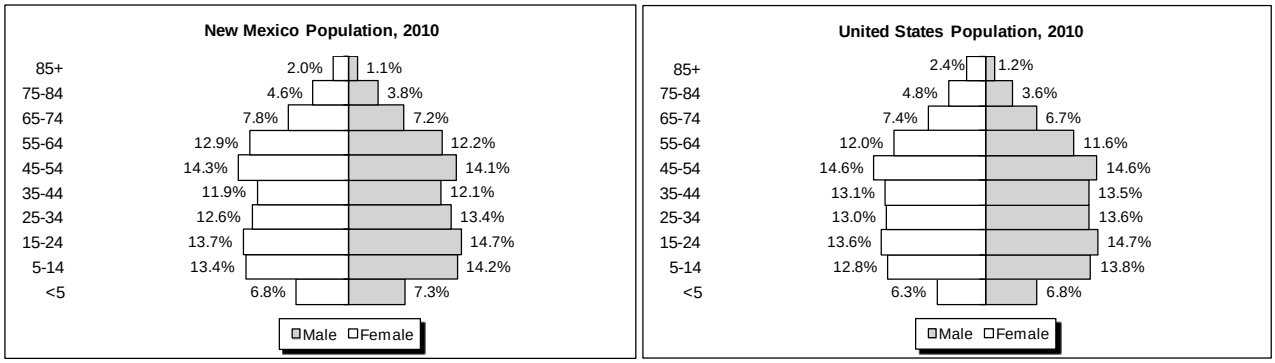


AGE

In 2011, for the United States, the largest portion of the population was between the ages of 45 and 54. The largest portion for New Mexico was 65 and older.

In 1900, both the United States and New Mexico were characterized by low life expectancy and high fertility rates resulting in a high proportion of young people and a low proportion of elderly. After World War II, the percent of the population in the younger age groups declined to produce a more uniform pyramid. At the same time, the national figure becomes more rectangular in shape, indicating a more even distribution of ages in the population. New Mexico's older population was slower to increase than that of the United States. By 2010, the state population distribution more closely reflected that of the nation (Figure 2).

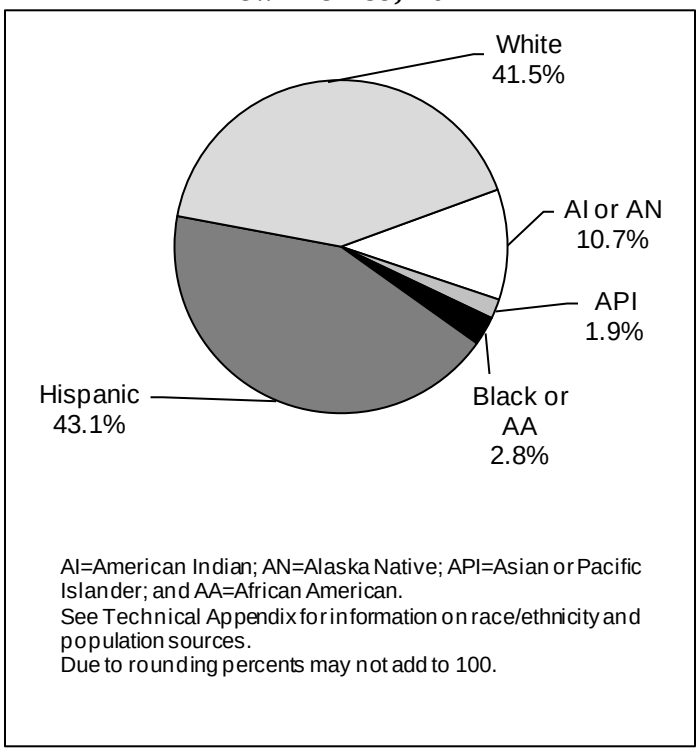
Figure 2, Population Pyramids
New Mexico and United States, 2010



RACE AND ETHNICITY

The New Mexico Department of Health combines race and ethnicity for reporting purposes.

Figure 3, Population Distribution by Race/Ethnicity,
New Mexico, 2011

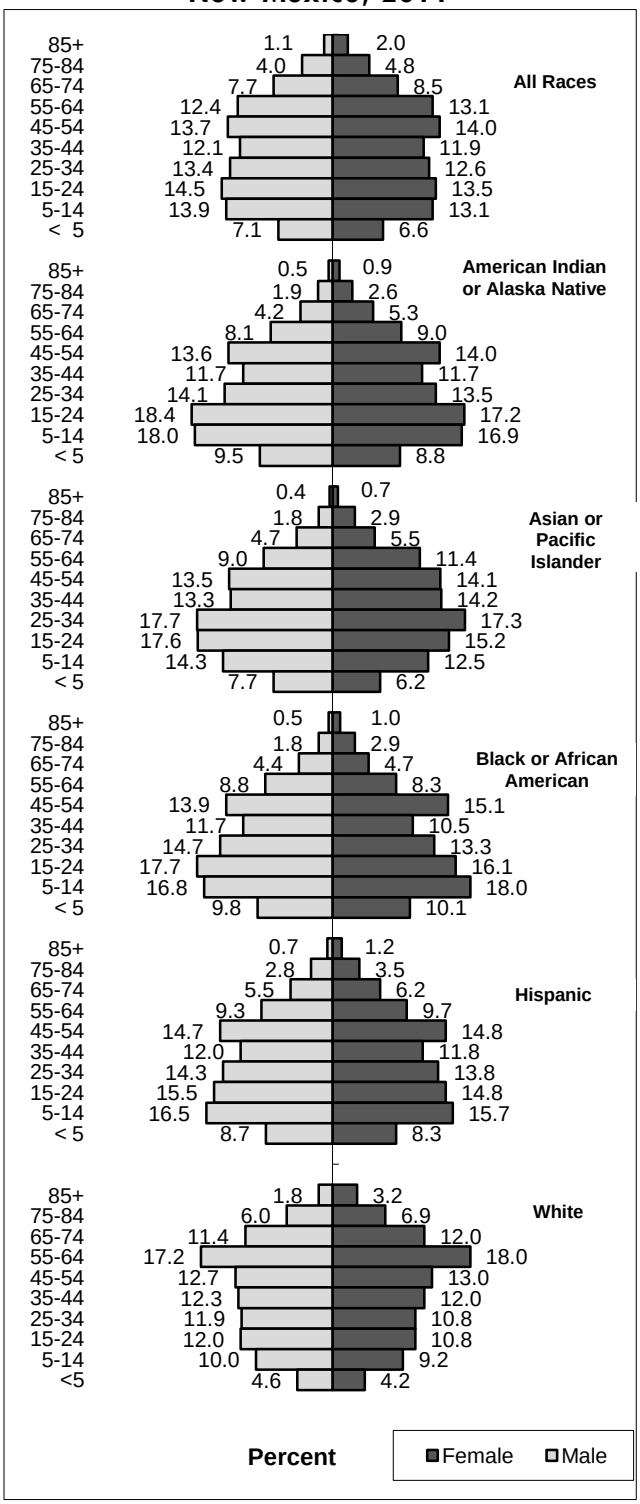


AI=American Indian; AN=Alaska Native; API=Asian or Pacific Islander; and AA=African American.
See Technical Appendix for information on race/ethnicity and population sources.
Due to rounding percents may not add to 100.

According to 2011 state population estimates 43.1% of New Mexicans were Hispanic and 41.5 % were White (Figure P-3). The Hispanic category does not include Black, American Indian, or Asian or Pacific Islander populations. The American Indian or Alaska Native population comprised 10.7% of New Mexico's population; the Black or African American population made up 2.8%; and the Asian or Pacific Islander population constituted another 1.9%.

The American Indian or Alaska Native and the Black or African American populations had higher percents of individuals under age 25 years compared to the other racial/ethnic groups. The White population had the highest percent of persons 65 years of age and older (Figure 4).

Figure 4, Population Distribution by Race/Ethnicity, Age, and Sex
New Mexico, 2011



As indicated previously, no single race/ethnic group makes up a majority of the state's population. Each of New Mexico's racial and ethnic groups faces its own health challenges. Differences, or disparities, in health status and the impact of diseases have been tracked. These disparities are based on comparisons of the health status, access to services, and/or health outcomes of population groups. Listed below by race/ethnic group are health conditions, injuries and diseases where the performance by racial/ethnic group is on the wrong end of the health disparity.

American Indian	African-American/Black	Hispanic	Asian/Pacific Islander	White
Adult Obesity Homicide Diabetes Deaths Alcohol-Related Deaths Motor Vehicle Deaths Pneumonia & Influenza Deaths Youth Obesity Late Prenatal Care Youth Suicide	HIV Infections Infant Mortality Adult Smoking	Chlamydia Teen Births Pertussis Adults with Diabetes Not Receiving Recommended Services Adults 65+ Not Ever Receiving Pneumonia Vaccinations	Acute and Chronic Hepatitis B	Adult Suicide Drug Overdose Deaths Fall Related Deaths

Between 2007 and 2011, 9.8% of New Mexicans report themselves as being foreign born. This is less than the national percentage of 12.7%. However, the percentage of residents over 5 years of age who speak a language other than English at home is 36.2%, which is much higher percentage than that for the U.S. as a whole (20.1%).

New Mexico has 22 federally recognized American Indian tribes. There are 19 Indian pueblos (Acoma, Cochiti, Isleta, Jemez, Laguna, Nambé, Okay Owingeh, Picuris, Pojoaque, Sandia, San Felipe, San Ildefonso, Santa Ana, Santa Clara, Santa Domingo, Taos, Tesuque, Zia, and Zuni) and three Indian reservations in the state (Jicarilla Apache nation, Mescalero Apache reservation, and Navajo Nation). New Mexico is home to 6.2% of the total U.S. American Indian and Alaska Native population.

The New Mexico State – Tribal Collaboration Act was passed in the NM Legislature in 2009. NMDOH submits a report to the Indian Affairs Department to describe collaboration efforts. (Attachment D)

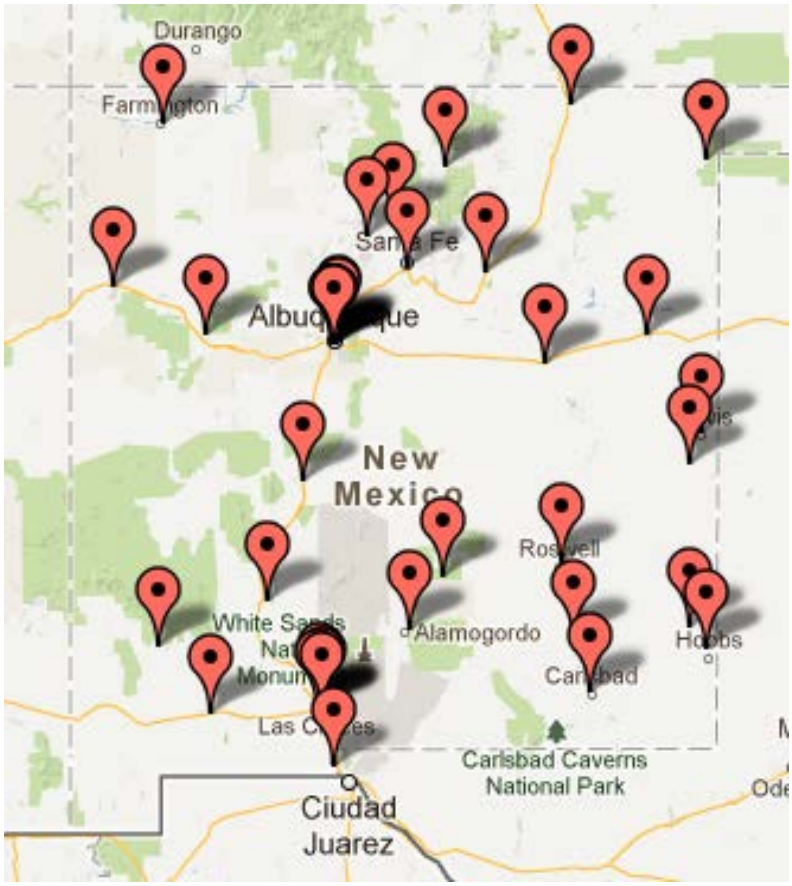
New Mexico's unemployment rate is lower than the national rate (NM 6.9%, US 7.6%). However, the per capita income measured in 2011 dollars is $23, 537, below the national figure of $27,915. The disparity in median household income was larger: New Mexico, $44,631; US $52,762. New Mexico has a higher rate of individuals living below 100% of poverty (NM 23.8%, US 20.2%).

New Mexico's level of education attainment is similar to that of the US as a whole. 83% of New Mexico's population has a high school diploma, compared to 85.4% of the US. 25.4% of New Mexico's population had received a Bachelor's degree or higher, compared to 28.2% for the US.

However, New Mexico has struggled with the problem of recruiting health professionals. This is due, in part, to the rural nature of the state. New Mexico has 94 primary health professional shortage areas (HPSA). In New Mexico, 40.5% of the population is living in a primary care HPSA compared to 19.1% of the US population as a whole. An estimated 26.6% of New Mexico's population is underserved compared to 11.4% of the US population. An estimated 125 additional practitioners are needed in New Mexico to remove the

HPSA designations and 254 more practitioners are needed to achieve the target population-to-practitioner rate. New Mexico has 770.5 RNs per 100,000 population compared to the US rate of 920.9. This ranks New Mexico 44th in the nation. Additionally, New Mexico has 125 LPNs per 100,000 population compared to the US rate of 225. This ranks New Mexico 42nd in the nation.

New Mexico has a total of 36 hospitals with a hospital bed to 1,000 population ratio of 1.9. The US ratio is 2.6.



THE HEALTH SYSTEM IN NEW MEXICO

Like most states, New Mexico's health system is comprised of multiple components across many different organizations, all which contribute to assessing, maintaining and improving health in our state. Broadly, the components in New Mexico include: state agencies such as NMDOH, NM Environment Department, NM Human Services Department, NM Children, Youth and Families Department and Aging and Long-Term Services Department; tribal entities; Indian Health Services; hospitals; managed care organizations; universities; advocacy groups; and county and local government. State agencies have worked together for many years to produce the *New Mexico Children's Cabinet Report Card and Budget Report*. This report summarizes current

progress on five priorities for the state and is intended to inspire discussion across public and private sectors about the needs in the state. Health Cabinet Secretary Retta Ward is convening secretaries from other Cabinet Departments as a stakeholder group to inform the State Health Improvement Plan.

The NMDOH is a centralized system health department with most state, regional and local health department staff as employees of the NMDOH. New Mexico has 33 counties, which are organized into five public health regions. Governance for these regions is from the state agency, NMDOH Public Health Division, not local boards of health or county officials. Public health regions have staff resources in all counties to provide local essential services access and to assure that health needs are being met. Recently, public health regions were realigned to better correspond geographically with patterns of care and to promote collaboration among local resources and state agencies. Public health regions are embarking on an assessment of community local health resources to identify assets and gaps in order to meet health care service needs. This system analysis is being piloted in one location and will be duplicated statewide. There are ongoing efforts on the part of NMDOH and its partners to prepare for the Affordable Care Act implementation.

CORE DOCUMENTS WITH STATE HEALTH ASSESSMENT INFORMATION

The NMDOH has several key resources that provide a comprehensive broad-based view of the health status in the state. These resources are used by many organizations and individuals to mobilize communities, develop priorities and develop action plans to improve the public's health. These resources include:

The State of Health in New Mexico

Every other year, the NMDOH publishes *The State of Health in New Mexico* report. This report provides a comprehensive view of the health issues that need attention and intervention to improve the health of the people of New Mexico. The document details health issues which are most important to the state, what is currently being done and what actions are needed in the future. The State of Health in New Mexico 2013 is part of this report (Appendix A). A press release was distributed statewide to publicize the availability of the document. The State of Health in New Mexico 2013 is posted on the NM Department of Health website. This document has historically been published every two years.

New Mexico's Indicator Based Information System for Public Health (NM-IBIS)

NM-IBIS is the New Mexico Department of Health's web-based system that provides access to comprehensive information on New Mexico's priority health issues; and the health system. NM-IBIS provides access to:

- Health indicator reports, which provide online numeric data and a public health context (such as why it is important and what is being done to improve it); there are 113 reports alphabetized and categorized by topic or subject.

- Information on a county level or a "community snapshot", which includes a dashboard with graphics to visibly compare the community indicator value with the state; there are snapshots for all 33 New Mexico counties.

- A query system that provides access to health datasets directly, with data tables and graphs, including:

    - Behavioral Risk Factor Surveillance System (BRFSS) the primary surveillance tool in New Mexico for chronic diseases since 1986 and is the primary source of data for estimating the prevalence of health conditions, major chronic diseases and their risk factors among NM adults.

    - Youth Risk and Resiliency Survey (YRRS), a health survey of high schools and middle schools students that generates estimates for risk and protective factors among adolescents, such as tobacco use, physical activity, weight status, and nutritional habits. This data is incorporated into the strategic planning and evaluation efforts of health programs throughout the Department, and disseminated broadly to schools, parents, and policy makers. The YRRS is implemented as a joint initiative between NMDOH and the New Mexico Public Education Department, and is New Mexico's version of the YRBS.

    - Vital Records data, birth and death data, which contain valuable statistical information on demographic characteristics and the distribution of health conditions, diagnoses and procedures.

    - Infectious Diseases (22 diseases) information from infectious diseases reported through New Mexico's National Electronic Telecommunication System for Surveillance (NETSS) and New Mexico Electronic Disease Surveillance System (NM-EDSS) databases, available on an almost real-time basis.

    - Hospital Inpatient Discharge Data containing information on both general hospitalization and injury specific hospitalizations. Additional demographic information is being added to HIDD data, including race/ethnicity and tribal identification.

- The New Mexico Injury Portal, which provides access to resources, related to injuries and injury prevention including best practices.
  NM-IBIS link: http://ibis.health.state.nm.us/indicator/Introduction.html

The State of New Mexico's Health System Workforce

In early 2013, NMDOH worked closely with the New Mexico Legislative Finance Committee (LFC) evaluation staff to assess the status of New Mexico's healthcare and public health workforce. The study was released on May 15, 2013 by the LFC in testimony to the full committee. The final report, *Adequacy of New Mexico's Healthcare Systems Workforce*, is included as an important contribution to the NMDOH State Health Assessment (Appendix B).

TOPIC SPECIFIC PLANNING AND HEALTH ASSESSMENTS

Health assessment information is available through advisory groups, surveys completed for specific topic areas and collaboration with other agencies. All these avenues provide valuable information to assess health needs in the state and to develop actions plans. (Appendix C: Engagement Activities). Examples with partners include:

Advisory Groups

- New Mexico Jurisdictional HIV Prevention Plan: 2012 – 2014 to be published in September 2012, being developed by the NM HIV Prevention Community Planning and Action Group, planning conducted with persons living with HIV/AIDS, gay/bisexual men and other men who have sex with men (MSM), transgender persons, injection drug users (IDU), heterosexuals at risk (HAR)

Collaboration Between Agencies

- NMDOH epidemiologists and the University of New Mexico State Tumor Registry Director have established a Cancer Concerns Working Group. The intent of the working group is to more effectively respond to public queries regarding perceived cancer clusters, the majority of which are believed by the caller to be related to shared exposures to environmental contaminants in a community or workplace. The working group is developing a secure web-based platform that will be built onto the Environmental Public Health Tracking (EPHT) System to streamline intake, data assessment, and response capabilities. Because the EPHT houses geo-coded bio-monitoring and cancer data that can be analyzed at the census tract level, it provides enhanced capacity for small area analyses of communities, when indicated.

- The NM Cancer Council collaborates with different organizations to reduce the impact of cancer on the people of New Mexico. Based on review of current data, program strategies and activities are modified to reduce the impact of cancer.

Specific Health Topic Assessments

- For the 2010 MCH Title V Needs Assessment, the MCH Epidemiology program developed an online survey to identify maternal and child health priorities. Respondents were asked to rank order 25 MCH priorities, which they felt were most pressing in their communities. Over 1,000 New Mexicans responded and over 200 respondents also utilized the comment box at the end of the survey. The results were published on the DOH website and in the Needs Assessment report. This report resulted in the following top five health issues: Access to Services and Health Insurance for the MCH Population; Child Abuse; Teen Pregnancy and STDs; Youth Alcohol and Substance Abuse; and Hunger and Food Insecurity.

- Children's Medical Services (CMS) continuously receives public input from its stakeholders and community partners. The MCH Collaborative meets monthly and includes CMS, Family Voices, Parents Reaching Out, and Education for Parents of Indian Children with Special Needs (EPICS). The advisory councils for the Genetic Screening program, the Newborn Hearing Screening

program and for the Children and Youth with Special Health Care Needs (CYSHCN) program meet regularly to ensure continuing efficacy of CMS programs. These advisory councils include representation from various stakeholders including professionals, families, and other agencies. The CMS Social Workers in the field also participate on community councils and receive input from the public on various local maternal and child health issues.

- Asthma summits were held in 2008 and 2009; and participants voiced a high need for more asthma outreach clinics, especially in the southeast part of the state. In addition, data from 2010 showed an increase in asthma in the central NM corridor. CMS responded to this input by adding 12 new asthma clinics over the past three years, concentrating on the areas of need.

- A survey of primary care providers at federally qualified health centers participating in the Breast and Cervical Cancer Early Detection (BCC) Program was conducted in partnership with the New Mexico Primary Care Association to identify program needs and improvements.

- The Family Planning Program held focus groups with Title X clinical providers statewide in June 2011. The providers were invited to attend a meeting at one of three NM locations: Las Cruces, Rio Rancho or Roswell. Participants were asked to provide input and discussion on three issues related to family planning services in their community

- School-based health centers funded by the NMDOH (approximately 50) require all students to complete a Student Health Questionnaire (SHQ) at their first visit or make arrangements to have it completed soon after the first visit. The SHQ is an individual risk-screening assessment; however, aggregated survey results inform school-wide health education promotion programs. In 2010-2011, over 18,000 students received care at a SBHC in New Mexico.

COMMUNITY HEALTH COUNCILS, ASSESSMENTS AND HEALTH IMPROVEMENT PLANS

New Mexico's current health council system is made up of 33 county-based councils and 5 tribal councils in American Indian communities, including Acoma, Cochiti, San Ildefonso, Santa Clara and To'Hajiilee. Since 2008, all 33 NM Counties have completed a health assessment or health profile and developed a community health improvement plan to address priority health issues. The health councils were originally established under provisions of the 1992 Maternal and Child Health Plan Act. Since that time, the New Mexico Department of Health, Office of Health Promotion and Community Health Improvement has provided training, coordination, technical assistance, and other kinds of support to the health councils. Most of the community health improvement plans include one or more of the health focus areas that are included in the NMDOH Turn the Curve on Health, 2012 Health Focus Areas (see below). Teen pregnancy, diabetes, substance abuse and obesity are priority health areas selected in most of the plans. The work done over the last twenty years by the Health Councils laid the groundwork for Community Transformation and Turn the Curve work (see below). One challenge to the Community Health Council system is a lack of funding to support their work at the local level. Funding was eliminated in mid-2010 and many of the councils have struggled to maintain solvency. (County Health Council Information: http://nmhealth.org/PHD/OHPCHI/health_councils.shtml)

COMMUNITY TRANSFORMATION GRANT ASSESSMENT

In applying for a community transformation grant, the department assessed all thirty-three counties and selected counties for the state's targeted efforts based on their risk factors for chronic disease and health outcomes, poverty levels, ethnic diversity, regional diversity and readiness to implement. Readiness to implement was defined as whether a community had: 1) an active county health council or was a *Healthy Kids Healthy Community*; and 2) it had demonstrated experience in planning and implementing policy and environmental strategies. Ten counties and 4 American Indian communities were selected to be the targeted communities for the grant.

OTHER ASSESSMENTS RELATED TO SYSTEM IMPROVEMENT

In 2010, the NMDOH Environmental Health Epidemiology Bureau (EHEB) completed an assessment using the Environmental Health Performance Standards. Areas of improvement were identified and included: Develop policies and plans that support individual and community environmental health efforts (related to Essential Service #5); assure a competent environmental health workforce (Essential Service #8) and evaluate the effectiveness, accessibility, and quality of personal and population based EH services (Essential service #9).

In 2002, Albuquerque Area Indian Health Service (AAIHS) initiated assessment using the CDC National Public Health Performance Standards to assess the ability to serve Native Americans. In 2003, the NMDOH collaborated with UNM Institute for Public Health to complete a state and local system assessment. The local systems in 21 counties were assessed. Over 600 people participated in these assessment processes. Areas for system improvement were identified; some of which have been addressed and others need to continue to be addressed in the NMDOH's work with their partners. We are looking at how we can compare the results from this system assessment to what has been accomplished and what resource gaps remain.

COMMUNITY HEALTH IMPROVEMENT PLAN

While the development of a community health improvement plan is a separate prerequisite required for Health Departments applying for accreditation, a brief description is included to illustrate how assessment data is utilized to mobilize communities and develop action plans. This year, NMDOH has selected a new model for health planning to develop a common agenda for improving health with community partners. The Results-Based Accountability (RBA) approach to planning is being used to collect additional community health assessment information and to develop the Health Improvement Plan.

The RBA approach is a disciplined way to collect the knowledge, perceptions and strategy actions from communities to improve health; and inform on how agencies are able to improve the performance of their programs. The RBA approach starts with the end result and then identifies what's needed to "turn the 'data' curve" in the desired direction (trend or baseline). The story behind the curve is included as an assessment.

To identify the potential health focus areas, an analysis was completed by compiling population health indicators identified in national and state reports and a selection was made of indicators where New Mexico ranked lowest in the United States; indicators that affected large segments of the population; and, indicators that reflect significant disparities. Based on this review, nine health focus areas were selected as proposed top areas of focus for the health improvement plan.

Turn the Curve on Health

Nine Health Focus Areas

- Healthy Weight
- Diabetes
- Tobacco Use
- Teen Births
- Adult Immunization
- Oral Health
- Fall-Related Injury and Deaths Among Older Adults
- Drug Overdose Deaths
- Alcohol-Related Deaths

In December 2011, the RBA approach and proposed health conditions were discussed at a meeting with key stakeholders from across New Mexico. Approximately 90 leaders from hospitals, community clinics and non-profit organizations came together for a Turn the Curve on Health summit to discuss public health status and to identify their organization's contribution to address these conditions. To further confirm the selection of health conditions and strategies, five regional meetings were held across the state to introduce the RBA approach, to collect input on the selected health indicators and to identify additional health indicators important to communities. These meetings resulted in commitments to continue to exchange information about the work community groups are doing to address the health priorities in their communities.

LOOKING TO THE FUTURE

The State Health Assessment Report will report on data that provide information on priority health issues and the health status of the New Mexico population. New Mexico has a formative version of the State Health Assessment Report in *The State of Health in New Mexico 2013* report.

The State Level Priority Groups (or State Single Issue Workgroups) will typically focus on one health priority area. These groups will focus on statewide objectives, the health indicator, measures, strategies and targets for the health priority area. Further they will determine needed policy change and the individuals and organizations responsible for the strategies and activities. The measure, strategies, and targets developed by these groups will provide input to the State Health Improvement Plan.

NMDOH programs and partners will implement planned health promotion activities, and NMDOH will use a variety of methods to track outcomes, including the "Results for People Scorecard" (Compliments the RBA model) for the Turning the Curve on Health measures, and NM-IBIS, NMTracking, and a variety of other surveillance systems for additional indicators. A similar process takes place at the county/tribal level. County or tribal health councils and their partners will review the community health assessment, identify health issues and themes, identify resources and assets, and determine county priority health issues.

To ensure stakeholder involvement in the state health assessment report, the New Mexico Department of Health has used a variety of methods to engage stakeholders and get their input to NMDOH activities and reports. Over the next 12 months, additional emphasis will be placed on the State Crosscutting Group. The group will review the nine "Turn the Curve" indicators and the rationale for elevating those issues to the "top priorities." They will review data and discuss prioritization methods, and will assess whether additional issues should be added and current issues should be dropped from the list.

The State Crosscutting Group will also review the State Health Assessment Report contents and will be asked for input to report's contents. The Quarterly Epidemiology Meetings will also be enhanced to invite more stakeholders.

The recommendations of the State Crosscutting Group regarding issue prioritization and State Health Assessment Report contents will be documented in meeting minutes. Enhanced stakeholder attendance at Quarterly Epidemiology Meetings will be documented in meeting attendance rolls.

Over this next year, NMDOH will expand the current report: *The State of Health in New Mexico 2013* report to include additional information that exists in separate documents, such as a section that describes the demographic characteristics of the population, a more thorough description of health disparities and high-risk population, and a more thorough description of state assets and resources that can be mobilized and employed to address health issues. (Appendix C: Engagement Activities)

The New Mexico Department of Health will need to allow the state population at large to review drafts of the State Health Assessment Report and contribute to it. The State Crosscutting Group will address this need and identify methods (e.g. publication of a summary of the findings in the press with feedback or comment forms, town forums, listening sessions, website comment forms, newsletters) for gathering input from the population at large.

Their decisions will be documented in meeting minutes and the actions taken will be documented in the New Mexico State Health Assessment document.

The New Mexico Department of Health will develop an email distribution list for distribution of the State Health Assessment Report. This distribution list will include state and regional NMDOH staff, state and local policy makers, faculty and staff at the University of New Mexico, private health plans and providers, members of the press, and members of the public who have expressed an interest in the reports. The NMDOH will also communicate results of the State Health Assessment Report to the public, including distribution of printed reports to libraries, publication on the NMDOH website, and press releases of report findings.

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Appendices

Appendix A
State of Health in New Mexico
2013

The State of Health in New Mexico 2013

New Mexico Department of Health

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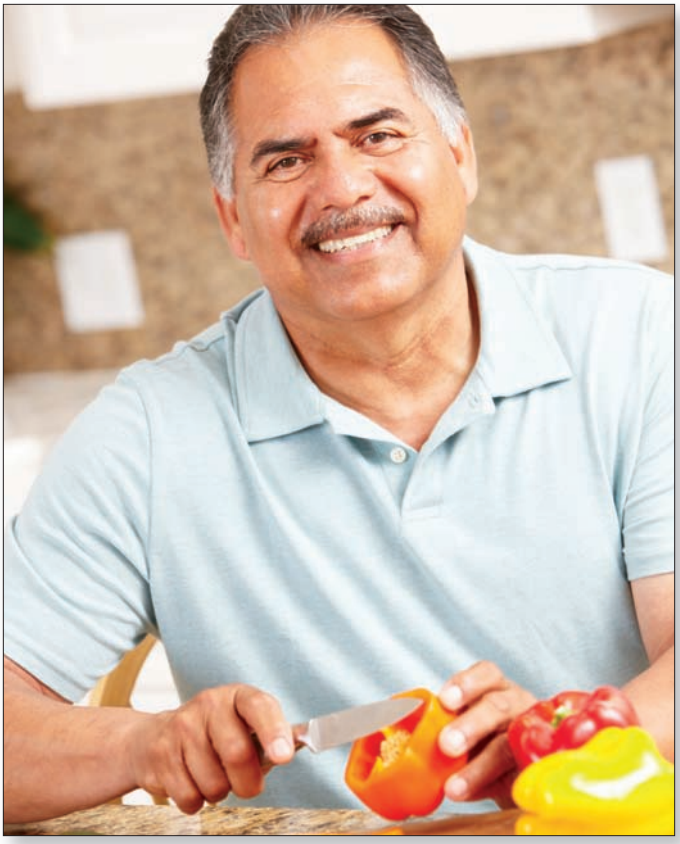
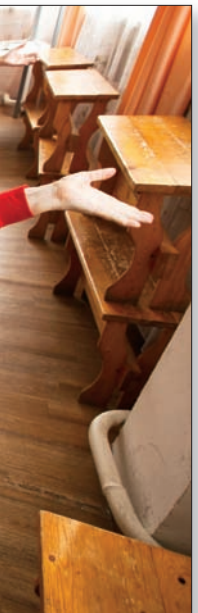




Health and Socioeconomic Status in

Wealthy New Mexicans are more likely to report that they experience "Good" or "Better" health than those who are poor (Figure 1). This year's New Mexico State of Health Report presents health status for New Mexicans within the context of the many influences on health, with a special focus on socioeconomic status (SES) and health. Issues of low SES and poverty affect individuals and families of all racial, ethnic and religious backgrounds in New Mexico.[1] Some of the many and complex factors that influence health include genetics, individual choices, as well as neighborhood, environmental and institutional factors. This report brings together information on health outcomes for New Mexicans, of all ages and backgrounds, with a broad view of the social and economic determinants of health that can influence wellbeing in our state.

More than half a million New Mexicans—over one-quarter of the state's population—live in poverty, with Hispanics and American Indians more likely to suffer from the problems of low-income than non-Hispanic Whites. Over one-third of the state's children live in low-income families that struggle to meet their most basic needs for food, shelter, transportation, healthcare, and other necessities.[1] Another way of measuring the burden of poverty is the Asset Poverty Rate. This measure expands the notion of poverty to include how much of a financial cushion a household has to weather financial crises, including job loss, medical emergency, or the need to fix a car or to live for three months without expected income. By this measure, in 2011, 29% of New Mexicans were considered poor.[2]

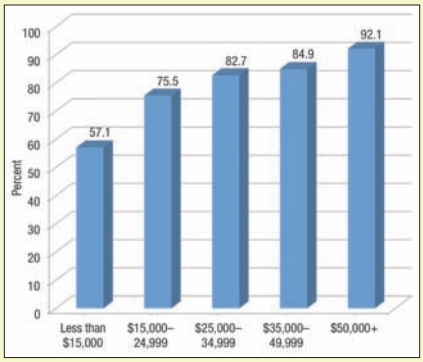
People's health is significantly influenced by their homes, jobs and schools. Food security, education and employment are also ways to document SES differences. Participation in SNAP, the food stamp program, increased by 20,000 during fiscal year 2012 and 17% of New Mexicans reduced or disrupted their eating patterns because the household lacked money and other resources for food.[3] Fifty-four percent of high-school seniors do not graduate from high-school and low-wage jobs comprise 33% of positions in the state, ranking New Mexico 48th for earning potential among other states.[3] Almost half of all New Mexico residents (47%, 914,000 people) are eligible for state assistance with health insurance premiums (Medicaid, State Coverage Insurance) due to low incomes and lack of employer-based health plans, and 21% of the population does not have health insurance[1] (Figure 3).

The impact of low SES on health in New Mexico can be seen at many levels. At the individual level this can appear as variable access to care due to health insurance coverage and ability to pay, or by differing opportunity to engage in healthy behavior given economic, family and/or employment demands. At the neighborhood or community level, differential exposure to environmental public health concerns by geography or the built environment, including quality housing, parks and public transport, should be considered. And at the institutional level, the influence of health policy, including the Affordable Care Act, and it's effect on health and healthcare accessibility, according to SES and poverty level, can be significant.

Health Disparities, SES and Health Information

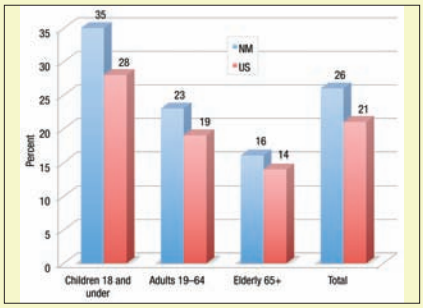
Poor health affects people of all racial and ethnic groups although there are some significant differences in disease or risk factor rates among groups, which can be described as health disparities. Health disparities can be defined as differences in the incidence, prevalence,

FIGURE 1. Respondents Who Reported "Good or Better Health" by Income, NM, 2011



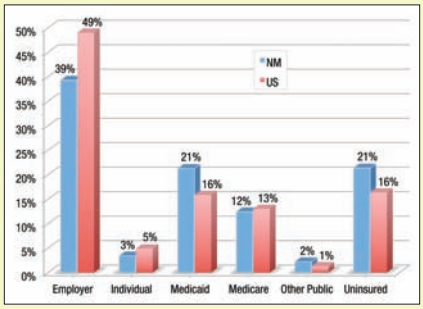
Source: Behavioral Risk Factor Surveillance System (BRFSS), NMDOH

FIGURE 2. Poverty by Age, NM and US, 2009–2010



Source: Kaiser Family Foundation

FIGURE 3. Distribution of Insurance Coverage by Provider, NM and US, 2011



Source: Current Population Survey, StateHealthFacts.org

Note: The grouping used for analysis is the health insurance unit (HIU), which groups individuals according to their insurance eligibility, rather than by relatedness or household

New Mexico

mortality, survival and burden of health conditions that exist between specific population groups. These population groups may be characterized by gender, age, ethnicity, education, income, social class, disability, geographic location, and sexual orientation.

One of the most important influences on health status and risk is socioeconomic status (SES). Socioeconomic status is the social standing of an individual or group in terms of their income, education and occupation. An individual's income, education and occupational status are often closely interrelated. Health status, access and outcome differences between groups of different means, and the resulting inequities, are complicated concepts which are infrequently captured within our regular public health data reporting systems.

Using SES measures is a way to identify groups with need of health care and social services. In New Mexico we have several data sources that can be used to identify health differences by SES including the Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Resiliency Survey (YRRS), the New Mexico Hospital Discharge Dataset (NMHIDD), death certificate data and the US Census.

These data sources include information that can be used to characterize populations, risk factors and health outcomes by various SES measures, although the need for more consistent collection of health data in conjunction with SES measures is a continued challenge that the New Mexico Department of Health has taken on.

Why Consider SES and Health?

Both physical and mental health are associated with SES. In particular, studies suggest that lower SES is linked to poorer health outcomes overall. Poor health may in turn decrease an individual's capacity to work, thus reducing their ability to improve their SES. Other health issues related to SES include:

- Low SES is associated with increased morbidity and mortality.
- Within families, economic hardship can lead to familial distress and disrupted parenting that in turn may increase mental health problems among children, such as depression, substance abuse and behavior problems.
- Educational and employment opportunities may be hindered by health problems.
- Access to health insurance and preventive services are part of the reason for health disparities.
- Those with low SES often experience barriers in obtaining health services, including lack of or limited access to preventive health care, child care and transportation.

Examples of SES related health issues that affect New Mexicans shown in this report include:

- Twenty-five percent of mothers living below the federal poverty level did not receive prenatal care, despite the availability of Medicaid.
- Children with special healthcare needs that live in poor families are least likely to have a source of regular medical care.
- Prevalence rates of smoking, physical activity, chronic disease and access to medical care vary by income and education.
- Risk of death from an unintentional injury varies by average county income.
- Risk of some infectious diseases, including pertussis (whooping cough), has been associated with household and dwelling size.
- Poor counties experience increased hospitalization rates due to asthma.
- Depression is more likely in the unemployed and those with multiple chronic diseases.

Throughout this report you will see the powerful linkage between socioeconomic status and health and wellbeing. For example, healthy activity varies by income in New Mexico and neighboring states. In our region, and in our state, poor people are less likely to engage in physical activity than those who have high incomes, and are more likely to subsequently suffer the effects of not exercising, including stress, weight gain and depression. Acknowledging the relationship between poverty, SES and health is important, and implementing policy strategies that address environmental, institutional and personal influences on SES and health are key to improving the health of New Mexicans.

What's Being Done

- ☑ New Mexico does not tax groceries.
- ☑ New Mexico has the Earned Income Tax Credit.
- ☑ Lottery scholarship for college attendees.
- ☑ New Mexico Workforce Solutions counseling, referral and job listings.
- ☑ Increased collection of socioeconomic status-related information in health surveys and datasets.

What Needs to be Done:

- ☐ Intervene in early childhood to support the health and educational development of low SES children.
- ☐ Increase resources for public education and access to higher education.
- ☐ Target interventions toward populations with the fewest resources.

A Healthy Start Brings Newborns a

The mechanisms through which early life shapes an individual's health trajectory are just beginning to be understood. The interplay of risk and protective factors, such as socioeconomic status, toxic environmental exposures, health behaviors, stress, and nutrition, plays a role in determining health status throughout one's lifetime. By creating the conditions for babies and pregnant women to have adequate health care, nutrition, social support, and a safe environment free of exposure to infectious agents, toxic substances, injury hazards, and emotional and social distress, we are investing in the future health of the next generation of New Mexicans.

The majority of children born each year in New Mexico are born into young families with limited resources. In 2010, 47% of infants were born into poverty—their families earned less than 100% of the Federal Poverty Level (FPL) which was $23,050 per year to support a family of four—and another 27% were born into low income families earning less than 235% of FPL. At this crucial developmental stage, these children are exposed to a confluence of coinciding neonatal risk factors that are more prevalent among those with lower incomes. New Mexico is also a rural state, with more than one-third of births to residents of rural and semi-rural areas, presenting challenges in service provision and transportation. Maternal and child health policy interventions provide a means to mitigate the harmful long-term health effects of being conceived and born into a low-resource environment.

Health Care

New Mexico has a relatively high proportion of unintended pregnancies. Overall nearly half (47%) of women with a live birth in 2010 said they wanted to be pregnant at a later time or never. Two-thirds (68%) of teen-aged mothers and over half (55%) of mothers 20–24 years old had unintended pregnancies, as did 51% of rural mothers. Access to effective family planning services allows individuals to achieve desired birth spacing and family size, and contributes to improved health outcomes for infants, children, and women. New Mexico has recently been successful at reducing the birth rate for adolescents 15–17 years of age among all racial/ethnic groups (Figure 1).

One-fifth (19%) of new mothers received inadequate prenatal care in 2010. This was

especially pronounced among American Indians (33%), teen-aged mothers (30%), mothers with incomes under 100% FPL (25%), and Medicaid recipients (20%).

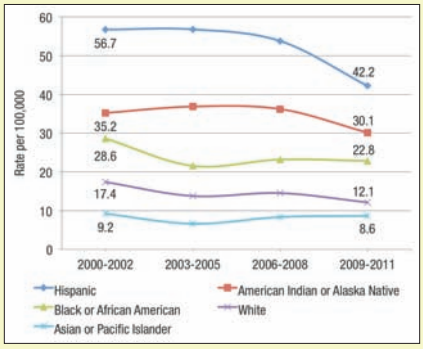
The New Mexico Newborn Screening Program is a universal program which currently screens all infants born in the state for 27 genetic and congenital conditions. Early diagnosis and treatment can result in normal growth and development and prevent permanent damage. Cases identified in 2011 include 216 hemoglobinopathies, 18 cases of congenital hypothyroidism, 5 cases of cystic fibrosis, and 17 cases of other disorders.

Nutrition

In New Mexico, 27% of mothers with a live birth in 2010 reported taking multivitamins or folic acid every day in the month prior to pregnancy. The Healthy People 2020 goal is 33%. Folic acid before pregnancy and in the first 12 weeks of pregnancy reduces the risk of neural tube birth defects.

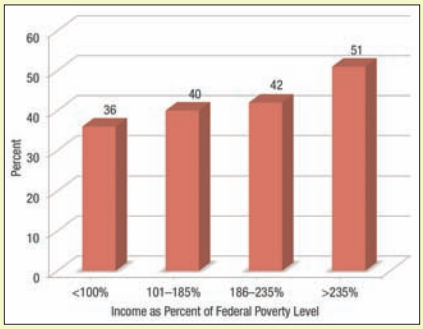
In 2010, 11% of mothers reported not having enough to eat at some point in the perinatal period when increased caloric and micronutrient intake is essential for healthy fetal development. Poor nutrition during pregnancy increases the risk of babies being underweight at birth, babies being delivered pre-term, stillbirth, as well as anemia and osteoporosis in the mother. One in five (20%) American Indian mothers reported not having enough to eat during or soon after pregnancy, as did 19% of those without a high

FIGURE 1. Adolescent Birth Rates by Race/Ethnicity, Ages 15–17, NM, 2000–2011



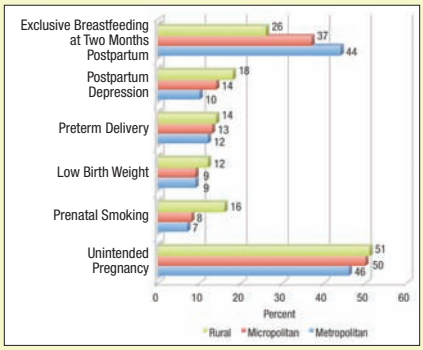
Source: NM Indicator Based Information System (IBIS), NM DOH.

FIGURE 2. Exclusively Breastfed at Two Months Postpartum by Family Income, NM, 2010



Source: NM PRAMS, NMDOH

FIGURE 3. Maternal Risk Factors by Urbanization of County of Residence, NM, 2010–2011



Sources: Unintended pregnancy, prenatal smoking, postpartum depression, exclusive breastfeeding: NM PRAMS: Low birth weight, preterm delivery: Vital Records and Health Statistics (VRHS), NMDOH

Lifetime of Good Health

school diploma, 18% of those with incomes below 100% FPL, and 14% of mothers living in semi-rural counties (counties with an urban area of 10,000–49,000 population).

The proportion of New Mexico mothers who breastfeed decreases as the level of family income decreases despite the fact that breastfeeding itself is essentially without cost. Sixteen percent of very low income mothers (<100% FPL) in 2010 never initiated breastfeeding after the birth of their child, and 12% of low income mothers (<185% FPL) never initiated breastfeeding, compared to 7% of mothers with incomes above 235% FPL. Similarly among mothers who do breastfeed, the length of time the baby is breastfed depends upon the level of family income. Exclusive breastfeeding is recommended for the first six months of the baby's life to reduce the risk of developing gastroenteritis, asthma, allergies, respiratory and ear infections, as well as obesity later in life. At two months postpartum, when the statewide New Mexico Pregnancy Risk Assessment Monitoring System (NMPRAMS) survey is administered, only 36% of very low income women were exclusively breastfeeding, compared to 51% of women with higher incomes (Figure 2).

Hazards

Sixty infants died in 2009–2011 from Sudden Infant Death Syndrome (SIDS) and other sleep-related causes of infant death. One-third of these deaths were among children whose parents were not following the guidelines to place their infant on their back when put to sleep, one-half of deaths occurred in an adult bed, and 56% of the infants were sharing a bed with an adult or with other children at the time of death. According to the 2010 NMPRAMS survey, one-third of infants sleep in a bed with another person, over one-third of mothers usually place their baby to sleep with thick blankets, bumper pads or toys, and one-fourth do not usually sleep in a crib. These sleep practices place the infant at risk of death from accidental strangulation or suffocation in bed and SIDS.

Substance Abuse

Maternal cigarette smoking during pregnancy causes a shortage of oxygen during fetal development and places the infant at risk of prematurity, low birth weight, congenital heart defects, stillbirth and SIDS. The Healthy People 2020 goal is to have 1.4% or fewer pregnant women smoking cigarettes. In New Mexico, 7.5% of women with a recent live birth reported smoking during pregnancy in 2010, with the highest prevalence among rural residents with one in six pregnant women smoking (Figure 3). A greater percentage of white non-Hispanic women smoked during pregnancy (9.5%) than Hispanic (7.2%) or American Indian women (5.2%). There is a gradient of smoking by income level: 10.5% of women at or under 100% FPL smoked during pregnancy, 6.5% of women at 101–185% FPL smoked, 4.8% of women at 186-235% FPL smoked, and 3.1% of women above 235% FPL smoked during pregnancy. The Healthy People 2020 goal for alcohol use during pregnancy is 1.7% or fewer. In 2010, 6.4% of women reported drinking alcohol in the last trimester of pregnancy, with the lowest percentages among teenagers (1.2%) and rural residents (3.0%), and the highest percentages among mothers 35 years of age and older (8.1%) and those with more than a high school education (8.1%).

Emotional and Social Environment

American Indian women reported the highest rates of physical abuse by a partner during pregnancy, with 10.8% reporting this experience in 2010, followed by teenage mothers with 7.9% reporting physical abuse. The lowest rates were found among women with higher income levels (0.5%). Eighteen percent of women living in rural counties report suffering from post-partum depression, compared to 14% of women in semi-rural counties (urban area of 10,000–49,999 population), and 10% of women in metropolitan counties (urban area of 50,000 population or greater)(Figure 3).

What's Being Done

- ☑ The Baby-Friendly Hospital Initiative is a global program to change hospital policies and maternity services to support breastfeeding. Twelve birth hospitals in New Mexico are currently working to meet the criteria necessary for the Baby-Friendly designation.
- ☑ The W.K. Kellogg Foundation has targeted four New Mexico counties for grant investments to improve birth outcomes, preconception health, and breastfeeding among the most vulnerable populations.
- ☑ Statewide DOH education series for case managers and home visitors on the Safe to Sleep campaign to reduce the risk for Sudden Infant Death Syndrome (SIDS) and other sleep-related causes of infant death.

What Needs to be Done

- ☐ Improve reproductive health care and education among adolescents through school-based health centers.
- ☐ Expand newborn screening to include Severe Combined Immunodeficiency Syndrome (SCIDS) and lysosomal storage disorders.
- ☐ Improve accessibility to prenatal and birthing services in rural and smaller urban areas of the state.

Child Health Depends on Enhanced

In 2011 there were an estimated 395,907 children ages 1–14 in New Mexico—19% of the total population. The US Census Bureau reports that in 2010, 30% of New Mexico children lived in poverty, an increase of 4.7% from the previous year. Twenty-nine percent of children lived in a household that experienced food insecurity at some point during the year. Approximately 13% of New Mexico children do not have health care coverage.

Child Mortality

From 2009–2011, there were 254 deaths of New Mexico children ages 1–14, resulting in a rate of 21.2 deaths per 100,000 children. Boys had a higher death rate than girls (26.4 vs. 20.6). American Indian children died at nearly twice the rate of White children (32.7 vs. 16.7), and Hispanic children died at a rate of 20.6/100,000. During that same time period, mortality rates for children ages 1–14 were highest in Cibola, De Baca, Lincoln, Mora, Quay, San Juan and Sierra counties, and lowest in Bernalillo, Colfax, Los Alamos, Roosevelt, San Miguel, Santa Fe, and Taos counties.

The leading cause of death for New Mexico's youngest children (ages 1–4) was unintentional injury with a rate of 15/100,000 children. The second leading causes were assault and homicide, and congenital malformations at 3.4/100,000 children each. Specific causes of unintentional injury death were motor vehicle traffic crashes, drowning, and motor vehicle non-traffic injuries. For older children ages 5–14 the leading causes of death were unintentional injury with a rate of 4.8/100,000, malignant neoplasm/cancer (1.4/100,000) and congenital malformations (1.3/100,000). The leading causes of unintentional injury deaths in this age group were motor vehicle traffic crashes (2.4/100,000), and suffocation (1.3/100,000).

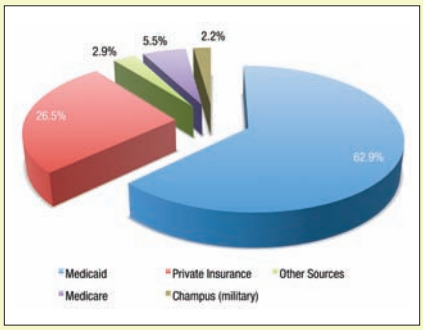
Child Hospitalizations

In 2011, there were 7,862 hospitalizations of children ages 1–14 for a rate of 198.6 hospitalizations per 10,000 children. For children ages 1–4, the rate was 298.7/10,000, and for those ages 5–14, the rate was 157.6/10,000. Medicaid paid for 4,948 of these hospitalizations, followed by 2,084 paid for by private insurance. The remaining were paid through other sources (Figure 1). In 2011, the majority of children in both age groups were hospitalized for respiratory problems at a rate of 60.8/10,000. The second and third major diagnoses for children ages 1–4 were injury and poisonings (22.4) and diseases of the digestive system (19.1). For children ages 5–14, mental disorders resulted in a hospitalization rate of 33.5, followed by digestive system diseases at 23.9.

Children with Special Health Care Needs

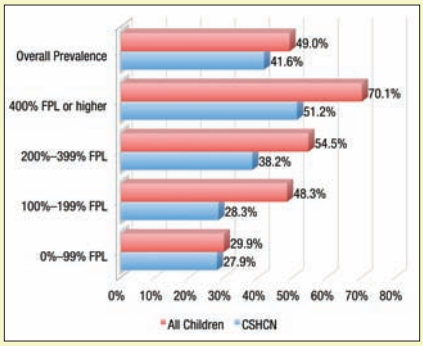
In 2010, there were approximately 71,000 children with special health care needs (CSHCN) in New Mexico. The highest proportion of CSHCN were Black/African-American (17.7%) followed by White (16.4%) and finally, Hispanic (15.1%). Most CSHCN reported 2–3 conditions (33.3%) followed by those with one condition

FIGURE 1. Child Hospitalizations by Payer of Care, NM, 2011



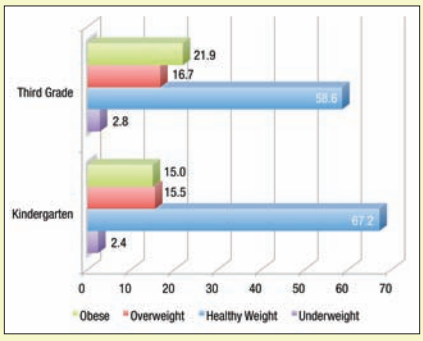
Sources: NM HIDD, NMDOH

FIGURE 2. Percent of Children with a Medical Home by Federal Poverty Level, NM, 2010



Source: National Survey of Children with Special Healthcare Needs

FIGURE 3. Percent of Students in Weight Categories by Grade, NM, 2011



Source: BMI Surveillance, NMDOH

Service Coordination

(25.8%) and those with four or more conditions (15.5%). Allergies, asthma, attention deficit/hyperactivity disorder, and developmental delays were the four most commonly reported conditions. Twenty-seven percent of parents surveyed reported that their special needs child's daily activities were "consistently affected, often a great deal," by his or her condition. A little over 70% reported that their child's condition caused difficulty with breathing, swallowing, circulation, pain, vision and/or hearing.

The Medical Home Model, first created by the American Academy of Pediatrics (AAP) in 1967, has been shown to be an excellent way of providing care for all children and especially for children with special health care needs (CSHCN). The Medical Home is not a physical location, but a model of care that is coordinated, accessible, compassionate, culturally sensitive, family centered and comprehensive. Having a usual source of care and receiving family-centered care are two essential components of a Medical Home. On the 2010 National Survey of CSHCN, 10.4% of CSHCN in New Mexico were reported to be without a usual source of care, compared to 9.5% nationally, and 9.7% of CSHCN in New Mexico have no personal doctor, compared to 6.9% nationally. New Mexico also has a higher proportion of CSHCN without family-centered care (40.0%), compared to the national 35.4%. The percentage of children in New Mexico with a Medical Home decreases with lower family income levels (Figure 2). This demonstrates a need for more medical practices in New Mexico to become true Medical Homes.

Overweight and Obesity Threaten New Mexico's Children

In 2010, 13.2% of kindergarten students and 22.6% of third grade students in New Mexico were obese. In comparison, 18% of 6–11 year olds nationwide were obese. The average weight for kindergarten students in the obese category was 61.6 pounds, or about 20 pounds heavier than for those in the healthy weight category. The average weight for third grade students in the obese category was 98.9 pounds with some children weighing between 150 and 200 pounds. Two thirds of kindergarten students (67.2%) and nearly three-fifths of third grade students (58.6%) in New Mexico in 2011 were in the healthy weight category (Figure 3).

Obesity in children has serious consequences. The increase in childhood obesity has resulted in a dramatic increase in youth onset diabetes. Sixty percent of overweight children ages 5 to 10 years have at least one metabolic risk factor for heart disease and stroke, including elevated total cholesterol, triglycerides, insulin and high blood pressure. Obesity also leads to increases in non-alcoholic fatty liver disease in children that can lead to liver scarring and cirrhosis.

What's Being Done

- ☑ Families with newborns receive home visiting services that include injury prevention education.
- ☑ Medicaid redesign is emphasizing Medical Homes and care coordination.
- ☑ Many schools are implementing walking and rolling to school days, creating edible gardens or conducting fruit and vegetable tastings.

What Needs to be Done

- ☐ Increase the number of families with newborns and young children receiving effective home visiting services.
- ☐ Integrate existing care coordination programs with medical providers.
- ☐ Understand the knowledge, attitudes and perceptions surrounding healthful eating and physical activity among New Mexicans.
- ☐ Ensure that all New Mexicans have access to affordable healthy foods.

Healthy Behaviors Vital to Fostering

The future success and health of New Mexico youth is largely determined by the behaviors they engage in as young people. In 2011, the three leading causes of death among New Mexicans ages 15–19 were unintentional injury (predominantly motor vehicle crashes), suicide, and homicide.[1] These causes of death are associated with alcohol and drug use, suicidal ideation and attempts, physical violence, and other behaviors. The chronic diseases that are among the leading causes of death for New Mexicans are associated with risk behaviors often initiated during adolescence, such as tobacco use, alcohol use, inadequate physical activity and poor dietary practices. Unsafe sexual behaviors put young people at risk of unplanned pregnancy and sexually transmitted infections including HIV/AIDS. The 2011 New Mexico Youth Risk and Resiliency Survey (YRRS) examined all of these behaviors among high school and middle school students.

Fewer Suicide Attempts

Past suicide attempts are a leading risk factor for future suicides. Suicide attempts among high school students have decreased over the past several years from a high rate of 14.5% in 2003 to 8.6% in 2011. In 2011, 7.0% of middle school students reported ever trying to kill themselves.

Suicide attempts are far more likely among girls than boys. This is true in both middle school (9.7% vs. 4.4%) and high school (12.3% vs. 5.0%) (Figure 1). Among high school students, American Indian (10.5%) and Asian or Pacific Islander students (13.5%) had higher rates than Hispanic (8.6%) or White (6.4%) students. These disparities were not apparent among middle school students.

Suicide attempts varied with parent education, an indicator of socioeconomic status. Suicide attempts were reported by 12.3% of high school students whose parents did not graduate from high school, 7.3% of those whose parents graduated from high school but not college, and 6.6% of those whose parents completed college or professional school.

Alcohol, Tobacco, and Other Drug Use

Alcohol use at an early age is associated with adverse outcomes later in life, such as alcohol dependence and abuse and chronic liver disease.[2] Alcohol use is also highly associated with traffic-related fatalities and other injuries. Most alcohol related behaviors have decreased in prevalence in recent years among New Mexico high school students. Current drinking (at least one drink in the past 30 days) decreased from 50.7% in 2003 to 36.9% in 2011; binge drinking decreased from 35.4% to 22.4%, and drinking and driving (19.1% to 9.3%). Among middle school students, 12.9% were current drinkers and 6.3% were binge drinkers.

High school students whose parents didn't finish high school had higher rates than those parents with a college or professional school education for drinking and driving (33.0% vs. 15.5%) and binge drinking (28.8% vs. 17.9%).

Illicit drug use among adolescents is associated with heavy alcohol and tobacco use, violence, and suicide.[3] Among participating states in the national 2011 Youth Risk Behavior Survey, New Mexico high school students had the highest rates for marijuana use before age 13, current and lifetime cocaine use, current Ecstasy use, and the second highest rate for lifetime heroin use. There have been no significant changes in drug use since 2007.

In descending order, drugs with the highest current use rates among high school students were marijuana (27.6%), painkillers to get high (11.3%), inhalants (6.7%), Ecstasy

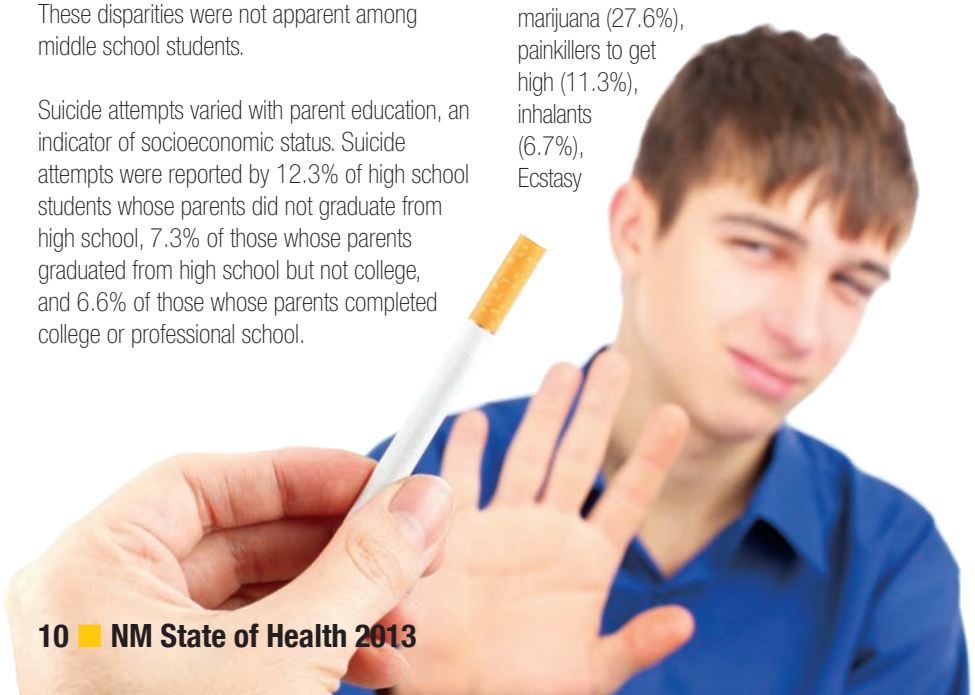
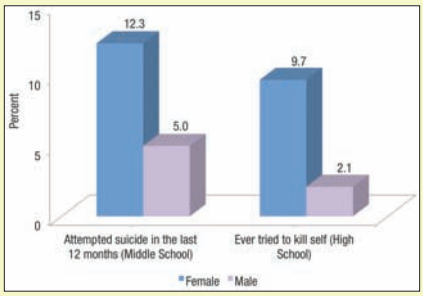
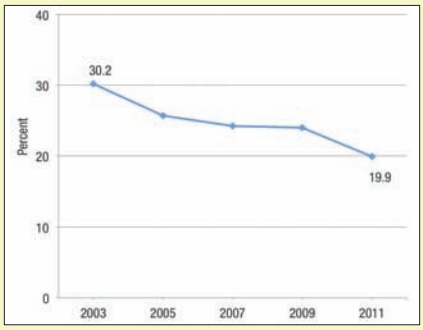


FIGURE 1. Suicide Attempts by Gender, Grades 6–12, NM, 2011



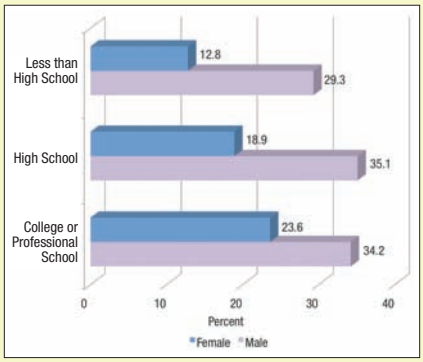
Sources: NM Youth Risk and Resiliency Survey (YRRS), NMDOH and PED

FIGURE 2. Current Cigarette Smoking by Year, Grades 9–12, NM, 2003–2011



Source: NM YRRS

FIGURE 3. Daily Physical Activity by Gender and Parent Education, Grades 9–12, NM, 2011



Source: NM YRRS

Healthy Youth

(6.4%), methamphetamine (3.9%), and heroin (3.2%). Among middle school students, lifetime use rates were 15.9% for marijuana, 11.8% for inhalants, 8.0% for prescription drug use without a doctor's prescription, 4.9% for painkillers to get high, and 3.6% for cocaine. In the case of every drug, students whose parents had a college or professional school education had a lower prevalence of use than students whose parents had less than a high school education.

Cigarette smoking increases the risk of several chronic diseases, such as heart disease, chronic obstructive pulmonary disease, acute respiratory illness, stroke, and various cancers.[4] Spit tobacco (chewing tobacco, snuff, or dip), is associated with oral cancer and other oral conditions, heart disease, and stroke. The rate of current cigarette smoking among high school students decreased dramatically from 2003 (30.2%) to 2011 (19.9%) (Figure 2). 9.5% of high school students were current spit tobacco users (chewing tobacco, snuff, or dip), with no trend in recent years. Among middle school students, 6.8% were current cigarette smokers and 3.7% were current spit tobacco users. Among middle school students there were no differences between boys and girls for any tobacco use. Among high school students, boys were more likely than girls to be current cigarette smokers (23.2% vs. 16.5%) and spit tobacco users (14.8% vs. 3.9%). High school students whose parents had more education were less likely to smoke cigarettes or cigars than those whose parents had less education.

Physical Activity

Regular physical activity can reduce body fat, maintain body weight, and reduce the risk of chronic diseases.[6] Obesity among adolescents is associated with a lack of physical activity and is a contributing factor for type 2 diabetes, hypertension, and adult obesity. At least 60 minutes of daily physical activity is recommended for children aged 6–17 years. In 2011, 26.3% of high school students and 31.2% of middle school students achieved this level of physical activity. In middle school, boys were 42% more likely than girls to attain recommended levels of physical activity (37.1% vs. 26.0%), while among high school students they were 83% more likely (33.8% vs. 18.5%). Higher levels of parent education were associated with a higher prevalence of daily physical activity among girls but not among boys. At every level of parent education, boys were more likely than girls to exercise daily (Figure 3).

Sexual Behaviors

Adolescents who initiate sexual intercourse at an early age are less likely to use contraception, are at higher risk for unplanned pregnancy, and are likely to have a greater number of lifetime sexual partners than those who wait until later to engage in sex.[7] In 2011, 47.8% of high school students and 10.4% of middle school students ever had sexual intercourse. Among those who ever had sex, middle school students had higher rates of condom use than high school students (69.1% vs. 54.4%). Among sexually active students in high school, condom use decreased with grade level (as students got older), while the prevalence of using reliable birth control methods (birth control pills, IUDs, or injectable birth control) increased. Among high school students, those whose parents had higher levels of education were less likely to engage in risky sexual practices such as having multiple sexual partners and initiation of sexual intercourse at an early age.

Although serious concerns remain, New Mexico has seen encouraging trends in health risk behaviors among youth in recent years. Rates for behaviors associated with mental health, alcohol use, tobacco use, and violence have decreased. Despite these improvements, rates for many of these same behaviors remain disturbingly high. Drug use rates were extremely high relative to the rest of the U.S. Disparities persist by gender, race/ethnicity, and parent education. Girls were less likely than boys to engage in daily physical activity, more likely to attempt suicide, and more likely to be victimized by sexual violence. Boys had higher rates than girls for tobacco use and physical fighting. American Indians and Asian or Pacific Islanders had relatively high rates for attempted suicide. For nearly every risk behavior discussed here, rates were higher among students whose parents had less education.

What's Being Done

- ☑ Trends in youth health statistics are being monitored with the NM Youth Risk and Resiliency Survey.
- ☑ Alcohol and drug prevention programs at the local level emphasize opioid use/misuse prevention.
- ☑ Seventy-nine school based health centers offer services and information throughout the state related to primary care, reproductive health, mental health, oral health and substance use.
- ☑ Comprehensive suicide prevention programs addressing depression, substance abuse and means restriction.
- ☑ Peer-to-peer mentoring that stresses positive youth development and engagement.

What Needs to be Done

- ☐ Increase positive youth development and leadership programs, with meaningful engagement of youth to develop, implement, and evaluate them.
- ☐ Increase and improve services available at school based health centers, including primary care and confidential health services, in areas such as reproductive and behavioral health.
- ☐ Increase healthy nutrition and physical activity interventions targeting middle school aged youth.

Aging Well Through Healthy Lifestyle,

With aging comes a higher risk for health problems, including chronic disease, disability and death. To stay disease- and disability-free as long as possible, we need to rely on healthy lifestyles along with early detection and management of chronic disease.

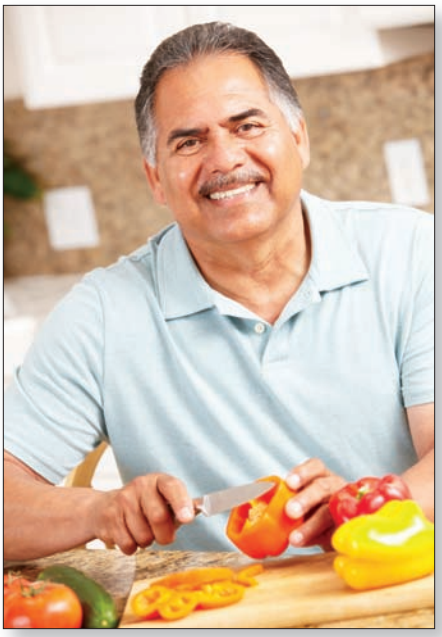
Hospitalization

Older adults use more health care than their younger counterparts. The top reasons for inpatient hospitalization in the 65-year-and-older age group are heart disease, influenza and pneumonia, septicemia, and injury from falls.

Deaths

The leading causes of death among New Mexicans age 65 years or older (older persons) are heart disease, cancer, chronic lower respiratory diseases (COPD), stroke, diabetes, and unintentional injuries (Figure 1). Among unintentional injury deaths in older persons, the most common cause was falls with 66% of all unintentional injury deaths.

From 2009–2011, risk of death from various causes among older persons varied significantly by race/ethnicity. Heart disease death rates were highest among Whites and lowest for Asian and Pacific Islanders. The risk of death from cancer was highest among White, Black and Hispanic persons, and lower in American Indian and Asian/Pacific Islander groups. Risk of death from COPD was highest among Whites, and risk of death from diabetes was highest in the American Indian population.



More than half of all heart attacks occur in people age 65 years or older. Modifiable risk factors include high blood pressure, high cholesterol, cigarette smoking, and physical inactivity. Heart disease deaths have been decreasing in New Mexico and elsewhere. While changes in lifestyle have played a role in reducing heart disease deaths, medical treatment, especially increased use of thrombolytic medications, has probably been a bigger factor.

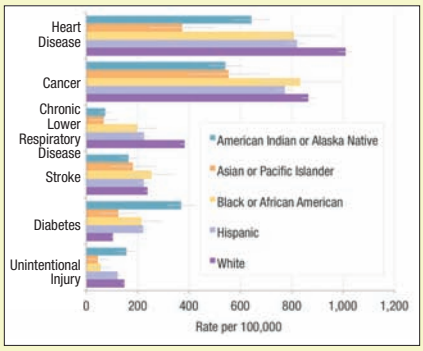
A stroke occurs when an artery in the brain is either ruptured or clogged. Nerve cells in the affected area of the brain die within minutes, potentially resulting disability or impairment. The risk factors for stroke are similar to those for coronary heart disease, including high blood pressure, cigarette smoking, and diabetes. Timely therapy with thrombolytic drugs is important for strokes caused by artery blockage.

Older adults who were hospitalized for injuries from falls were least likely to have a routine discharge, and had the highest likelihood of being transferred to another inpatient facility, such as a skilled nursing facility or an inpatient rehab facility (Figure 2). A decrease in bone density increases the likelihood of serious injury from falls. Bone density can be increased through weight-bearing exercise. In a study of risk factors for falls among elderly persons, sedative use was identified as a predisposing factor. Environmental hazards may also be a factor. Death from fall injuries increased markedly from 2000 to 2008, but in recent years has begun to decline.

Cancer was the second-leading cause of death from 2009–2011 for older New Mexicans. Preventing cancer is best accomplished by quitting smoking, improving one's diet, and limiting exposure to the sun. Early detection of cancer, with colonoscopy, mammography and Pap smear tests, is an important step in reducing death and disability from the disease.

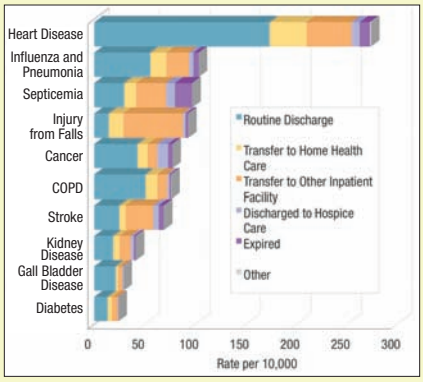
The risk of diabetes increases with age, and older adults are also more likely to suffer from complications of the disease. Diabetes can lead to heart disease, blindness, kidney failure, high blood pressure, nerve damage, and lower extremity amputations. Diabetes incidence has

FIGURE 1. Leading Causes of Death by Race/Ethnicity, Age 65+, NM, 2009–2011



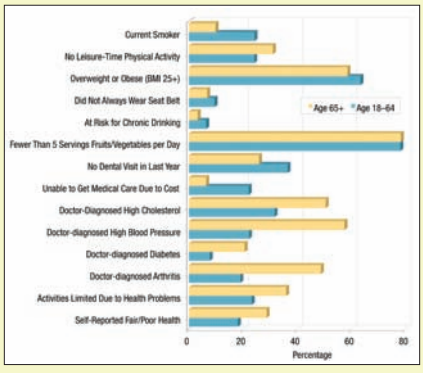
Source: Death Certificate Database, Vital Records and Health Statistics, NMDOH

FIGURE 2. Leading Reasons for Hospitalization by Discharge Status, Age 65+, NM, 2011



Source: NM HIDD, NMDOH

FIGURE 3. Health Risk from Selected Factors, Age 65+ and Age 18–64, NM, 2011



Source: New Mexico Behavorial Risk Factor Surveillance System, NMDOH

Early Disease Detection

increased in New Mexico, as in the rest of the US, primarily because of increases in type 2 diabetes, which increases with obesity and age. 20.5% of New Mexicans over 65 reported that they had been diagnosed with diabetes.

Influenza is highly contagious, as are most kinds of pneumonia. Older adults are more susceptible to complications if they become ill. The national goals for seasonal influenza and pneumococcal vaccination among adults age 65+ are each 90%. In New Mexico in 2011, 58.8% reported having an influenza vaccination in the last year and 69.2% reported ever having had a pneumococcal vaccination.

Risk Factors for Illness and Disease

Older adults are more likely to have chronic diseases, such as arthritis and diabetes, as well as certain risk factors, including high blood pressure and high cholesterol (Figure 3). But older adults also reported lower participation in leisure-time physical activity, and a high prevalence of obesity.

Cigarette smoking is a major risk factor for the leading causes of death and illness, including heart disease, stroke, cancer and chronic obstructive pulmonary disease. Older New Mexico adults were less likely to be current smokers than younger adults.

A 1996 Surgeon General's report suggested that the amount of physical activity required to achieve health benefits was a daily expenditure of 150 calories from moderate or vigorous activities. Physical inactivity is associated with heart disease, diabetes, high blood pressure, and colon cancer. Regular activity also builds and maintains healthy bones, muscles and joints. Older New Mexico adults were more likely to be inactive than their younger counterparts: 30.9% of older adults were inactive.

A healthy diet, one that contains less fat and more fresh fruits and vegetables, is associated with a reduction in obesity, heart disease, diabetes, and some cancers. Older New Mexicans (30.9%) were more likely than younger adults (24.1%) to eat five fruits and vegetables a day.

Lower income and education levels put older adults at higher risk for a number of health problems. Older adults with annual incomes under $15,000 were more likely to have diabetes and be physically inactive. They were three times more likely to smoke cigarettes, twice as likely to be physically inactive, and four times as likely to report that their health is "fair" or "poor" compared to those with incomes over $50,000. Those with less than a high school education were more likely to have diabetes and more likely to be overweight or obese. They were more than twice as likely to smoke cigarettes, more than twice as likely to be physically inactive, and more than three times as likely to report that their health was "fair" or "poor" compared to those who were college graduates.

What's Being Done

- ☑ Offering evidence-based programs such as the Tai Chi: Moving for Better Balance program, the Enhance Fitness program, the Chronic Disease Self Management program, the Strong Women (and men) Strong Bones program.
- ☑ Increasing awareness about fall risks and fall prevention at health fairs and other venues where older adults participate.
- ☑ Influenza and pneumonia surveillance and vaccination programs.

What Needs to be Done

- ☐ Improved clinical management of high blood pressure, high cholesterol, diabetes, arthritis, and other chronic diseases.
- ☐ Coordination of care between multiple health care providers.
- ☐ Create a comprehensive coordinated approach to using evidence-based healthy aging programs and services statewide.
- ☐ Identify mechanisms for reimbursement for fall screening and prevention activities.

Some New Mexicans at Greater Risk

Remarkable progress has been made toward the control of infectious diseases since the beginning of the 20th century, primarily due to effective vaccines, behavioral prevention strategies and improved medical care. But many infectious diseases, both old and emerging, continue to evade efforts at control and elimination. The epidemiology of the following infectious diseases in New Mexico demonstrates that some groups continue to be affected disproportionately. Distinct racial and ethnic disparities continue to exist for these infectious diseases in New Mexico, and the reasons behind these disparities are not always clear.

HIV/AIDS Affects Men Who Have Sex with Men

When Acquired Immunodeficiency Syndrome (AIDS) was first reported in the United States, gay, bisexual, and other men who have sex with men (MSM) played a key role in the Human Immunodeficiency Virus (HIV) epidemic. When screening tests for HIV antibodies were first made available, MSM accounted for 65% of new diagnoses. Now rates of new diagnoses have declined dramatically, but MSM still account for over 60% of new diagnoses.[1,2]

From 2007–2011, 64% of new HIV diagnoses among men in New Mexico were attributable to MSM (Figure 1). MSM with a history of injection drug use (MSM/IDU) comprised an additional 6% of new diagnoses, making MSM and MSM/IDU the groups at highest risk for HIV infection among men. Young MSM are at especially high risk for HIV infection. Among New Mexicans under 35 years of age, MSM and MSM/IDU accounted for 65% of new diagnoses from 2007 through 2011, as compared to 54% among persons age 35 and older.

American Indian, Black, and Hispanic New Mexicans are also disproportionately affected by HIV. In New Mexico, those groups account for just over half the total population, yet from 2007 through 2011, they accounted for 70% of new HIV diagnoses. Among MSM and MSM/IDU, American Indian, Black, and Hispanic New Mexicans comprised 67% of all new HIV diagnoses.

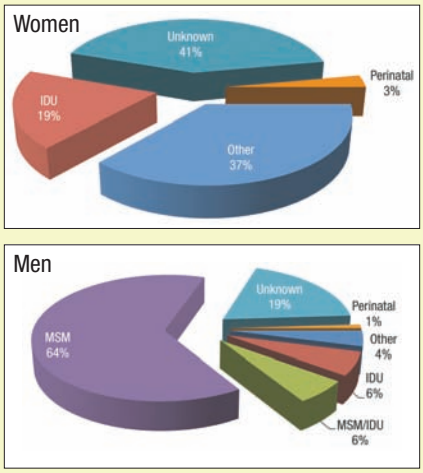
Pertussis (Whooping Cough) in the Hispanic Community

New Mexico is in the midst of a statewide pertussis outbreak. In 2011, 277 pertussis infections were reported to the New Mexico Department of Health, which represented more cases in a single year than in any year going back to the 1980s. In 2012, over 874 pertussis infections were reported. The Centers for Disease Control and Prevention (CDC) predict that the United States will experience more whooping cough in 2012 than in any year since 1959.[3]

The reasons for the dramatic rise in pertussis in New Mexico and nationally are not completely understood. Evidence suggests that a change in childhood pertussis vaccine formulation that occurred in the 1990s may be partially responsible for recent events.[4] Improvements in pertussis testing and diagnosis may have contributed to an increase in diagnoses. Also, the number of school-aged children receiving vaccination exemptions has increased in the last 15 years, a trend that has been associated with increased risk of contracting pertussis.[5]

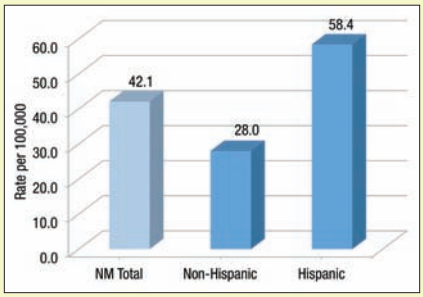
A key feature of the outbreak in New Mexico is the distribution of cases by ethnicity. Approximately 42% of the New Mexico

FIGURE 1. Diagnosis of HIV Infection Among Adults and Adolescents by Gender and Transmission Category, NM, 2007–2011



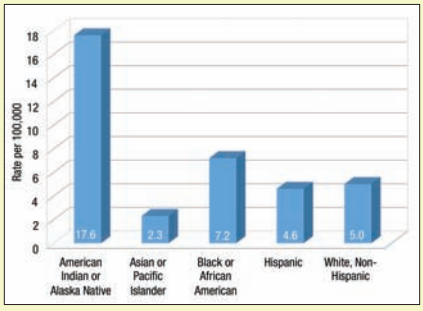
Source: Enhanced HIV/AIDS Reporting System, NMDOH

FIGURE 2. Pertussis Rates by Ethnicity, NM, 2012



Source: NMEDSS, NMDOH

FIGURE 3. Invasive Pneumococcal Disease Rates by Race/Ethnicity, NM, 2006–2011



Source: Emergency Infection Program, NMDOH

# of Infectious Disease

population is Hispanic (U.S. Census). During 2012, approximately 60% of New Mexico pertussis cases have occurred among Hispanics. Overall, the rate of pertussis among Hispanics is twice the rate among non-Hispanic New Mexicans (Figure 2).

Evidence from investigations in New Mexico suggests that household size plays an important role in pertussis transmission. For 2012, the mean household size among pertussis cases is 4.5 persons, compared to a statewide mean of 2.6 persons per household. Pertussis cases of all races and ethnicities in New Mexico tend to have larger household sizes than average, so household size alone does not explain the ethnic disparity that exists. Within the 6 counties with the highest pertussis rates, the average household size of pertussis cases who are Hispanic exceeds the average county household size and the average household size of Hispanics in the county.

What exactly is driving the higher household size of Hispanic cases is not known, but may be influenced by income or other factors, such as the size of extended family groups. Notably, Hispanic pertussis cases tend to have more identified contacts requiring antibiotic prophylaxis than cases of other races and ethnicities. The median number of contacts per case for 2012 is 2, but 69% of Hispanic cases had 4 or more identified contacts requiring antibiotic prophylaxis. Additional investigation is being conducted to explain why Hispanics appear to be at greater risk of pertussis infection in New Mexico.

Invasive Pneumococcal Disease

Invasive pneumococcal disease (IPD) is caused by the bacterium *Streptococcus pneumoniae.* The infection is considered invasive when the bacteria invade a normally sterile body site, such as blood or cerebrospinal fluid. IPD is a vaccine-preventable disease. The national estimate of IPD between 2006 and 2009 was approximately 14.1 cases per 100,000 U.S. population per year. According to 2006–2009 estimates from the Centers for Disease Control and Prevention (CDC), 11.1% of IPD infected persons died.

Certain groups are at higher risk of IPD infection. This includes the elderly, children under two years of age, immune compromised persons, and certain racial and ethnic groups.[6] The American Indian population has historically experienced

higher rates of IPD compared with the non-Indian population in the U.S. and in New Mexico.[6] From 2006–2011, the rate of IPD in New Mexico was highest in the American Indian population.

From 2006–2010, the number of cases and percentage of deaths was highest among those aged 65 years and older. New Mexico IPD rates were higher among infants (42/100,000) than the national estimate of 37 infections/100,000 people. With the introduction of a new vaccine for children that targets 13 types of the pneumococcal bacteria (PCV13, available since February 2010), overall IPD rates may decrease.[7,8] This might result in an overall decrease in the burden of IPD resulting from increased immunity in the population; however, other types of pneumococcal bacteria not included in the vaccine may emerge to replace the types found in the vaccine.[7,9]

Further investigation regarding factors contributing to IPD infection among New Mexicans is ongoing. New Mexico is participating in a vaccine efficacy evaluation with a number of other states. As the PCV13 vaccine becomes more widely used, it is important to continue to monitor the annual burden of IPD and detect infections caused by pneumococcal bacteria that are not in the vaccine. This information is useful to determine if new vaccines are needed.

What's Being Done

- ☑ Behavioral intervention strategies, such as those targeting sexual risks or substance misuse, to reduce transmission of HIV.
- ☑ Interventions to increase pertussis vaccination rates.
- ☑ Evaluation of vaccine effectiveness and development of treatment guidelines for invasive pneumococcal disease.

What Needs to be Done

- ☐ Increase HIV testing and linking those newly diagnosed with HIV to care.
- ☐ Better understand the reasons for higher rates of pertussis in Hispanics and use the information to target prevention efforts.
- ☐ Identify factors contributing to invasive pneumococcal disease infection among New Mexico subpopulations.

The Changing Tobacco Environment

Tobacco use, the leading cause of death, results in about 2,100 deaths in New Mexico annually. Also, an estimated 42,000 New Mexicans are afflicted with tobacco-related diseases.[1] Cigarette smoking has a harmful impact on nearly every organ in the human body and is linked to conditions such as chronic bronchitis, heart disease, emphysema, stroke, pneumonia, and cancers of the lung, stomach, pancreas, cervix, and kidney.[2] The leading causes of smoking-related death in New Mexico are chronic obstructive pulmonary disease and lung cancer.[3] New Mexico has some of the lowest rates of smoking-related death in the nation, however, the burden of death related to smoking is much greater than that of alcohol and other drugs.

In addition to the disease and death burden, smoking is estimated to cost New Mexico $461 million in direct health care costs and $493 million in lost productivity.[4] In 2012, the state excise tax per pack of cigarettes was $1.66, while the average retail price of a pack of cigarettes is $6.06.[5] Each pack of cigarettes sold in New Mexico costs the state about $14.00 in smoking-related medical and lost productivity costs.[6]

Who is Using and Being Affected by Tobacco

In 2011, 21.5% of New Mexico adults smoked cigarettes, comparable to the national rate of 21.2%.[7] This translates into about 335,000 adult smokers in the state. Some adults use other tobacco products, including chew or spit tobacco, cigars, or tobacco in a hookah (water pipe), often in combination with cigarettes.

Among New Mexico high school youth, 30.1% reported using any form of tobacco in the previous month. Cigarette smoking was reported by 19.9% of youth, compared to 18.1% in the US (Figure 1). There has been a significant decline in New Mexico youth smoking since 2003 when 30.2% of youth smoked. Declines in spit tobacco and cigar use were also seen in 2011 compared to previous years.

There are specific population groups who smoke at higher rates than the general population, which may result from complex factors, including social stressors, targeted marketing, and inadequate access to a variety of health and economic resources. For example, there are significant differences in adult smoking prevalence based on socioeconomic characteristics such as education, income, employment, and insurance status (Figure 2). Other groups with elevated smoking include lesbian, gay, and bisexual New Mexicans, people with disabilities, African Americans, and American Indians (Figure 3).

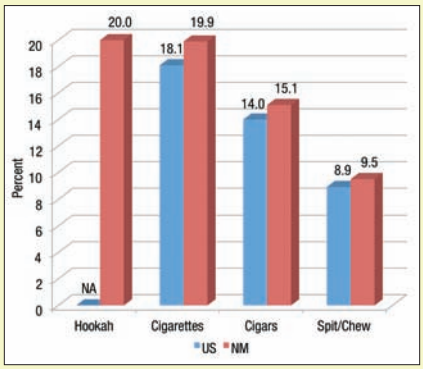
Differences in smoking can also be seen among different groups of high school youth. For example, smoking is highest among 12th graders and American Indians; and boys are more likely to smoke than girls. Students whose parents had less than a high school education were more likely to smoke than those whose parents were college graduates. Another important difference is that youth who earned mostly C, D or F grades were significantly more likely to smoke than youth earning mostly A or B grades.[8]

Smoking-related deaths can also differ by group. For example, death rates for males are about double those of females across all racial/ethnic groups.[3] Among both males and females, Whites have the highest rates, followed by African Americans. Counties with the highest smoke-related death rates include Torrance, Sierra, Quay, Valencia, and Socorro counties.

Preventing Tobacco Use and Exposure to Secondhand Smoke

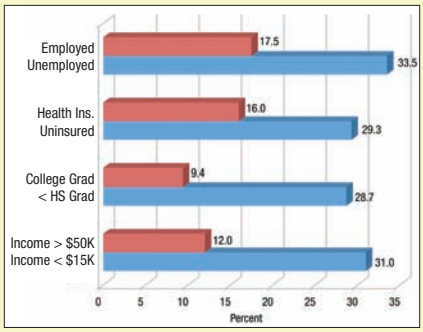
According to a 2012 Surgeon General's Report, nearly 90% of adult smokers tried their first cigarette before age 18 and about three of every four high school smokers continue to smoke well into adulthood.[9] In addition, there is evidence that the younger individuals are when they start using

FIGURE 1. Youth Tobacco Use in Past 30 Days, Grades 9–12, NM and US, 2011



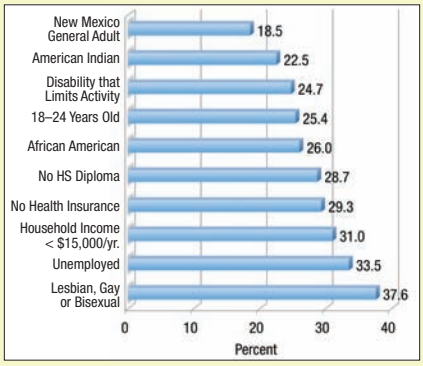
Sources: NM Youth Risk and Resiliency Survey (YRRS), NMDOH and CDC Youth Risk and Behavior Surveillance (YRBS)

FIGURE 2. Adult Smoking Prevalence by Socioeconomic Factors, NM, 2008–2010



Source: NM Behavioral Risk Factor Surveillance System (BRFSS), NMDOH

FIGURE 3. Smoking, by Selected Population Groups, NM, 2008–2010



Source: NM Behavioral Risk Factor Surveillance System (BRFSS), NMDOH

in New Mexico

tobacco, the more likely they are to become addicted and the more heavily addicted they will become. In New Mexico, there are an estimated 23,100 high school youth who smoke, making prevention of tobacco use a critical issue.

Key strategies for preventing young people from starting to use tobacco include mass media campaigns, higher tobacco prices, and smoke-free laws and policies. New Mexico's most recent cigarette tax increase ($0.75) became effective in 2010, which may be partially responsible for recent declines in youth smoking. The state has a clerk-assisted tobacco sales law and also prohibits the sale of tobacco products to minors. Another policy likely to have impacted youth smoking by changing social norms is the Dee Johnson Clean Indoor Air Act (2007), which made most non-tribal indoor workplaces and public places in the state smoke-free.

Statewide mass media campaigns continue to focus on preventing smoking initiation, promoting and facilitating cessation, and shaping social norms related to tobacco use. Innovative media initiatives are also in place to reach and engage young people in tobacco education and promoting awareness of issues. Other complementary activities in the state include supporting the development of voluntary smoke-free policies in multi-unit housing complexes, school and work campuses, and homes and vehicles.

Supporting People in Quitting Tobacco

Among New Mexico smokers, about half have tried quitting in the past year. To support tobacco users in quitting, the State uses mass media statewide to promote its free tobacco cessation services. Current services include a telephone helpline (1-800-QUIT NOW), with a personalized quitting plan, a trained quitting coach, and multiple calls per enrollee. Web-based cessation services such as www.QuitNowNM.com are also available stand-alone or in combination with the telephone helpline. Additional services include free nicotine patches or gum and text-messaging support. Web-based training is being developed to reach health care providers statewide to teach them how to screen patients for tobacco use, provide brief interventions, and to refer them to the statewide QUIT NOW services.

Emerging Issues in Tobacco Use and Environment

Although cigarette smoking remains at the forefront and results in the greatest health and economic burden, the introduction and use of emerging tobacco products requires attention. In New Mexico, one in five high school youth report smoking tobacco or flavored tobacco in a hookah (waterpipe) in the past month (Figure 1). Among adults in the state, about 14% report ever having tried smoking tobacco in a hookah.[10] A recent national study showed that 13.6% of adults have tried at least one emerging tobacco product, including snus, waterpipe, dissolvable tobacco products, or electronic nicotine delivery systems (i.e., e-cigarettes).[11] The tobacco prevention community will need to track the use and impact of these emerging products to inform efforts related to public health policy and interventions.

Another developing issue is the impact of the 2009 Family Smoking Prevention and Tobacco Control Act, which gives the Food and Drug Administration authority to regulate the manufacture, distribution, and marketing of tobacco products to protect public health.[12] The Tobacco Control Act seeks to prevent and reduce tobacco use by young people through activities such as requiring age and identification verification at retailers, restricting the sale of single cigarettes, a ban on certain candy and fruit-flavored cigarettes, and prohibiting false or misleading labeling and advertising. The Act also requires bigger, more prominent warning labels of tobacco product packaging, but this and other parts of the law continue to be challenged in the legal system. The full implementation and public health impact of the Tobacco Control Act will likely take many years to unfold.

What's Being Done

- ☑ QUIT NOW telephone- and web-based cessation services, including quit coaching, free nicotine patches, and text messaging support are available to NM tobacco users.
- ☑ Statewide priority population networks are in place to help maximize the reach, involvement, and mobilization of people in greatest need of tobacco-related services.
- ☑ Youth are being reached with tobacco use prevention approaches, including mass media and cutting edge social media and marketing.

What Needs to be Done

- ☐ Encouraging tobacco users to quit altogether instead of switching to lower priced tobacco products.
- ☐ Exploration of interventions allowable under the Family Smoking Prevention and Tobacco Control Act, such as protecting young people by regulating the time, place, and manner in which tobacco can be advertised and sold.
- ☐ Extending protections from secondhand smoke exposure to people in places not covered by the Dee Johnson Clean Indoor Air Act.

Burden of Substance Abuse Affects

The consequences of substance abuse are severe in New Mexico. Substance abuse is one of the state's leading causes of death (Figure 1), and New Mexico consistently ranks among the worst in the nation for death from drugs and alcohol. The devastation caused by substance abuse is also associated with domestic violence, crime, poverty, motor vehicle crashes, chronic liver disease, infectious diseases, mental illness, and other medical problems.

In 2006, the cost of excessive alcohol consumption in the U.S. was $223.5 billion dollars, including the costs of medical care, treatment services, criminal justice, and lost productivity.[1] In 2007, the estimated cost of excessive alcohol consumption in New Mexico was more than $2.8 billion, or $1,400 per person.[2] This economic burden falls heavily on New Mexico, since it is one of the nation's poorest states—with the second highest percentage of people living in poverty in 2010–2011 (20.2%)[3]—and has among the highest rates of health problems associated with substance abuse. Vulnerable populations who experience considerable negative consequences from substance abuse include youth, pregnant women, injection drug users, and prison inmates.

Higher Rates of Substance Abuse Among Youth in NM Compared to US

Substance abuse prevention among adolescents is critical considering the negative long-term consequences of early substance use.[4,5] In the 2011 New Mexico Youth Risk and Resiliency Survey, 37% of high school students reported that they had a drink of alcohol in the past month while 22% reported having at least five drinks on one occasion, similar to U.S. rates (39% and 22%, respectively). However, a larger proportion of students reported having their first drink before age 13 years (27%) compared to students nationwide (21%).

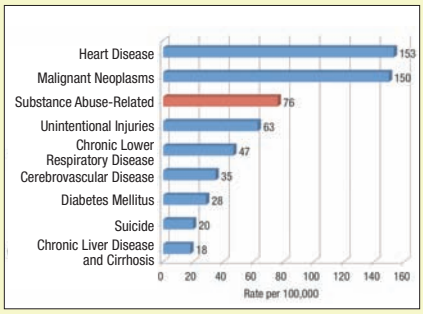
Rates of illicit drug use among New Mexico youth are also relatively high. Marijuana use in the past month was reported by 28% of students, compared with 23% nationwide. New Mexico students also reported higher use of cocaine, heroin, methamphetamine and Ecstasy than students nationally. Prescription drug abuse among youth has emerged as a concern in New Mexico. In 2009, 14% of New Mexico high school students reported current nonmedical use of prescription painkillers, which decreased to 11% in 2011. The prevalence of nonmedical use of prescription painkillers is higher among high school students whose parents have less than a high school education (Figure 2).

Alcohol-Related Death Rates Remain High Despite Decreases in DWI-Related Death

Alcohol-related health problems result from excessive alcohol consumption, either chronic heavy drinking or acute binge drinking. Heavy drinking, defined as drinking more than two drinks per day for men and more than one drink per day for women, is often associated with alcoholism or alcohol dependence, and can cause or contribute to a number of diseases, including alcohol-related chronic liver disease.

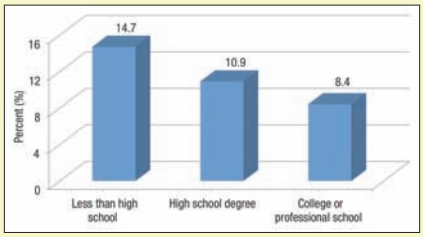
For the past 15–20 years, New Mexico's death rate from these diseases has consistently been first or second in the nation, and 1.5 to 2 times the national rate. Furthermore, while the national death rate from alcohol-related chronic diseases fell during this period, New Mexico's rate increased.[6] Rio Arriba and McKinley counties have death rates for diseases associated with heavy drinking that are 4–5 times the national rate.

FIGURE 1. Leading Causes of Death, Primary and Substance Abuse-Related, NM, 2007–2011



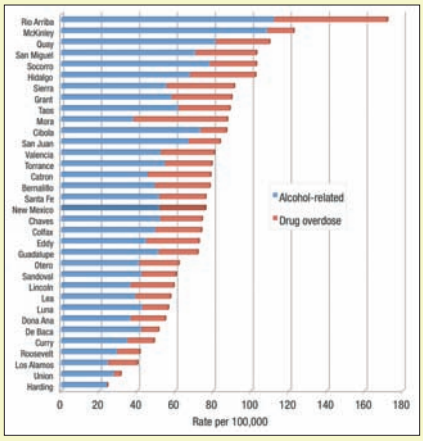
Sources: BVRHS, NMDOH, UNM-GPS

FIGURE 2. Percent of High School Students (Grades 9–12) Who Used Painkillers to Get High in Past 30 Days by Parents' Education, NM, 2011



Sources: YRRS, NMDOH and PED

FIGURE 3. Alcohol-Related and Drug Overdose Death Rates by County, NM, 2007–2011



Sources: BVRHS, NMDOH, UNM-GPS

All New Mexicans

Acute binge drinking, defined as having five drinks or more on an occasion for men and four drinks or more on an occasion for women, is a high-risk behavior associated with numerous injury outcomes, including motor vehicle crash fatalities, homicide, poisoning, and suicide. New Mexico's death rate for alcohol-related injury also has consistently been among the worst in the nation, ranging from 1.4 to 1.8 times the national rate over the past 15–20 years. While New Mexico's alcohol-impaired motor vehicle crash death rate has declined almost 70% during this period, death rates from other alcohol-related injuries have remained stable or increased.

Overdose Death Rate Increases

New Mexico has one of the highest drug overdose death rates in the nation. In 2011, the age-adjusted drug overdose death rate in New Mexico was 25.9 deaths per 100,000 persons.[7] Since 2007, the rate has increased 15%. Deaths due to prescription drugs now outnumber illicit drug deaths. In 2010, the most common drug types causing overdose death in New Mexico were prescription opioids (e.g., oxycodone, methadone, morphine), heroin, cocaine, tranquilizers (e.g., Diazepam, Alprazolam) , muscle relaxants (e.g., Carisoprodol) and antidepressants.[8] Prescription drug deaths have been fueled by the increase in sales of Schedule II and III prescription opioids, which have increased 144.7% since 2001.[9] Rio Arriba County had the highest 2007–2011 drug overdose death rate at 59.5—a rate more than twice the state rate. Combined alcohol-related and drug overdose death rates by county are shown in Figure 3.

How Do We Tackle the Problem of Substance Abuse?

Given the tremendous burden from substance abuse problems, prevention and treatment is of critical importance in New Mexico. Primary prevention attempts to stop a problem before it starts. In New Mexico, primary prevention of alcohol-related health problems has focused on regulating access to alcohol and altering the alcohol consumption behavior of high-risk populations. Regulatory efforts have included increasing the price of alcohol—which is effective in deterring alcohol abuse,[10] establishing and enforcing a minimum legal drinking age, regulating the density of liquor outlets, and increasing penalties for buyers and servers of alcohol to minors. Efforts to reduce drug overdose death are currently focused on reducing prescription drug overdoses by requiring more medical provider training in the area of pain management and promoting use of the Prescription Monitoring Program database to detect and reduce prescription drug misuse and inappropriate prescribing. DOH is also working with various community groups to provide naloxone (a drug which reverses respiratory depression during an overdose) to at-risk patients who are prescribed opioid painkillers.

Secondary prevention efforts try to detect and treat emergent cases before they cause harm. In New Mexico, screening and brief intervention (SBI) could be more widely used to identify at-risk drinkers and address problem drinking before it causes serious harm.

Tertiary prevention involves the treatment of individuals diagnosed with substance use disorders so they can recover to the highest state of health while minimizing the long-term effects of the disease. There are 141 facilities in New Mexico that provide substance abuse treatment services, including eight facilities that offer substitution therapy such as methadone and buprenorphine.[11] Roughly 141,000 New Mexicans abused or were dependent on alcohol during the past year while approximately 50,000 abused or were dependent on illicit drugs.

Only a small portion, approximately 6%, of current substance abusers received treatment for their substance abuse or dependence in the past year.[12] Nationally, the most common reasons that people who need treatment do not receive it are because they are not ready to stop using, have no health insurance and can't afford the cost, or are concerned about the possible negative effect on their job.[13]

Harm reduction is another important part of the substance abuse prevention model. Syringe exchange, which prevents the transmission of blood-borne pathogens among injection drug users, is one such strategy. Harm reduction programs in New Mexico deliver disease and overdose prevention education, acu-detox, health promotion, social service and treatment referral, and, in some locations, primary medical care to injection drug users.

What's Being Done

- ☑ More than $15 million is spent each year to help fund local DWI programs.
- ☑ Roughly 15,000 people were enrolled in substance abuse treatment in 2009, including a mix of mental health services, in outpatient, inpatient and residential settings.
- ☑ The New Mexico Prescription Drug Misuse and Overdose Prevention and Pain Management Advisory Council consisting of DOH and the healthcare provider licensing boards and professional associations is tightening regulations and requirements and promoting the use of Prescription Monitoring Program data to reduce the misuse of prescription drugs.
- ☑ Trainings on guidelines for effective and safe opioid prescribing among pain patients and those who are opioid dependent.

What Needs to be Done

- ☐ Increase support in adult primary care settings for screening and brief interventions (SBI) to address potential alcohol-related problems. Promote wider implementation of alcohol electronic SBI (e-SBI).[14]
- ☐ Expand the existing DOH overdose prevention program to include distribution of naloxone to persons with high risk opioid prescriptions.
- ☐ Support ongoing and new evidence-based programs for substance abuse prevention, treatment and recovery, ensuring thorough program evaluation.
- ☐ Educate the general population about the importance of safe medication use, secure storage in the home and proper disposal of leftover medicine.

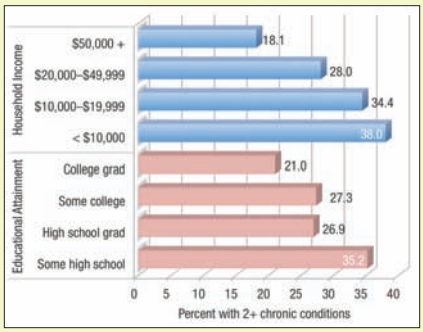
Multiple Chronic Conditions Present

Chronic diseases such as heart disease, cancer, emphysema, stroke, and diabetes account for five of the leading six causes of death in New Mexico.[1] Another common chronic disease, arthritis, is a leading cause of disability among adults. Public health efforts to prevent and manage chronic diseases have traditionally been funded and organized to focus on a specific disease or risk factor. There has been growing recognition, however, that this disjointed approach may not best serve populations that are particularly burdened by multiple risk factors and chronic diseases. The reality is that many chronic diseases share potentially modifiable risk factors such as physical inactivity, tobacco use, unhealthy eating, and excess weight, which tend to cluster in communities and individuals. These shared chronic disease risk factors, in turn, are strongly related to potentially modifiable social determinants such as poverty, unsafe neighborhoods, discrimination, and low educational attainment.[2]

Over one in four adults in NM ages 45 years and older has been diagnosed with two or more chronic diseases.[3] Not surprisingly, multiple chronic conditions are more common in communities and individuals with more risk factors and adverse social determinants of health, such as lower income and education levels (Figure 1). While learning to live with any chronic disease takes skills and resources, it is particularly challenging to manage multiple chronic diseases and risk factors at the same time. This means that many New Mexicans living with the challenge of multiple chronic conditions may not have the health literacy skills, income, community resources, and access to healthcare services that they need to successfully take care of themselves.

Arthritis and cardiovascular disease (CVD, i.e., heart disease, heart attack or stroke) are common conditions that often co-exist. Physical activity, such as moderate aerobic exercise and strength training, is important in the management of both arthritis and CVD by improving physical function, controlling weight, lowering blood pressure and improving cholesterol levels. However, NM adults with arthritis or CVD are more likely to be physically inactive than those with neither condition. This is especially true for persons who have both arthritis and CVD (Figure 2). These results are consistent with a national study that found arthritis might be a barrier to increased physical activity among persons with heart disease, perhaps due to arthritis-associated joint pain and fear of further joint damage.[4] The authors recommended several specially tailored self-management programs that can help adults learn to manage arthritis pain and safely increase physical activity. They concluded that greater integration of heart disease and arthritis intervention efforts by health-care providers,

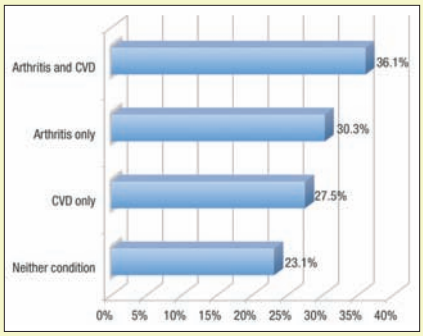
FIGURE 1. Prevalence of Multiple Chronic Conditions by Annual Income and Educational Level, Age 45+, NM, 2011



Source: NM Behavioral Risk Factor Surveillance System, NMDOH

Note: Multuple Chronic Conditions include two or more of the following: Cardiovascular disease (heart attack, coronary heart disease, and/or stroke), current asthma, cancer (excluding skin cancer), COPD, arthritis, kidney disease, or diabetes.

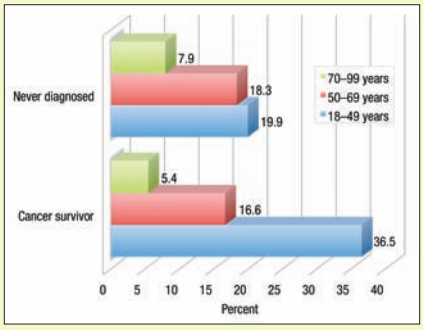
FIGURE 2. Prevalence of Physical Inactivity Among Adults by Disease Status, NM, 2011



Source: NM Behavioral Risk Factor Surveillance System

Notes: Physical inactivity is defined as no leisure time physical activity or exercise in past 30 days. Arthritis is defined as diagnosed with some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia; CVD is defined as diagnosed with one or more of the following: heart attack, coronary heart disease, and/or stroke.

FIGURE 3. Current Smoking Among Adult Cancer Survivors vs Adults Never Diagnosed with Cancer, NM, 2009–2010



Source: NM Behavioral Risk Factor Surveillance

Note: "Cancer" excludes non-melanoma skin cancer.

Challenges for NM

payers, and health departments might better address the effects of these co-occurring conditions.

Cancer survivors face a number of challenges, including increased risk for future cancer (either recurrent or a second type). Unfortunately, many cancer survivors are chronically addicted to nicotine, further increasing their risk for future cancer and other tobacco-related illnesses by continuing to smoke cigarettes.[5] Among NM cancer survivors in the 18 to 49 year age group, smoking rates are significantly higher than among their peers who have never been diagnosed with cancer (Figure 3). This suggests missed opportunities by clinicians and the public health community to encourage all cancer survivors who use tobacco to quit and to connect them to affordable evidence-based cessation services.

The Four Key Domains

In support of coordinated chronic disease efforts, the Centers for Disease Control and Prevention (CDC) is encouraging state chronic disease programs to work collaboratively by sharing basic functions such as data management, communication, partnership development, and implementation of a statewide chronic disease plan. CDC has provided funding to a number of states, including New Mexico, to maximize the reach of chronic disease programs by working with statewide partners across the following four key domains:[6]

- Achieving policy and environmental changes that support healthy communities.
- Achieving improvements to the way that health care systems detect, manage and control chronic diseases and risk factors through early detection and clinical preventive services.
- Enhancing clinic-community linkages so that people at high risk can better take charge of their health through self-management programs and other community supports.
- Providing data and information for decision making at the state level through a strong foundation in surveillance and epidemiology.

The goal of using shared resources to address overlapping chronic conditions, risk factors, and social determinants of health is the delivery of more efficient and effective chronic disease prevention and management efforts that will benefit all New Mexicans.

As chronic disease prevention and management activities become more strongly coordinated in our state, it will be crucial to evaluate whether improvements in the health and quality of life of our residents are actually being realized. This will be especially important to determine for those communities and individuals most heavily burdened by chronic disease risk factors, adverse social determinants of health, and multiple chronic conditions.

What's Being Done

- ☑ The NM Chronic Disease Prevention Council, a statewide coalition, is working with diverse partners to implement the NM Shared Strategic Plan for Chronic Disease Prevention and Control 2012–2016.
- ☑ Community and health care system partners throughout NM are delivering the Stanford University-developed Chronic Disease Self-Management Program in English and Spanish, providing skill building crucial to managing one or more chronic conditions.
- ☑ The National Diabetes Prevention Program is being piloted in a number of NM worksites and communities to help individuals with pre-diabetes avoid or delay getting diabetes.
- ☑ Chronic disease public health data are readily available to stakeholders and policy makers through queryable websites such as the DOH Indicator-Based Information System (IBIS).

What Needs to be Done

- ☐ Creating sustainable funding mechanisms for chronic disease self-management programs, such as their incorporation into health plan networks and covered benefits.
- ☐ Assessing the potential public health benefits and dangers of all proposed policies and legislation to make decisions that best support the long term health of New Mexicans.
- ☐ Increasing access to affordable, healthy foods and safe places to be physically active in New Mexico's rural and frontier areas.

Injuries Affect New Mexicans Across

Unintentional injury is the leading cause of death among 1 to 44 year olds in New Mexico. It is the third leading cause of death among the total population in New Mexico and accounts for 68% of all injury deaths. New Mexico's unintentional injury death rate of 59.3 per 100,000 population in 2010 was 1.6 times higher than the national rate of 37.9/100,000. Poisoning was the leading cause of unintentional injury death in 2011. In 2007, poisoning surpassed motor vehicle traffic crash injury as the leading cause of unintentional injury death. The other leading causes of unintentional injury death, in order, were motor vehicle traffic crash injuries, fall-related injuries and suffocation. The leading causes of unintentional injury death vary by age group. In 2011, suffocation was the leading cause of unintentional injury death among infants less than one year of age, motor vehicle traffic crash injury was the leading cause among 1–24 year olds, poisoning was the leading cause among 25–64 year olds and fall-related injury was the leading cause among 65+ year olds.

The unintentional injury death rate among males (83.0/100,000 population) was almost double the rate among females (43.3/100,000 population) in 2011. Poisoning (319 deaths) was the leading cause of unintentional injury death among males in 2011, followed by motor vehicle traffic crash injury (219) and fall-related injury (140). For females, poisoning (184 deaths) was the leading cause of unintentional injury death, followed by fall-related injury (156) and motor vehicle traffic crash injury (82).

During 2010–2011, American Indians had the highest unintentional injury death rate at 82.2/100,000 population, followed by Hispanics (61.5/100,000 population) and Whites (56.0/100,000 population). African-Americans and Asians had the lowest unintentional injury death rates (43.9/100,000 population and 31.4/100,000 population, respectively). The leading causes of unintentional injury death varied by race/ethnicity. Motor vehicle traffic crash injuries were the leading cause of unintentional injury death among American Indians and Asian/Pacific Islanders. Poisoning was the leading cause of unintentional injury death among Hispanics, Whites and African Americans.

Fall-related injury was the leading cause of unintentional injury hospitalizations and emergency department visits in 2010. Poisoning was the second leading cause of unintentional injury hospitalization. Motor vehicle traffic crash injury was the third leading cause of unintentional injury emergency department visits.

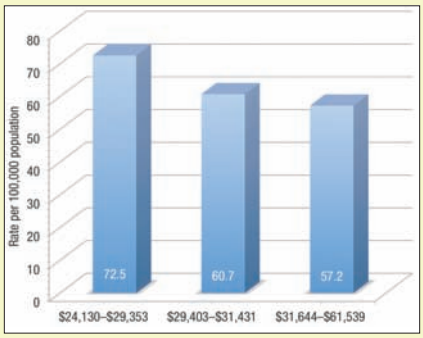
Poverty is a risk factor for unintentional injuries. The unintentional injury death rate was 1.3 times higher among counties with the lowest average county income compared to counties with the highest average county income in 2010 (Figure 1). The unintentional injury hospital discharge rate was also higher among counties with the lowest average county income (36.4/100,000) compared to counties with the highest average county income (31.3/100,000) in 2010.

Suffocation Among Infants

From 2007 through 2011, 20 infants less than one year of age died of suffocation in NM. The United States suffocation death rate (22.3/100,000) from 2006–2010 was two times higher than the rate in NM (11.6/100,000). Suffocation accounted for 36% of infant deaths due to unintentional injuries. Another 40% of unintentional injury deaths among infants was due to other specified and unspecified injuries. Males accounted for 70% of the infant suffocation deaths.

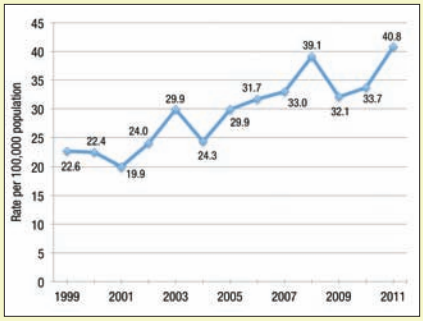
Suffocation deaths among infants have been increasing in NM. During 2002–2006 there were eight infant deaths due to suffocation in NM compared to 20 in the 2007–2011 period. Infants are most at risk for suffocation while sleeping. Infants should sleep in safe cribs, alone, on their backs, with no loose bedding or soft toys.

FIGURE 1. Unintentional Injury Death Rate by County Income, NM, 2010



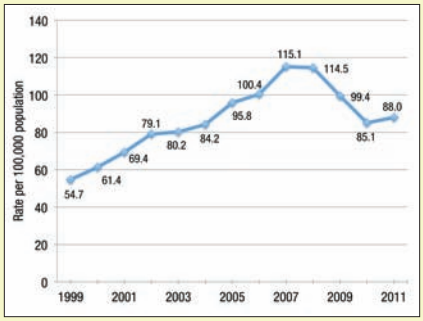
Source: VRHS, NMDOH

FIGURE 2. Unintentional Poisoning Death Rate, Aged 25–64, NM, 1999–2011



Source: VRHS, NMDOH

FIGURE 3. Fall-Related Injury Death Rate, Aged 65+, NM, 1999–2011



Source: VRHS, NMDOH

Entire Lifespan

Motor Vehicle Traffic Injury Among 1–24 Year Olds

From 2007 through 2011, 468 children and young adults died in a motor vehicle crash. Motor vehicle traffic injury deaths have decreased 46% from 2002 through 2011 among 1–24 year olds. The rate in 2011 was 11.7/100,000. The highest motor vehicle traffic death rate during 2007–2011 occurred among 15–24 year olds (26.7/100,000). The motor vehicle traffic death rate among males was two times higher than the rate among females. For this age group, American Indians had the highest motor vehicle traffic injury death rate (23.8/100,000) followed by Hispanics (13.2/100,000) and Whites (11.2/100,000).

The success in the reduction in motor vehicle traffic injury deaths can be attributed to several factors. Improvements continue to be made in roadway design and vehicle safety. New Mexico has invested in seat belt and child safety seat laws and set tighter penalties against drinking while driving. Graduated drivers licensing policies for teenage drivers have helped bring the number of teen crash deaths down.

Poisoning Among 25–64 Year Olds

From 2007 through 2011, 1,875 adults 25 to 64 years of age died of unintentional poisoning. Poisoning deaths increased 81% from 1999 to 2011 (Figure 2). The poisoning death rate during 2007–2011 was highest among 35–44 year olds (42.7/100,000) and 45 to 54 year olds (42.4/100,000). The male poisoning death rate was two times higher than the female rate. Hispanics had the highest unintentional poisoning death rate (41.0/100,000) followed by Whites (32.1/100,000) American Indians (30.6/100,000) and Blacks (29.6/100,000).

About 90% of unintentional poisoning deaths are due to drug overdose. Deaths due to unintentional drug poisoning can result from drug misuse such as taking too much of a drug for medical reasons and drug abuse. The American Association of Poison Control Centers has developed safety tips for the public to follow while using prescription drugs. People should follow the directions on the label, only take prescription drugs that were prescribed to them by a health care provider, never take larger or more frequent doses of their medication and never share or sell their prescriptions.

Falls Among 65+ Year Olds

From 2007 through 2011, 1,348 older adults 65+ years of age died of unintentional fall-related injuries. Fall-related injury deaths increased dramatically among older adults from 1999 through 2007 (115.1/100,000), increasing 110% during this period (Figure 3). The death rate decreased 24% from 2007 through 2011 (88.0/100,000). The dramatic increase in the fall-related death rate from 1999 through 2007 may be linked to increased life expectancy that results in a larger proportion of older adults living with chronic diseases that cause them to be at increased risk and vulnerability to fall-related injuries.[1]

Another possible explanation for the dramatic increase in the fall death rate in older adults is the effect of improved reporting quality after updating the International Classification of Disease-9 (ICD-9) to ICD-10.[2] However, the fall-related death rate among older adults in NM decreased in 2009 and 2010 for unknown reasons.

The fall-related injury death rate increased dramatically with age. From 2007–2010 the fall-related death rate among 85+ year olds (484.3/100,000) was 20 times higher than the rate among 65-74 year olds (23.6/100,000) and five times higher than the rate among 75–84 year olds (95.8/100,000). The female fall-related death rate was slightly higher than the male rate. Whites had the highest fall-related death rate (114.2/100,000) followed by American Indians (79.6/100,000) and Hispanics (79.3/100,000).

For many older persons, injuries due to falls, such as a hip fracture or traumatic brain injury, are so disabling that they never return to independent living in the community. Falls also have psychological consequences. Many people who fall, even those who are not seriously injured, develop a fear of falling. This fear can result in depression, isolation and reduced mobility, which lead to a decline in physical function and an increased risk of falling. The most effective strategies for prevention of older adult falls include home safety improvements, physical activity that focuses on maintenance of strength and balance, and medication safety.

What's Being Done

- ☑ The Safe Sleep Campaign involves educating parents about ways to reduce the risk for Sudden Infant Death Syndrome and other sleep-related causes of infant death, including avoiding having the baby co-sleep with parents or siblings, avoiding breast feeding in bed and keeping the crib free of all accessories.
- ☑ The New Mexico Safe Kids Coalition teaches parents on the correct use of seat belts, car seats and booster seats for children, as well as use of rear facing car seats until age 2.
- ☑ Implementation of evidence based adult falls prevention programs in various communities.

What Needs to be Done

- ☐ Increase provision of evidence-based Early Childhood Home Visiting programs to include at-risk families with other children.
- ☐ Provide training regarding safety protocols of the "Safe Sleep" and "Cribs for Kids" campaign to all home daycare providers, home visitors, parents and other caregivers of infants.
- ☐ Increase the availability of free car seats and booster seats, as well as "fitting stations" and clinics for inspection, replacement and parent training regarding proper and safe fitting.
- ☐ Incorporate adult fall risk assessment and proven interventions into clinical practice.

New Mexico's Violence Rate Second

Violence is a public health problem of epidemic proportions, both nationally and in New Mexico. In 2010, violence accounted for more than 55,000 deaths in the United States. New Mexico had the second highest violent death rate in the nation, 28.5 deaths per 100,000 population.[1]

Violence may have lasting harmful effects on individuals, families, and communities. The health effects may remain for years following the initial injury, accounting for significant, permanent disabilities such as spinal cord and brain injuries and limb loss. Victims of violence are also at an increased risk for psychological and behavioral problems, such as depression, anxiety, post-traumatic stress disorder, substance use disorders, and suicidal behaviors; and reproductive health problems, such as unwanted pregnancy and sexually transmitted infections.

Violence related injuries and deaths include both intentional, self-harming injuries due to suicidal behaviors, and intentional, interpersonal injuries, such as intimate partner violence, child maltreatment, and sexual assault. Although mortality data are the most collected and available source of violence related data, deaths represent only a fraction of the health and societal impact of violence. Apart from deaths, there were an estimated 1,484 inpatient hospital discharges and 8,557 visits to emergency departments for violence related injuries in NM during 2010.[2,3] According to recent NM survey data results, 8.6% of high school students reported making a suicide attempt in the past 12 months, and 5.9% of adults 18 years and older reported a suicide attempt during their lifetimes.[4,5]

Suicide

Over the past 15 years, suicide rates in NM have consistently been more than one and a half times greater than U.S. rates. In 2010, NM had the fourth highest suicide rate among the 50 states and the District of Columbia.[1] From 1999–2011, the NM suicide rate increased 13.4%, from 17.9 per 100,000 to 20.3 per 100,000, mirroring a similar increase (15%) in suicides at the national level.

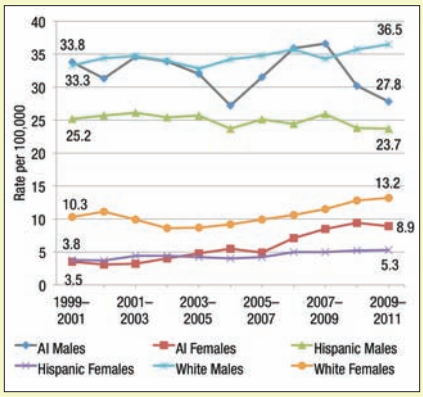
In 2011, suicide was the eighth leading of cause of death in New Mexico, accounting for a total of 419 deaths.[6] The majority of suicides (52.5%) were caused by firearm injuries.[7] However, there were differences in the causes of death between male and female suicide victims. The majority of male suicides were due to firearm injuries (59.9%), followed by hanging/suffocation (23.6%) and poisoning (9.9%). In contrast, the most common cause of death among female suicide victims was poisoning (41.9%), followed by firearms (30.5%) and hanging/suffocation (22.9%).

Male suicide rates in NM have traditionally been 4–5 times higher than female suicide rates. However, recent increases in female suicides have narrowed the rate disparity between the sexes to three to one. White males have the highest suicide rates, followed by American Indian (AI) males, although AI male suicide rates have recently been declining (Figure 1).[7] In contrast, female suicide rates have increased among the three most common racial/ethnic groups, with the AI female suicide rate more than doubling from 3.5 per 100,000 in 1999–2001 to 8.9 per 100,000 in 2009–2011.

According to results from the 2010 NM Violent Death Reporting System (NM–VDRS), the most common circumstances associated with female suicides were current mental health problems (56.5%) and current treatment for mental illness (54.6%).[8] Among male suicide victims, the most common circumstance was a current depressed mood (42.1%). Male victims were more likely to disclose their intent to commit suicide (39.6%) than female victims (24.1%). Intimate partner problems were more frequent among male (33.3%) compared to female (24.1%) suicide victims, whereas physical health problems were more common among females (37.0%) than males (24.5%). Substance use, particularly alcohol use, was common among suicide decedents. More than a third (37.2%) of suicide victims who were tested for blood alcohol tested positive; and almost one quarter (23.2%) of suicides were alcohol related, or had a blood alcohol concentration (BAC) greater than or equal to 100 mg/dl or 0.10%.

A previous suicide attempt is a risk factor for completed suicide, and suicide attempts may also result in injuries serious enough to merit inpatient hospitalizations or emergency department (ED) visits for medical attention. In 2010, there were 1,010 inpatient hospitalizations for suicide attempt.[2] In contrast to completed suicides that are more common among males, hospital discharges for suicide attempt were more common among females

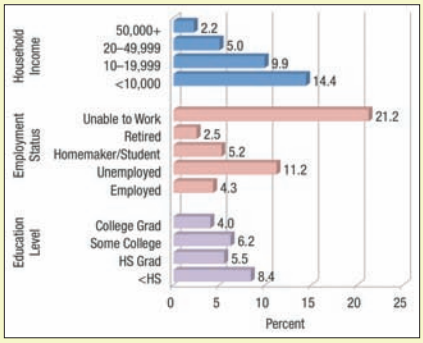
FIGURE 1. Suicide Rates by Gender and Race/Ethnicity, NM, 1999–2011



Source: VRHS, NMDOH

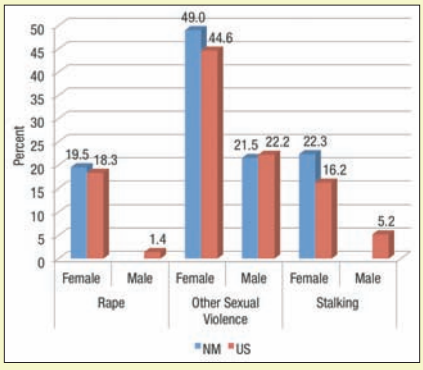
Note: Suicide rate defined as 3-year rolling average rates, age-adjusted to the 2000 US standard population

FIGURE 2. Lifetime Prevalence of Suicide Attempt Among Adults Aged 18+ by Socioeconomic Status Indicators, NM, 2011



Source: NM BRFSS, NMDOH

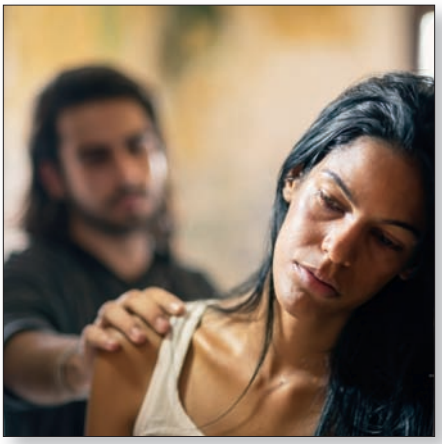
FIGURE 3. Lifetime Prevalence of Sexual Violence by Gender, NM and US, 2010



Source: CDC.

Note: State estimates of rape among men not available due to small numbers; state-level stalking estimates for men were not reported.

Highest in America



(63.6%). The majority of the 2,148 ED visits for suicide attempt were also female patients (56.3%).[3] New Mexican adults 18 years and older with lower household income, lower levels of employment, and less education reported higher rates of having ever attempted suicide during their lifetimes (Figure 2).[5]

Homicide

Homicide, or death caused by an intentional assault of another person, is a significant public health problem in New Mexico. In 2011, homicide was the third leading cause of death among persons 15–34 years.[6] In 2010, the latest year for which state comparison data are available, NM's homicide rate was the sixth highest in the nation (7.6 per 100,000).[1]

In 2011, there were 146 assault deaths in New Mexico, an age-adjusted homicide rate of 7.4 per 100,000.[7] From 2009-2011, the male homicide rate (12.5 per 100,000) was 4 times higher than the female rate (3.2 per 100,000). American Indian (26.1 per 100,000) and Black (24.8 per 100,000) males had the highest homicide rates, followed by Hispanic males (14.0 per 100,000); the White male homicide rate (6.2 per 100,000) was significantly lower compared to male rates in the other racial/ethnic groups. Homicide rates were highest among males between the ages of 15–44 years; males in the age group 35–44 years (21.2 per 100,000) had the highest rate.

Firearm was the leading cause of death among homicide victims, accounting for 51.8% of all homicide deaths in NM during 2009–2011.[7] Firearm deaths were more common among male homicide victims (55.3%) compared to female homicide victims (38.8%). Overall, 9.3% of homicides in NM were intimate partner violence related, i.e. the victims were either the current or former intimate partner of the suspect; or the deaths were associated with intimate partner conflict or violence, but were not deaths of the intimate partners themselves.[8] The most common circumstance related to homicide deaths among males was an argument over something besides intimate partners/jealousy, or money, property or drugs (46.9%). In contrast, almost a third (31.3%) of female homicides were related to intimate partner violence.

In 2010, there were 474 inpatient hospitalizations for assault related injuries, an age-adjusted hospital discharge rate of 24.0 per 100,000.[2] Infants less than one year had the highest assault hospitalization discharge rate of 92.1 per 100,000. There were also 6,842 ED visits for assault, an overall age-adjusted rate of 348.2 per 100,000.[3]

Sexual Violence

Sexual violence is a major public health problem with serious long-term physical and mental health consequences. In New Mexico, nearly one in five (19.5%), or 149,000 adult women, reported being raped at some time in their lives (Figure 3).[9] In addition, 49.0% of women and 21.5% of men 18 years and older have experienced some form of sexual victimization other than rape during their lifetimes.

Among women in NM who experienced rape, physical violence, and/or stalking by an intimate partner during their lifetimes, 29.9% reported an impact on their lives, including being fearful, having safety concerns, experiencing symptoms of posttraumatic stress disorder (PTSD), being injured, needed housing, legal or victim's advocate services, and missing school or work.[9] Twenty-two percent of these victims had symptoms of PTSD, and 20.0% reported an injury or need for medical care.

Sex crimes in NM go largely unreported. In 2010, the number of rapes that came to the attention of law enforcement represented about one-fifth of the estimated rapes that occurred.[10] According to these reports, the offender was known by the victim in an average of 72% of rapes perpetrated; and, of known offenders, 24% were family members.

What's Being Done

- ☑ The New Mexico Human Services Department is developing a statewide suicide prevention plan to inform suicide prevention programming across the lifespan.
- ☑ The NM Department of Health was awarded a three-year grant from the Substance Abuse and Mental Health Services Administration to implement and evaluate youth suicide prevention programs.
- ☑ The Coalition for Suicide Prevention and Survivor's Support in Las Cruces was established in December 2011 to address public health and community concern about suicide and attempted suicide in southern New Mexico.
- ☑ The NM Department of Health funds community-based sexual violence prevention programs that target caretakers, school personnel, and law enforcement officials serving persons with disability statewide; and youth and young adults, including LGBT, Spanish speaking, and youth of color, in select counties.

What Needs to be Done

- ☐ Promote and implement effective clinical care practices to assess, treat and refer persons at high risk for suicide, focusing on primary care and emergency department settings.
- ☐ Develop suicide prevention programs targeted towards adult populations in NM with the highest suicide rates, especially veterans and White males ages 45 years and older.
- ☐ Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk through counseling by health care professionals, community-based health promotion, and mass media campaigns.
- ☐ Raise awareness and promote safe gun storage practices in the home, particularly the use of a lockbox or gun safe; and encourage parents to remove firearms from the homes of adolescents, especially adolescents with a high risk of suicide.

Burden of Mental Illness Touches All

Mental illness is common in the United States and around the world. According to the U.S. Surgeon General, mental disorders are health conditions characterized by"alterations in thinking, mood or behavior (or some combination thereof) associated with distress and/or impaired functioning."[1]

Approximately 1 in 4 adults in the U.S. has a mental disorder of some kind in any given year. 13 million (5.8%) suffer from serious, debilitating disorders that are associated with suicide attempts, significant role impairment or lost work productivity.[2] Mental disorders are also common in childhood and adolescence. Approximately one in 5 children has a mental illness diagnosis associated with some impairment.[1] Adult mental illness is commonly preceded by psychiatric conditions that begin during childhood. The various types of mental disorders are defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).[3]

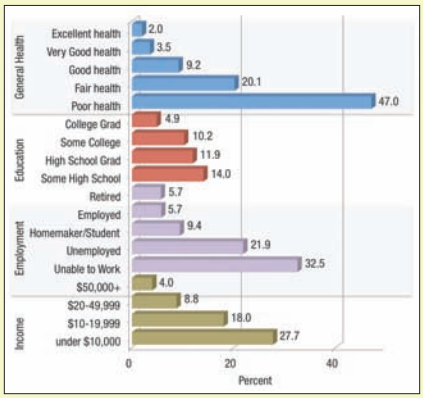
Mental illness affects not only the mental and physical health and well being of the individual, but also has a tremendous impact on families and communities. According to the latest update of the Global Burden of Disease Report, mental illness is one of the main causes of years of healthy life lost to disability (YLD).[4] Individuals with serious mental illness have higher mortality rates and die earlier than the general population. The overall burden among females is 50% higher than among males. Psychiatric conditions contributing to the higher burden in females include anxiety disorders and senile dementias. In contrast, one quarter of the male burden is due to alcohol and drug use disorders—six times higher than the burden of these conditions among females.

Treatment of mental illness can reduce the level of disability and improve quality of life. However, only 41% of U.S. adults with a 12-month mental health disorder defined in the DSM-IV used mental health services in the prior year.[5] Barriers to receiving treatment include cost and insurance issues, not feeling a need for treatment or thinking that the problem can be handled without treatment, and stigma associated with mental illness.

Depression

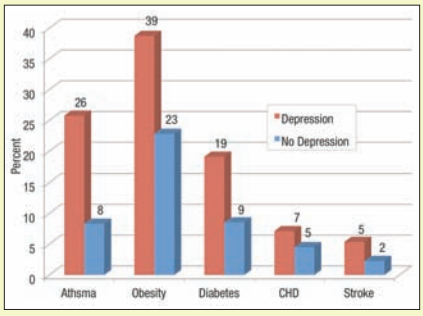
Major depression is a mental disorder characterized by an all-encompassing low mood accompanied by low self-esteem and by loss of interest or pleasure in normally enjoyable activities.[3] Depression is one of the most prevalent and treatable mental disorders. Unipolar depression was the third leading cause of disease

FIGURE 1. Prevalence of Depression by Selected Sociodemographic Characteristics, NM, 2010



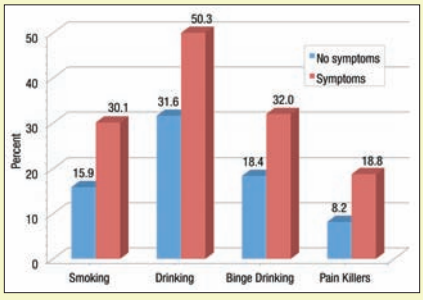
Source: NM Behavioral Risk Factor Surveillance System, NMDOH

FIGURE 2. Chronic Health Conditions and Depression, NM, 2010



Source: NM Behavioral Risk Factor Surveillance System, NMDOH

FIGURE 3. Youth Substance Abuse Behavior and Symptoms of Depression, High School, NM, 2011



Source: NM Youth Risk and Resiliency Survey, NMDOH

NM Residents

burden globally according to the Global Burden of Disease Report, and the number one cause of YLD.[4] Depression accounted for 65.5 million disability-adjusted life years (DALYs), or 4.3 percent of the total DALYs.[4] The DALY is a summary measure of population health that combines years of life lost from premature death and years of life lived in less than optimal health due to disease and injury.

Major depression is often associated with co-morbid mental disorders, such as anxiety and substance use disorders. It is also a risk factor for suicide and has been associated with an increased prevalence of chronic medical conditions such as heart disease, stroke, asthma, diabetes and obesity.[7]

Estimates of the prevalence of mental disorders in the general population come from both national and state surveys that use both screening and diagnostic measures to quantify mental illness. According to results from the 2009–2010 National Survey of Drug Use and Health, 8.6% of New Mexico youth 12–17 years had a major depressive episode in the last 12 months, along with 7.7% of young adults 18–25 years and 5.5% of adults over 26.[6]

Depression Among Adults

The New Mexico Behavioral Risk Factor Surveillance System survey estimated 9.1% of NM adults were suffering from depression in 2010. There were no significant differences in current depression by gender or age group. The prevalence among Native Americans (15.1%) was considerably higher than that among Whites (7.3%) and Hispanics (9.8%). The prevalence of depression was strongly and inversely related to reported general health (Figure 1) with almost half of those reporting poor overall health afflicted with depression compared to only 2% among those in excellent health.

Depression is also strongly related to education, employment and income (Figure 1). College graduates suffered from depression at less than half the rate of people with lower levels of education. The prevalence of depression was 4.9% for college graduates, compared to 10.2% for those with some college, 11.9% for high school graduates and 14.0% for those who did not complete high school. People who are employed or retired had much lower rates of depression (5.7%) than those who are unemployed (21.9%) or unable to work (32.5%). Depression was much less common among adults with household incomes of $50,000 or more (4.0%) than among those with household incomes of $10,000 or less (27.7%).

Depression is strongly associated with other chronic health conditions. Adults with one or more chronic medical conditions were much more likely to suffer from depression than adults without these conditions (Figure 2). Rates of health care provider diagnoses of asthma (25.8%), diabetes (19.1%), coronary heart disease (7.1%), and stroke (5.4%) were much higher in those suffering from depression. In addition, adults with depression were much more likely to be obese than those who were not.

Depression Among Youth

Persistent feelings of sadness and hopelessness are criteria for and predictors of clinical depression for youth. Results from the 2011 NM Youth Risk and Resiliency Survey indicated that 29.1% of high school students reported feeling sad or hopeless every day for two weeks or more in the previous year. This is essentially the same as the national rate of 28.5%. NM female students (37.3%) were more likely to report persistent feelings of sadness or hopelessness than male students (21.2%).

Persistent feelings of sadness and hopelessness were also associated with other risky behaviors. High school students who reported sadness and hopelessness were more likely to report substance use (Figure 3), including cigarette smoking, current alcohol use, binge drinking, using painkillers to get high and a variety of other behaviors. They also reported involvement in physical fights and being victims of intimate partner violence and sexual violence more often than students without these feelings.

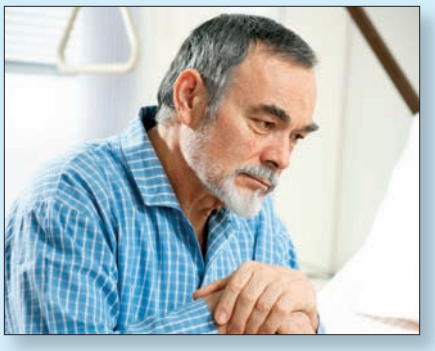
Mental health problems are common in New Mexico. They affect individuals of all ages and racial/ethnic backgrounds. Depression is a serious, common and treatable disease. It was most prevalent among adults with lower socioeconomic status. These health disparities, along with higher rates of chronic disease, lack of social and emotional support, and substance use, contribute to poorer outcomes among adults with mental health conditions.

What's Being Done

- ☑ The New Mexico Health Care Reform Leadership Team is aligning with national health care reform legislation to include behavioral health services in essential benefits packages provided through health insurance exchanges.
- ☑ Behavioral health services for middle and high school students are offered at 59 school-based health centers throughout New Mexico.
- ☑ Core service agencies in local collaborative areas coordinate the continuum of mental health and substance abuse treatment for people with serious mental health needs.
- ☑ The NM Behavioral Health Collaborative implemented "Talk About It," an anti-stigma and wellness campaign to raise public awareness about prejudices surrounding mental illness and its treatment.

What Needs to be Done

- ☐ Continue to improve youth and adult access to services through braided funding strategies.
- ☐ Implement collaborative care for the management of depressive disorders as recommended by the U.S. Preventive Services Task Force.
- ☐ Increase the capacity to provide mental health and substance abuse assessment, crisis intervention and early intervention services at school-based health centers.
- ☐ Expand early recognition and intervention programs for young people with early signs of serious mental illness.
- ☐ Expand the continuum of the behavioral health workforce and provide incentives for providers to work in rural, frontier and tribal areas.



Reducing Health Disparities Benefits

Health Disparity and Health Equity

"Health disparities" are defined as "differences in the incidence, prevalence, mortality and burden of disease and other adverse health conditions that exist among specific population groups in the United States." Health disparities are relative and are identified by comparing health status, access to services, and/or health outcomes of population groups. Health equity is defined as "the attainment of the highest level of health for all people." Although there have been national efforts at reducing health disparities and achieving health equity during the past two decades (e.g., Healthy People 2000, 2010, 2020 and the National Partnership for Action to End Health Disparities), the 2011 National Healthcare Disparities Report states that the quality of care is improving but access to care and disparities in care are not improving particularly for minority groups and low-income individuals.

Socioeconomic Characteristics Associated with Health Disparities

Characteristics such as race or ethnicity, limited English proficiency, disabilities, sexual orientation, age, economic status and geographic location may affect one's ability to achieve good health. Unfortunately health data systems have not routinely collected sufficient data to allow for the monitoring of the association between a characteristic such as limited English proficiency or economic status and health status or access to care.

The Patient Protection and Affordable Care Act passed in 2010 not only addresses access to care, but also addresses the need for improved data collection to identify significant health differences that often exist between segments of the population. As a result, the Office of Minority Health in the United States Department of Health and Human Services has released new minimum data standards for race/ethnicity, sex, primary language and disability status. Improved data collection will assist in efforts to prioritize affected populations and monitor efforts to reduce health disparities.

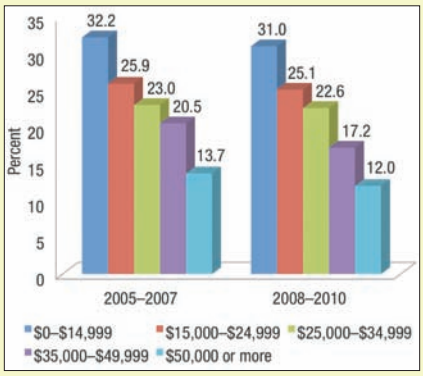
New Mexico's Population and Health Disparities

New Mexico's diverse population exhibits many of the social and economic characteristics associated with health disparities. New Mexico is a minority-majority state with Hispanics constituting the largest segment of the population (46.7% in 2011), followed by Whites at 40.2%. American Indians are the third largest population in New Mexico (10.1%) with African-Americans constituting 2.5% and Asians 1.6% of the population. In addition 36% of the population over the age of four speaks a language other than English at home and nearly one-fifth of the population lives below the poverty level.

Tobacco Use and Economic Status

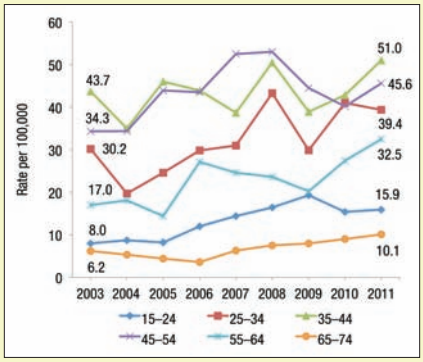
There is a clear association between economic status and smoking among adults both in New Mexico (Figure 1) and nationally. Low income adults have the highest rates which represents a reversal from the situation prior to the release of the first Surgeon General's Report

FIGURE 1. Adult Smoking by Income Level, NM, 2005–2010



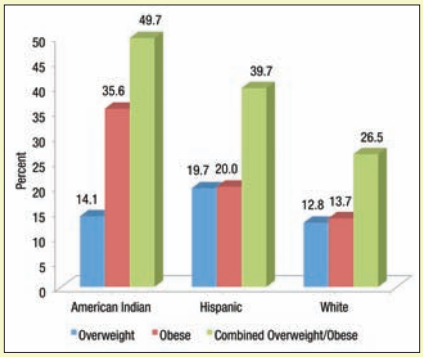
Source: NM Behavioral Risk Factor Surveillance System, NMDOH

FIGURE 2. Drug Overdose Death Rates by Age Group, NM, 2003–2011



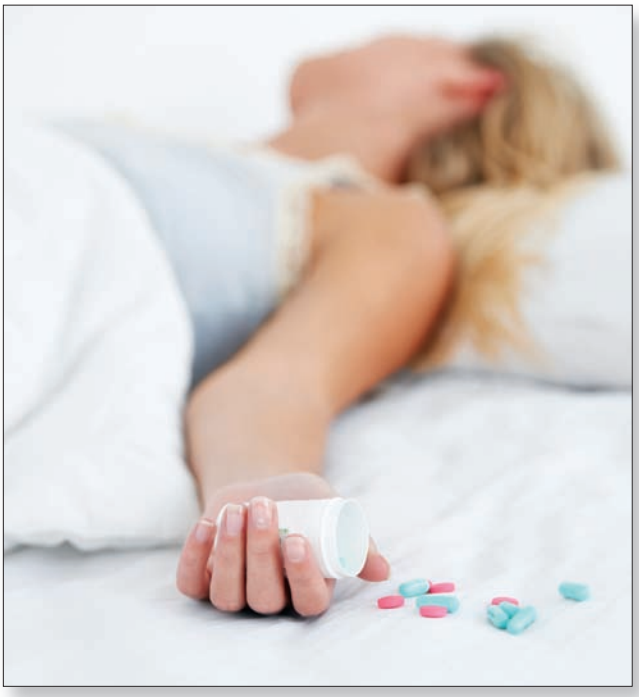
Source: Death Certificate Database, Vital Records and Health Statistics, NMDOH

FIGURE 3. Percent of Third Grade Students Overweight and Obese by Race/Ethnicity, NM, 2011



Source: BMI Surveillance, NMDOH

All New Mexicans



on Smoking in 1964, at which time higher income individuals smoked more than lower income individuals.

Smoking rates have decreased at all income levels, but smoking rates for the lowest income group ($0–14,999) were 2.6 times higher than for the highest income group ($50,000 and above) during the 2008–2010 time period. One of the components associated with the higher smoking rates among low income individuals is that low income smokers are less likely to quit smoking than higher income smokers, which may be due to difficulty in accessing tobacco cessation materials and programs.

The 2010 Patient Protection and Affordable Care Act contains a number of provisions expanding access to tobacco cessation through requiring Medicaid and private health plans to offer cessation coverage.

Drug Overdose Deaths and Age

New Mexico has the second highest drug overdose death rate in the nation. Historically in New Mexico fatal overdoses have been linked to illicit drugs such as heroin and cocaine. Recently prescription drugs, particularly opioid pain relievers, have caused more overdose deaths. Drug overdose deaths are an example of an issue for which the differences between groups is actually decreasing but this decrease is not a positive trend because it is due to the fact that rates for all groups are increasing. The highest rates of drug overdose deaths are found among adults ages 35–44 followed by the age group adults 45–54 (Figure 2). These two age groups have rates more than four times that of the age group 65–74 and nearly three times that of youth ages 15–24.

Child and Youth Obesity and Race/Ethnicity

Obesity is an increasing problem nationally and in New Mexico, where it is occurring among the very young, particularly in our American Indian children. Data from the Youth Risk and Resiliency Survey (YRRS) have indicated that obesity is a problem for American Indian youth as this group exhibits the highest obesity rates each survey. In 2010 New Mexico instituted an obesity surveillance system for elementary students and the results were similar to the data from the YRRS with White students having the lowest rates of obesity and American Indians having the highest rates. Nearly 1 of 2 American Indian children in the third grade in 2011 was overweight or obese compared to 1 of 4 White children (Figure 3).

What's Being Done

- ☑ A standard set of small areas have been developed for New Mexico to provide health status information at the community level and better permit the study of the relationship between place and health disparity.
- ☑ The U.S. Office of Minority Health has released new minimum data standards for Race and Ethnicity, Sex, Primary Language, and Disability Status. Improved data will assist in efforts to target affected populations and to monitor efforts to reduce health disparities.
- ☑ By selecting a limited number of health priorities the Department of Health is better able to enlist partners in addressing persistent health disparities and targeting resources to the populations most affected by these issues.

What Needs to be Done

- ☐ More multi-sector and collaborative approaches are needed to address the underlying risk factors that contribute to health disparities.
- ☐ Improved dissemination of evidence-based and promising practices from state-level organizations to local communities for implementation in high-risk populations.
- ☐ Increasing Geographic Information System (GIS) capacity to allow for combining or layering data from various data systems in order to associate social, environmental or economic data with health outcomes or access to health services and more precisely identify populations experiencing disparities.

Many Environmental Factors Affect

A healthy environment is essential to the health of New Mexicans. Environmental health addresses the interaction between human health and the chemical, physical, and biological agents found in both our natural and human-made surroundings. The environment can include the indoor and outdoor air we breathe; water we use for drinking, cooking, and bathing; food we eat; products we use; buildings we work in; and recreational areas we use.

Determining Environmental Exposures

Exposure to many toxic substances can be determined through biological samples, such as blood, urine, or hair. As part of New Mexico's notifiable disease surveillance, laboratory reports that indicate exposure to mercury, arsenic, uranium, lead, pesticides, and nitrates are collected and investigated. Lead exposure, for example, can be determined through blood testing.

Lead comes from a variety of sources, including older lead-based paints, ceramics with lead-based glazes, some imported toys and jewelry, fishing weights and bullets. In recent years, the percent of children tested for lead has increased (from 3.5 % of children under age 6 years of age tested in 2006 to 8.5% of children tested in 2011) while the rate of children found to have high blood lead levels has fallen (from 2.2 children per 1,000 screened in 2006 to 1.9 per 1,000 screened in 2011).

The northwestern and southwestern regions of the state had the highest rates of elevated lead levels in young children. Even small amounts of lead can affect brain development in fetuses, infants, and children, while high levels in adults can cause high blood pressure and other health problems. Thus, the collection and analysis of lead testing data combined with case management for lead-poisoned children and adults are very important. One of the main challenges is getting physicians to comply with the mandatory requirement that all children receiving Medicaid be tested for lead.

Air Quality and Health

Particulate matter pollution refers to particles suspended in air, such as dust, dirt, soot and smoke, and little droplets of liquid. Some particles are large or dark enough to be seen, like soot or dense smoke. Other particles are too small to be seen.

Air quality for the state is generally good, but some areas (e.g., parts of southern New Mexico and San Juan County) have relatively high levels of air pollutants. Industries adversely affecting air quality include power plants, oil and gas development, and confined animal feeding operations.

Short-term exposure to high particle pollution contributes to increased mortality from cardiovascular events and also can result in increased hospital admissions for several cardiovascular and pulmonary diseases, including heart attacks, congestive heart failure, stroke, asthma, and chronic obstructive pulmonary disease. The heart attack death rate is greatest in the northwestern and southeastern regions of the state and particle pollution may play a role.

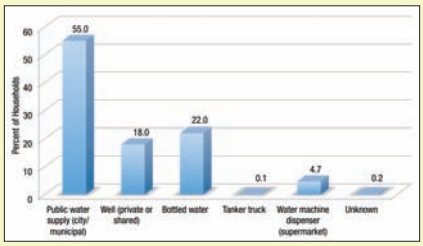
Long-term exposure to high levels of particle pollution can reduce overall life expectancy by a few years.[1] Research indicates exposure to air pollution can increase the rates of infant mortality.[2] Because there are not air quality monitors in every county, methods to forecast episodes of poor air quality including high ozone and dust concentrations are being developed. Air quality health advisories can then be developed to notify potentially affected communities so that they can take action to protect themselves.

Water Quality and Health

Polluted and unhealthy water can contribute to gastrointestinal illness, various cancers, birth defects, and developmental problems in children. Routine sampling and analysis of the state's water reveals that the quality is generally good, but problems can occur. One such problem arises from bacteriological contamination, which may lead to boil-water advisories. In 2011, there were eleven boil-water advisories issued by the New Mexico Environment Department's Drinking Water Bureau. When a boil-water advisory is issued, the Department of Health provides educational materials for the public and advises public health officials to be on alert for cases of gastrointestinal illness.

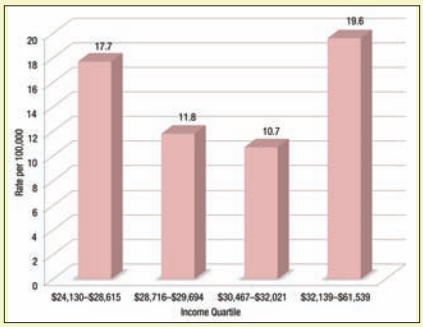
Nitrates from fertilizers, animal waste, or improperly maintained septic tanks can contaminate drinking water sources. Most of our drinking water (about

FIGURE 1. Main Source of Drinking Water, NM, 2007



Source: NM Behavioral Risk Factors Surveillance Survey, NMDOH

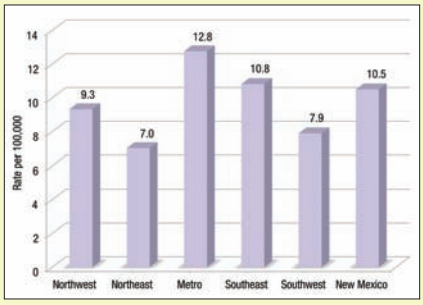
FIGURE 2. Asthma Hospitalization Rates Among Children (<15) by County Income, NM, 2010



Sources: Hospital Inpatient Discharge Database, NM Department of Health

Note: These data include hospital inpatient discharges where asthma is the first-listed diagnosis. They include state residents who were discharged from a non-federal hospital. Because many American Indians are admitted to federal IHS hospitals, they are not included in these rates.

FIGURE 3. Cleft Lip with or without Cleft Palate by Region, NM, 2008–2010



Source: NM Birth Defects Surveillance Database, NMDOH

Ability to be Healthy

90%) comes from groundwater; therefore, monitoring groundwater quality in New Mexico is important. An estimated 18% of state residents, or roughly 350,000 people, get their water from untested private wells (Figure 1).

Arsenic is one naturally-occurring contaminant of our groundwater. Exposure to high arsenic levels in drinking water is associated with bladder and other internal organ cancers. The relatively new Environmental Protection Agency (EPA) drinking water standard for arsenic of 10 ug/L requires that water systems modify their source water supplies and/or install arsenic removal technology, such as reverse osmosis. Exposure prevention measures continue to be promoted by creating and disseminating fact sheets and other educational materials among potentially exposed New Mexicans.

Homes and Health

Housing affects health both directly, through physical, chemical and biological exposures, and indirectly, through psychological effects. Young children spend about 70% of their time in homes, and elderly people are at home 90% of the time. Lower quality housing can increase asthma exacerbation, lead poisoning and radon and mold exposure.

Housing and health assessments determined the areas where resources should be focused. Health conditions included asthma hospitalizations and lead poisoning. Lea and Doña Ana counties had the most overlap of housing and health risk factors. For example, in Hobbs, 72% of all housing was built before 1979; therefore, there is a lead paint risk. Hobbs resides in Lea County, which had one of the highest rates of asthma emergency department visits among children under age 15. In Portales, 60% of renters are cost-burdened, indicating renters pay more than 30% of income toward rent. Colonias most at risk were along the Rio Grande Valley, in farming communities, and those outside the Las Cruces city limits.

Asthma

About 150,000 adults and 42,000 children in New Mexico had asthma in 2010. To reduce the burden of asthma we collect and analyze health surveillance data and work with partners to develop effective and sustainable public health actions.

One primary goal of state and local agencies, physician groups, and non-profit organizations is to reduce the rates of asthma emergency room visits, hospitalizations, and deaths in southeastern New Mexico where the rates are highest. Income plays a role in asthma hospitalizations among youth, where rates tend to decrease as per capita income increases, with the exception of the highest quartile (Figure 2). When the three southeastern counties with the highest asthma rates (Curry, Lea, Eddy) are removed from the highest income quartile, the rate decreases from 19.6 to 12.0 per 10,000 population.

Efforts to address these rates include increasing: 1) health care provider training on the latest National Heart, Lung, and Blood Institute asthma guidelines, 2) asthma education in elementary schools and, 3) indoor air quality education in grades K–12. The indoor air quality education components highlight potential asthma triggers on school campuses.

Tracking Environmentally-Related Disease

Linking environmental hazard or human exposure data with health data is needed to determine if and how the environment may affect health. Examples include the connections between air quality and asthma emergency room visits, or between arsenic levels in drinking water and bladder cancer incidence.

Prevalence rates for major birth defects have been tracked in New Mexico since 1998. For some birth defects, doctors and public health scientists know how they happen and in some cases they can help women prevent some of these.

For many birth defects, however, there are no clear causes. It is likely that most birth defects happen for many reasons, not just one reason, and the environment might contribute. Differences in the prevalence of cleft lip with or without cleft palate by health region from 2008 to 2010 may be connected to a variety of risk factors, including air pollution (Figure 3). The Environmental Public Health Tracking website has been developed to disseminate this type of information to New Mexicans. This information can help residents avoid potentially harmful exposures.

What's Being Done

- ☑ Asthma self-management education in a clinical setting is being provided in order to reduce hospital admissions.
- ☑ The Environmental Public Health Tracking Web data query system has publicly available New Mexico environmental and health data and continues to be updated and expanded.
- ☑ Lead exposure is being assessed, and individuals with high blood lead levels receive education and home visits, if necessary with the goal of eliminating the source of exposure.

What Needs to be Done

- ☐ Increase collaboration to implement evidence-based asthma curricula in elementary schools
- ☐ Educate communities at risk for adverse environmental exposures so that they can protect themselves.
- ☐ Develop environmental health advisories, such as when increased ozone and dust concentrations occur.
- ☐ Increase evidence-based awareness of environmental conditions that may affect the health of New Mexicans through timely dissemination of data and information.

Healthy Workplaces Provide Benefits

Injuries and illnesses due to work are costly to workers, employers and society, both economically and in terms of human suffering. In New Mexico almost $277 million or $384 for each covered worker was paid out in benefits for workers' compensation insurance in 2010. This likely represents a fraction of the costs of work-related illness and injury as costs are shifted to insurance systems other than workers' compensation.

Furthermore, not all employees are covered by Workers' Compensation. Laws in New Mexico exclude employers with fewer than three employees, domestic workers; farm and ranch laborers and real estate salespersons are exempt from mandatory workers' compensation coverage. The average annual cost of worker compensation per worker has risen in both New Mexico and the United States but the gap between the cost per worker in New Mexico appears to be rising faster than for the U.S. overall (Figure 1).

Illnesses Due to Work

Since the passing of the Occupational Health and Safety (OSH) Act in 1970, diseases due to work exposures have decreased, but have not been eliminated. Many of the OSHA standards were passed within the first 10 years of the act but the pace of standards setting has decreased sharply in recent years. Only one standard (for hexavalent chromium) has been established in the last 10 years.

Certain occupational illnesses that are almost always associated with workplace exposure, such as coal workers pneumoconiosis (CWP) or mesothelioma, a rare cancer associated with asbestos exposure, are reportable to the NMDOH. In 2011, there were 15 persons discharged from New Mexico acute care hospitals with CWP (age-standardized rate of 9.2 per million NM residents over 16 years of age); 39 discharges with asbestosis (22.3/million); and 19 persons discharged from hospitals with silicosis (10.8/million).

According to the New Mexico Tumor Registry, there were 16 incident cases of mesothelioma in 2009, or an age standardized rate of 9.2 per million residents aged 15 and over. Other reportable occupational illnesses include hypersensitivity pneumonitis, noise-induced hearing loss, occupational asthma and occupational pesticide poisoning.

Non-Fatal Injuries on the Job

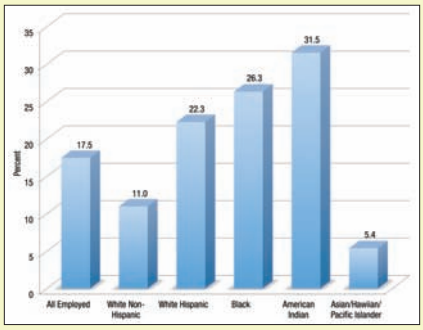
The United States Department of Labor, Bureau of Labor Statistics collects data annually from employers on occupational illness and injury, as recorded on OSHA 300 logs. This Annual Survey of Occupational

FIGURE 1. Workers' Compensation Costs, NM and US, 2000–2010

Source: Total amount and average benefits paid, National Academy of Social Insurance

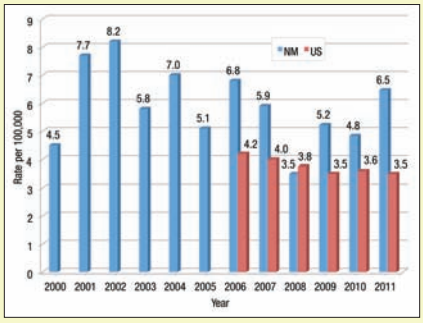
Note: All workers who are eligible for compensation should they sustain work-related injuries or illnesses are considered "covered" workers

FIGURE 2. Relative Percentage of Employment by Race in High-Morbidity Risk Occupations, NM, 2008–2010



Source: Bureau of Labor Statistics (BLS) Current Population Survey

FIGURE 3. Occupational Injury Death Rates, NM and US, 2000–2011



Sources: Deaths from BLS Census of Fatal Occupational Injury, Denominator from BLS Current Population Survey

for Everyone

Illness and Injury (SOII) is the basis of many of the health and safety statistics that are reported on workplaces in America. Injuries or illnesses with lengthy onsets or long latency periods, such as hearing loss and carpal tunnel syndrome, are less likely to be captured on OSHA logs and reported in the SOII than easily identifiable traumatic work injuries, such as lacerations or fractures. This is, in part, due to the timely nature of SOII data, which are collected shortly after the calendar year.

In 2010, private employers in New Mexico reported an estimated 5,540 traumatic injuries, or 1,098 per 100,000 FTEs, that required one day or more days away from work. Traumatic injuries comprised about 93% of all reported conditions, both illness and injury. The estimated rate for the U.S. overall was 1,007 per 100,000 FTEs.

According to the SOII, there were an estimated 60 amputations from work in New Mexico or 11 per 100,000 FTEs in 2010 while the rate for the US overall was 6 per 100,000. In 2012, the NMDOH added traumatic amputations and work-related burns requiring hospitalization to the list of notifiable conditions.

Disparities in Occupational Illness and Injury

In New Mexico, certain racial and ethnic groups are over-represented in occupations at high risk for non-fatal occupational illness and injury (Figure 2). For example, 11.0% of Whites are employed in occupations at high risk for morbidity, but 31.5% of American Indians work in a high-risk occupation. Furthermore, many of these occupations, such as construction laborers, janitors, and home health aides, are in the lower end of the earnings bracket.

Occupations considered high-risk are those with at least twice the average rate of illness and injury and are based on Bureau of Labor Statistics "days away from work" cases and employment estimates for private sector workers for the year 2008 from the SOII.

Workplace Injury Fatalities

While the rate of occupational fatalities in New Mexico appears to be declining, New Mexico's rate remains well above the US rate (Figure 3). In 2010 there were 38 deaths of which 31.6% were transportation-related. The second most frequent cause of death was homicide, comprising 26% of deaths; half of those were the five employees who died during the July 2010 shooting at Emcore in Albuquerque. Falls were noted as the cause in 15.8% of deaths. Construction was the single industry with the largest percentage of fatalities with 26% of deaths. The NMDOH added occupational injury fatality to the list of reportable conditions in 2012.

What's Being Done

- ☑ Guidelines have been formulated for health care providers on occupational exposures, such as lead.
- ☑ Surveillance is focused on industries that national and state data indicate have high health hazards, such as healthcare.
- ☑ Collecting respondents' occupation and industry in New Mexico health and behavior survey data.
- ☑ Partnering with employers and regulators to disseminate worker exposure prevention messages.

What Needs to be Done

- ☐ Improve dissemination of worker health and safety information to workers, employers and health care providers through website development.
- ☐ Continue cooperative efforts between state agencies and the National Institute of Occupational Safety and Health (NIOSH) on prevention programs.
- ☐ Evaluate occupational health programs to determine effectiveness.

Health Care Availability Essential to

In 1978, nearly all nations of the world signed the World Health Organization Declaration of Alma Ata,[1] proclaiming the right of all people to primary care. Primary care is defined as basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system. In 2010, 34% of the total NM population resided in designated primary care Health Professional Shortage Areas (HPSA). All or part of thirty-one of the thirty-three counties were designated a primary medical HPSA.

Important health maintenance information and tools, such as mammograms, PAP tests, measurements of blood cholesterol, and many others, are only available through health care providers. For most individuals and families, the high cost associated with accessing health care can only be managed through some form of health care plan, be it private health insurance, employer-provided insurance, or some form of public-sponsored coverage such as Medicare.

Lack of health care coverage has been associated with delayed access to health care and increased risk of late stage diagnosis of chronic disease and mortality.[2] Individuals without health care coverage are much less likely than those with coverage to receive recommended preventive services, are less likely to have access to regular care by a personal physician, and are less able to obtain needed medication or health care services. Consequently, the uninsured are more likely to succumb to preventable illnesses, more likely to suffer complications from those illnesses, and are more likely to die prematurely.[2,3]

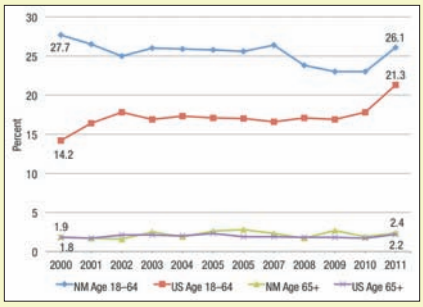
The New Mexico Department of Health routinely monitors health care coverage. Throughout the past decade, New Mexicans were less likely than those living in the rest of the country to have any form of health care coverage (Figure 1). Adults sixty-five years of age or more qualify for federally-sponsored Medicare. Nearly all adults in this age group have access to health care. In 2011, among children under the age of 19, 9.9% of New Mexico children and 9.4% of U.S. children were without any form of health care coverage.[4] This represented an improvement over 2010 figures.

For each preventive measure or health screen, the percentage of adults who have received the given service varied by health care coverage status (Figure 2). For example, 69.7% of adults age 65 or older who had coverage had received the recommended pneumococcal vaccination while only 49.3% of those without coverage had received the vaccination. Adults who were covered by a health plan were significantly more likely to have received each form of potentially life-saving service by the recommended age and within the recommended time frame than those without coverage. In 2011, nearly forty-four percent (43.9%) of adults without coverage experienced a time in the previous 12 months in which they needed medical care but could not get it because of the cost, while cost prevented only twelve percent (12.2%) of adults with coverage from obtaining needed medical care.

Demographic Disparities in Accessing Health Care

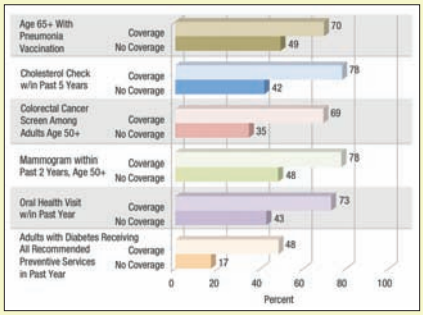
Ideally, all individuals would have effective access to health care. However, access to health care varies by gender, race/ethnicity, education level, annual household income, employment status, and region of residence (Figure 3). In 2011, adult men were slightly less likely than adult women to have health care coverage (74.9% vs. 81.3%). However, cost was slightly more likely to have prevented adult women from getting necessary medical care during the previous year (20.3% vs. 18.0%). White (85.4%) and Asian or Native Hawaiian/Pacific Islander (92.0%) adults were more likely than American Indian (81.9%), Black or African American (74.1%), and Hispanic (67.7%) adults to have health care coverage. Hispanic adults were least likely of all racial/ethnic groups to have health care coverage.

FIGURE 1. Lack of Healthcare Coverage Age 18–64 and 65+, NM and US, 2000–2010



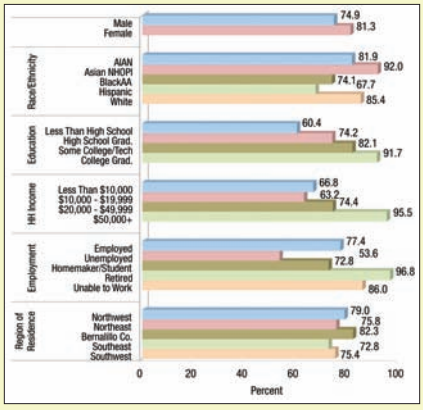
Source: NM Behavorial Risk Factor Surveillance System (BRFSS), NMDOH

FIGURE 2. Access to Important Preventive Health Care by Health Care Coverage Status, NM, 2010–2011



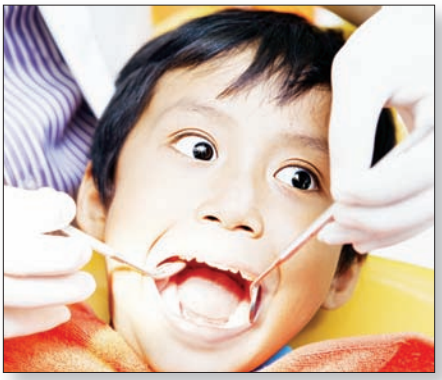
Source: NM Behavorial Risk Factor Surveillance System (BRFSS), NMDOH

FIGURE 3. Demographic Disparities in Health Care Coverage, NM, 2011



Source: NM Behavorial Risk Factor Surveillance System (BRFSS), NMDOH

Health Care Use



Adults with greater education levels or living in households with annual incomes of greater than $20,000 were significantly more likely to have health care coverage. At each level of completed education, the prevalence of health care coverage was significantly higher. Adults who were employed were significantly more likely to have coverage than adults who were unemployed (77.4% vs. 53.6%). Retired adults were most likely to have coverage (96.8%). Of course, most retired adults are 65 or older and qualify for Medicare.

Adults living in the southeastern region of New Mexico (72.8%) were significantly less likely to have coverage than adults living in other regions. Adults living in Bernalillo County (82.3%) had the highest coverage of any region.

Community-Based Primary Care

For more than 20 years, there has been an effort to build a system of community-based primary care centers for New Mexico's underserved. This has been a collaborative effort, linking federal, state, and local programs with community groups and non-profit agencies. The impact has been considerable; there are primary care centers in 97 communities serving more than 300,000 patients through more than 1 million visits each year. Roughly 88% of these patients have annual incomes below 200% of the Federal Poverty Level and approximately 43% are without any form of health care coverage.

Primary care centers are serving a significant portion of the unmet need in New Mexico, making clear the necessity of continuing to build the primary care center sector. Under the Federal Primary Care Cooperative Agreement, the Office of Primary Care & Rural Health (OPCRH) of the NMDOH will continue its work facilitating the expansion of primary care centers by providing support to the NM Primary Care Association and individual community groups and primary care centers seeking to initiate or expand community-based primary care centers in underserved parts of the state. The OPCRH will develop and disseminate information about areas of highest need and will promote coordinated planning to meet local needs, including coordination between primary care centers, rural hospitals, local health councils and public health offices.

While the focus of these centers is on medical services, there is an increased emphasis on expansion of dental services in the primary care setting. Fewer than half of primary care clinic sites have dental service capacity. But even with this limited capacity, primary care centers provide more than 21% of all Medicaid dental services in New Mexico.

The community-based primary care sector in New Mexico is a major public health success story. Few other states have such a widespread system caring for such a large percentage of the state's underserved population.

Affordable Care Act

The recently approved Affordable Care Act (ACA) will have some important benefits for residents of New Mexico.[5] ACA includes a small business tax credit designed to support small businesses in providing health care coverage to employees. An estimated 25,700 businesses in New Mexico will be eligible for this tax credit. Frequently, adults who retire early will lose employer-provided coverage but will be too young to receive coverage through Medicare. Through ACA, the Early Retiree Reinsurance Program will provide support to employers to ensure continuation of coverage of employees who retire early. ACA will allow children to be covered through their parent's plan through age 26. ACA makes available to New Mexico $37.5 million to provide coverage for uninsured residents with pre-existing medical conditions through a new transitional high-risk pool.

Additionally, the ACA includes many consumer protections, including: elimination of lifetime limits on coverage; restrictions against denial of coverage based on pre-existing conditions; regulation of use of annual limits to coverage; requirement of appeals processes to ensure pathways to dispute denial of medical claims; and, increased flexibility in choice of physician.

What's Being Done

- ☑ Preparations are underway for the initiation of the new federal Affordable Care Act.
- ☑ $1.38 million from U.S. Department of Health & Human Services to the NM Medical Insurance Pool to support coverage of those who have been denied coverage due to pre-existing conditions.
- ☑ Supplemental questions on health care access will be added to the 2013 New Mexico Behavioral Risk Factor Surveillance System to provide baseline data that will serve to assess the impact of the Affordable Care Act in future years.
- ☑ Planning assistance and low-interest loans are being given to community groups and agencies developing or expanding community-based primary care centers.
- ☑ Tax incentives and education loan repayment programs encourage medical professionals to settle and work in under-served areas.

What Needs to be Done

- ☐ Careful study of and integration of New Mexico primary care and other medical resources with the federal Affordable Care Act.
- ☐ Monitor distribution of medical professionals and services across the state to identify geographic areas of need.
- ☐ Expansion of primary care centers to meet the needs of more underserved people.
- ☐ Expansion of services provided by primary care centers to include dental services, behavioral health services, health promotion and disease prevention services, and chronic disease management.
- ☐ Continue, and expand, monitoring of access to and utilization of health care across the entire population of New Mexico.

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The State of Health in New Mexico 2013

New Mexico Department of Health

Appendix B
Adequacy of the Heathcare System's Workforce

Report
to
The LEGISLATIVE FINANCE COMMITTEE

Department of Health and Allied Agencies
Adequacy of New Mexico's Healthcare Systems Workforce
May 15, 2013

Report #13-03

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David Abbey
Director

May 15, 2013

Ms. Retta Ward, MPH, Secretary
New Mexico Department of Health
1190 S. St. Francis Dr.
Santa Fe, New Mexico, 87501

Dear Secretary Ward:

On behalf of the Legislative Finance Committee, I am pleased to transmit the *Adequacy of New Mexico's Healthcare Systems Workforce*. The evaluation assessed workforce adequacy in meeting the demands of the Affordable Care Act when it is implemented in 2014.

An exit conference was conducted with the Department of Health and allied agencies on April 4, 2013 to discuss the contents of this report. We will present the report to the LFC on May 15, 2013.

I believe this report addresses issues the Committee asked us to review and hope all participating entities will benefit from our efforts. We very much appreciate the cooperation and assistance we received from your staff as well as from representatives of other state agencies and associations.

Sincerely,

David Abbey, Director

Cc: Representative Luciano "Lucky" Varela, Chairman, Legislative Finance Committee
Senator John Arthur Smith, Vice-Chairman, Legislative Finance Committee

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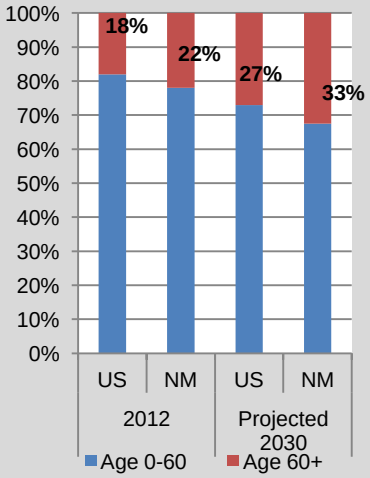
Approximately 415,000 New Mexicans are currently uninsured; more than 98,000 New Mexicans will gain insurance coverage through Medicaid expansion.

Percent of the Population Over 60



Source: NM ALTD

By 2030, New Mexico will rank 4th in the nation for proportion of the population over age 65.

Sixty-two percent of adults in New Mexico were overweight or obese in 2009.

The health system in the United States, including New Mexico, is changing dramatically with the full implementation of the Affordable Care Act (ACA) in 2014 and the corresponding Medicaid and private insurance expansion.

New Mexico's workforce of medical, dental, public health, and behavioral health professionals is fully engaged with the current demand for healthcare services, including providing care to at least some of the state's estimated 415 thousand residents who lack healthcare insurance. Federally Qualified Healthcare Centers (FQHC), Indian Health Services, the Veterans Administration, public health clinics, and hospital emergency rooms have provided care to many of the state's uninsured. In 2014, up to 172 thousand of the state's uninsured population will receive coverage, either through Medicaid expansion or through participation in the health insurance exchange. The newly insured population is expected to include a mix of relatively healthy individuals and chronically ill patients. As with most newly-insured populations, pent up demand will initially drive an early, enhanced pressure for healthcare and related services.

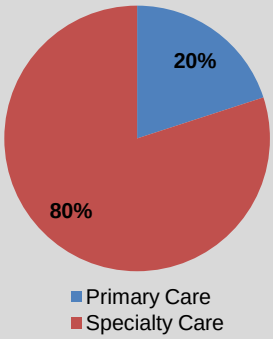
The number of healthcare professionals and their maldistribution throughout the state cannot adequately meet current demand, let alone the additional pressures brought about by the newly insured in 2014. In the near-term, the lack of supply will result in longer wait times to see a provider and more difficulty accessing specialists. As New Mexico's population expands and becomes proportionately older, the state can expect even greater healthcare access problems. Problems will become paramount unless the state employs a more coordinated approach to healthcare service delivery.

This evaluation addresses the adequacy of New Mexico's health system to meet the demands brought about by the implementation of the ACA, exploring current, near-term, and anticipated long-term demand for preventative services and health care and looking at key areas where workforce strategies can be developed to meet demand. Opportunities to address healthcare needs include service delivery systems and patient support structures, recruitment and retention, education and training, and barriers to expanding the workforce, including regulatory and statutory reform.

Healthcare service delivery models that target level of care to patient need are being deployed successfully in the state. About half of the population is basically healthy and can be cared for by NPs and PAs, a professional group that can be trained more quickly and at less cost than physicians. Meanwhile, patients with chronic illness, who consume a disproportionate share of healthcare resources, can benefit from coordinated care using a treatment team of primary care doctors, specialists, case managers, pharmacists, behavioral health specialist and other service providers.

Professionals, such as allied health positions, occupational therapy, physical therapy, radiography, lab technicians, public health workers, emergency

Reported Specialty of 2012 Medical School Graduates



Source: Journal of the American Medical Association

Of the 4,690 doctors actively practicing in the state, only 1,633 (35 percent) list their specialty as primary care.

43.5 percent of New Mexico's practicing physicians report their practice is full and they cannot accept new patients, or they can only accept a few more patients.

medical technicians, are important parts of the healthcare team but were excluded from this report due to time constraints.

Report findings highlight the need for a targeted approach that accounts for the distribution of the population's demand for care and the existing maldistribution of healthcare providers. This evaluation presents opportunities for the Legislature to meet healthcare needs by aligning educational trends to state needs, recruiting and retaining needed professionals, improving the state's regulatory environment, and addressing barriers that prevent the expansion of the workforce.

KEY FINDINGS:

New Mexico's supply of healthcare professionals, particularly in primary care, does not adequately address current needs, let alone those brought about by the ACA and Medicaid expansion, or longer-range demands from population growth and aging. Accurate information about provider supply is limited but improving through the work of the New Mexico Center for Health Care Workforce Analysis at the UNM (UNM), which collects survey data from licensed healthcare professionals.

Despite wide acceptance of a physician shortage, particularly in primary care, the state lacks a strong measure for quantifying shortages. New Mexico has 7,673 licensed medical doctors. However, only 4,690 (61 percent) of these doctors actually practice in the state. The remaining licensees practice in other states, are inactive, or are retired. Of the 4,690 doctors actively practicing in the state, only 1,633 (35 percent) list their specialty as primary care. New Mexico's doctors are not equally distributed across the state with the majority of physicians practicing in the urbanized counties of Bernalillo, Santa Fe, and Dona Ana. When asked about practice plans within the next twelve months, 13.5 percent of New Mexico physicians report that they plan to retire or to significantly reduce their patient care hours.

Applying the Kaiser Foundation ratio of physician population per 100 thousand produces an estimated shortage of 655 doctors. However, most interviewed healthcare professionals seem to place this estimate a bit higher and tend to agree with the UNM Health Sciences Center, which estimates the actual shortage is closer to total 2,000 physicians and roughly 400 to 600 primary care physicians.

Nurse practitioners and physicians assistants could help mitigate the doctor shortage, but their numbers are also inadequate. Nurse practitioners (NPs) and physician assistants (PAs) are growing in importance in the provision of primary care and, in some cases, specialty medicine. New Mexico currently has 970 licensed NPs. Applying the Kaiser Foundation ratio of NPs per 100 thousand population yields a shortage of 236 NPs. The true number is probably much higher. In New Mexico NPs are licensed to practice fully independent of a physician and can perform 70 percent to 80 percent of the procedures performed by a primary care doctor. New Mexico has 577 PAs. PA scope of practice is more limited than that

of NPs because they must have a supervisory physician on their license. However, PAs have the same prescribing authority as NPs and a physician need not be physically present when a PA practices.

New Mexico lacks an accurate and consistent measure for determining provider shortages and needs.

New Mexico has a nursing shortage – as do most other states. No exact benchmarks for how many nurses a population should have exist, but according to the UNM College of Nursing, the state should target the national average, which is 874 nurses per 100 thousand population. Kaiser reports that New Mexico has around 740 RNs per 100 thousand population. Based on the per capita registered nurse (RN) difference between New Mexico and the national average, the target becomes approximately 3,000 additional RNs. Recently the need for additional nurses has been somewhat suppressed by the poor economy, which forces older nurses to continue to work past retirement and tends to make hospitals more conservative in hiring.

HED and DWS data confirm healthcare providers tend to practice near their location of training and are more likely to practice in urban than in rural areas.

New Mexico has too few dentists, and they are maldistributed across the state. Kaiser ranks New Mexico 38th nationally with 1,069 professionally active dentists as of November 2012. Again, this ranking is based on licensure data. It does not accurately reflect those engaged in clinical practice part time versus full time or geographic distribution. According to New Mexico Health Resources (NMHR), a more realistic estimate of practicing dentists in New Mexico is between 700 and 800.

Nine hundred seventy Nurse Practitioners and 577 Physician Assistants are licensed in New Mexico. These advanced practice providers can be trained in roughly one-third of the time and for one-quarter of the cost to train a physician.

The state's supply of dentists suffers from maldistribution. According to information from the New Mexico Regulation and Licensing Department, the vast majority of dentists are concentrated the urban areas of Albuquerque, Santa Fe and Las Cruces. Kaiser Family Foundation estimates that the state needs 155 more dentists to achieve a satisfactory target population-to-practitioner ratio. NMHR places this need closer to 400 more practicing dentists.

New Mexico also experiences a pronounced shortage of clinically-trained behavioral health professionals. To adequately provide for the state's mental health and substance abuse treatment needs, New Mexico needs additional psychiatrists, psychologists and masters-level behavioral health counselors. New Mexico currently has 334 licensed psychiatrists and 705 licensed psychologists. How many are actually practicing and employment location cannot be determined from licensure data.

Sixty-one percent of NPs and 67 percent of PAs are concentrated in Bernalillo, Dona Ana, and Santa Fe counties.

The primary source of behavioral health counseling is provided via masters-prepared counselors. In New Mexico, these are generally licensed social workers and licensed professional counselors.

Over 38 percent of the state's population lives in dental health professional shortage areas.

Little information regarding the ideal numbers of behavioral health professionals needed in the state exists. However, most advocates in mental health and substance abuse would agree that a very pronounced shortage exists. Maldistribution is also a major problem as psychiatrists, psychologists and masters-level counselors are more concentrated in the larger population centers of the state and are much scarcer in rural New Mexico.

Given the growing shortage of healthcare professionals and their

Following healthcare reform, wait times for primary care appointments and some specialty care exceeded 40 days in Massachusetts, despite a larger physician population and a lower newly insured rate. New Mexico should anticipate similar wait time increases following ACA implementation.

distribution across the state, New Mexico should expect some deterioration in access to health care in the near-term. Beginning in 2014, as insurance coverage is expanded, it's unlikely that New Mexico will experience a train wreck. To some degree, most New Mexicans will likely experience the effects of the projected shortfall in the numbers and distribution of the healthcare workforce through reduced access to healthcare professionals and longer wait times to see doctors, dentists, and specialists. Expected decreases in hospital emergency department use will not happen overnight because of gradual insurance uptake rates and the continuing shortage of healthcare professionals. In the long run, as the population increases and gets proportionately older, the state will face critical healthcare workforce supply problems if changes are not made to the way healthcare is delivered.

Healthcare service delivery models must also evolve to adequately address New Mexico's healthcare needs. A new approach is needed to determine where resources can be best deployed to meet the varied healthcare needs of the state's population. Workforce planning, recruitment, and training should then follow this strategy, taking into consideration that not every patient needs the same level of care and that care can be delivered in more efficient and effective ways.

According to the National Ambulatory Survey, one billion physician visits are made in the U.S. annually; 57 percent of these visits are made to primary care physicians.

Not all individuals need the same level of healthcare services. Half of the nation's population is basically healthy. However, patients with chronic health conditions require more specialty care and absorb a greater proportion of healthcare resources. The distribution of the U.S. patient population and corresponding use of healthcare resources is characterized by the Kaiser Family Foundation as follows:

- The top 1 percent of the patient population uses about 22 percent of the healthcare resources, or an average $52 thousand per person per year.

The most frequently reported principal reason for a physician visit is to receive a general medical examination.

- Taken together, the top 50 percent of the population uses 97 percent of the healthcare resources, about $4.5 thousand annually per person. Individuals with stable chronic conditions fall into this group as do some patients over 65 years old, as elderly healthcare needs can increase six-fold.

Five percent of patients consume 50 percent of all healthcare resources, or an average of $17 thousand per person annually.

- The bottom 50 percent of the population is basically healthy and requires only preventative care. The percent of the population that falls into this category consumes only 3 percent of the nation's healthcare resources, roughly $900 per person annually.

A smarter service delivery model will target level of care to level of need. In recent years, an approach that targets resources to the level of patient need has begun to evolve. Patients with multiple chronic illnesses benefit from coordinated care using a treatment team of primary care doctors and specialists working with case managers and other service providers. These teams can return complex patients to more stable, healthy lives and reduce the need for future hospitalizations and specialty care. Correspondingly, relatively healthy patients may be best served through low levels of care and preventative approaches. Fair and realistic payment schemes, ones that

Half of the population is basically healthy and needs little more than occasional care.

Hidalgo Medical Services and First Choice serve as effective community-based models which bring coordinated care to the neediest patients and stress prevention and health promotion.

Known Safety-Net Practitioner Vacancies Reported to New Mexico Health Resources February 2013

Medical Doctors	157
Registered Nurses	11
NPs	46
PAs	18
LISWs	9
Pharmacists	14
Dental Hygienists	6
Dentists	30
Physical Therapists	7
Occupational	2

Source: NMHR

Nationally, the average 2012 medical school graduate holds a debt load of more than $166 thousand.

reward healthcare outcomes rather than the volume of procedures, can be developed to support these models.

In the short-term, if the majority of newly insured New Mexicans are relatively healthy, their needs may be met by increasing the state's supply of NPs and PAs and stressing prevention. New Mexico should shift its emphasis from sick care to wellness and prevention, thus redefining the healthcare workforce and delivery of healthcare services beyond the traditional clinical setting. As the state's population grows and ages, the care-coordination, team model will be the most effective and efficient way to address the needs of patients with chronic diseases. The state's approach to healthcare recruitment and training should reflect this targeted approach.

New Mexico needs to better position itself to recruit and retain an adequate workforce in an increasingly competitive environment. Current healthcare provider recruitment is not able to keep up with demand. New Mexico Health Resources (NMHR) recruits candidates for safety net providers, such as community health centers and critical access hospitals. During the last five years, 255 practitioner placements resulted from NMHR referrals. While statewide provider vacancy rates are unknown, NMHR is currently recruiting for 331 vacant positions.

At the medical school level, recruitment into primary care is a considerable challenge because existing pay systems provide incentives for specialty care practice. The annual income gap between primary care physicians and subspecialty physicians exceeds $135 thousand, and medical students are increasingly selecting subspecialties over primary care. Primary care physicians currently account for 35 percent of practicing medical doctors, but this number is rapidly declining. Twenty percent of all U.S. medical students are now choosing primary care specialties. Yet, 57 percent of all patient visits to doctors are made to primary care physicians.

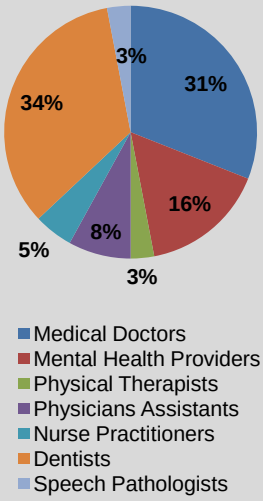
Loan repayment and other financial assistance programs are major incentives to encourage healthcare professionals to work in underserved areas and in primary care. Participation in state and federal programs, including the HED loan-repayment program and the National Health Service Corps, influences practitioner decisions to work in designated medical shortage areas. HED reports funding 48 loan-repayment recipients and 45 loan-for-service recipients in FY13.

Loan-repayment programs seem to provide a better return on investment than scholarship for service programs because practitioners have already selected primary care practice. A 2012 retention study, which included New Mexico, reported substantially more loan-repayment program participants than loan-for-service participants anticipate remaining in their service sites beyond term commitments. Loan-repayment program participants are also less likely to default than loan-for-service recipients.

Pipeline programs help develop a healthcare workforce for underserved

Health Professional Loan Repayment Program Recipients in FY12

total new recipients = 22



Source: HED

Over 70 percent of the state's newly prepared and practicing doctors, pharmacists, PAs, and physical therapists remain in Bernalillo County.

Between 2007 and 2011, New Mexico educated over 4,700 RNs, 263 medical doctors, and 79 physician's assistants.

areas. Research confirms that rural background and specialty preference are associated with physician decisions to work in rural communities. Programs, such as UNM Dream Makers and Forward New Mexico, recruit diverse students into the healthcare pipeline before or during high school. These programs are imperative. The UNM BA/MD program, designed to address the state's physician shortage, admits 28 students each year, and 50 percent of current program participants are minorities. Finally, Hidalgo Medical Service's Forward New Mexico program supports career clubs, enrichment, and academic preparation programs for students in southwestern New Mexico. These pipeline programs will help stimulate interest in health science careers to address shortages in the long-term.

Tort liability laws and tax credits can also serve as incentives for healthcare professionals. Two additional incentives act as tools for recruitment and retention. New Mexico's Medical Malpractice Act limits a provider's personal liability and provides for informal hearings prior to court action. New Mexico's rural tax credit provides a personal income tax credit to healthcare practitioners who provide services in underserved rural areas. During the 2010 tax year, DOH reported that a total of 1,726 recipients took advantage of this tax credit. Almost 50 percent of these were physicians.

Educational strategies may also address the workforce shortage. New Mexico's public and private institutions do an admirable job of educating healthcare professionals but they cannot, by themselves, keep up with growing demand.

Degree production in healthcare professions remained relatively stable between 2007 and 2011, with a few notable exceptions. Between 2007 and 2011, New Mexico educated over 4,700 RNs at various levels. At the same time, New Mexico educated 263 medical doctors and 79 physician's assistants. The state also prepared over 1,000 professionals who may provide behavioral health services, including social workers, substance abuse counselors, and counseling psychologists. The production of RNs declined slightly, while the production of physical therapists, occupational therapists, dental hygienists, and social workers increased during the same period.

New Mexico has not increased the number of nurses educated by the state's public institutions, despite state and national calls for more nurses with bachelor's degrees. In response to the national call for more bachelor-level nurses, New Mexico's colleges of nursing aim to increase the production of BSNs. From FY04 to FY09, $16.5 million in supplemental funding was allocated to New Mexico's public institutions for nursing program enhancement, and $12.2 million was allocated between FY10 and FY13. While the numbers of associate and master-level degrees awarded increased slightly between 2007 and 2011, the number of bachelor degrees produced in-state declined.

Graduate Medical Education residency caps severely limit the numbers of

Between FY10 and FY13, New Mexico allocated $12.2 million in supplemental funding to New Mexico's public institutions for nursing program enhancement and support.

The total number of RN degrees awarded decreased from 1062 in 2007 to 932 in 2011.

Medical residency slots funded by Medicare were capped by the Balanced Budget Act of 1997.

UNMH supports 470 residency slots, most of which are funded through Medicare.

State I&G funds supported 8.1 family medicine residents in FY13.

doctors produced in New Mexico and the United States. To practice medicine, medical school graduates must complete a residency program, also known as graduate medical education (GME). Residencies are primarily supported through Medicare funds, and the total number of funded slots was capped by the Balanced Budget Act of 1997. At the current expansion rate of U.S. medical graduates, the AAMC (AAMC) predicts that the number of graduates from U.S. medical and osteopathic schools will exceed residency slots by the end of the decade, squeezing out applicants from foreign medical schools. International medical graduates make up a disproportionate share of physicians practicing in rural communities.

Nearly five hundred medical residents are working in New Mexico. According to the 2012 National Residency Match Report, 133 new residents matched in New Mexico, and UNM reports that 470 total GME FTE and 120 fellowships were funded in FY13. In 2012, residency programs in New Mexico were located in Albuquerque, Santa Fe, Las Cruces, and Roswell, though Roswell has since lost its accreditation and will not continue to receive residents in the future. In 2008, *House Memorial 2: State Funded Primary Care Residency Slots* recommended increasing the state's 25 family medicine residency slots by 50 percent using recurring general fund appropriations. Since 2008, total family residency slots in New Mexico remain unchanged.

All of the residency slots outside of UNM are devoted to family medicine. Twenty-five doctors began family medicine residency in New Mexico in 2012. While 171 (31 percent) of the residency and fellowship slots at UNM are classified as primary care, many of UNM's primary care residents go on to sub-specialize and ultimately practice specialty care.

The ACA provides new options for GME training which may benefit the state. The ACA created the Teaching Health Center Graduate Medical Education program to support the training of primary care residents and dentists prepared in community-based ambulatory care settings, such as FQHCs. Hidalgo Medical Services, located in southwestern New Mexico, has been approved to become a Teaching Health Center.

Residency programs serve as a major recruitment tool but need to be strengthened in New Mexico. Residency programs help attract and retain practitioners to communities with the greatest medical needs since medical providers tend to establish initial practices near their residency sites. However, UNM's physician survey reveals that only 17 percent attended medical school in New Mexico, suggesting that New Mexico recruits the majority of its physician workforce from out-of-state. Existing medical, nursing, and dental residency programs are insufficient.

Regulatory and practice barriers prevent the full expansion of New Mexico's healthcare workforce. Part of any healthcare workforce strategy should involve an examination of professionals whose roles can be further expanded to extend the impact of the healthcare team. Plans should also identify and reduce barriers to workforce expansion.

The impact of doctors and dentists can be effectively extended through the

Total UNM Residency FTE Funded in FY13, by Specialty

Anesthesiology	31.17
Dermatology	6
Emergency Medicine	33.17
Family Medicine	54.76
General Dentistry	10.60
Internal Medicine	82.13
Neurology	12
Obstetrics/ Gyn.	26
Orthopedic Surgery	25
Pathology	17.7
Pediatrics	46.30
Psychiatry	36.85
Radiology	27.50
Surgery, General	34.50
Neurosurgery	11.66
Ophthalmology	2
Otolaryngology	5.75
Thoracic Surgery	0
Urology	7

Source: UNM HSC

UNM reports 70 percent of dental residents accepted in 2012 are from New Mexico, and 62 percent of dental residents are retained in the state following program completion.

Advanced Care Providers Educated by Public New Mexico Institutions, 2007-2011

MDs	263
NPs	234
PAs	79

Source: HED

expanded use of NPs, PAs and non-dentist practitioners. Part of any healthcare workforce strategy should involve an examination of professions whose roles could be further expanded to extend the impact of the healthcare team. The strategy should also identify barriers to workforce expansion.

New Mexico's limited production of NPs and PAs will inhibit the state's ability to expand its primary care workforce. While medical doctors must complete four years of medical school and a minimum of two years of residency before practicing independently, an NP may be trained in approximately two years after earning a BSN, and a PA requires roughly two years of graduate-level training. NCSL estimates that NPs can be trained at 20 to 25 percent of the cost to train a physician, while a previous LFC evaluation of the UNM HSC estimated the cost to educate a physician exceeds $500 thousand. The UNM College of Nursing estimates educating a BSN-level nurse to the NP level costs roughly $64 thousand. The state's public institutions educated 234 NPs and 79 PAs between 2007 and 2011, while the state's medical school educated 263 physicians during the same period of time.

The state needs to address barriers that prevent the expansion of NP training programs. Despite lower educational costs, the state's production of physicians continues to surpass that of NPs. Colleges of Nursing cite several significant barriers that prevent program expansion. Qualified nursing faculty serve as a barrier to expanding the nursing workforce. Colleges of nursing also report that the discrepancy between nursing faculty salaries and clinical nursing salaries is a significant barrier to attracting qualified faculty. Colleges also cite a limited BSN pool, inadequate clinical placement sites, and credentialing inefficiencies as barriers to expanding the state's NP workforce.

Modifying regulatory statutes that govern other advanced practice providers, including physician assistants and prescribing psychologists, may help eliminate barriers to full practice. PAs may examine, prescribe, and treat patients, and may effectively provide common primary care services but must work under the license and supervision of a physician. Requiring supervision of PA practice may restrict their ability to deliver primary care. Modifying supervision requirements for LISW and prescribing psychologists would facilitate the expansion of the state's behavioral health workforce.

KEY RECOMMENDATIONS:

The Legislature should:

Consider passing legislation to expand state-funded family medicine residencies. To accomplish this objective, the Legislature should appoint a panel of industry experts to study realistic strategies including revisiting the recommendations made in the 2008 Health Policy Commission report on state-funded family medicine residency slots. The study group should make recommendations to the Legislature no later than November 2013.

Expand WICHE funding, expand state-funded rural residencies, create

NCSL estimates the cost to educate an NP is 20 percent to 25 percent of the cost to educate a physician.

Advanced Primary Care Training at UNM

	Length of Training	Credit Hours	Tuition Cost
MDs	6+ years	4 years	$65,000
NPs	2 years	54-56	$31,000
PAs	27	86	$32,000

Source: UNM

Both NMSU and UNM have moved toward replacing master's-level nursing programs with doctoral-level programs, increasing nursing faculty supply but reducing the supply of NPs and advanced practice nurses available to provide direct services.

In New Mexico, the PA scope of practice is more limited than that of NPs.

training programs for dental auxiliaries, and revisit the concept of dental therapists.

Increase appropriations to loan repayment programs as opposed to loan for service programs, which tend to have lower rates of retention.

Work with UNM Health Sciences Center to ensure adequate base funding for the New Mexico Center for Health Workforce Analysis at UNM.

Ensure the Department of Health has adequate resources to carry out its statutory responsibility to conduct workforce planning. The Department of Health should collaborate with the New Mexico Center for Healthcare Workforce Analysis at UNM.

A single agency, such as New Mexico Health Resources, should coordinate all healthcare workforce recruitment for both the public and private sectors in New Mexico.

New Mexico's public universities should not require all NPs to earn a doctorate degree since this may restrict the number of NPs providing direct care. Universities should maintain master's-level clinical nurse training programs.

New Mexico's public universities should report on the feasibility of creating additional master's-level clinical nursing programs.

The Medical Board should revisit the scope of practice for PAs to allow these professionals the same degree of independence that NPs are allowed in the state. PAs should be allowed this independent practice status after completing three to five years of clinical supervision by a physician.

New Mexico's Behavioral Health Licensing Boards should expand the mental health masters degrees that qualify for supervision and licensure, streamlining the requirements for mental health counselor reciprocity with other states, and expanding the capacity for clinical licensure supervision, including the use of teleconferencing to provide supervision to remote sites.
New Mexico's healthcare licensing boards should conduct a comprehensive review of all healthcare professional practice acts to judiciously reduce barriers to workforce expansion.

BACKGROUND

The two principal forces that will expand healthcare coverage are the Affordable Care Act (ACA) and the Medicaid expansion program in New Mexico.

The Affordable Care Act The ACA of 2010, formally titled the Patient Protection and Affordable Care Act, is intended to expand healthcare insurance coverage, to improve healthcare delivery and control costs. The law includes the following key provisions:

1. Requires U.S. citizens and legal residents to have health insurance or pay a penalty
2. Creates state-based health insurance exchanges through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals/families with income between 133 percent to 400 percent of the federal poverty level;
3. Creates separate insurance exchanges through which small businesses can purchase coverage;
4. Requires employers to pay penalties for employees who receive tax credits for health insurance through an exchange, with exceptions for small employers;
5. Imposes new regulations on health plans in the insurance exchanges and in the individual and small group markets ;
6. Expands Medicaid to 133 percent of the federal poverty level;
7. Requires states to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019 and then extend funding for CHIP through 2015; and
8. Provides premium and cost-sharing subsidies to eligible individuals in the exchanges.

Major provisions of the Patient Protection and Affordable Care Act (ACA), including mandatory health insurance, healthcare insurance exchanges and state-optional Medicaid expansion, go into effect on January 1, 2014.

Insurance Exchange New Mexico is creating and operating its version of the mandatory health benefit exchange, through which individuals can purchase coverage. Premium and cost-sharing credits are available to those with incomes between 133 percent and 400 percent of the federal poverty level. The 2013 federal poverty level is $19,530 for a family of three.

Table 1. 2013 Federal Poverty Level

Household Size	100%	133%	150%	200%	300%	400%
1	$11,490	$15,282	$17,235	$22,980	$34,470	$45,960
2	$15,510	$ 20,628	$23,265	$31,020	$46,530	$62,040
3	$19,530	$ 25,975	$29,295	$39,060	$58,590	$78,120
4	$23,550	$ 31,322	$35,325	$47,100	$70,650	$94,200
5	$27,570	$ 36,668	$41,355	$55,140	$82,710	$110,280
6	$31,590	$ 42,015	$47,385	$63,180	$94,770	$126,360
7	$35,610	$ 47,361	$53,415	$71,220	$106,830	$142,440
8	$39,630	$ 52,708	$59,445	$79,260	$118,890	$158,520
For each additional person, add	$4,020	$5,347	$6,030	$8,040	$12,060	$16,080

Source: Families USA

The individual mandate provision of the ACA requires U.S citizens and legal residents to have qualifying health coverage or pay a tax penalty. By 2016, this penalty becomes the greater of $695 per year or 2.5 percent of income. The penalty will be phased-in according to the following schedule: $95 in 2014, $325 in 2015, and $695 in 2016. After 2016, the penalty increases annually by the cost-of-living adjustment.

While the ACA expanded insurance coverage to an additional 48.6 million people nationally, universal coverage does not equal universal access (U.S. Census Bureau). There are exemptions from this penalty available for identified groups, such as Native Americans. Depending upon the insurance premiums available in the exchange, some individuals will likely chose the penalty over insurance coverage.

Additionally, estimating the exact size and make-up of New Mexico's uninsured population remains difficult. Uncertainty and disagreement surround estimates of the state's uninsured population, which range from 400 thousand to 430 thousand, though several groups have attempted to measure and describe this group. The Human Services Department (HSD) reports that in New Mexico, 35 percent of Native Americans, 22 percent of Hispanics, and 13 percent of non-Hispanic whites are uninsured. In 2012, the Hilltop Institute used 2009 U.S. Census data to project the 2012 uninsured population and reported that the largest proportion of the state's uninsured are poor adults. The U.S. Census Bureau estimates approximately 20 percent of the uninsured population comprises undocumented immigrants. In 2008, Pew Research Hispanic Institute study estimated between75 thousand and 85 thousand undocumented immigrants lived in New Mexico.

Table 2. Percent of Uninsured by Federal Poverty Level (FPL), 2009

Total Estimated Uninsured= 428,249
FPL= $23,050 annual income for family of four

Age Group	Below 100% FPL	100%-199% FPL	200%-299% FPL	300%-399% FPL	400%+ FPL	Total
0 to 17	9%	3%	2%	1%	0.7%	**15.7%**
18-64	26%	22%	15%	7%	12%	**82%**
65+	0.6%	0.6%	0.2%	0.2%	0.4%	**2%**
Total	**35.6%**	**25.6%**	**17.2%**	**8.2%**	**13.1%**	

Source: Hilltop Institute

Quantifying demand increases remains difficult as uncertainty about the demographics of the uninsured population and how their healthcare decisions will change with the implementation of the ACA are unknown. Determining how many New Mexicans will enroll in the health insurance exchange is difficult. HSD uses a range of enrollment estimates derived from three sources:

Table 3. Projected Enrollment in the New Mexico Health Insurance Exchange

	2014	2015	2016	2017	2018	2019	2020
Hilltop Institute	52,055	96,718	106,958	118,397	127,549	134,796	141,930
Congressional Budget Office	63,020	101,331	167,361	182,893	191,240	192,287	185,913
Leavitt Partners	73,876	102,605	128,637	153,389	173,855	172,779	177,574

Source: NMHSD -- January 17, 2013

Medicaid Expansion New Mexico adopted the ACA provision that allows states to expand Medicaid eligibility to 138 percent of the federal poverty level (FPL). Medicaid currently provides healthcare coverage to approximately 560 thousand New Mexicans, mostly dependent children. The expanded program will extend eligibility to another 170 thousand individuals. The New Mexico Human Services Department (HSD) estimates that about 137 thousand new individuals will actually enroll in Medicaid. This number will grow to 167 thousand by FY20.

Table 4. Estimated Medicaid Enrollment under ACA (up to 138 percent FPL)

	FY14	FY15	FY16	FY17	FY18	FY19	FY20
Baseline	554,274	574,773	588,787	602,402	616,304	630,503	645,002
Woodwork*	14,089	15,677	17,292	18,910	20,587	22,265	22,538
Expansion **	123,019	136,081	149,075	150,067	146,979	147,775	144,492
Total	691,382	726,531	755,154	771,379	783,870	800,543	812,033
Net ACA Change	**137,108**	**151,758**	**166,367**	**168,977**	**167,566**	**170,040**	**167,030**

Source: NMHSD -- January 17, 2013

*Enrollment by those who are already eligible but enroll primarily because of the mandate
**Includes those formerly covered by State Coverage Insurance Program.

According to the HSD, 39 thousand individuals are currently enrolled in State Coverage Insurance (SCI) and are included in the newly eligible for Medicaid estimate, leaving 98 thousand New Mexicans newly covered by health insurance.

The effect of healthcare insurance coverage under the ACA and Medicaid expansion is expected to increase the demand for healthcare services in New Mexico in 2014, with gradual expansion in outgoing years.

DEMAND FOR HEALTHCARE IS DRIVEN IN THE NEAR-TERM BY EXPANSION OF THE INSURED POPULATION AND IN THE LONGER TERM BY POPULATION GROWTH AND AGING

New Mexico's newly insured population will be unevenly distributed and demand more care. With the implementation of the ACA in 2014, New Mexico's previously uninsured population will fall into three general categories. When New Mexico's insurance exchange and the Medicaid expansion are implemented in 2014, currently uninsured New Mexicans will include: those newly eligible for Medicaid, those projected to participate in the insurance exchange, and those who will remain uninsured either because they choose not to participate in the insurance exchange or because they are undocumented immigrants. Additional detail about these groups may be found in **Appendix J.**

Table 5. New Mexico's Previously Uninsured Population Following ACA Implementation

Newly Eligible Medicaid (~170,000 eligible, including the 39,000 currently enrolled in SCI)*	Exchange Participants (~189,000 eligible for subsidies)	Remaining Uninsured
Projected enrollment (HSD): 137,000 in 2014 167,000 by 2020	Projected enrollment: 52,000 to 75,000 in 2014 144,000 to 177,000 in 2020	Urban Institute Projection:~ 240,000 (12% of the population)
Predicted Demographics	**Predicted Demographics**	**Predicted Demographics**
Mix of healthy and chronically ill adults Initial enrollees will have the most significant healthcare needs Poorest individuals will be the most likely to enroll and have the highest levels of morbidity and chronic disease, as compared to adults with incomes closer to 138% of the FPL	Enrollees will be relatively older, less educated, have lower incomes, and be more racially diverse than individuals privately insured prior to the ACA Adults between the ages of 19 and 64 will account for 64 percent of enrollees, and the average age of enrollees with be approximately 35 52 percent of enrollees will be male and 48 percent will be female Likely enrollees report being in worse health but having fewer diagnosed chronic conditions than individuals privately insured prior to the ACA	This group will be composed of undocumented immigrants and individuals who elect not to obtain coverage This group is predicted to be of greater income and better health than the population predicted to enroll in the Exchange. However, individuals who elect not to purchase insurance are predicted to be of lower income than people projected to enroll in the private insurance market

Source: LFC analysis

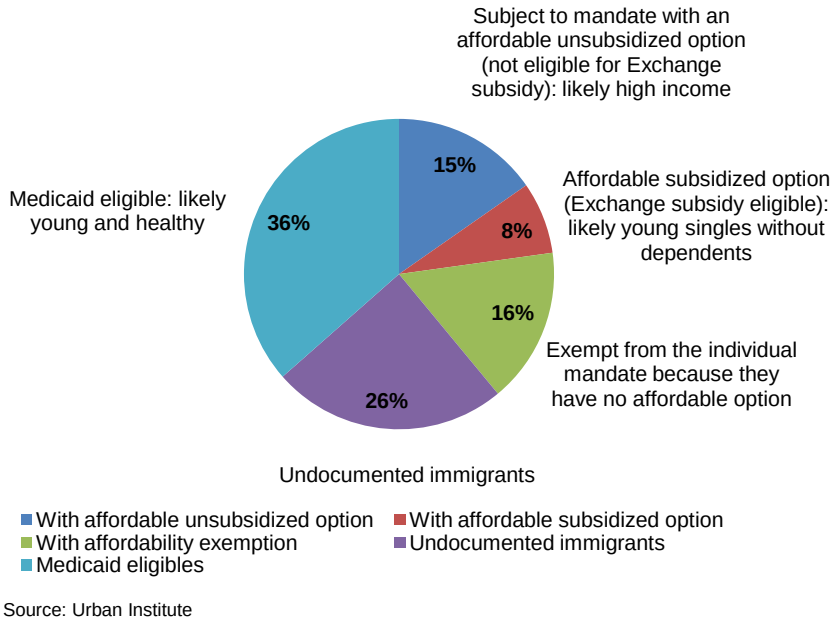
*The projected Medicaid enrollment of 137 thousand in 2014 includes 39 thousand individuals currently enrolled in State Coverage Insurance, who will be transferred to Medicaid.

New Mexico's uninsured population is not evenly distributed. According to the U.S. Small Area Health Insurance Estimates of 2010, the counties with the largest uninsured population are Bernalillo (116,535), Dona Ana (46,450) and San Juan (33,447), while McKinley, Catron, and Harding counties have the highest uninsured rates in the state. Luna, Dona Ana, and Hidalgo counties have the highest rates of uninsured adults who are predicted to qualify for Medicaid under the approved expansion (**Appendix L**)**.** Newly insured patients are expected to seek services in their communities, and counties should expect varying levels of new demand for services in 2014.

Despite the ACA individual mandate, the state should not expect all New Mexicans will obtain insurance. Medicaid has always experienced under-enrollment, and individuals who do not qualify for Medicaid may elect to pay the penalty for not obtaining insurance rather than to purchase coverage. Kaiser estimates one-third of the

currently eligible Medicaid population remains uninsured. Massachusetts reported that 3.4 percent of the state's population remained uninsured five years after implementing healthcare reform and began with a considerably lower uninsured rate (9.6 percent) than New Mexico now experiences (21 percent).

Chart 1. Distribution of Nonelderly Uninsured Adults Under the ACA
n= 19 million Americans



Source: Urban Institute

The Hilltop Institute predicts Medicaid take-up rates will vary among the state's population and range between 52 percent and 62 percent. Take-up among Native Americans, exempt from the ACA mandate, is expected to be only 20 percent. However, additional New Mexicans who are currently eligible are expected to enroll in Medicaid as a result of the ACA. This enrollment is categorized as the "woodwork effect." By FY19, HSD forecasts 800 thousand eligible New Mexicans will enroll in Medicaid, including a base of 630 thousand enrollees, 22 thousand individuals who enroll because of the "woodwork effect," and 148 thousand individuals who will enroll as a result of Medicaid expansion.

Resource utilization by newly-insured individuals will likely be influenced by pent-up demand. Rather than being simply a change in the source of payment for healthcare, the ACA will produce an increase in the level of care received by New Mexicans who are currently without insurance coverage. Insured and uninsured patients utilize healthcare differently, as the uninsured often choose not to seek elective or primary care. Insured patients tend to make a quarter to two and a half more primary care visits per year than uninsured patients, suggesting that the state should assume that newly insured patients will seek previously deferred care. Research also suggests that pent-up demand for physician care exists among aging patients, as new Medicare beneficiaries make 30 percent more physician visits during the two years following enrollment (Chen et. al 2004).

The HSD reports pent-up demand when newly-insured clients begin receiving State Coverage Insurance (SCI) or enroll in the coordination of long-term services (CoLTS) program. Thus, while quantifying the behavior of newly insured patients may remain difficult, New Mexico should assume pent-up demand will influence the volume of services sought by patients gaining insurance coverage.

Estimating if and where New Mexico's uninsured are currently receiving health care remains difficult. Some of the uninsured are receiving care from government or tribal programs, while others appear to be using New Mexico's healthcare safety net. The implementation of the ACA will bring about a change in the way that many New Mexican's receive healthcare. Currently, many of the estimated 400 thousand-plus uninsured New Mexicans are receiving primary care services through the state's system of rural health clinics, federally qualified health centers (FQHC), Indian Health Service (IHS), the Veteran's Administration (VA) and, to some degree, hospital emergency rooms. An unspecified number of the uninsured receive no health care – either because they are young and relatively healthy or for some other reason.

In 2011, New Mexico's FQHCs provided primary care services to 111,181 uninsured patients. The uninsured population represented 39 percent of the total patient census that year. These uninsured patients were distributed across the state as follows:

Table 6. Distribution of Uninsured FQHC Patients in New Mexico

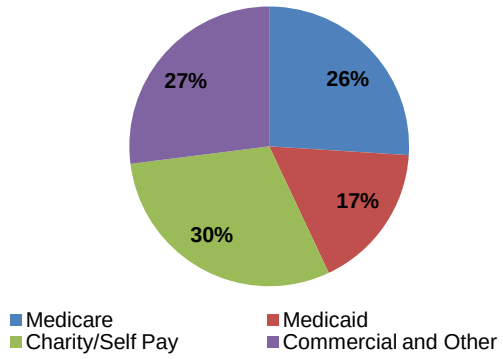
Central	Southwest	Southeast	Northeast	North Central	Northwest
35,888	28,853	15,287	1,791	22,128	7,234

Source: New Mexico Primary Care Association

Though most healthcare professions agree that emergency departments (ED) serve as default sources of primary care among uninsured patients, trying to determine the exact degree of ED use by the uninsured is difficult. The Center for Disease Control and Prevention reports that uninsured adults are more likely than insured adults to report visiting the ER because they have no other place to receive care. The Pew Center on the States 2010 report revealed that 800 thousand Americans per year use the ED for dental emergencies annually.

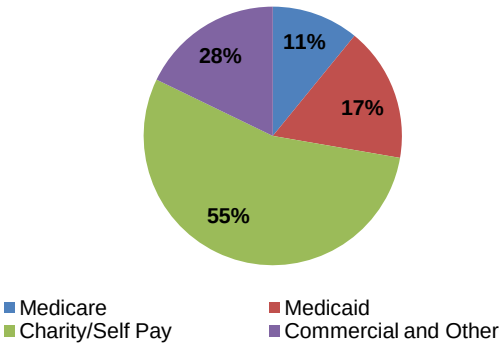
The UNMH reported 25,678 ED visits during the last half of 2012. Seventy-nine percent of these patients were discharged home, rather than being admitted to the hospital. Of these, 17 percent were Medicaid recipients, and 55 percent were considered self-pay or charity care.

Chart 2. Patients Admitted to UNMH from the Emergency Department



Source: UNMH

Chart 3. Patients Discharged Home from the UNMH Emergency Department



Source: UNMH

The ACA intends to reduce the use of urgent care and emergency rooms for non-emergent conditions. With Medicaid expansion and increased coverage under the ACA, patients should have more choices, and providers who previously absorbed the cost of uncompensated care will begin to see some level of reimbursement. However, as primary care providers will not likely be able to meet demand in the short-term, the newly insured will likely continue to use EDs as their principal source of care initially.

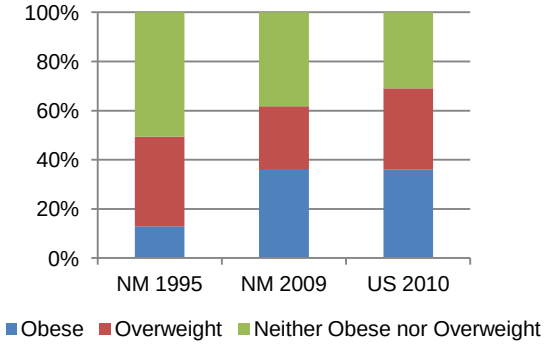
New Mexico's Department of Health (DOH) emphasizes population-based public health services and research. However, when necessary, the Public Health Division provides direct services delivered in a one-to-one clinical setting. These direct services are provided where the existing healthcare workforce cannot meet a particular need. For example, DOH provides prenatal care in the southeast region of the state. The Public Health Division does not purport to be a fully-integrated primary care system, nor do they want to be. Where service gaps exist, DOH can provide direct services to individuals, including the uninsured. DOH will take on a greater role in assuring that the evolving health care system is responsive to the ACA.

Indian Health Services (IHS) and Veterans Affairs (VA) also provide services for qualifying patients. See **Appendix J.**

Demand will be shaped, in part, by the specific demographics of New Mexico. Access to care in New Mexico is limited. Thirty-two of New Mexico's 33 counties are designated as health professional shortage areas (HPSA). According to the U.S. Health Resources and Services Administration (HRSA), a primary care HPSA is based on a ratio of one primary care physician to 3.5 thousand population, a dental HPSA is based on a ratio of 1 dentist to 5 thousand population and a mental health HPSA is based on one psychiatrist to 30 thousand population. As the insured population grows, epidemiological trends in New Mexico suggest further stress on demand for medical and mental health resources in the state. The following trends will only further increase demand for care in the state as the state ages and rates of chronic conditions rise:

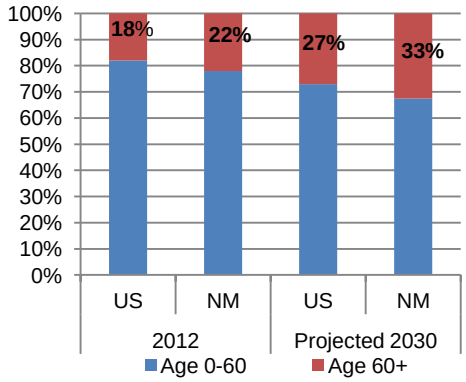
- By 2030, New Mexico's Aging and Long Term Services Department projects the state will rise from 39th to 4th in the nation with respect to the proportion of the population that is age 65 or older;
- The U.S. Administration of Aging predicts 33 percent of the state's population will be age 60 or older by 2030;
- Sixty-two percent of adults in New Mexico were overweight or obese in 2009;
- Morbid obesity (defined as 100 pounds or more overweight) doubled in New Mexico during the last decade; and
- Twenty-one percent of New Mexico third graders are obese.

Chart 4. Increase in Obesity Prevalence



Source: DOH

Chart 5. Percent of the Population Over 60



Source: NM ALTD

Because behavioral health concerns are prevalent in New Mexico, expansion of insurance coverage will likely increase the population's demand for mental health services. States that have expanded public insurance coverage, including Oregon, report the utilization of mental health services among newly covered childless adults is significantly greater than that of previously eligible adults.

- Over the last 15 years, the death rate for alcohol-related chronic diseases, such as cirrhosis of the liver, has increased to almost twice the national average, and New Mexico is ranked first in the nation in alcohol-related mortality;

- Injury death rates attributable to alcohol abuse are almost twice the national rate;
- Overdose death rates from illicit drugs and prescription drugs (particularly opioids) have increased 150 percent in the past five years and according to DOH, the state is second in the nation in substance abuse overdoses;
- In 2011, 29.1 percent of New Mexico high school students felt persistent sadness or hopelessness;
- Behavioral health surveys estimate 9.1 percent of the state's adult population suffers from depression.

Regional health disparities also shape demand. DOH notes that health status can vary according to a number of factors, including geographic location. Pronounced disparities are apparent among the five major health regions. For example, Chaves, Curry, De Baca, Eddy, Harding, Lea, Quay and Roosevelt counties, tend to have the worst health status, with high rates of diabetes, asthma, heart disease, cancer, chronic lower respiratory disease, and cerebrovascular disease.

Table 7. Leading Causes of Death by Region, NM, 2011
Deaths per 100,000 per year

	NW	NE	Metro	SW	SE
Heart Disease	143.9	120.2	145.8	147.8	185.5
Cancer	144.0	130.9	139.5	146.1	157.2
Unintentional Injury	83.1	75.8	59.7	47.8	60.9
Chronic Lower Respiratory Disease	45.2	36.0	42.8	45.9	66.1
Cerebrovascular Disease	21.1	27.4	37.3	32.8	32.3
Diabetes Mellitus	38.5	28.4	25.0	22.2	25.8
Drug Overdose	14.9	34.7	28.5	23.7	20.4
All Causes	800.3	678.9	721.4	720.9	825.8

Source: New Mexico Death Certificate Database, Office of Vital Records and Statistics of Health Indicator-Based Information

Pockets of disparity exist throughout the state. For example, immigrants tend to have lower levels of drug overdose, lower alcohol-related mortality, less chronic disease, and lower suicide rates. Native Americans tend to have high rates of injury deaths, alcohol-related problems, and suicide. A thorough analysis of New Mexico's health status, and the demand for healthcare services, needs to take into consideration these sub-state factors. Notably, regional health disparities that drive healthcare demand are not always in sync with the distribution of healthcare resources in the state, as will be discussed later in this report.

NEW MEXICO'S SUPPLY OF HEALTHCARE PROFESSIONALS, PARTICULARLY IN PRIMARY CARE, DOES NOT ADEQUATELY ADDRESS CURRENT NEEDS, LET ALONE THOSE BROUGHT ABOUT BY THE ACA AND MEDICAID EXPANSION

Accurate information regarding New Mexico's current and projected supply of healthcare workers remains vague. The state has no mechanism for accurately collecting information on the number of professionals practicing in New Mexico. For example, information on physicians practicing in rural areas is only available from the rural healthcare practitioner tax credit program. Most information regarding healthcare practitioner distribution is gathered from licensure data. As practice addresses have not been verified, determining if a person is licensed but not practicing, or is practicing in multiple locations, in different counties, or in another state is impossible. The number of hours an individual works, or provides direct care, is also unavailable via licensure data.

Data availability is improving with the transfer of health professional licensure and survey data from DOH to the UNM Health Sciences Center (UNMHSC). As a condition of New Mexico licensure, healthcare professionals are now required to complete a survey providing, among other things, more specific information regarding hours and locations of practice. The first year of this data is presently being analyzed by the New Mexico Center for Health Workforce Analysis at UNMHSC. The entire study should be available later this year. Physician survey information for 2011 through 2012 is now available.

Despite wide acceptance of a physician shortage, particularly in primary care, the state lacks a strong measure for quantifying shortages. According the UNM Workforce Analysis Center 7,673 medical doctors are licensed in New Mexico. However, only 4,690 (61 percent) of these doctors practice in the state. The remaining licensees practice in other states, are inactive, or are retired.

Of the 4,690 doctors actively practicing in the state, only 1,633 (35 percent) list their specialty as primary care. New Mexico's primary care doctors spend about 83 percent of their time providing direct patient care, and 70 percent of their practices are in outpatient or clinic settings. The survey data does not reveal the numbers of New Mexico doctors who practice part time. A number of physicians have likely cut back practice hours in anticipation of retirement.

The nation lacks standardized benchmarks for determining the ideal size of a physician population. For example, a 2009 estimate by Dr. Daniel Derksen, former director of the New Mexico Office of Health Care Reform, used two standards patient panel to primary care physician ratios: 1,250 patients and 1,500 patients. Based on a 1,250 patient standard, the report determined that the state is short 380 primary care physicians, while a 1,500 patient standard indicates the state is short 112 primary care physicians.

A standard of physicians per 100 thousand population is also commonly cited but is misleading. According to the Kaiser Foundation, in 2008, the national average ratio was 257 physicians per 100 thousand population. Applying this standard in New Mexico translates to 5,355 doctors, suggesting a shortage of 655 doctors. However, as the Health Policy Commission pointed out in a 2006 report, using ratios alone to project long-term needs or shortages fails to account for population aging or usage rates. According to a UNMHSC report to the HHS, New Mexico has a current shortage of approximately two thousand physicians. The same report places the state's primary care physician shortage between 400 and 600 doctors.

The AAMC reports a national shortage of more than 13 thousand physicians and predicts that this shortage will continue to expand. The AAMC believes that within 5 years the nation will experience a deficit of 62,900 physicians. This shortage is expected to double by 2025.

Table 8. National Projections for Full-Time Physicians Active in Patient Care

Year	Physician Supply (All Specialties)	Physician Demand (All Specialties)	Physician Shortage (All Specialties*)	Physician Shortage (Non-Primary Care Specialties)
2008	699,100	706,500	7,400	**None**
2010	709,700	723,400	13,700	4,700
2015	735,600	798,500	62,900	33,100
2020	759,800	851,300	91,500	46,100
2025	785,400	916,000	130,600	64,800

Source: AAMC Center for Workforce Studies

A 2012 report in the *Annals of Family Medicine* used census data to predict how many doctors will be needed as the population grows, ages, and gains access to insurance and what proportion of the need increase may be attributed to each of these drivers. The main driver of provider demand is population growth, accounting for 63 percent of the need, followed by the aging of the population, accounting for 19 percent of the need. Lastly, 15 percent of the need for new primary care physicians is driven by expansion of the newly insured.

UNM survey data reveal that 43.5 percent of New Mexico physicians report that their practice is full or they can only accept a few more patients. The traditional image of the solo, private practice physician is disappearing. Sixty-four percent of New Mexico physicians practice in groups of three to ten or more physicians. About one-third of physicians work in independent practice; the remainder work for hospitals, clinics, agencies, government facilities, or corporate practices.

New Mexico experiences shortages among other key healthcare practitioners. Nurses, PAs, therapists, behavioral health providers, and dentists provide essential services but are also in short supply.

New Mexico has successfully integrated NPs into the healthcare workforce because of the state's expansive practice act. A NP is an RN with an advanced graduate education, including extensive clinical training in medicine. NPs must have a master's or doctorate-level degree to be licensed. Approximately 970 NPs are licensed in the state, according to the New Mexico Board of Nursing. The Kaiser Foundation (2011) cites the national average as 58 NPs per 100 thousand population. If New Mexico applies the national average to its population, the state requires 1,206 NPs. To reach the national average, New Mexico will need approximately 236 more NPs. UNM surveyed provider organizations about their current need for NPs and received 110 reports from providers requesting NPs. Presbyterian Health Care alone reported a need for 60 additional NPs.

New Mexico has 577 licensed PAs. Nationally, New Mexico ranks 31st in the nation with 29 PAs per 100 thousand population. However, this ratio is still above the national average of 27 PAs per 100 thousand. Although PAs can be an effective workforce extender in primary care, particularly in rural areas, currently they tend to work in hospitals with physicians, often as part of a surgical team.

Despite the fact that more RNs are practicing in the United States than at any other point in history, New Mexico has a nursing shortage – as do most other states. Though no benchmark for ideal nursing supply size exists, the UNM College of Nursing suggests the state should aim for the national average, 874 nurses per 100 thousand population. Based on 2011 data, New Mexico ranks 44th in the nation with 740 RNs per 100 thousand population and requires 3 thousand additional nurses.

The New Mexico Center for Nursing Excellence reports the current number of licensed nurses with New Mexico residency as 19,402. The Center also reports a current employment rate of New Mexico nurses of 80.5 percent, approximately 15.6 thousand nurses in the workforce. The Center's director, Pat Boyle, indicates that there is very little information on the demand for nurses from employers. Estimates of nursing demand generally take into consideration retirement rates, new demand driven by the Affordable Care Act, and population growth. In 2009, the House Joint Memorial 40 taskforce reported that New Mexico will face an estimated shortage of 5 thousand nurses by the year 2020.

Estimates of the national nursing shortage range from 300,000 to 1 million RNs by 2020. In a 2012 study published in *Public Health Resources*, researchers used projected changes in population and age to develop demand and supply models to forecast the nursing shortage in all 50 states. The model projected a severe shortage throughout the county by 2030, with the western region (including New Mexico) having the largest shortage.

Kaiser ranks New Mexico 38th nationally with 1,069 professionally active dentists as of November 2012 (see **Appendix F**). However, this ranking is based on licensure data and does not accurately reflect dentists engaged in full-time clinical practice. According to Jerry Harrison of NMHR, a more realistic estimate of practicing dentists in New Mexico is between 700 and 800. Kaiser reports that in 2012 over 38 percent of New Mexico's population lived in a dental health professional shortage area, and 25 percent of the state's population (over half a million people) remains underserved. Kaiser estimates an additional 155 dentists are needed to achieve a satisfactory population-to-practitioner ratio. New Mexico Healthcare Resources places this need closer to 400 more practicing dentists.

Additionally, the Dental Board reports 997 dental hygienists licensed in the state, though the number of hygienists in practice is unknown (see **Appendix F**). In 2012, 44 percent of the state's hygienists reported licensure addresses in Bernalillo County; 9 percent listed Dona Ana County, and 12 percent listed Santa Fe County.

New Mexico has 1,700 Registered Pharmacists. The UNM College of Pharmacy produces about 86 pharmacists per year, and 85 percent to 90 percent of these graduates are from New Mexico. The College estimates that 62 percent of all pharmacists practicing in New Mexico are UNM alumni.

Nationally, the pharmacist workforce is experiencing growth; the number of pharmacy schools recently expanded from 80 to 129 nationally and is still growing, according to UNM. National estimates place the number of required pharmacists at 30,000 by 2020 – largely driven by the ACA. Determining the need for pharmacists in New Mexico is more difficult, since the actual numbers of practicing pharmacists and practice locations have not been determined with any precision. However, more accurate information is anticipated with the full implementation of licensing surveys in the state.

Currently, New Mexico has 334 psychiatrists, representing 14 percent of all medical specialists. Though evidence regarding the adequacy of New Mexico's supply of psychiatrists is largely anecdotal, appointment wait times reported by UNM's Center for Behavioral Health Training and Research suggest the existing supply is woefully inadequate. Shortages tend to be more pronounced in rural areas and are felt at the national level as well; the Department of Veterans Affairs reports a 20 percent psychiatrist vacancy rate in its VA hospitals.

Behavioral health services are primarily provided by master's-prepared counselors and social workers. The New Mexico Social Work Board is responsible for overseeing the licensing of social workers with varying levels of education. At the highest level, LISWs undergo considerable supervised clinical training, are able to operate under their own license, and bill independently. LMSWs have passed a licensing test and are eligible for additional training under an LISW to achieve independent status but cannot bill independently. The New Mexico Social Work Board reports that 1,668 LISWs are currently licensed in the state.

The state's other major group of behavioral health professionals is licensed through the New Mexico Counseling and Therapy Practice Board. Counseling preparation ranges from certificate programs directed at treating substance abuse problems, to fully independent master's-level counselors. A total of 4,354 behavioral health professionals are currently licensed by this board.

The New Mexico Psychological Board reports that 705 licensed psychologists are currently licensed in the state. In New Mexico, this doctoral-level professional group tends to engage in psychological testing and sophisticated diagnostic work.

New Mexico is one of only a few states that provides for the licensing of psychologists who are allowed limited prescribing privileges under consultation with a primary care physician. Preparation essentially involves an American Psychological Association accredited, post-doctoral master's program with strict training and supervisory requirements. Legislation enabled the prescribing psychologist practice in 2002, largely in response to the state's psychiatrist shortage. Presently, 39 prescribing psychologists are licensed in New Mexico.

Table 9. Mental Health Providers Licensed in 2013

Counseling Board	
Licensed Alcohol and Drug Abuse Counselors	650
Licensed Professional Clinical Counselors	1875
Licensed Mental Health Counselors	832
Licensed Marriage and Family Therapists	314
Licensed Professional Counselors	357
Licensed Substance Abuse Associate	326
Psychological Board	
Psychologists	705
Prescribing Psychologists	39
Social Work Board	
Licensed Bachelor's Social Workers	650
Licensed Master's Social Workers	1,296
Licensed Independent Social Workers	1,668

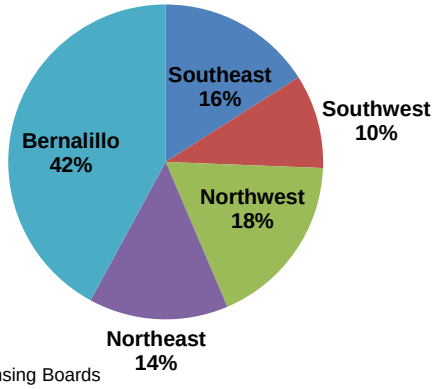
Source: New Mexico Regulation and Licensing Department

Little information regarding the ideal numbers of mental health counselors needed in the state exists. However, most advocates in mental health and substance abuse agree a pronounced shortage of effective, trained counselors exists. Unfortunately, the number of substance abuse counselors is also declining. According to the *2012 New Mexico Substance Abuse Prevention and Treatment Block Grant – Independent Peer Review Committee Annual Report*, the pool of licensed professional applicants to substance abuse treatment agencies continues to shrink. A declining provider pool may result in "possible deficiencies during auditing and accreditation visits." While the committee is not certain about the cause of this decline, low salary, lack of third party payee/resources, lack of license reciprocity, and non-competitive salaries for potential candidates may be contributing factors. The cost of training and licensure in the field of substance abuse may also be a disincentive, reported the committee.

Maldistribution is also a significant problem among New Mexico's healthcare workforce. Approximately half of New Mexico's population is concentrated in three counties with urban areas: Bernalillo (32 percent), Dona Ana (7 percent) and Santa Fe (10 percent). Yet survey and licensure data reveal that a disproportionate majority of the state's healthcare workforce is concentrated in the counties where many of the state's major medical centers are located.

DOH's Public Health Division points to regional disparities in the distribution of healthcare resources in New Mexico that correspond to significant differences in healthcare outcomes. Typically, regions in New Mexico with the greatest health outcome disparities also experience disproportionate provider shortages. New Mexico's healthcare workforce is concentrated in Bernalillo County, while the southern regions of the state tend to experience more pronounced shortages.

Chart 6. Distribution of Healthcare Workforce in New Mexico



Source: UNM & Licensing Boards

New Mexico's doctors are not equally distributed across the state. While the urbanized counties of Bernalillo, Santa Fe, and Dona Ana comprise roughly 49 percent of the state's population, over 58 percent of the state's primary care physicians practice in these counties. Similarly, 60 percent of the state's internal medicine specialists, 65 percent of its surgeons, and 65 percent of other specialists are concentrated in these three counties.

In an older but still relevant study, Johnson et al (2006) assessed disparities in provider availability in rural and urban areas and found that primary care physicians were over four times more available in urban areas than in rural New Mexico. Similar ratios were found for other physician groups, and the availability of registered nurses in urban areas was twice that of rural areas as well. New Mexico could explore ways that hospitals, particularly sole community providers, and managed care organizations may expand rural primary care networks.

Table 10. Urban/Rural Physical Health Provider Disparities in New Mexico

Provider Group	Rural		Urban		Disparity Ratio*
	Number	Ratio of Provider to Population	Number	Ratio of Provider to Population	
Primary care physicians	630	1:1824	1586	1:429	4.25
Family practice	229	1:5017	369	1:1843	2.72
OB/GYN	52	1:22095	127	1:5356	4.13
Emergency Medicine	47	1:24445	125	1:5442	4.49
Pediatrics	78	1:14730	271	1:2510	5.87
Internal Medicine	223	1:5152	629	1:1081	4.76
PAs	146	1:7869	163	1:4173	1.89
Registered nurses	2566	1:448	3581	1:190	2.36
NPs	231	1:4974	329	1:2068	2.41

Source: Administration and Policy in Mental Health and Mental Health Service Research

*Disparity ratio = number individuals served per provider in rural area divided by number served per provider in urban area.

The availability of NPs and PAs in urban areas is approximately twice that for rural areas, suggests 2006 data. Nursing licenses suggest that roughly 61 percent of NPs and 67 percent of PAs are concentrated in Bernalillo, Dona Ana, and Santa Fe counties. Again, licensure data does not specify practice location(s) but does tend to reinforce the notion that practitioners are more available in the larger, urban areas of the state.

According to information from NMRLD, the vast majority of dentists are concentrated in the urban areas of Albuquerque, Santa Fe, and Las Cruces. As stated in the 2008 Western Interstate Commission on Higher Education (WICHE), the dental workforce is designed to work primarily in private practice. This model has been successful for providers but, "has been ineffective in expanding access to dental care for underserved populations." According to NMHR, the majority of Albuquerque dentists are practicing in the northeast heights.

Behavioral health professionals (psychiatrists, psychologists and master's-level counselors are much scarcer in rural New Mexico than in urban centers. Psychiatrists are seven times more abundant in urban New Mexico than in rural areas in the state. Additionally, psychologists were almost six times more accessible in urban areas than in rural communities. Social workers were two and one-half times more prevalent in urban areas, and counselors were almost three and one-half times more prevalent in urban versus rural areas. Disparities have not likely changed significantly since this data was collected in 2006.

Table 11. Urban/Rural Mental Health Provider Disparities in New Mexico

Provider Group	Rural		Urban		Disparity Ratio*
	Number	Ratio of providers to population	Number	Ratio of providers to population	
Psychologists	104	1:11,047	366	1:1,859	5.94
Psychiatrists	54	1:21,276	229	1:2,970	7.16
Social Workers	1122	1:1,024	1672	1:407	2.52
Mental Health Counselors	680	1:1,690	1370	1:497	3.40

Source: Administration and Policy in Mental Health and Mental Health Service Research
*Disparity ratio = number individuals served per provider in rural area divided by number served per provider in urban area

Among several healthcare professions, existing temporary supply bulges will disappear in the near future. Despite current or projected shortages in all of New Mexico's healthcare professions, transitory factors presently create the illusion of an adequate supply.

The state's nursing shortage was more apparent prior to 2009, but the recession motivated nurses to return to the workforce, and the shortage waned. The impact of the recession may explain why current nursing graduates report difficulties finding jobs; Jeff Dye of the New Mexico Hospital Association reports that hospitals in the state have been conservative in filling nursing positions during uncertain economic times, and when they do hire, they tend to look for individuals with more experience. As the economy improves, however, there will be an "explosive need" for more nurses.

The pharmacy workforce is experiencing growth; in recent years, the number of U.S. pharmacy schools has expanded from 80 to 129. Nevertheless, because of the implementation of the ACA, the national pharmacist shortage will exceed 30 thousand by 2020 (UNM College of Pharmacy). As pharmacists take on expanded roles, which include prescriptive authorities and chronic disease management, estimating New Mexico's need for pharmacists becomes more difficult, however.

Dentistry is experiencing a recession of its own because of the growth of corporate dentistry and patient deferral of care. As a result, record numbers of dental practices are in bankruptcy. Yet, dentist production has increased in recent years. During the 1990's, a perceived glut in the number of dentists resulted in the reduction of eleven dental schools nationally. Since then, five schools have been established. Utah, in particular, has invested in dental programs and produced more dentists than the state needs, resulting in a bulge in New Mexico's urban dentist supply. As a result, FQHC executive directors report an excess of dentist job-seekers. However, the general supply and misdistribution of dentists in the state is expected to worsen over time as the population ages and retires.

Significant sectors of New Mexico's healthcare provider population are approaching retirement age. As New Mexico's population ages, its professional population is also aging and quickly approaching retirement.

Nearly one-third of the nation's physicians are expected to retire in the next decade. According to the Kaiser Foundation, approximately 24 percent of the nation's 1 million physicians are older than 55, and 21 percent are over age 65. The UNM Center for Workforce Analysis physician survey reveals that 38 percent of New Mexico-licensed doctors are age 55 and older, and 13.5 percent of New Mexico physicians plan to retire or to significantly reduce their patient care hours in the next 12 months. Another 4.3 percent plan to move out of state.

The American Medical Association expects that the number of elderly physicians will increase continue to increase as doctors work beyond traditional retirement age for personal and economic reasons, presenting the potential for problems. University of California gerontologist William Norcross cites the lack of mandatory competency evaluations for doctors and estimates that, "about 8,000 doctors with full-blown dementia are practicing medicine in the United States."

The general supply and maldistribution of dentists in the state are expected to worsen over time as the population ages. The New Mexico Dental Board reports that the average age of dentists licensed in the state is 51. Nationally, 6,000 dentists retire each year, while only 4,700 graduate annually. The New Mexico Health Action Alliance reports that our state is ranked first with respect to dentists age 55 and older (51 percent). However, according to the New Mexico Dental Association, dentists do not often walk away from the profession when they turn 65; they simply slow down. Thus, the dental bubble will not burst; it will simply deflate.

Nationally, both nurses and nurse faculty are rapidly approaching retirement age. According to the American Association of Colleges of Nursing (AACN), the average age of employed registered nurses is 43.3 years. In New Mexico, 42 percent of all licensed nurses are age 50 or older. The average age of nursing school associate professors is 52. The AACN points to average faculty age as a factor that will severely limit nurse production to meet future demand.

Determining nurse retirement rates in New Mexico is difficult and best estimated through re-licensure rates. The New Mexico Center for Nursing Excellence reports that the total number of new nurses (1,936) did not fully replace newly inactive licenses (2,685), suggesting the state's supply is dwindling.

Many professionals will not accept, or will continue to limit, the number of patients with Medicare and Medicaid in their practices. Nationally, the Government Accountability Office reports insufficient dentists, primary care physicians, and specialists willing to care for Medicaid and Medicare patients, while the National Center for Health Statistics reports that only two out of three primary care physicians are willing see new Medicaid patients. Practitioners are more willing to see new patients with Medicare or private insurance, though, and cite low reimbursement rates as major factors in their decisions to accept patients (Evans, 2012).

Nationally, Medicaid pays physicians approximately 59 percent of the reimbursement rate paid by Medicare for primary care services. In New Mexico, the Medicaid-to-Medicare ratio is better than average; the state has the 9th smallest discrepancy among the states, with Medicaid reimbursing 85 percent of Medicare rates for primary care (Kaiser, 2012). However, Medicare's reimbursement rate is about 80 percent of what commercial insurance pays (CMS, 2010). As 78 million baby boomers gain Medicare coverage over the next two decades, financial pressures may deter providers from serving the aging population, exacerbating existing shortages.

Given the growing shortage of healthcare professionals and their maldistribution across the state, New Mexico should expect some deterioration in access to health care, at least in the near term. Most New Mexicans will feel the pinch of an inadequate healthcare workforce as wait times increase**.** Much of the existing information regarding wait times to see doctors, dentists, and specialists is anecdotal as the state fails to systematically collect this information. The New Mexico Primary Care Association (NMPCA) recently conducted an informal survey of its member FQHC clinics regarding wait times for new patient appointments and found that 76 percent of sites reported wait times for initial, non-urgent, between one week and four weeks.

New Mexico should anticipate wait times will increase with the expansion of insurance coverage, as was seen in Massachusetts following healthcare reform; despite a greater physician supply, average wait times for primary care appointments and some specialty care exceeded 40 days. Other states are predicting similar situations; the California Academy of Family Physicians recently predicted that, "people should be expecting longer waits and shorter appointment times." Particular problems will be seen in areas already underserved, and most New Mexicans will likely feel the pinch of an inadequate healthcare workforce.

The remaining uninsured population and patients who cannot wait to see an assigned healthcare professional will continue to use hospital emergency departments (ED) to access care. In turn, EDs will continue to experience shortages of key professionals. With insurance coverage expansion in 2014, policymakers might anticipate a decrease in ED use for primary care. However, such decreases will not happen overnight because of gradual insurance uptake rates. Also, because of the continuing shortage of providers and lengthy wait times for new patients, the newly insured may continue to have problems accessing physicians and dentists. UNMH and the New Mexico Hospital Association anticipate that emergency departments will continue to see individuals using ED services for primary care, at least in the near future.

New Mexico should implement the following four strategies to improve the healthcare workforce supply: systems of delivery, recruitment and retention, education, and removing barriers to expansion. New Mexico needs an effective, multifaceted approach to expanding the healthcare workforce. Unless decisive action is taken to address our healthcare workforce issues, New Mexico can expect to experience continuing problems.

No single approach will provide a lasting solution; instead, a diverse, multifaceted strategy is required. Such a plan should include teams of professionals working to the full extent of their licenses, a robust recruiting and retention effort, and an approach to healthcare education that focuses on producing professionals in high demand fields. The state should also stimulate interest in healthcare professions among New Mexico's school children, enhance pipeline programs to facilitate entry into professions, and review all healthcare practice acts to reduce possible barriers to expanding the workforce. The fundamentals of such a targeted approach are in place in New Mexico but need to be strengthened.

Recommendations:

The Legislature and the UNM Health Sciences Center should work together to ensure adequate base funding for the New Mexico Center for Health Workforce Analysis at UNM.

The Legislature should ensure the Department of Health has adequate resources to carry out its statutory responsibility to conduct workforce planning. The Department of Health should collaborate with the New Mexico Center for Healthcare Workforce Analysis at UNM.

The Department of Health should provide periodic reports and recommendations on the state's health systems workforce, including the needs specific to individual regions of the state, the deployment of residencies, and the initiation of a comprehensive assessment of the numbers of practitioners needed across disciplines.

HEALTHCARE SERVICE DELIVERY MODELS MUST EVOLVE TO ADEQUATELY ADDRESS NEW MEXICO'S HEALTHCARE NEEDS

Service delivery systems will change to models that place the patient at the center of a coordinated system of care. A more effective approach to delivering healthcare should match healthcare practitioner skill to patient need to serve more clients at a lower cost.

The Affordable Care Act (ACA) envisions new patient-centered healthcare service delivery models which involve professionals working in teams to meet established patient outcome standards and reduce healthcare costs. The ACA established the Centers for Medicare and Medicaid Innovation to facilitate the development of new integrated care models, such a medical homes, to provide comprehensive, coordinated care. Additionally, HRSA is motivating New Mexico's FQHC's to adopt a medical home model of care.

The medical home (or health home) model comprises networks of providers addressing all of the patient's healthcare needs. Care coordinators (typically nurses or social workers) ensure that the patient accesses resources identified in an individualized care plan. Teams often receive a per-member-per-month fee with bonuses for meeting cost and care targets. The ACA also envisions increasing use of community prevention interventions and increase use of community health workers to promote positive health behaviors and outcomes. Additionally, telehealth may be used to connect remote practitioners to specialists, while emergency medical technicians (EMTs) may also be used to administer basic primary care services in communities which lack access to primary care. Eastern New Mexico University is currently piloting a community medic model in Eunice, Lovington, and Taos, which will train EMTs and paramedics to provide intervention and prevention services to promote community health and reduce costly emergency transports to hospitals.

Addressing the healthcare workforce problem requires an assessment of how the population uses healthcare. Half of the nation's population is basically healthy. According to the National Ambulatory Survey, one billion physician visits are made in the U.S. annually; 57 percent of these visits are made to primary care physicians. The most frequent principal reason for a physician visit is to receive a general medical examination.

Table 12. Most Frequent Principal Reasons for Physician Visits

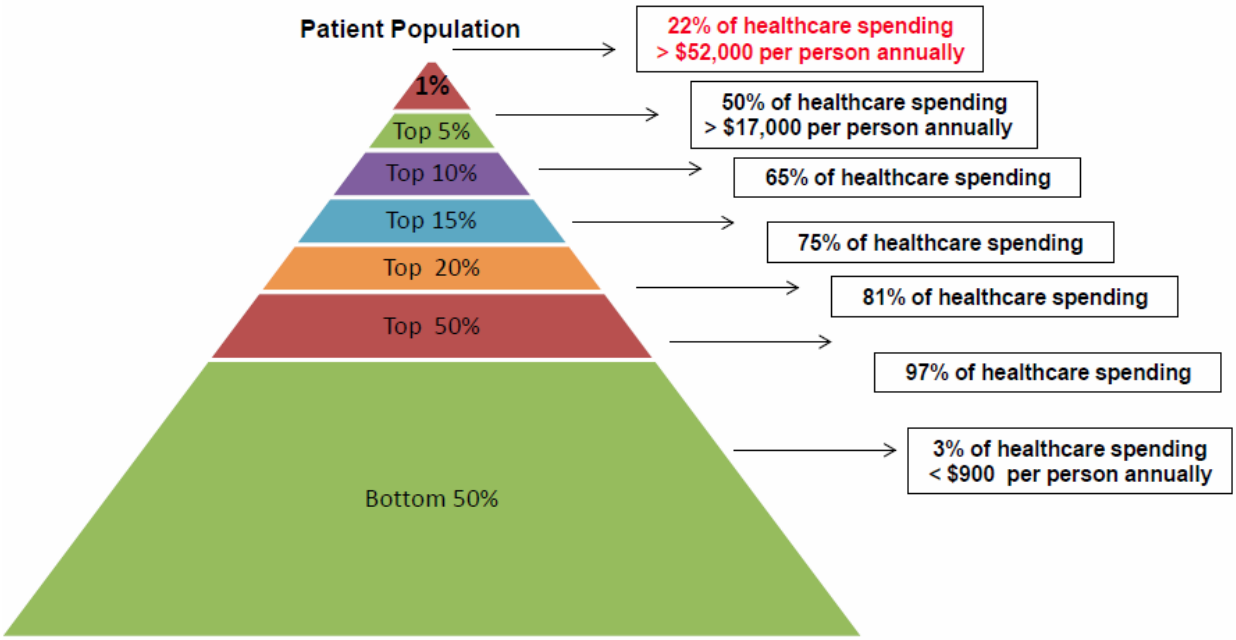
1. General medical examination
2. Progress visit, not otherwise specified
3. Cough
4. Post-operative visit
5. Unspecified test results
6. Counseling, not otherwise specified
7. Diabetes
8. Hypertension
9. Stomach pains
10. Symptoms referable to the throat

Source: National Ambulatory Survey

Patients with chronic health conditions require more specialty care and absorb a greater proportion of healthcare resources. As discussed below, 5 percent of the population, those with multiple chronic conditions, consume about half of the nation's healthcare resources each year.

A smarter service delivery model will target level of care to level of need. A new approach to health care delivery which targets complex, high-cost patients is evolving. Designing coordinated and comprehensive care for individuals who consume the majority of health resources helps mitigate health-related socio-economic barriers, ensures that patients with complex chronic diseases receive better care, and reduces costs. UNM's Dr. David Sklar envisions the growth of chronic care intensivists--doctors who specialize in the management of very complex chronic diseases and coordinate healthcare teams. These physician specialists may return complex patients individual to more stable, healthy lives and reduce the need for future hospitalizations and specialty care.

Figure 1. Concentration of Healthcare Spending in the U.S. Population



Source: Kaiser Family Foundation

The distribution of the U.S. patient population and corresponding use of healthcare resources is portrayed in Figure 1, as reported by the Kaiser Family Foundation. While other authors report slightly different annual spending levels in each category, the distribution of costs is well established.

- The top 1 percent of the patient population uses about 22 percent of healthcare resources, or an average $52 thousand per person per year. Individuals who account for this share of spending tend to have multiple chronic diseases along with diagnosed mental illness. These patients receive care within the existing healthcare system, but their care is often uncoordinated.

- Moving down the pyramid, the top fifty percent of the population, on average, uses 97 percent of the healthcare resources, about $4.5 thousand annually per person. Individuals with stable chronic conditions fall into this group. Patients over 65 years old are often in the upper 50 percent of the pyramid as elderly healthcare needs may increase six-fold.

- The bottom 50 percent of the population is basically healthy and requires only preventative care, such as flu shots, and occasional treatment for acute illness. The percent of the population that falls into this category consumes only 3 percent of the nation's healthcare resources, roughly $900 per person annually.

NPs and PAs can provide good health care to at least half of the population. The 50 percent of the population that is basically healthy can be cared for by NPs and PAs for most of their medical needs. Assuming the population also receives prevention services, such as wellness programs, and population-based public health services.

Patients with chronic diseases benefit from coordinated care models that employ a team approach. UNM's Care One program in Albuquerque is currently implementing a care coordination program for medically complex uninsured patients. In the Care One model, a primary care physician leads a team which includes case managers, community healthcare workers, and behavioral health specialists to help identified patients efficiently use the healthcare system and improve their health. UNMH refers patients have accumulated an excess of $144 thousand in medical charges within a 12 month period to the program. Care One then aims to stabilize these patients so that they may be turned over to the University's primary care clinics.

An analysis of 446 Care One patients determined that the program cut hospital admissions by almost 80 percent and emergency room visits by almost 60 percent. Patient outcomes also dramatically improved, and high-cost patients were better able to manage their own health.

Care coordination models may also be used to manage care and reduce costs in community settings. Hidalgo Medical Services (HMS) in Silver City and First Choice in Albuquerque serve as effective community-based models. Both providers attempt to bring highly coordinated care to their neediest patients, while building strong prevention models in communities. HMS and First Choice implement patient-centered, medical home models that match care to the healthcare statuses of patients; patients with multiple, chronic conditions receive case-coordination, specialist care, and services provided by community health workers. HMS also employs a broader, community-based health integration model that stresses prevention and healthy lifestyles attempts to address the underlying socio-economic factors that contribute to poor health. These models hold promise for a more effective healthcare system which reduces costs and improves health outcomes through targeted prevention and public health initiatives.

Recommendations:

Institutions of higher education and healthcare providers should ensure that public health approaches to individual and community-based services are fully integrated

NEW MEXICO NEEDS TO BETTER POSITION ITSELF TO RECRUIT AND RETAIN AN ADEQUATE WORKFORCE IN AN INCREASINGLY COMPETITIVE ENVIRONMENT

Current healthcare recruitment is not able to keep up with demand. New Mexico Health Resources (NMHR), a referral agency that finds eligible candidates and connects employers seeking practitioners, conducts much of the state's recruitment effort. NMHR principally recruits candidates for safety net providers, such as community health centers and critical access hospitals. During the last five years, 255 practitioner placements, including those of 108 physicians, 15 NPs, 26 PAs, and 85 dentists, resulted from NMHR referrals. While statewide provider vacancy rates are unknown, NMHR is currently recruiting for over 300 vacant positions. During FY12, NMHR reported an awareness of 602 vacant positions in New Mexico and estimates that they know of only one-third of the vacancies in the state.

Table 13. Known Safety-Net Vacancies Reported to NMHR February 2013

Physicians	157
Registered Nurses	11
NPs	46
PAs	18
LISWs	9
Pharmacists	14
Dental Hygienists	6
Dentists	30
Physical Therapists	7
Occupational Therapists	2

Source: NMHR

Table 14. FY12 Vacancies Reported to NMHR*

Physicians	59
LISWs	31
Medical Doctors	290
NPs	93
Occupational Therapists	6
Pharmacists	14
Physical Therapists	17
Physician's Assistants	29
Psychiatrists	23
Registered Nurses	29

Source: NMHR

*Excludes several position categories

New Mexico is not alone in its attempts to recruit providers. A 2010 survey conducted by the American Hospital Association revealed the following vacancy rates in hospitals nationally: 9 percent for various therapists and 4 percent for pharmacists and registered nurses. Additionally, 65 percent of hospitals reported efforts to increase the number of employed physicians, and 80 percent reported efforts to increase the number of employed primary care providers. The licensing survey of physicians practicing in the state reveals that only 17 percent attended medical school in New Mexico, suggesting that New Mexico recruits the majority of its physician workforce from out-of-state.

Practitioner recruitment is costly, however. Current literature suggests that the cost of recruiting a physician may range between $20 thousand and $123 thousand (Misa-Helbert et al, 2004). NMHR reports a considerably lower cost per placement, though specialty recruitment is more expensive. Recruitment estimates do not account for revenue lost because of vacant positions.

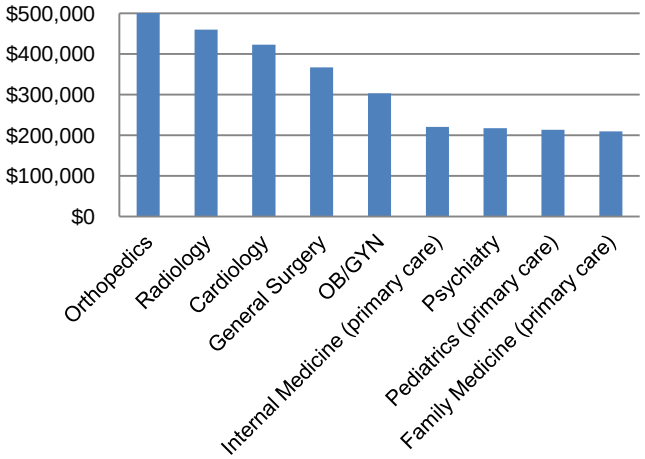
New Mexico also recruits a small number of J-1 visa physicians, who are foreign medical doctors that have completed medical training in the U.S. Typically, J-1 visa recipients must return to their home countries for a minimum of two years after completing medical education, but this requirement may be waived in exchange for three years of service in the state. DOH administers the waiver program and has approved 75 physician waivers in New Mexico since 2010. The state may grant 30 waivers annually, though 20 waivers must be to physicians practicing in shortage areas.

Special challenges exist in recruiting for rural areas and for specific professions and specialties. Attracting and retaining healthcare providers in rural areas has been a long withstanding challenge throughout the country and in New Mexico, prompting governments and medical education programs to pursue strategies that might attract and retain rural providers.

According to the American Association of Family Practice, the two strongest predictors that a physician will choose rural practice are specialty and background; family physicians are more likely than those with less general training to go into rural practice, and physicians with rural backgrounds are more likely to locate in rural areas than those with urban backgrounds. Research also suggests that several factors influence physician decisions to practice in rural communities, and these same factors presumably affect other healthcare providers as well. These factors include: training with a rural component, access to cultural and recreational activities in the community, spouse desires, and receptivity of other physicians in the community (Geyman et al, 2000).

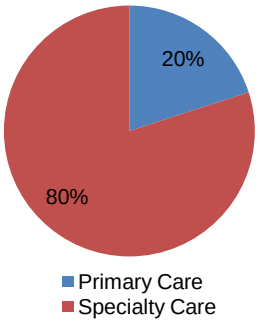
At the medical school level, recruitment into primary care is a considerable challenge because existing pay systems provide incentives for specialty care practice. According to the American Academy of Family Physicians, the annual income gap between primary care physicians and subspecialty physicians exceeds $135 thousand. Medical students understand the financial benefits of specialty practice and are increasingly selecting subspecialties over primary care, though implementation of the ACA will depend on primary care practitioners. The AAMC claims primary care physicians currently account for 35 percent of practicing medical doctors, but this number is rapidly declining; 20 percent of all U.S. medical students are now choosing primary care specialties. Without changes to medical payment structures, the supply of primary care physicians may further decrease, exacerbating recruitment challenges.

Chart 7. National Median Physician Salary by Specialty



Source: American Medical Group Association Compensation Survey

Chart 8. Reported Specialty of 2012 Medical School Graduates



Source: Journal of the American Medical Association

Loan repayment and other financial assistance programs provide incentives to encourage healthcare professionals to work in underserved areas and in primary care. Participation in state and federal programs, including the HED loan-repayment and loan-for-service programs, the New Mexico Health Service Corps, and the National Health Service Corps (NHSC), encourage practitioners to work in designated medical shortage areas.

Healthcare professionals, especially those with graduate and professional degrees, often graduate with considerable debt. According to the American Dental Education Association, the average debt of a dental school graduate exceeds $200 thousand, while the AAMC reported that the average 2012 medical school graduate held a debt load over $166 thousand. Student loan debt makes financial assistance and repayment programs appealing to practitioners, and existing programs effectively attract providers to underserved areas in New Mexico.

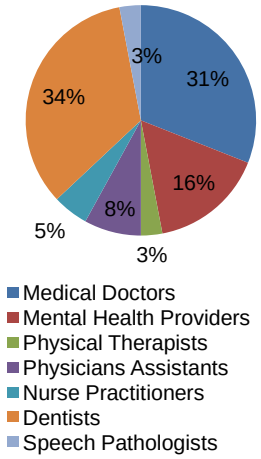
State-supported financial assistance programs effectively recruit providers and should be expanded. New Mexico funds several programs designed to recruit and retain primary care healthcare professionals to underserved communities. HED oversees the Health Professional Loan-for-Service and Loan-Repayment programs. In FY13, the state appropriated $1.4 million from the General Fund for these programs. According to HED, the default rate among loan repayment recipients is 2 percent, though the rate is higher among Loan-for-Service participants. Additionally, DOH sponsors the New Mexico Health Service Corps (NMHSC), which provides awards for practitioners who commit to two years of service in New Mexico. Twelve NMHSC received awards in FY13.

Table 15. State-Sponsored Financial Aid Programs

Program	Description	FY13 Awards	Award Amount
Health Professional Loan-for-Service (HED)	State-sponsored loans to students in exchange for service in areas of the state which experience health professional shortages. Students may receive loans for up to four years, and a portion of the loan is forgiven for every year of service, up to the full amount. Professionals must commit to a minimum of three years of service and begin working in a professional shortage area within six months of graduation. Penalties may be assessed if the service agreement is not satisfied. Allied health professionals, dental providers, nurses, and physicians are eligible for participation.	45	Physicians: $25,000 annually Nurses: $12,000 annually Allied Health Professionals: $12,000
Health Professional Loan Repayment (HED)	The program will pay its participants for the principal and reasonable interest accrued on loans obtained for educational purposes. Recipients must commit to practice full-time in a designated medical shortage area for two years.	48	$25,000 annually Up to $35,000 for recipients working in HPSA areas
New Mexico Health Service Corps (DOH)	Participants receive a stipend amount in exchange for two years of service in a designated HPSA. Sites include community health centers, rural health clinics, health departments, IHS, and the VA.	12	$20,000 per year for two years Non-physicians receive less

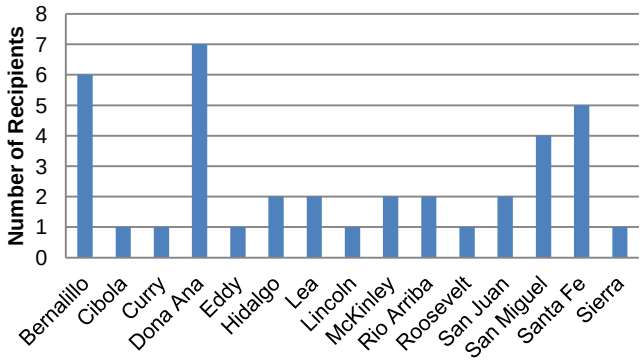
Source: HED

Chart 9. New Health Professional Loan Repayment Program Recipients in FY12
total awards= 22



Source: HED

Chart 10. FY12 Health Professional Loan Repayment Program Recipients by County of Service



Source: HED

Loan-repayment programs seem to provide a better return on investment than loan for service programs. A 2012 NHSC Collaborative retention study, which included New Mexico, reported that among NHSC clinicians, substantially more loan-repayment program participants than loan-for-service participants anticipate remaining in their service sites beyond their committed terms; 70 percent of loan-repayment participants report planning to remain a year beyond their commitment, whereas only 36 percent of loan-for-service program recipients anticipate remaining. HED reports that loan-repayment program participants are also less likely to default than loan-for-service recipients, and 98 percent of loan-repayment recipients complete their service obligations.

National research suggests, however, that while financial incentive programs bring health practitioners to rural communities, retaining award recipients beyond their commitments remains a challenge. Retention among non-NHSC physicians tends to be higher than NHSC physicians in rural communities (Geyman et al, 2000).

According to HED, interest in its Loan-for-Service and Loan-Repayment programs considerably exceeds available award funds. In FY13, HED received 138 applicants for 28 new award slots. According to the agency, applications for the healthcare loan programs have declined in recent years, and HED cites frustration among rejected applicants as the cause. In FY13, the Legislature appropriated $150 thousand to the student financial aid program of HED for the primary care physician conditional tuition waiver established by the Conditional Tuition Waiver for the Primary Care Medical Students Act. However, HED never promulgated rules for program implementation. The Legislature did not appropriate funds for the waiver program in FY14. While HED could request additional state or federal funding for the Health Professionals Loan-Repayment of Loan-for-Service programs, the agency did not in FY14.

Table 16. Unmet Need for Loan-for-Service and Loan Repayment Programs, FY 13

Medical LfS	27%
Nursing LfS	48%
Allied Health LfS	60%
Health Professional Loan Repayment Program	89%

Source: HED, estimated

The Western Interstate Commission for Higher Education (WICHE) exchange program supports the education of New Mexico's future dentists. WICHE allows dental students to attend participating out-of-state dental schools at a subsidized rate in exchange for three years of service in New Mexico. Partnering institutions reserve a specific number of dental school slots for New Mexico students, and the state pays the difference between out-of-state and in-state tuition at the partnering institution, an amount equal to roughly $23 thousand per student each year.

The number of WICHE slots awarded to New Mexico students is based upon legislative appropriations. HED reports that 92 percent of WICHE recipients return to New Mexico and complete mandatory service obligations, suggesting the program is effectively growing the state's dental workforce. During FY13, 14 new dental students received WICHE awards, and the state supported a total of 39 WICHE students who will be expected to return to New Mexico for future service.

Table 17. State Support for New Mexican Dental Students

2012-2013 Academic Year			
Program	**Total Number of Recipients**	**New Awards FY13**	**FY 13 Expenditures**
WICHE Loan for Service Dentistry	39	14	$1,035,000
Baylor School of Dentistry Loan	4	1	$54,000
TOTAL	**78**	**23**	**$1,978,200**

Source: HED

Funded by the U.S. Health and Human Services (HHS) Department, the National Health Service Corps (NHSC) provides stipends toward student loan repayment or scholarships for medical, dental, and mental health professionals working in health professional shortage areas (HPSA) around the county in exchange for a minimum of two years of practice. New Mexico Health Resources reports that 138 NHSC loan repayment participants and 28 NHSC scholarship recipients are currently serving in New Mexico. The number of NHSC practitioners serving in the state will decline in the near future as federal American Recovery and Reinvestment (ARRA) funds, which previously supported the program, have disappeared. NMHR also anticipates funding for NHSC will decline considerably under federal sequestration.

Table 18. NHSC Participants in New Mexico

Obligations ending 2013	93
Obligations ending 2014	59
Obligations ending 2015	5
Obligations ending 2016	8

Source: NMHR

Table 19. NHSC Working in New Mexico

Physicians	42
NPs	22
PAs	23
Certified Nurse Midwives	5
Licensed Clinical Social Workers	5
Dental Hygienists	9
Dentists	31
Licensed Professional Counselors	21
Psychologists	8

Source: NMHR

Recruitment in hard-to-staff areas appears to be a greater challenge than long-term retention. Retention for generalist physicians is minimally, if at all, different for physicians in rural HPSA areas and rural non-HPSA areas, suggests a 2004 study published in the *American Journal of Public Health*. Though research is limited, studies also suggest that retention rates among physicians in rural and urban areas are similar (Williams & Wilkins, 1993; Misa-Helbert et al, 2004). The National Rural Recruitment and Retention Network claims that 12 percent of all newly hired physicians leave their initial employment site within one year. One-third of physicians change practice arrangements within five years of the start of their careers (Vanasse et al, 2007). Coupled with studies that suggest fewer physicians move into shortage areas, these findings indicate rural shortage areas result primarily because of insufficient recruitment and not major differences in retention, as compared to urban areas.

Pipeline programs help develop a healthcare workforce for underserved areas. Research suggests certain individual characteristics are associated with provider decisions to practice in communities especially vulnerable to workforce shortages, including background and specialty preference. Minority providers play an important role in caring for minority populations, as studies indicate that black and Hispanic physicians are more likely than non-Hispanic whites to practice in physician shortage areas and to care for black and Hispanic patients (Saha & Shipman, 2006). Given New Mexico's diversity, the state has a considerable interest in recruiting and preparing a healthcare workforce that reflects the population.

Several programs around the state aim to recruit students into the healthcare pipeline before or during high school. UNM's Dream Makers program introduces middle and high school students to paths associated with health sciences through afterschool programs. The program currently operates in 13 communities around the state. UNM also supports diverse pre-healthcare students by providing courses to prepare for admission tests.

First Choice in Albuquerque plans to partner with a new health leadership charter high school to implement a curriculum that will allow high school students to gain exposure to health careers and earn certificate-level degrees. Finally, Hidalgo Medical Service's Forward New Mexico program supports career clubs, academic support, and enrichment programs for students in southwestern New Mexico. These pipeline programs will help stimulate interest in health science careers to address shortages in the long-term.

The BA/MD Program supports medical students beginning at the undergraduate level. The UNM BA/MD program was designed to address the state's physician shortages by assembling a class of diverse students committed to the needs of underserved communities. The program is a long-term investment; between FY06 and FY11, the state appropriated $15.7 million in for the BA/MD. Since FY11, state support for the BA/MD has been included in UNM's I&G funding. The first BA/MD class will graduate from UNM SOM in 2014 and begin residency programs.

Each year the program admits 28 students, and 50 percent of current program participants are minorities. Students who identify as minorities represent only 37 percent of the total UNM School of Medicine (SOM) population. While UNM hopes that BA/MD students will practice in New Mexico, students will not be penalized if they choose to work out-of-state. Students may apply for any residency program, though research suggests physicians tend to practice near their residency placement.

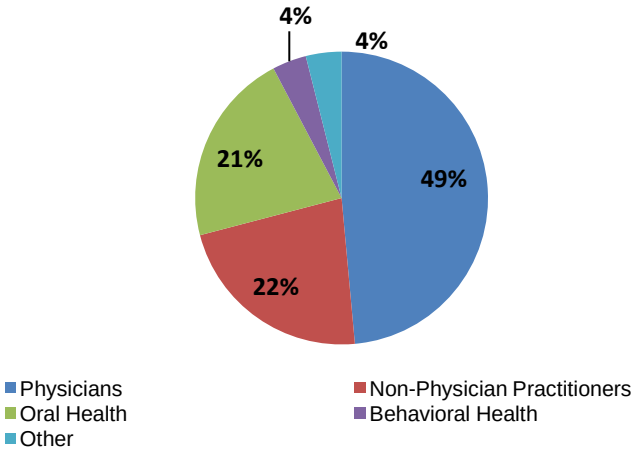
The UNM HSC has proposed a BA/DDS program as a more realistic alternative to building a dental school in New Mexico to address the state's shortage of dentists. Students would complete their undergraduate studies at UNM and then attend an out-of-state dental school under contract with UNM. Dental graduates would then return to UNM for dental residency. The UNM sought planning funds for this program in the 2013 Legislative Session. However, this effort was not successful.

Other potential recruitment and retention strategies are worth considering. In January 2011, the New Mexico Health Policy Commission (HPC) released a study with 12 recommendations to address healthcare workforce shortages in the state (see **Appendix B**). These strategies include a mix of additional stipends and rural community contracts, the enhancement of scholarships and loan repayment programs, the creation of graduate medical education residencies, and the expansion of mid-level provider programs in medical and oral health areas.

Tort liability limits provide incentives for healthcare professionals. New Mexico's Medical Malpractice Act limits a provider's personal liability and provides for informal hearings prior to court action. New Mexico's Medical Malpractice Act places a cap of $600 thousand on the aggregate dollar amount recoverable from any injury or death to a patient and establishes an informal hearing process that allows cases to be settled before ever going to trial. The New Mexico Medical Society thus reports that New Mexico's malpractice statute and procedures are more attractive to physicians than statutes in other states. The New Mexico Dental Association, however, expresses concern that dentists are not protected by the New Mexico's Medical Malpractice Act which may, in their opinion, deter recruitment.

New Mexico's rural tax credit provides a personal income tax credit to healthcare practitioners who provide services in underserved rural areas. During the 2010 tax year, DOH reported that a total of 1,726 recipients took advantage of this tax credit. Almost 50 percent of these were physicians.

Chart 11. Rural Healthcare Tax Credit Recipients



Source: NMDOH for 2010 Tax Year

Recommendations

The Legislature should identify a single agency, such as New Mexico Health Resources to coordinate all healthcare workforce recruitment activities for both the public and private sectors in New Mexico. Recruitment funding should be expanded to allow New Mexico to compete effectively with other states.

The healthcare workforce strategy committee under the auspices of the UNM Health Sciences Center should take into consideration the recruitment recommended strategies identified by the NM Health Policy Commission in its 2011 report, *Recommendations to Address New Mexico Healthcare Workforce Shortages*, the New Mexico Health Policy Commission recommended twelve strategies (see **Appendix B**).

The Legislature should increase funding for loan repayment programs for healthcare professionals as opposed to loan for service programs, which tend to have lower rates of retention.

EDUCATIONAL STRATEGIES MAY ALSO ADDRESS THE WORKFORCE SHORTAGE

New Mexico's public and private institutions do an admirable job of educating healthcare professionals, but cannot, by themselves, keep up with growing demand. Colleges throughout the state prepare students for work in healthcare professions; twelve of the state's public colleges offer registered nursing programs; all of the state's four-year institutions offer counseling programs, and three of the state's four-year institutions offer social work programs. UNM's Health Science Center houses many of the programs which prepare graduate-level health professions. However, New Mexico cannot simply educate its way out of the current healthcare workforce shortage.

Degree production in health care professions remained relatively stable between 2007 and 2011, with a few notable exceptions. Between 2007 and 2011, New Mexico educated over 4,700 registered nurses (RN's) at various levels. At the same time, New Mexico educated 263 medical doctors and 79 physician's assistants. The state also prepared over one thousand professionals who may provide behavioral health services, including social workers, substance abuse counselors, and counseling psychologists. The production of RNs declined slightly, while the production of physical therapists, occupational therapists, dental hygienists, and social workers increased during the same period.

Table 20. New Mexico Degrees Produced 2007-2011
(All Degree Levels Included)

	2007	2008	2009	2010	2011
Medical Doctor	54	53	54	53	49
Occupational Therapy	27	11	30	34	61
Pharmacy	85	88	82	84	86
Physical Therapy	15	21	43	38	25
PA	18	14	14	15	18
Radiography	88	73	64	74	68
Registered Nurses	1062	886	953	919	932
Social Work (MSWs)	199	193	191	192	206
Social Work (BSWs)	136	146	160	160	151
Dental Hygiene	35	50	51	57	59

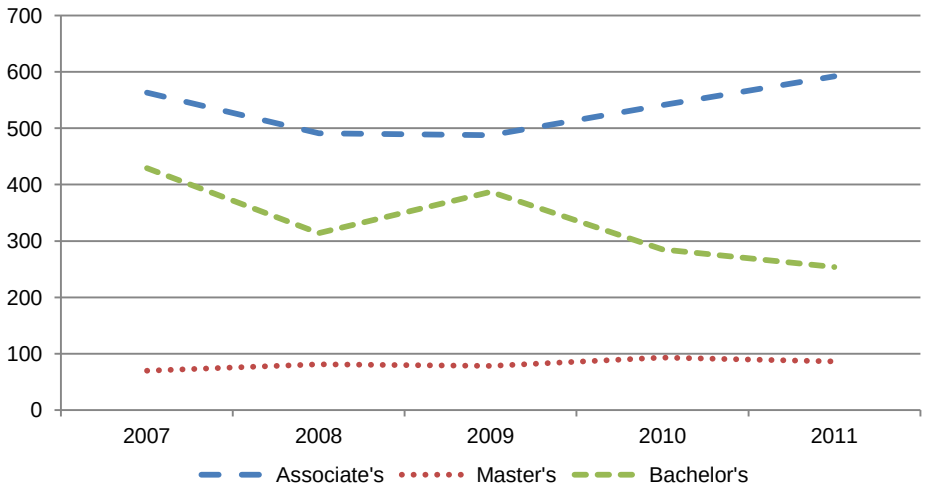
Source: LFC analysis of HED data

New Mexico has not increased the number of nurses educated by the state's public institutions, despite state and national calls for more nurses with bachelor's degrees. RNs may hold either an associate (ADN) or a bachelor-level (BSN) nursing degree. Nationally, 66 percent of all nursing graduates earn ADNs, as opposed to BSNs, but the 2011 *Future of Nursing* report released by the Institute of Medicine called for a more highly educated nursing force. The report recommended that 80 percent of the nursing workforce hold bachelor's degrees by 2020 to meet the nation's demand for health care.

New Mexico's colleges of nursing responded and aim to increase the production of BSNs. The 2011 LFC evaluation of the UNM HSC reported that approximately $16.5 million in supplemental funding was allocated to New Mexico's public institutions from FY04 to FY09 for nursing program enhancement through line-item appropriations to individual institutions, and $12.2 million was allocated between FY10 and FY13.

Despite support for the state's public nursing programs, fewer total nursing students have graduated in recent years. While the numbers of associate and master-level degrees awarded increased slightly between 2007 and 2011, the number of bachelor degrees produced in-state declined. The total number of RN degrees awarded decreased from 1062 in 2007 to 932 in 2011, when the effects of increased funding would be expected.

Chart 12. RN Degrees Awarded 2007-2011



Source: LFC analysis

Additionally, HED data reveal that few of the state's recent ADN graduates rapidly earn BSNs. Between 2007 and 2011, New Mexico institutions granted 2,675 ADNs and 1,669 BSNs. Of the 559 nurses who earned associate's degrees in 2007, 22 (4 percent) had earned a BSN by 2011. Economic factors may partially explain declining BSN production, as RNs with associate-level degrees and RNs with bachelor-level degrees make roughly the same amount in clinical practice.

However, the state Board of Nursing reports an increase in the first time completers of the National Council Licensing Exam (NCLEX), the test required to become a licensed RN in the state. Despite declining program graduates, the NCLEX increase suggests more RN candidates have sought licensure in recent years. The discrepancy between public institution nursing degree production and NCLEX growth may be explained by the expansion of proprietary nursing programs in the state or an influx of nurses from other states.

Table 21. Candidates for First Time Nurse Licensing Exam
Includes graduates from public and private institutions

	2007	2009	2011
ADN	616	673	826
BSN	242	186	177
Total	858	859	1003

Source: NM Board of Nursing

Graduates of various health programs differ in their decisions to practice in the state. To best meet the healthcare needs of New Mexicans, graduates should practice in regions with demand needs. Data from HED and the Department of Workforce Solutions reveal maldistribution among the practice patterns of recent graduates. Healthcare graduates with professional degrees are more likely to practice in Bernalillo County than graduates with associate or bachelor-level degrees. While only 54 percent of the state's recent nursing graduates practice in Albuquerque, over 70 percent of the state's newly prepared and practicing doctors, pharmacists, physicians assistants, and physical therapists remain in Bernalillo County.

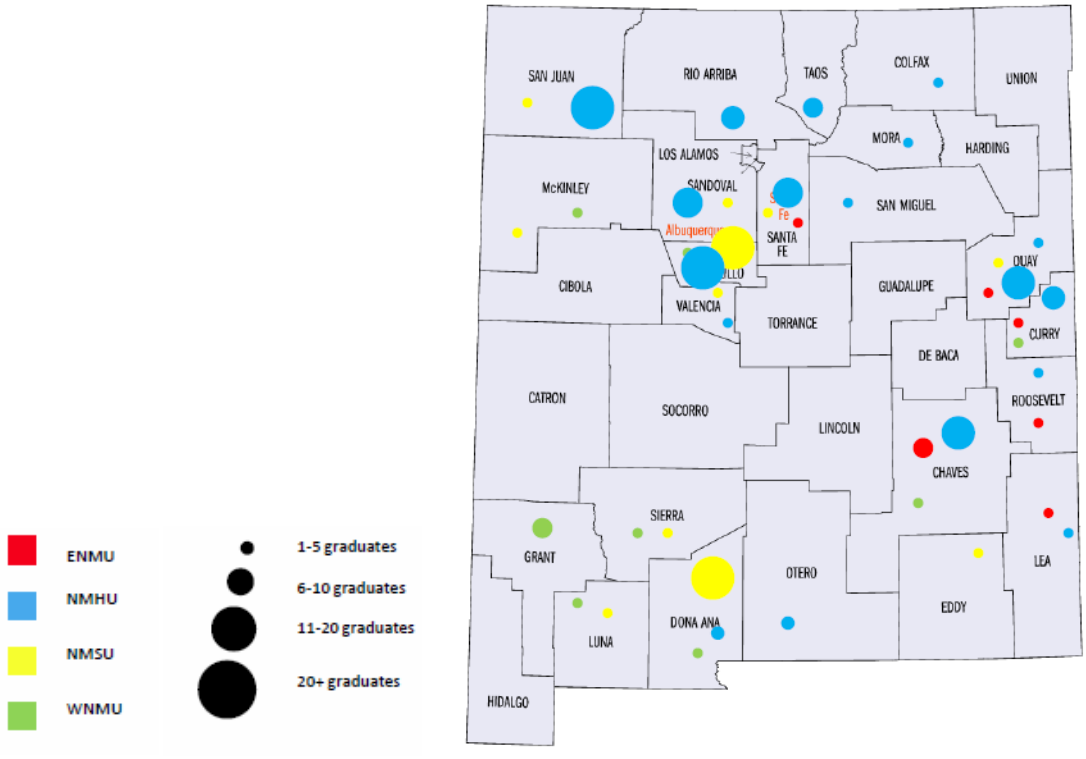
Table 22. 2007-2011 Health Care Graduates in the Workforce

	N	Percent Employed in Practice in New Mexico 2012	Other Employment Field in New Mexico 2012	Percent Practicing in Bernalillo County	Not Reported 2012
Certified Nurses Assistants	104	58%	3%	7%	39%
Counseling Psychology	49	63%	8%	4%	29%
Dental Hygiene	252	62%	37%	40%	0%
Medical Doctors	263	45%	0%	97%	55%
Occupational Therapy	163	70%	0%	62%	30%
Pharmacists	425	65%	3%	84%	32%
Pharmacy Technician	164	37%	25%	82%	37%
Physical Therapy	142	57%	1%	78%	42%
Physician's Assistants	79	61%	1%	73%	38%
Radiographers and Nuclear	367	63%	32%	56%	5%
Registered Nurses	4752	62%	17%	54%	21%
Social Work (BSWs)	753	15%	75%	38%	10%
Social Work (MSW)	981	41%	32%	53%	27%
Substance Abuse Counselors	44	27%	18%	25%	55%

Source: LFC analysis

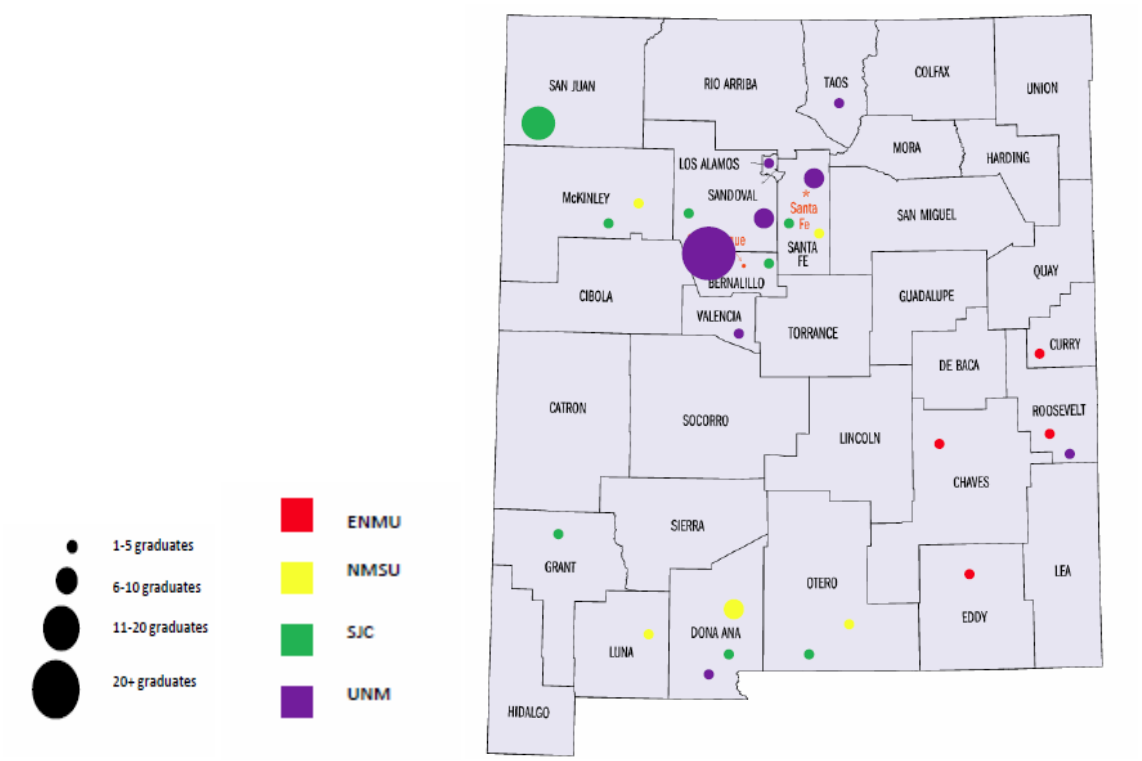
Inequitable provider distribution may be explained by the concentration of medical education within the UNM Health Science Center. While many of the state's institutions offer associate and bachelor-level programs, graduate and professional degree preparation remains concentrated in Albuquerque, potentially contributing to the maldistribution of health care providers. Across programs, recent graduates tend to practice near where they received training, supporting the notion that the state's colleges serve local workforce needs. Additionally, the concentration of specialty care in Albuquerque and the presence of the state's only level 1 trauma center may contribute to these patterns.

Figure 2. 2007-2011 Practicing Social Work Graduates by County and Program



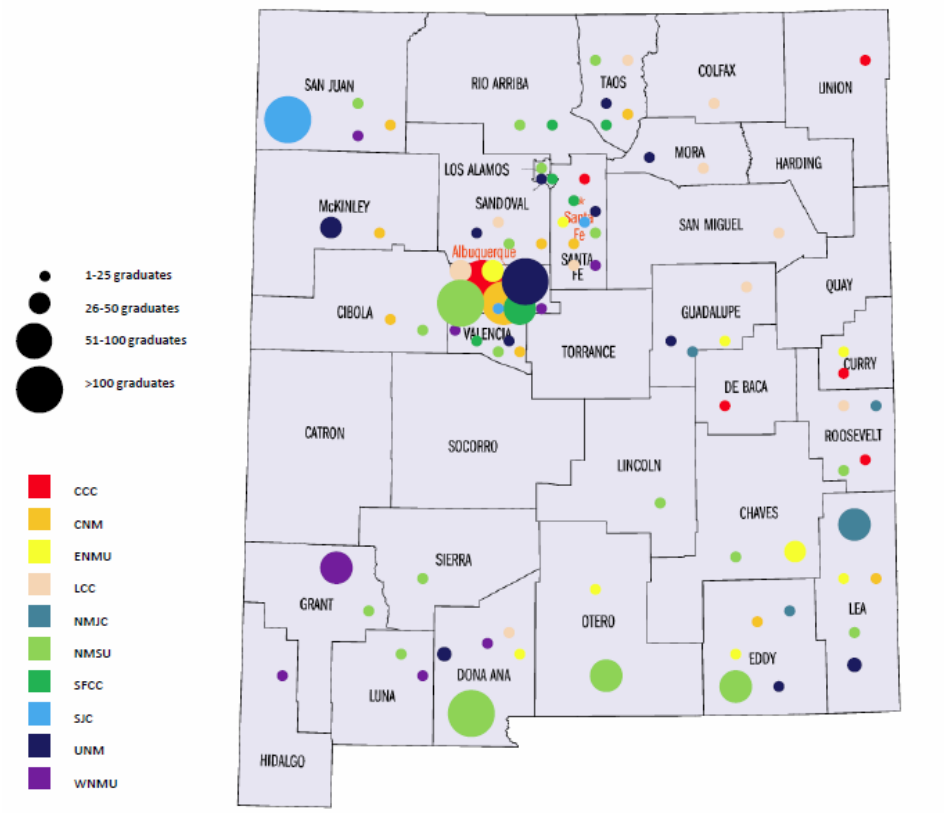
Source: LFC analysis

Figure 3. 2007-2011 Practicing Dental Hygiene Graduates by County and Program



Source: LFC analysis

Figure 4. 2007-2011 Practicing RN Graduates by County and Program



Source: LFC analysis

Graduate Medical Education residency caps severely limit the numbers of doctors produced in New Mexico and the United States. Physicians tend to begin practice in close geographic proximity to their residency placements, and primary care physicians are more likely than specialists to choose a practice location closer to their residency program (Geyman et al., 2000). These findings indicate strategic investment in residency positions may enable shortage areas to recruit physicians and the state to increase its physician workforce overall.

In 2006, the Association of American Medical Colleges (AAMC) recommended medical schools increase the supply of physicians by 30 percent to meet the patient needs of the new millennium. In response, medical schools around the country increased enrollment, but graduates cannot practice medicine without completing a residency program, also known as graduate medical education (GME).

GME is primarily supported through Medicare funds, and the total number of funded residency slots was capped by the Balanced Budget Act of 1997. The Centers for Medicare and Medicaid Services (CMS) currently contribute $9.5 billion annually to support the training of 94 thousand residents nationally. Medicaid and other sources, such as hospitals or states, fund roughly 10 thousand additional slots. Currently, the number of U.S. medical graduates exceeds residency slots, and the remaining positions are filled by graduates of U.S. osteopathic schools or foreign medical school graduates. At the current expansion rate of U.S. medical graduates, the AAMC predicts that the number of graduates from U.S. medical and osteopathic schools will exceed residency slots by the end of the decade, squeezing out applicants from foreign medical schools. This squeeze should alarm New Mexico because international medical graduates make up a disproportionate share of physicians practicing in rural communities.

The American Medical Association estimates that the direct cost to train one resident averages $100 thousand per year. UNMH funds 348.65 FTE residency slots, many of which are supported through CMS funds. UNMH reports exceeding the CMS cap by approximately 80 FTE in FY13. State I&G funds supported 8.1 family medicine residency FTE in FY13.

Nearly five hundred medical residents are working in New Mexico. According to the 2012 National Residency Match Report, 133 new residents matched in New Mexico, and UNM reports that 470 total GME FTE and 120 fellowships were funded in FY13. In 2012, residency programs in New Mexico were located in Albuquerque, Santa Fe, Las Cruces, and Roswell, though Roswell has since lost its accreditation and will not continue to receive residents in the future. In 2008, *House Memorial 2: State Funded Primary Care Residency Slots* recommended increasing the state's 25 family medicine residency slots by 50 percent using recurring general fund appropriations. Since 2008, total family residency slots in New Mexico remain unchanged.

All of the residency slots outside of UNM are devoted to family medicine. Twenty-five doctors began family medicine residency in New Mexico in 2012. While 171 (31 percent) of the residency and fellowship slots at UNM are classified as primary care, including internal medicine, general practice, and pediatrics, many of UNM's primary care residents go on to sub-specialize and ultimately practice specialty care. National trends indicate that only 20 percent of medical school students ultimately practice primary care, and 8 percent practice family medicine, though nearly half of all patient visits are to primary care providers. Institutions should develop and place residents based on where specific services are needed in the state.

Table 23. 2012 Resident Matches in New Mexico

Program Placement	2013 Resident Matches
UNM School of Medicine (Albuquerque)	121
Northern NM Family Medicine (Santa Fe)	3
Memorial Medical Center (Las Cruces)	6
Eastern NM Medical Center (Roswell)	3

Source: National Residency Match Program

Table 24. Total UNM Residency FTE Funded in FY13, by Specialty

Anesthesiology	31.17
Dermatology	6
Emergency Medicine	33.17
Family Medicine	54.76
General Dentistry	10.60
Internal Medicine	82.13
Neurology	12
Obstetrics/ Gyn.	26
Orthopedic Surgery	25
Pathology	17.7
Pediatrics	46.30
Psychiatry	36.85
Radiology	27.50
Surgery, General	34.50
Neurosurgery	11.66
Ophthalmology	2
Otolaryngology	5.75
Thoracic Surgery	0
Urology	7

Source: UNM HSC

National attempts to redistribute GME slots have failed in the past. The Medicare Modernization Act of 2003 sought to address ongoing physician shortages by gathering unfilled residency slots and redistributing for primary care and rural residency programs. However, many of the hospitals that received the redistributed slots were not located in rural areas or created new specialty positions instead. The ACA of 2010 similarly called for a redistribution of residency slots, though the GME cap was not lifted. Without accountability measures, efforts by state or federal governments to increase rural and primary care residency positions will likely fail because existing incentives favor specialty over primary care. The newly created New Mexico Residency Consortium, a collaboration among the state's residency program leaders, could serve a coordination and leadership role to ensure that residency allocations meet New Mexico's needs. Finally, funding alone will not remove all barriers for GME expansion as new programs must receive approval from the Accreditation Council of Graduate Medical Education.

The ACA provides new options for GME training which may benefit the state. The ACA created the Teaching Health Center Graduate Medical Education program to support the training of primary care residents and dentists prepared in community-based ambulatory care settings, such as FQHCs. The ACA provides $230 million over five years for direct and indirect expenses associated with the creation of 600 additional primary-care residencies. The resident slots created through Teaching Health Centers will not affect the capped GME slots and instead provide an opportunity for communities that experience provider shortages to attract new residents, though new programs must receive accreditation, and funding is only guaranteed through 2015. Hidalgo Medical Services in southwestern New Mexico is approved to become a Teaching Health Center.

Finally, expanding residency slots and increasing the physician supply is necessary but will not likely be sufficient to meet future demand. The AAMC notes that even a robust expansion of GME would not eliminate the physician shortage, and the nation will need to transform the way health care is delivered, financed, and used to overcome the projected physician shortage.

Existing nursing and dental residency programs are insufficient. Residencies are not a mandatory component of nursing or dental training, but graduates may elect to participate in residency programs to develop specialized skills and receive support as they transition into the clinical workforce. Residency programs also help attract practitioners to medically underserved communities.

UNM's dental residency program funnels practicing newly-educated dentists into New Mexican communities with dental care needs. Following dental school, residents undergo a one-year residency through UNM to develop advanced skills. Though increasing access to oral health care in underserved populations is not the primary goal of the program, residents gain clinical experience in hospitals and clinics which serve as safety net providers, and the program serves as a pipeline for dental providers in underserved communities. Thus, residency programs are a promising mechanism for recruiting providers to the state. Ten residents are accepted into UNM's program annually, at a cost of $125 thousand per resident. The state appropriated $1 million for the program in FY13. UNM reports that 70 percent of the residents accepted in 2012 were from New Mexico, and 62 percent of dental residents are retained in the state following program completion. According to program directors, UNM would require additional faculty and capital investment to expand the program.

The New Mexico Center for Nursing Excellence supports the New Mexico Rural Nurse Residency program through a partnership with the Northwest Rural Nurse Residency program at Iowa State University. The program is funded by a HRSA grant. Like the UNM dental residency program, nursing residents complete a one-year residency program to assist their transition into the workforce. Three cohorts of nurses are accepted each year and placed in facilities with fewer than 200 beds around the state. Ten nurses are currently completing residency, and 15 nurses have completed the residency program since 2010. The Center for Nursing Excellence estimates a retention rate that exceeds 90 percent in the year following residency completion, though program evaluation will officially be conducted by Iowa State. Nationally, turnover among first-year nurses ranges between 35 percent and 60 percent, reports the Robert Wood Johnson Foundation. Thus, the New Mexico Rural Nurse Residency program suggests promising results and may be a model worth replicating or expanding.

Recommendations:

The Legislature should consider passing legislation to expand state-funded family medicine residencies. To accomplish this objective, the Legislature should appoint a panel of industry experts to study realistic strategies including revisiting the recommendations made in the 2008 Health Policy Commission report on state funded family medicine residency slots. The study group should make recommendations to the Legislature no later than November 2013, taking the following into consideration:

- Funds should be used to establish new residency slots, not supplant existing residency positions.
- The majority of these new residencies should be located in rural or underserved areas of the state.
- State I&G funded residents should be encouraged to commit to practice in New Mexico following residency.
- Planning should include locations, costs, possible matching revenue from Medicaid managed care organizations, and other medical groups, expected benefits, and reporting and accountability measures.

The Legislature should expand funding for WICHE slots to train additional dentists for New Mexico.

The Legislature should also examine the expansion of state-funded rural dental and nursing residencies in New Mexico.

New Mexico's public universities should report on the feasibility of creating additional master's-level clinical nursing programs to increase the state's NP supply.

REGULATORY AND PRACTICE BARRIERS PREVENT THE FULL EXPANSION OF NEW MEXICO'S HEALTHCARE WORKFORCE

The impact of doctors and dentists can be effectively extended through the expanded use of NPs, PAs, and non-dentist practitioners. Part of any healthcare workforce strategy should involve an examination of professionals whose roles can be further expanded to extend the impact of the healthcare team. Plans should also identify and reduce barriers to workforce expansion.

New Mexico should train more advanced practice professionals as force multipliers to help address healthcare needs. New Mexico will not likely be able to recruit or prepare a sufficient number of physicians to meet care demands. While working to increases its physician supply, the state should further develop its supply of NPs (NP) and PAs (PA). NPs and PAs already extend the physician workforce; 970 are licensed to practice in New Mexico, and many are effectively deployed in rural areas of the state. Similarly, New Mexico's 570 licensed PAs, although slightly less independent than NPs, are filling roles in primary care as well as assisting in specialty areas, such as surgery. Studies comparing the quality of care provided by physicians and NPs consistently confirm clinical outcomes of patients served by NPs and primary care physicians are no different (Mundinger et al, 2000; Kirkwood, Coster & Essex, 2006). Expanding the workforce with NPs and PAs could greatly ease New Mexico's physician shortage. Currently, UNM and New Mexico State University (NMSU) prepare NPs, while only UNM prepares PAs.

Table 25. New Mexico Institutions Offering Advanced Primary Care Training

	Physicians	NPs	PAs
Public	UNM SOM	NMSU UNM	UNM SOM
Proprietary		University of St. Francis	University of St. Francis

Source: LFC

New Mexico's limited production of NPs and PAs will inhibit the state's ability to expand its primary care workforce. NPs and PAs may perform approximately 70 percent to 80 percent of the procedures typically performed by a primary care physician, yet they may be trained more quickly and cheaply. While medical doctors must complete four years of medical school and a minimum of two years of residency before they are able to practice independently, an NP may be trained in approximately two years after earning a BSN, and a PA requires roughly two years of graduate-level training. NCSL estimates that NPs can be trained at 20 to 25 percent of the cost to train a physician, while a previous LFC evaluation of the UNM HSC estimated that the cost to educate a physician exceeds $500 thousand. The UNM College of Nursing estimates educating a BSN-level nurse to the NP level costs roughly $64 thousand.

Appendix G compares the professional scope and training required to produce physicians, NPs, and PAs and demonstrates that augmenting the state's healthcare workforce with NPs and PAs will be faster and cheaper than exclusively training doctors. However, New Mexico's production of NPs and PAs lags behind its production of medical doctors; between 2007 and 2011, UNM graduated 97 NPs and 79 PAs. NMSU graduated 137 NPs during the same period. The University of St. Francis graduates approximately 25 NPs and 30 PAs annually.

Table 26. Advanced Primary Care Training at UNM

	Length of Study After Bachelor's	Credit Hours	Approximate Total Tuition Cost
Physicians	6+ years	4 years/ full-time	$65,000
NPs	2 years	54-56	$31,000
PAs	27 months	86	$32,000

Source: UNM

Table 27. Advanced Care Providers Educated by Public New Mexico Institutions, 2007-2011

All Physicians	263
NPs	234*
Physicians Assistants	79

Source: HED

*Includes Certified Nurse Specialist graduates

The state needs to address barriers that prevent the expansion of NP training programs. Despite lower educational costs, the state's production of physicians continues to surpass that of NPs. Colleges of nursing cite several significant barriers that prevent program expansion.

Qualified nursing faculty serve as a barrier to expanding the nursing workforce. The shortage is healthcare professional faculty is cited as a significant barrier to expanding the clinician workforce nationally. Nurse educators must have master's degrees, at a minimum, to prepare associate's or bachelor's-level nurses.

Colleges of nursing and the state's nursing associations continue to cite nursing faculty shortages as a major barrier to expanding the nursing workforce, and UNM reports that schools must maintain a one to six faculty-to-student ratio in clinical courses for accrediting purposes. Colleges of nursing also report that the discrepancy between nursing faculty salaries and clinical nursing salaries is a significant barrier to attracting qualified faculty, and the HJM 40 report issued in 2009 cited nursing faculty salaries as a major barrier to expanding the nursing workforce. Since 2009, average nursing faculty salaries reported by the Department of Workforce Solutions have increased nearly 15 percent. Other states have attempted to address the shortage of nursing faculty through tuition assistance or repayment programs for clinicians considering teaching and other strategies including mentoring and partnerships with health care institutions.

Table 28. Nursing Salaries

Position	Average Salary
Instructor/ Lecturer (UNM HSC)	$78,336
Tenure Track Faculty (UNM HSC)	$89,883- $135,269
Instructor/Lecturer (NMSU)	$53,700
Tenure Track Faculty (NMSU)	$71,784
Instructor/Lecturer (SFCC)	$40,484 - $47,415
Nursing Instructor (statewide average)*	**$65,348**
Practicing Clinical Nurse (NM average)	$68,107
Practicing Clinical Nurse (national average)	$70,610
NP (NM average)	**$86,000**
NP (national average)	$90,583

Source: UNM HSC, Workforce Solutions, and Salary.com

* As reported by Workforce Solutions. Includes proprietary institutions

Healthcare education trends may further constrain the number of professionals providing direct care. Academic and professional communities increasingly call for advanced and professional degrees as entrance into practice requirements. While increasing academic requirements will ensure more extensive training for providers, new requirements may also limit the number of providers able or interested in providing direct care. In recent years, academic creep has affected allied health professions; both pharmacists and physical therapist must now earn doctoral degrees to enter practice.

New Mexico's nursing educator programs have worked through New Mexico Nursing Education Consortium (NMNEC) to develop a standardized ADN and BSN curriculum that will be adopted by all of the state's public institutions and facilitate student progression from ADN to MSN. Through collaboration, students at the state's community colleges will complete three years of training at the community college level, and then take a final year of courses at either UNM or NMSU, earning a BSN after four years. An efficient ADN to MSN pipeline is essential to provide nurses with the level of training required to enter practice as a NP, and an increase in BSNs will provide a larger pool of nurses who may earn master's degrees. UNM and NMSU currently offer graduate-level nursing programs, and ENMU is developing a master's level nurse-educator program.

Both NMSU and UNM have moved toward replacing master's-level nursing programs with doctoral-level programs. While this shift will increase the supply of nurses with advanced degrees who may serve as faculty, requiring practicing nurses to obtain doctorate-level degrees will reduce the supply of NPs and advanced practice nurses available to provide direct services.

The state's colleges and nursing organizations also identified the following as additional barriers to expanding the NP supply:

- Lengthy and cumbersome credentialing processes, delaying and preventing NPs from practicing;
- Differences between physician and NP reimbursement for identical procedures;
- Insufficient clinical sites and clinical proctors.

To address insufficient clinical sites, several states, including Michigan, Tennessee, and Oregon, have developed centralized clinical placement agencies which coordinate health care institution and education institution needs. To provide financial incentives for institution participation in clinical placement, Colorado has considered institution subsidies and tuition increases to pay clinical sites. To reduce credentialing barriers, NCSL suggests that instituting a single process for verifying and credentialing providers may streamline the process and reduce administrative health costs.

The state should also examine regulations which may limit providers from working to the full extent of their licenses. New Mexico's nursing scope of practice act is one of the most expansive in the county and serves as a model for other states. New Mexico is one of 18 states which allows NPs to practice independently. Practice acts for other healthcare professionals are not as expansive, however.

Modifying regulatory statutes that govern other advanced practice providers, including PAs and prescribing psychologists, may help eliminate barriers to full practice. Like NPs, PAs may be trained much more quickly than doctors, and their training is relatively inexpensive. However, PAs must work under the supervision of a physician, though the supervising physician need not be present when a PA practices. In New Mexico, PA scope of practice is more limited than that of NPs, though PAs can examine, prescribe, and treat patients. Prohibiting independent PA practice may thus serve as a barrier to expanding this workforce. PAs are licensed by the New Mexico Medical Board to practice as part of a physician-led team.

Similarly, New Mexico allows for specially trained, doctoral-level psychologists to prescribe medication in consultation with primary care physicians. Presently, 39 prescribing psychologists are licensed in the state. Practitioners report that the supervision required for independent prescribing practice may limit the supply of prescribing psychologists. Prescribing psychologist supervision barriers should thus be further examined for possible ways to expand this workforce as a method to assist psychiatrists, a critical shortage area in New Mexico.

New Mexico should examine barriers to expanding the state's supply of master's-level behavioral health counselors. The state must move quickly to remove possible barriers to expanding the behavioral health workforce by streamlining restrictions on mental health counselor reciprocity, expanding capacity for clinical supervision, and expanding the activities that can be reimbursed under Medicaid, such as case consultation. The behavioral health master's degrees that qualify for licensure in New Mexico are limited to social work and several counseling areas. Other states, including Arizona, Colorado, and Oregon, have expansive licensure regulations that allow more professionals to provide care by accepting a wider array of mental health master's-degrees, including various counseling and psychology degrees, to qualify for supervision and licensure. Oregon's Qualified Mental Health Professional designation is a model worth considering to expand the state's pool of mental health counselors.

Telehealth may also facilitate the supervision of counselors seeking licensure in areas where an on-site supervisor is difficult to arrange. Supervision, particularly in remote areas, is challenging but is crucial to the training and licensing of independent providers who may bill for mental health services. To become a Licensed Independent Social Workers (LISW), Licensed Masters Level Social Workers (LMSW) must complete 3.6 thousand clinical hours under the supervision of an LISW. Supervision must occur in person and is costly and time-consuming. Exploring telehealth models of clinical supervision may reduce barriers to the acquisition of LISW status. The New Mexico branch of the National Association of Social Workers suggests telecommunication may be an effective way to facilitate the supervision of LMSWs seeking licensure at remote sites and increase the supply of behavioral health providers in New Mexico.

New Mexico may expand the dental workforce through the use of trained professionals working under the guidance of dentists. In 2011, legislation to allow dental hygienists to take on additional dental duties, such as administering local anesthesia in prescribed situations, was passed. The New Mexico Dental Board has since adopted rules on these expanded hygienist functions. However, the state has not established training programs and lacks faculty to prepare expanded hygienists. Developing the capacity to train dental hygienists for expanded functions would enable the extension of the dental workforce. The Legislature should also revisit the concept of dental therapists as an additional way to provide care to under-served areas under the supervision of dentists.

Recommendations:

New Mexico's healthcare licensing boards should conduct a comprehensive review of all healthcare professional practice acts to judiciously reduce barriers to workforce expansion.

The New Mexico Medical Board should revisit the scope of practice for PAs to allow these professionals the same degree of independence that NPs are allowed in the state. PAs should be allowed this independent practice status after completing three to five years of clinical supervision by a physician.

The New Mexico Dental Board should coordinate planning that will provide programs to train dental hygienists in the expanded practice skills that are now allowed in administrative rule.

The New Mexico Psychological Board should examine the regulatory steps required to become a full-fledged prescribing psychologist to reduce the two years that are currently required as a "conditional" prescribing psychologist. After training, completing 400 hours of clinical supervision, and passing the required examination, prescribing psychologists should be allowed to practice in consultation with a primary care physician.

The New Mexico Regulation and Licensing Department should explore rules to expand the number of mental health masters degrees that qualify for supervision and licensure – using Arizona, Oregon and Colorado as examples.

The New Mexico Regulation and Licensing Department should consider ways to streamline the requirements for mental health counselor reciprocity with other states to facilitate adding experienced professionals to the New Mexico workforce and study ways to expand the capacity for clinical licensure supervision – including the creation of rules to allow the supervision of master's level therapists (LPCCs and LMSWs) to take place via telecommunication technology at sites where a licensed supervisor cannot be physically present.

The New Mexico Legislature should revisit the concept of dental therapists as an additional way to provide dental care to underserved areas, under the direction of supervisory dentists.

The New Mexico Legislature should create a single state-wide credentialing agency for healthcare professionals and require that all healthcare insurers operating in the state use the agency for credentialing purposes.

New Mexico's public major should <u>not</u> require all NPs to earn a doctorate degree. In addition to the emerging Doctor of NP degree program, New Mexico's public institutions should maintain master's-level clinical nursing programs to ensure an adequate supply of NPs providing direct care.

APPENDIX A: Evaluation Objectives, Scope And Methodology

Evaluation Objectives:

This evaluation examines the adequacy of New Mexico's healthcare workforce to meet the demands of the Affordable Care Act when it is implemented in 2014. The evaluation also looks at the adequacy of the healthcare workforce to meet longer-range demands associated with population growth and aging.

Objective 1: Assess the demand for healthcare workers stemming from the expansion of insurance coverage with the Affordable Care Act and with Medicaid expansion in New Mexico. Also access the longer-range demand associated with population changes. Determine the current and projected supply of healthcare professionals in New Mexico, including physicians, NPs, PAs, registered nurses, dentists, dental hygienists, psychologists, and masters-level behavioral health counselors. Also assess potential barriers to expanding the healthcare workforce.

Objective 2: Assess how healthcare service delivery systems will need to change to address New Mexico's healthcare needs.

Objective 3: Assess the current training and education of healthcare professionals in New Mexico.

Objective 4: Assess current recruitment and retention activities for New Mexico's healthcare workforce

Scope and Methodology:

- Interviewed healthcare professionals organizations, associations, licensing boards, educators, recruiters, and other key individuals to obtain a picture of the adequacy of New Mexico's healthcare workforce.
- Obtained and analyzed data from the NM Higher Education Department regarding the education and working status of selected healthcare professionals in New Mexico.
- Obtained physician survey data from the New Mexico Center for Health Workforce Analysis at the UNM HSC.
- Researched national literature dealing with all aspects of the healthcare workforce and emerging demand.

Evaluation Team:

- Jack Evans, Program Evaluator, Project Lead
- Rachel Mercer-Smith, Program Evaluator

Authority for Evaluation: LFC is authorized under the provisions of Section 2-5-3 NMSA 1978 to examine laws governing the finances and operations of departments, agencies, and institutions of New Mexico and all of its political subdivisions; the effects of laws on the proper functioning of these governmental units; and the policies and costs. LFC is also authorized to make recommendations for change to the Legislature. In furtherance of its statutory responsibility, LFC may conduct inquiries into specific transactions affecting the operating policies and cost of governmental units and their compliance with state laws.

Exit Conferences: The contents of this report were discussed with the Department of Health and with other key participants on April 4, 2013.

Report Distribution: This report is intended for the information of the Office of the Governor; the New Mexico Department of Health; Office of the State Auditor; and the Legislative Finance Committee. This restriction is not intended to limit distribution of this report, which is a matter of public record.

Charles Sallee
Deputy Director for Program Evaluation

APPENDIX B: HPC Recommendations

In its January 2011 report, *Recommendations to Address New Mexico Healthcare Workforce Shortages*, the New Mexico Health Policy Commission recommended twelve strategies:

1. Expand New Mexico Health Services Corps to provide additional stipends and community contracts to encourage rural practice
2. Expand the New Mexico Health Professional Loan Repayment Program
3. Expand the New Mexico Loan-for-Service Program
4. Establish a Primary Care Physician conditional tuition waiver program
5. Promote legislation to tax alcohol, tobacco or sugared soft drinks to fund healthcare loan reimbursement programs
6. Explore ways to promote a more diverse healthcare workforce
7. Expand the number of federally subsidized Graduate Medical Education residency slots
8. Support the development of mid-level oral health providers
9. Promote legislation to create 60 lottery scholarship slots for NPs and PAs who agree to work in NM for 3 years
10. Create a state entity to coordinate health professional workforce needs and efforts
11. Support efforts to track the health workforce
12. Expand New Mexico mid-level provider training programs

Bernalillo	310
Catron	0
Chaves	8
Cibola	4
Colfax	3
Curry	3
De Baca	0
Dona Ana	29
Eddy	7
Grant	19
Guadalupe	0
Harding	0
Hidalgo	1
Lea	6
Lincoln	1
Los Alamos	10
Luna	3
McKinley	12
Mora	0
Otero	10
Quay	0
Rio Arriba	13
Roosevelt	1
San Juan	30
San Miguel	6
Sandoval	23
Santa Fe	48
Sierra	5
Socorro	2
Taos	19
Torrance	0
Union	0
Valencia	4
Total	577

Source: NM Medical Board

APPENDIX D: Registered Nurses Licensed by County, 2012

Bernalillo	7,678
Catron	26
Chaves	504
Cibola	132
Colfax	99
Curry	384
De Baca	16
Dona Ana	1,864
Eddy	471
Grant	366
Guadalupe	31
Harding	3
Hidalgo	13
Lea	440
Lincoln	170
Los Alamos	179
Luna	108
McKinley	539
Mora	41
Otero	478
Quay	55
Rio Arriba	217
Roosevelt	108
San Juan	975
San Miguel	347
Sandoval	1,550
Santa Fe	1,453
Sierra	79
Socorro	83
Taos	290
Torrance	81
Union	36
Valencia	586
Total	19,402

Source: NM Nursing Board

Bernalillo	410
Catron	0
Chaves	29
Cibola	7
Colfax	7
Curry	19
De Baca	1
Dona Ana	103
Eddy	26
Grant	13
Guadalupe	2
Harding	1
Hidalgo	1
Lea	22
Lincoln	9
Los Alamos	8
Luna	8
McKinley	18
Mora	2
Otero	10
Quay	6
Rio Arriba	14
Roosevelt	5
San Juan	22
San Miguel	12
Sandoval	68
Santa Fe	81
Sierra	3
Socorro	7
Taos	23
Torrance	4
Union	4
Valencia	25
Total	970

Source: NM Board of Nursing

APPENDIX F: Oral Healthcare Providers Licensed by County, 2013

	Dentists	Hygienists
Bernalillo	446	434
Catron	1	0
Chaves	24	23
Cibola	7	9
Colfax	5	4
Curry	23	22
De Baca	1	1
Dona Ana	97	95
Eddy	15	21
Grant	15	13
Guadalupe	0	1
Harding	0	0
Hidalgo	0	0
Lea	11	14
Lincoln	10	4
Los Alamos	15	12
Luna	6	7
McKinley	17	8
Mora	0	1
Otero	14	14
Quay	1	2
Rio Arriba	4	10
Roosevelt	3	4
San Juan	71	77
San Miguel	9	9
Sandoval	69	72
Santa Fe	122	80
Sierra	5	4
Socorro	3	1
Taos	19	13
Torrance	2	4
Union	0	0
Valencia	21	44
Total	1036	1003

Source: NM Dental Board

APPENDIX G: Primary Care Provider Comparison

	Length of Training after Bachelor's Degree	Clinical Training	Approved Procedures	Independent Practice	Median Annual Salary	Reimbursement	Practice Specialty
MD	6+ years	3+ years in clinical and residency training	May examine, diagnose, and treat patients; may prescribe medication; may perform surgery and other invasive procedures; may order related therapies, screenings, and hospice care; may admit patients for in-patient hospital care and may pronounce death. Scope of practice determined by the Medical Practice Act.	Yes	$185,000	According to insurance fee-schedule	35% work in primary care, nationally
NP	2-3 years	NPs must hold a BSN prior to earning an advanced degree and thus often have years of clinical experience	May serve as a primary care provider and examine, diagnose and treat patients; may prescribe medication; may order screenings and related therapies; may assist in surgery; Cannot perform invasive procedures, such as colonoscopies or tumor biopsies; may not order home health or hospice care; may not admit patients for in-patient hospital care; may pronounce death.	Yes	$86,000	Medicare reimbursement if typically 85% of physician fee-schedule	75% work in primary care, nationally
PA	27 months, full-time after bachelor's degree	9-15 months	Specific services provided are agreed upon by the PA and supervising physician and must conform to the Medical Practice Act. May examine and treat patients; may prescribe and administer medication under the direction of a physician; may assist in surgery but cannot independently suture major lacerations or manipulate fractures if the procedure requires general anesthesia; cannot perform invasive procedures, such as colonoscopies or tumor biopsies; may not order home health or hospice care; may not admit patients for in-patient hospital care; may not pronounce death.	Physician remains the head of the practice. PAs must be supervised by a physician. The physician need not be on-site but the PA should have prompt access to the physician	$75,000	Medicare reimbursement is typically 85% of physician fee-schedule	32% work in primary care, nationally

Source: LFC analysis

APPENDIX H: Active Physicians in New Mexico

County	Primary Care	Internal Medicine	Surgical	Other Specialty	Unknown
Bernalillo	587	267	224	897	1
Catron	1	-	-	-	-
Chaves	45	11	10	47	-
Cibola	19	-	1	4	-
Colfax	9	-	2	6	-
Curry	24	5	9	11	-
DeBaca	-	-	-	1	-
Dona Ana	111	32	32	116	-
Eddy	27	5	11	24	-
Grant	23	2	5	23	-
Guadalupe	2	-	-	-	-
Harding	-	-	-	-	-
Hidalgo	1	-	-	-	-
Lea	17	3	4	23	-
Lincoln	8	1	1	8	-
Los Alamos	26	6	7	14	-
Luna	7	3	3	8	-
McKinley	43	7	10	35	-
Mora	-	-	-	-	-
Otero	25	6	7	26	-
Quay	5	-	-	4	-
Rio Arriba	24	1	5	12	-
Roosevelt	8	-	1	5	-
San Juan	69	22	17	72	-
San Miguel	23	1	6	18	-
Sandoval	60	6	4	22	-
Santa Fe	146	30	31	153	-
Sierra	6	1	-	3	-
Socorro	10	-	1	9	-
Taos	31	2	10	14	-
Torrance	1	1	-	-	-
Union	2	-	2	-	-
Valencia	21	-	-	5	-
Not Specified	27	7	6	33	39
Not NM*	42	27	28	199	-
Total	**1,450**	**446**	**437**	**1,792**	**40**
Adjusted for missing 12.6%	**1,633**	**502**	**492**	**2,018**	**45**

Source: New Mexico Center for Workforce Analysis at UNMHSC

* Not Specified means that the doctor does not have an identified practice county - such as a locum tenens

** 12.6% were not yet collected at the time of analysis and total is adjusted to more accurately reflect the number of doctors practicing in NM.

APPENDIX I: Predicted Levels of the Insured and Uninsured after ACA Implementation

Newly Eligible Medicaid Population	Exchange Population (~189,000 eligible for subsidies)	Remaining Uninsured Population
• HSD projects that 170 thousand New Mexicans, including the 38 thousand people currently enrolled in SCI, will become eligible for Medicaid under expansion. Of these, 137 thousand of the newly eligible will enroll in 2014 and 167 thousand will enroll by 2020. • Mathematica predicts that the newly eligible Medicaid population will include a mix of healthy and chronically ill; • Many of the first adults to enroll will likely those with the most significant health care needs • Mathematica also predicts that individuals who are below 50 percent of the FPL will have the highest levels of morbidity, including high rates of mental illness and substance abuse • States that have expanded coverage to low-income adults previously provide evidence about the likely healthcare needs and costs of the newly insured: • Oregon extended coverage to childless adults and found that the newly enrolled have greater healthcare utilization across all categories of service, including inpatient admissions, emergency room visits, and mental health/substance abuse services. • The newly eligible tended to use services most intensively during the month following coverage • Oregon found that the group most likely to enroll among the newly eligible was those with the lowest-incomes. These individuals tended to have more complex, chronic health needs than those close to the 133%FPL threshold • Maine expanded Medicaid coverage to adults up to 100% of the FPL and found that this population tended to have multiple, chronic health needs	• Currently uninsured New Mexicans who are ineligible for Medicaid. Exchange enrollment will be subsidized for New Mexican's with incomes below 400% of the FPL • The projected 2019 population is relatively older, less educated, lower income, and more racially diverse than the current privately-insured population (Kaiser). • Adults 19-64 account for 84% of projected enrollees, while the average age of enrollees is 35 • Males make up a slight majority of the Exchange population (52%) • Hispanics are predicted to account for 25% of the projected enrollees, while Whites will account for 58% • The majority of projected Exchange enrollees will transition from being previously uninsured (65%) and will demonstrate pent-up demand • Adults projected to enroll in the Exchanges report that they are in worse health but have fewer diagnosed chronic conditions than currently privately-insured populations • The Exchange population is much lower income than the projected non-Exchange population	• New Mexico's undocumented immigrant population will remain uninsured and continue to access care through the state's safety net system • The Pew Hispanic Center estimated New Mexico's undocumented population to be between 75 and 85 thousand in 2008 • Documented immigrants are eligible for Medicaid coverage after five years in the U.S. • The tax penalties may not be enough to induce adults to enroll in Medicaid or the Exchange; the penalty will only only apply to those with gross incomes above the income tax filing threshold ($9,350 for single filers under age 65 in 2009). In addition, the maximum penalty in 2014 will be only $95. • According to Kaiser, the projected population forgoing purchasing health insurance in the Exchange is of middle to upper-income and reports better health than the Exchange population. However, the eligible population projected not to enroll in the Exchange tends to have a lower income than individuals who are projected to purchase insurance in the non-Exchange non-group market. • Nationally, the Urban Institute predicts that 19 million Americans will remain uninsured after the implementation of the ACA • The Institute predicts that New Mexico's uninsured rate will decrease to 12% following the implementation of the ACA (~240 thousand people)

APPENDIX J: Additional Uninsured Groups

New Mexico is home to over 177 thousand veterans, 13 thousand of whom are uninsured veterans, representing 12.7 percent of the non-elderly veteran population. However, veterans are typically less likely than the rest of the non-elderly population to be uninsured. Nationally, one in 10 veterans under the age of 65 reported neither having health insurance coverage nor using the VA for healthcare needs. Approximately 900 thousand veterans in the United States use VA care but have no other health insurance coverage. These uninsured veterans tend to be younger, recently discharged, have lower levels of education, are less likely to be married and more likely to be unemployed than their insured counterparts. Forty-one percent of uninsured veterans report unmet medical needs, while 34 percent report having delayed care.

Veterans are eligible for VA healthcare and are not subject to the individual insurance mandate. To take advantage of their VA benefits, patients must receive care from an approved VA healthcare site. With the expansion of Medicaid in New Mexico, more veterans will now have insurance coverage and hence more choices in where they receive services. Like IHS, private insurance and Medicaid provide additional revenue for the VA.

The New Mexico Department of Health (DOH) reports a 2010 uninsured rate for Native Americans of 35 percent, approximately 72,800 people. Native Americans who are enrolled members of federally recognized tribes can receive free medical care from Indian Health Service (IHS) facilities or from tribal-run clinics organized under federal law.

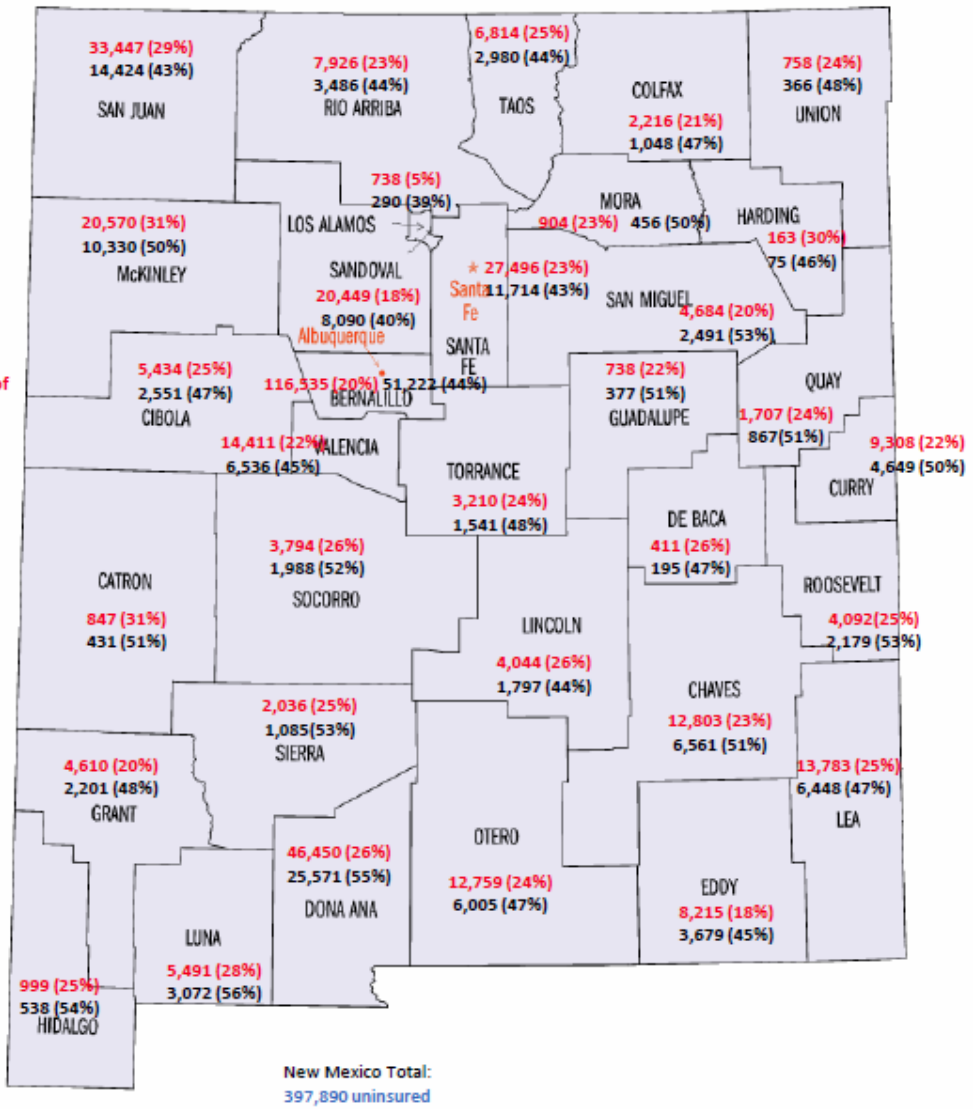
With the expansion of Medicaid, newly eligible tribal members will have additional choices as to where they receive health care. IHS providers and tribally-operated healthcare systems, which may receive Medicaid and private insurance reimbursement, will have additional sources of revenue as Native Americans seek coverage. However, Native Americans are exempt from the individual mandate to obtain insurance under the ACA and may instead choose to continue utilizing IHS services. Native Americans who are not eligible for Medicaid and choose not to purchase private insurance will still be considered uninsured, though they will not be subject to the individual mandate penalty, and may still be unable to access inpatient care or specialty services. Therefore, an uninsured Native American population will likely continue to exist after the implementation of the ACA and the expansion of Medicaid.

APPENDIX K: Health Care Preparation Offered by New Mexico's Public Institutions

	CCC	CNM	ENMU	LCC	NMHU	NMJC	NMSU	NNMC	SFCC	SJC	UNM	WMNU
Clinical Social Work (BSW+)			√		√		√					√
Counseling (Master's Level)			√		√		√				√	√
Dental Hygiene			√				√			√	√	
Medical School											√	
Occupational Therapy											√	
Pharmacy											√	
Physical Therapy											√	
PA											√	
Radiography	√	√	√				√	√			√	
Registered Nursing	√	√	√	√	√	√	√	√	√	√	√	√

Source: HED

Estimated Uninsured Population Under Age 65 by County



Source: U.S. Census Small Area Health Insurance Estimates, 2010

Appendix C
Engagement Activities

State-Level, Issue-Specific Engagement Activities

List of Priority Public Health Issues[1]	Coalitions	Example How Group Discussion Contributed to Understanding the Priority	Dissemination	Collection
1) Healthy Weight	Healthy Kids New Mexico (HKNM) (NMDOH Lead)	Participating communities were selected based on their population size, poverty status, racial/ethnic diversity, geographic diversity, chronic disease burden and readiness to implement. Communities are working together to improve active lifestyles and healthy eating behaviors by using RBA to develop action plans, which are monitored and improved.	HKNM has the following membership: Chaves County Cibola County Curry County Doña Ana County Guadalupe County Lea County Luna County McKinley County No. Rio Arriba County Socorro County Mescalero Apache Tribe San Ildefonso Pueblo Santa Clara Pueblo Zuni Pueblo	The CDC Community Transformation Grant supports much of the work of HKNM, which was a no-cost/low-cost project that started in Dona Ana County.
2) Teen Births	MyPower, Inc.	MyPower, Inc., a non-profit 501(c)3, organized in 2009 in Hobbs N.M., has implemented two group mentoring programs that are proven to help empower young women to successfully navigate the teen years by helping them make good choices, succeed academically, and avoid teen pregnancy. These youth development programs provide girls with straight talk about issues they will face as they enter the teen years; and, these programs	The community is aware of the organization and the work that they are doing in the community. The staff members of MyPower are active in participating in meetings for other community organizations. They are also active in meeting with the local school board to garner support for abstinence-plus programming.	The J. F Maddox Foundation had the MyPower curriculum evaluated by Dr. Escamila. This has helped MyPower with quality improvement efforts.

		provide participants with the tools to help them along that path.		
Healthy Seniors				
4) Fall-Related Injury and Deaths Among Older Adults	Healthy Aging Collaborative	The group provides a forum for information sharing and partnership development and acts as a statewide advisory resource to improve the overall health status and quality of life for seniors and the frail elderly, which includes falls prevention.	The recommendations and resources developed by this group have been provided to senior constituents and organizations representing various public health agencies and aging network providers.	The Collaborative members represent the broad and diverse New Mexico state and tribal healthy aging partnership, and share their communities' perspectives with the group.
	New Mexico Adult Fall Prevention Coalition	This group is a multi- agency group working to develop and implement evidenced based prevention strategies based on the Falls Free National Action Plan. Currently the Falls Prevention Coalition is working on developing and circulating a survey to assess current availability of community fall prevention programs for the purpose of acquiring evidence of which organizations are practicing, and how many individuals are participating in Falls Prevention interventions.	The NM Falls Coalition information is disseminated on the National Council Aging website, and is widely distributed to fall preventionists around the state	Group members represented many different state agencies and state and local organizations involved in behavioral health promotion and falls prevention, and shared their colleagues' and constituents' perspectives with the group.

Infectious Diseases	NM Healthcare-associated Infections Advisory Committee (HAI AC)	The HAI AC discusses all aspects of HAI reporting and prevention activities among the members. This encompasses both hospital mandatory reporting (central line-associated bloodstream infections and *Clostridium difficile* laboratory identified events) as well as voluntary reporting (e.g., healthcare personnel (HCP) influenza vaccination) from a variety of healthcare facilities. Facilities represented on the AC participated in a pilot of HCP influenza vaccination reporting and the AC continues to monitor and respond to challenges in improving HCP influenza vaccination rates.	The NM HAI AC provides an annual public report on HAI surveillance and prevention activities that occur in collaboration with NMDOH. The report is available in hard copy on request and is posted on the NMDOH HAI website. A four-page consumer-oriented overview was also prepared and released in 2012.	Information included in the public report pulls from data provided directly by healthcare facilities across NM and from participants in prevention collaboratives. Data is accessed through National Healthcare Safety Network (NHSN) a CDC-supported national database. Subjective reports from participants are collected by members of the HAI AC during prevention activities that they are involved in such as the NM Hospital Association Hospital Engagement Network.
	HIV Community Planning and Action Group	The group has several members that belong to high risk populations and regularly discuss ways to improve testing and services to these high risk populations	We have provided the group a link to our Annual report, and CPAG members may have disseminated the link to other people outside of the group.	Both HIV program in ERD and PHD have presented information/data to this group
5) Adult Immunization	Influenza Sentinel Surveillance Network	Data reported by the network healthcare sites within health regions of the state will track and highlight areas of increased influenza	A weekly Influenza Surveillance Report is posted on the NMDOH Influenza website that details the influenza activity in the state as measured by outpatient visits for influenza-like illness which are reported by	Not sure if this answers the question but referring to the other indicators above: 1) the *laboratory testing for influenza* data are reported

		activity. NMDOH uses that data to plan enhanced influenza immunization activities in a region as a response to the increased activity noted.	the sentinel network (other indicators such as *laboratory testing for influenza* and *influenza-associated hospitalizations* are also reported in the surveillance report).	by a separate network of hospital-based labs around the state, and 2) the Emerging Infections Program collects and reports data on *influenza-associated hospitalizations*. The data are reported by Infection Preventionists located at the reporting hospitals.
	New Mexico Immunization Coalition (NMIC), Clinical Prevention Initiative (CPI), New Mexico Association for Professionals in Infection Control (APIC)	1. New Mexico Immunization Coalition (NMIC): This group promotes public education, provider education, policy development, and advocates for adult immunizations across the state. They also periodically sponsor special immunization events across New Mexico. 2. CPI: This group focuses on promotion of clinical preventive services, including adult immunization. Published data suggests that the efforts of the CPI have improved adult pneumococcal vaccine uptake in New Mexico 3. New Mexico APIC: This group is active in promoting influenza immunization of healthcare workers in hospitals statewide. Data support	Information from all 3 groups is disseminated in the form of meeting minutes, published articles (CPI, APIC), annual reports, presentations at professional meetings (APIC, NMIC), annual immunization policy revisions (NMIC), and on their respective websites	Example: NMDOH and NMIC are currently collaborating on a survey of vaccine exemptors that will inform education and policy. Example: NMIC works every year to gather stakeholders from a variety of organizations to review data and existing research in order to make recommendations for revisions to the adult and childhood immunization schedules in New Mexico.

		that collaboration between NMDOH and APIC have improved HCW influenza vaccination rates in New Mexico		
6)Tobacco Use	The Disability Advisory Group About Tobacco (DAGAT)	DAGAT's participation in TUPAC has resulted in adaptations to our QUITNOW services that have increased access for the Deaf and Hard of Hearing. DAGAT has made presentations to other TUPAC partners and other health groups to increase their understanding and awareness of access issues for people with disabilities, in particular, the Deaf culture. DAGAT's advisement to TUPAC has helped in justifying data collection needs for this population, notably strengthening the support and rationale for adding questions to the Youth Risk and Resiliency Survey (YRRS) about youth with disabilities. Working with DAGAT has helped TUPAC understand how living with a disability creates isolation which is a risk factor for tobacco use and access to services is a barrier which prevents	DAGAT has designed a logo, brochures and posters that have been displayed at conferences and community events. TUPAC with its evaluation partner designed a Grantee Fact Sheet which has been disseminated at conferences and community events, as well. Recently, a representative from DAGAT attended two national conferences and presented the work of the coalition at a break-out session and a tabling event.	NA

		people with disabilities from getting the services they need for tobacco cessation. By linking the DAGAT coalition with other partners and providers, TUPAC can help increase reach and awareness about people living with disabilities and their need to be connected and able to access services.		
	Tobacco Program - Evolvement Statewide Youth Coalition	At the 2012 Evolvement New Mexico Leadership Team Summit, Kim Rutley from DOH gave an educational presentation on hookah, and the dangerous influence it may have on teens in the state. The youth members of the leadership team shared personal stories of classmates and friends who use hookah, and how prevalent and "cool" it is in their communities. Many shared that parents and teachers did not seem to know it was a dangerous product. The result is the planning of a new Evolvement campaign focused on hookah awareness.	High school teens across New Mexico go through a 4- hour training to become Evolvement members. During the training, they learn tobacco-related facts as well as worldwide, nationwide, and statewide statistics about tobacco use and health effects. Youth also learn about Evolvement's campaign efforts in New Mexico, and how they can get involved and take action to promote tobacco-free lifestyles in their schools and communities. Once they are trained, Evolvement members have educated members of their community about the importance of tobacco-free schools, tobacco-free homes and cars, and flavored OTPs. For each of these respective campaigns, members of the public received an informational handout (known as an info card) after completing a Measure of Progress for the campaign -such as a survey or message card	As part of their campaigns, Evolvement members collect Measures of Progress from the public. Measures of Progress are tangible and quantifiable measures that the public takes in support of the campaign - such as surveys or message cards. The findings from Evolvement's Meltdown campaign were submitted to the FDA's Tobacco Products Scientific Advisory Committee. This past fall, an Evolvement member had the opportunity to present those findings with Dr. Lawrence Deyton, Director of the FDA's Center for Tobacco Products, during a joint session at the National Conference on Tobacco or

				Health in Kansas City. Right now, Evolvement members are collecting surveys from the public as part of its new campaign around flavored tobacco products, (dis)tasteful. The surveys will help 1) assess the perception of flavored OTP in New Mexico 2) assess youth and adult consumption of, and access to, flavored OTP, and 3) measure support for a ban on all flavored tobacco products.
	Fierce Pride (LGBTQ Network)	Fierce Pride has been very involved in working toward the establishment of smoke-free Gay Pride events in Albuquerque. The positive presence they have established has led to restrictions on smoking at Albuquerque Pride that limits smoking to an established smoking area only. Previous to this effort, Albuquerque Pride events, which are conducted over one week and culminate in an outdoor festival, had not restricted smoking at any of	Fierce Pride has been instrumental in helping develop training tools for medical providers to assess the providers' ability to provide culturally competent and respectful health care. These trainings have been particularly focused on the LGBT community in Santa Fe.	In previous years, Fierce Pride has conducted convenience sample surveys at Gay Pride events in an effort to assess opinion from among the LGBT community. They surveys have asked questions about such issues as tobacco cessation and attitudes toward smoke-free Gay Pride events.

		its outdoor events. Additionally, Fierce Pride has partnered with advocates from Santa Fe to work toward refusal of tobacco industry funding for Santa Fe Pride events.		
	Tobacco Program – Mosaic Voices (Asian/PI Network)	The training plan for the current fiscal year for MV includes efforts to train network members in data collection specifically to make up for the fact that very little disaggregated data exists for Asian and Pacific Islander (A/PI) populations in New Mexico. This is due to the fact that the percentage of the population of the A/PI community is very small in New Mexico.	No. This group is only in its second year of existence and is still working to build capacity among network members and to establish itself as a force for change among the A/PI communities of Albuquerque	The efforts to build this coalition has been informed by concerned members of the community, especially including the Board of Directors of the New Mexico Asian Family Center
	Smoke Free New Mexico Housing Coalition (SFNMH)	Shared information about American Lung Association Smoke Free Training Online in FY 12. Provided Live Smoke Free full-day training in Albuquerque in FY 12.	Not at this time. The Georeferenced database was completed and there is discussion within the SFNMH Coalition on how to best use the data collected. This effort began in FY 12 and was completed in FY 13. This Coalition is relatively new and they have recently created a name and logo. More information from the coalition will be forthcoming in FY 14.	.The Geo-referenced database was completed in FY 13. A statewide poll to 500 rental homes was created and is in the process of being approved. We anticipate having the poll completed by the end of FY 13 and a training will be given to the SFNMH Coalition on the results.

	Tobacco Program – Southwest Tribal Tobacco Coalition	The STTC has been in existence since 2007. There primary goal is to improve the health of tribal people living in New Mexico (NM)by focusing on youth through commercial tobacco prevention, cessation, and policies, while respecting traditional practices and ceremonies associated with tobacco use. This group has had several discussions concerning the differences in using tobacco for ceremonial and commercial purposes. The coalition has emphasized the use of tobacco for ceremonial purpose as a healing element. There have been discussions about adding a question pertaining to ceremonial use for the New Mexico Youth Risk and Resiliency Survey. The coalition members have had discussions and training on the issue of Native American Historical Trauma. Discussions have been centered around tribal community needs that affect	The members of the group are active in their respective communities. The information is disseminated through health councils, media literacy presentations and community events.	Over the years some members of the STTC have sought out qualitative information from their respective communities as related to traditional tobacco use. There is also an effort to conduct some focus groups regarding whether to add a traditional tobacco use caveat to the YRRS tobacco module of questions to ensure that Native American youth are reporting only on commercial tobacco use.

		the pueblos as well as other New Mexico tribes. The group has established a connection with the Southwest Navajo Tobacco Education Prevention Project (SNTEPP). The STTC and SNTEPP are collaborators in addressing secondhand smoke exposure in Native American casinos.		
Substance (Drug and Alcohol) Use and Mental Health	State Epidemiological Outcomes Workgroup (Lead agency: NMHSD)	This group provides annual input regarding the content of the New Mexico Substance Abuse Epidemiology Profile (e.g., in 2010-11 the group requested the addition of several mental health indicators to the report, to support requests from the federal Substance Abuse and Mental Health Services Administration; these indicators been included in the report since the 2011 edition); and reviews the draft report prior to publication	The New Mexico Substance Abuse Epidemiology Profile informed by this group's input is disseminated on the NMDOH website, and is widely distributed in hard copy format to community substance abuse coalitions and preventionists around the state; it is not known at this time whether NMHSD BHSD distributes this report in hard copy to community mental health providers that it funds	Group members represent the broad and diverse New Mexico state and tribal substance abuse prevention community, and share their communities' perspectives with the group
	Prevention Policy Consortium (Lead agency: NMHSD)	This group drafted and published the 2012 Five-Year Behavioral Health Promotion and Prevention Plan for New	The Five-Year Behavioral Health Promotion and Prevention Plan developed by this group has been widely disseminated in New Mexico, both to the multiple state agencies	Group members represented many different state agencies and state and local organizations involved

		Mexico, which included goals to: reduce binge drinking and underage drinking by 5% in New Mexico by June 2017 (Goal 2); reduce alcohol-related injury and death by 5% in New Mexico by June 2017 (Goal 3); and reduce alcohol-related motor vehicle crashes and deaths by 5% in New Mexico by June 2017 (Goal 4); andReduce prevalence and/or negative effects of mental, emotional and behavioral (MEB) disorders by 5% in New Mexico by June 2017 (Goal 6). NMDOH contributed substantially to shaping this focus of the strategic plan on alcohol.	that were partners to the plan's development (including NMDOH); and to groups such as the New Mexico Behavioral Health Collaborative.	in behavioral health promotion and substance abuse prevention, and shared their colleagues' and constituents' perspectives with the group
7) Drug Overdose Deaths	Prescription Drug Misuse and Overdose Prevention and Pain Management Advisory Council (Lead agency: NMDOH)	Prescription Drug Misuse and Overdose Prevention and Pain Management Advisory Council (Lead agency: NMDOH)	The recommendations developed by this group have been provided to the New Mexico Office of the Governor; and disseminated from there as deemed appropriate by the Governor.	Invited participants in this group included representatives from each of the New Mexico healthcare provider licensing boards, who brought their colleagues' input to the group; the meetings were also open to the public, and were regularly attended by and received meaningful input from important community partners,

				including patient advocates and substance abuse treatment specialists
	Prevention Policy Consortium Rx Abuse and Related Consequences Goal Action Team (Lead agencies: NMDOH and NMHSD)	Prevention Policy Consortium Rx Abuse and Related Consequences Goal Action Team (Lead agencies: NMDOH and NMHSD)	This group is still in the process of developing deliverables, which have not yet been disseminated beyond the coalition members.	This group includes representatives of different state agencies and state and local organizations involved in behavioral health promotion and substance abuse prevention, who will share their colleagues' and constituents' perspectives with the group
8) Alcohol-Related Deaths	DWI Leadership Team (Lead agency: NMDOT)	This Governor's multi-agency advisory group advised the delivery of a comprehensive 5-year DWI prevention campaign based on Community Guide recommended strategies; NMDOH led a Prevention Subcommittee of the group in a mid-course review of the state's DWI strategic plan, and made recommendations for additions to the campaign's prevention programming	The recommendations developed by this group were provided to the New Mexico Office of the Governor; and disseminated from there as deemed appropriate by the Governor. Recommendations and findings from this program were also shared with the National Highway Traffic Safety Administration, which partly funded the campaign.	Invited participants in this group included representatives from all New Mexico state agencies involved in DWI prevention, as well as tribal agencies and non-governmental organizations working in this area; all participants shared their agencies' and constituents' perspectives with the group
	Prevention Policy Consortium Alcohol and Related Consequences Goal Action Team (Lead agencies: NMHSD,	This group is a multi-agency group working to operationalize Goals 2-4 of the 2012 Five-Year Behavioral Health Promotion and Prevention Plan (listed	This group is still in the process of developing deliverables, which have not yet been disseminated beyond the coalition members.	This group includes representatives of different state agencies and state and local organizations involved in alcohol-related prevention, who will share

	NMDOT, NMDFA)	under item 3 above)		their colleagues' and constituents' perspectives with the group
Chronic Disease				
9) Diabetes	▪ NM Diabetes Advisory Council (NMDAC) ▪ NM Chronic Disease Prevention Council (CDPC) ▪ NM Health Care Takes on Diabetes ▪ NM Primary Care Association ▪ NM State University County Extension ▪ UNM Project ECHO ▪ Indian Health Service/Special Diabetes Programs for Indians (SDPI)	**NMDAC,** a member organization that represents a diverse group of diabetes professionals, stakeholders, and advocates, provides CEU training sessions on a variety of topics for its members three times a year. For example, December's meeting was about NM's efforts to implement and sustain the National Diabetes Prevention Program (National DPP), an evidence-based program to prevent or delay diabetes among people at risk for diabetes/with prediabetes. DPCP presented and was also one of several organizations that participated in a panel discussing these efforts.	NMDAC posts their agendas, minutes and CEU presentations on their website, which is accessible to anyone.	Yes, e.g. information in the form of CEU presentations is collected from experts and others in the diabetes field that are not always members. Most of the outreach and planning for these trainings is conducted by the board; one session per year is developed in consultation with the DPCP. Some input on these sessions comes from members who are surveyed at every meeting.
Unintentional Injury	Data Work Group (DWG) of the NM Injury Prevention Coalition (NMIPC)	The DWG developed and published the New Mexico Injury Portal in the NM Indicator Based Information System (NM-IBIS). This portal provides links to a	Information from the DWG was distributed to NMIPC members. The Injury Portal was published online in NM-IBIS in December 2009, and has been available to anyone with online access since that time. The Injury Data Inventory was distributed to the	During the development of the Injury Portal, the DWG met with Lee Annest, then director of the Office of Statistics and Programming at the CDC National Center

		comprehensive set of online injury resources organized into three categories: (1) injury data and reports; (2) injury prevention best practices; and (3) injury prevention programs and partners. The DWG also developed an Injury Data Inventory for New Mexico.	NMIPC meeting in June 2012.	for Injury Prevention and Control, to discuss the design of the portal and of injury reporting within NM-IBIS. This meeting resulted in better alignment of New Mexico injury reporting with the CDC WISQARS (Web-based Injury Statistics Query and Reporting System) system; and improvements to the design of the injury portal. During the development of the injury portal the DWG also reached out to various injury reporting entities in New Mexico (e.g., the Health Policy Commission; the Office of the Medical Investigator) to insure that the portal represented the most complete available repository of injury reporting links in New Mexico.
Violence				
Suicide and Homicide	NM Statewide Suicide Prevention Planning Team.	HSD has convened regular meetings of suicide prevention stakeholders who provided input about current suicide prevention programs implemented at the state, tribal and local levels and discussed evidence-based	HSD is currently drafting a NM Suicide Prevention Plan, which will be submitted to the Substance Abuse and Mental Health Services Administration (SAMHSA) as part of the combined Substance Abuse Prevention and Treatment and Community Mental Health Block Grant application. A state dissemination plan has not been developed to date.	This group includes representatives from state agencies, local behavioral health collaborative(s), other agencies working on behavioral health issues, suicide prevention coalitions, and local community organizations

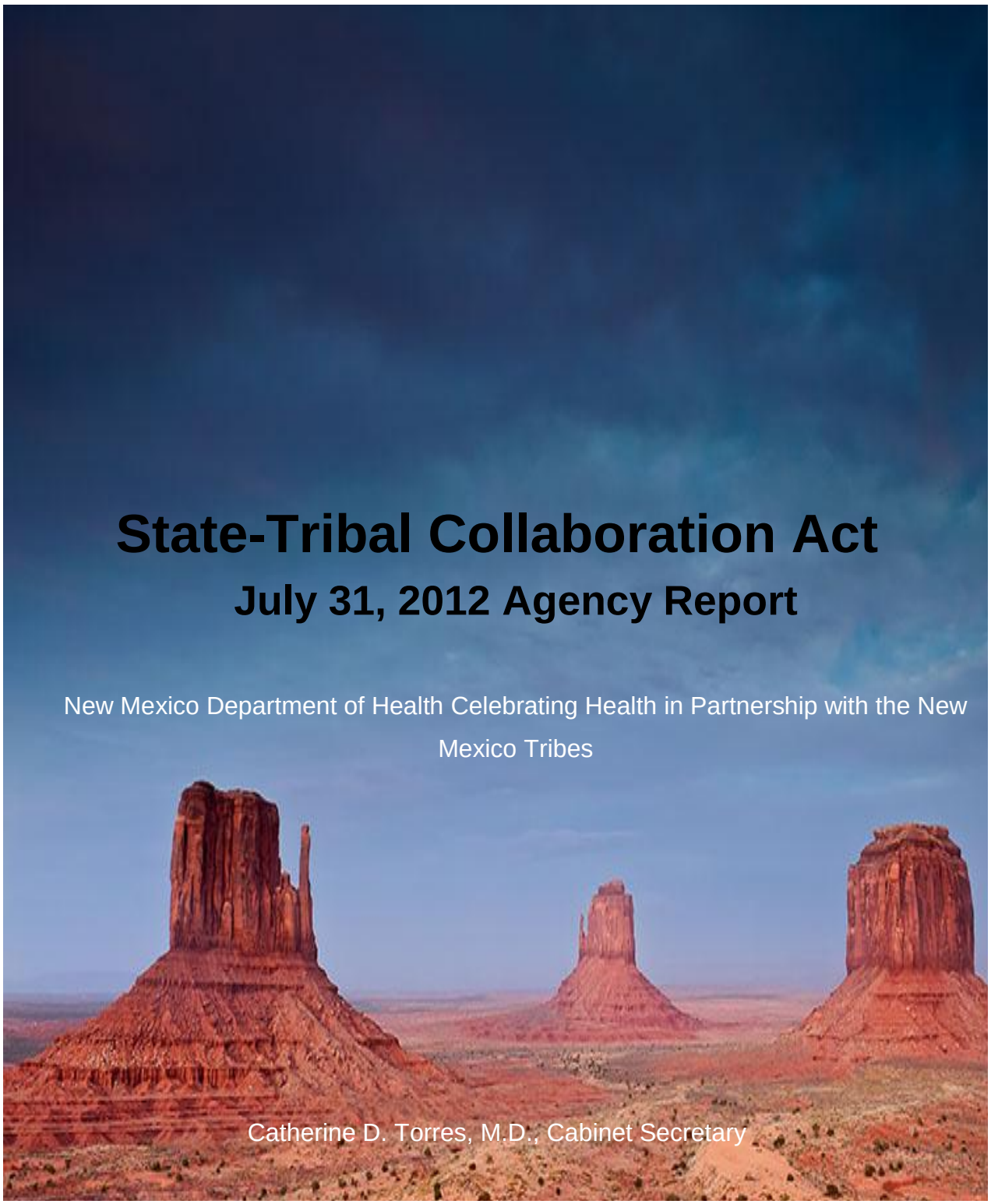
		recommendations and comprehensive, population-based approaches to suicide prevention. Recently, team members attended a planning session to identify the key goals and objectives for the NM suicide prevention plan.		who share their agency and constituents' perspectives with the team.
	NM Injury Prevention Coalition (NMIPC).	Staff from ERD presented NM data on suicide and homicide at a NMIPC meeting and a NMIPC Policy Subcommittee meeting to help members prioritize areas for injury prevention initiatives. A matrix of evidence-based suicide prevention interventions was distributed for review and discussion.	NMIPC members share data and information on violence prevention resources and programs with their colleagues and local community groups.	Group members represent state, tribal, private and local organizations working in the area of violence prevention. Each brings their collective experiences and knowledge to share with others working on these issues.
	NM Suicide Prevention Coalition.	Unknown	This group developed, produced and distributed two brief public service announcements for TV and radio to raise awareness about suicide and suicide risk factors and to promote suicide prevention. Dr. Satya Rao, founder of the Coalition, also did a radio interview about suicide facts and myths on KRWG, All Things Considered.	Unknown
	Southern NM Suicide Prevention and Survivor Support Coalition.	Unknown.	This coalition holds regular suicide prevention gatekeeper trainings using the Question, Persuade, Refer (QPR) model program.	Unknown.
Sexual Violence	The NETWORK	The NETWORK is a collaborative of	The team members share the knowledge with their agencies, staff, and others	Yes - This group invited participants and speakers

		multidisciplinary, multicultural domestic violence and sexual assault program providers and organizations dedicated to strengthening policies, protocols and services to reduce the incidence of sexual assault and domestic violence in communities throughout the state. The NETWORK has sponsored awareness-raising events for candidates to elective offices.	throughout the state, in the hope of contributing to improved system and community response to all acts of violence. The results of the work of the NETWORK are disseminated by participants to their organizations.	who are the leading experts in the field of domestic and sexual violence and stalking.
	Intimate Partner Death Review Team meeting (should this be reported under a different standard? Same issue for child fatality review committee)	The Intimate Partner Violence Death Review Team is tasked with reviewing the facts and circumstances surrounding each intimate partner and sexual violence-related death that occurs in the state of NM, with aim of reducing the incidence of these deaths statewide. The IPVDRT prepares and submits an annual report to the Governor and the Legislature.	The team monitors statewide developments in legislation, policy and agency practice to assess the relevance of their recommendations. Annual reports are submitted to the Governor and the Legislature.	Yes - This team collects case-specific data including demographic information, autopsy reports, criminal and civil court histories of the victim and the offenders, other known history of intimate partner violence, information regarding the use of legal or advocacy services, media reports, and the details of the incident including those occurring both just prior to and those following the death.
	New Mexico Coalition of Sexual Assault Programs	This coalition provides training on a variety of sexual abuse topics designed to improve a community's response to victims and	The team members share the knowledge with their agencies, staff, and other throughout the state, in order to contribute to improvement of the system and community response to sexual violence.	Yes - The group members represent many different state agencies and state and local organizations involved in rape crisis services,

		offenders of sexual abuse. Services include providing sexual abuse information materials, conducting school prevention projects, applying for statewide grants, purchasing and distributing sexual assault evidence collection kits, suspected offender evidence kits, and child abuse protocol packets, and operating the New Mexico Clearinghouse on Sexual Abuse and Sexual Assault.	Many of the materials are distributed to victims, supporters, and agencies, including law enforcement, health care providers and hospitals.	mental health services, and share their colleagues' and constituents' perspectives with the group.
Access to Health Care Services		MCH survey of community members solicits input from community on priority MCH issues. Worked with HSD to map behavioral health service points (assets). Gap analysis survey of health providers (IDEpi).		

1. The list of priority health issues was inferred from 2013 State of Health Report and "Turn the Curve" initiative. This list was intended to provide a starting point and mechanism to organize the group's information collection effort.

Appendix D
NMDOH-Tribal Collaboration



State-Tribal Collaboration Act

July 31, 2012 Agency Report

New Mexico Department of Health Celebrating Health in Partnership with the New Mexico Tribes

Catherine D. Torres, M.D., Cabinet Secretary

Table of Contents

SECTION I. EXECUTIVE SUMMARY

Health care is a vital service that touches the lives of New Mexicans at their most significant and vulnerable times (i.e. birth, illness and death, etc). In the spirit of this, the New Mexico Department of Health (NM DOH) has successfully partnered and collaborated with the (22) Tribes, Nations and Pueblos and the Off Reservation groups. This partnership has led to the creation, cultivation and expansion of services and resources which has enhanced the quality of life for all American Indian people and the people of this Great State!

The requirements set forth by NMSA 11-18-1 et seq., the State-Tribal Collaboration Act (SB196), serves as a guidepost for the Department's activities this report highlights these efforts, including:

- Coordinating the State's response with tribal communities to provide vaccines for influenza.
- Facilitating a State & Tribal Celebration of Health and Wellness with six tribes, nations and pueblos in partnership with the New Mexico Department of Health. Currently the Secretary of Health is organizing efforts to have a second annual State-Tribal Health week with five tribes.
- Participating as a member of the Bernalillo County Off-Reservation Native American Commission.
- Working with the University of New Mexico Center for Native American Health and the Robert Wood Johnson Foundation Center for Health Policy at UNM to plan an engage the (22) Tribes, Nations and Pueblos in developing tribal community health profiles.
- NM DOH programs participated in Health Fairs hosted by Isleta, KEWA, Laguna, San Felipe and Tesuque Pueblos.
- Participation in both the Santa Fe Indian School and Cochiti Health Career Day.
- Participation as a member of the Indian Affairs Tribal Infrastructure Board that distributes funding annually for planning and capacity building.
- Partnering with other health care entities to determine the impact of National Health Care Reform on tribal communities.
- Publishing annual health data useful to tribes for planning activities.
- Partnered and provided technical support to Tribal Health boards in their 638 health clinic process.
- The NM DOH continues to collaborate with the tribes, nations and pueblos and the off reservation groups to articulate, create and develop health resources.

- Publishing a resources guide that catalogs existing NM DOH services being provided to the tribes, nations and pueblos and the off reservation Indian Health groups.

- Supporting New Mexico's tribal epidemiology centers.

- Participating as a member of the NM DOH State Team in the Infant Mortality initiative.

- Participated in the 2012 Annual State-Tribal Health Summit.

- The NM DOH continues to provide Navajo interpretation services for health professionals.

SECTION II. AGENCY OVERVIEW/BACKGROUND

A. Mission Statement

The mission of the New Mexico Department of Health is to promote health and sound health policy, prevent disease and disability, improve health services systems and assure that essential public health and safety net services are available to New Mexicans.

The Department strives to succeed in its mission by committing to and practicing the following principles every day: Integrity that Builds Trust; Open and Respectful Communication; Consistent and Compassionate Service; Teamwork that Values Individuals; Pride in Leadership; and Continuous Learning that Fosters Ongoing Improvement.

B. Agency Overview

NM DOH is one of the executive agencies of the State of New Mexico. The NM DOH supports, promotes, provides, or funds a wide variety of initiatives and services designed to improve the health status of all New Mexicans.

The Department's primary responsibility is to assess, monitor, and improve the health of New Mexicans. The Department provides a statewide system of health promotion, disease and injury prevention, community health improvement and other public health services. Prevention and early intervention strategies are implemented through the Department's local health offices and contracts with community providers. The health care system is strengthened through Department activities including contracted rural primary care services, school-based health centers, emergency medical services, scientific laboratory services, vital records and health statistics.

The Department provides safety net services to eligible individuals with special needs. These services include both community-based and facility-based behavioral health treatment and long-term care, provided directly by the Department or through its contract providers. The Department operates six health treatment and long-term care facilities and one community-based program.

The Department also plays a key regulatory role in the healthcare system. It promulgates regulations pursuant to its statutory authority and is an enforcement entity for health care providers statewide for compliance with state and federal health regulations, standards and law. Over 900 public and private sector inpatient and outpatient providers are licensed annually by the Division of Health Improvement (DHI) which is one agency within the NM DOH; those providers participate in Medicare or Medicaid and are certified, inspected and monitored by the DHI.

SECTION III. AGENCY EFFORTS TO IMPLEMENT POLICY

NM DOH has a long history of working and collaborating with New Mexico's tribes, pueblos, nations and off-reservation groups. NM DOH was a key participant in the development of the 2007 Health and Human Services (HHS) Department's State-Tribal Consultation Protocol (STCP). The purpose of 2007 STCP was to develop an agreed-upon consultation process for the HHS Departments as they developed or changed policies, programs or activities that had tribal implications. The 2007 STCP provided the Department with critical definitions and communication policy, procedures and processes that guided our activities for several years.

With the signing of SB196 (now NMSA 11-18-1 et seq) in March 2009, a new commitment was established that required the State to work with Tribes on a government-to-government basis. In the fall of 2009, the Governor appointed several workgroups to address these requirements. The Healthy New Mexico Group comprised of representatives from DOH, the Aging and Long Term Services Department, the Children, Youth and Families Department, the Department of Veterans' Services, the Human Services Department, the Indian Affairs Department, the Office of African American Affairs, and several tribes, met to develop an overarching Policy that:

1. Promotes effective collaboration and communication between the agency and Tribes;

2. Promotes positive government-to-government relations between the State and Tribes;

3. Promotes cultural competence in providing effective services to American Indians/Alaska Natives; and

4. Establishes a method for notifying employees of the agency of the provisions of the STCA and the Policy that the agency adopts.

The work group met for several months and culminated in the signed State and Tribal Protocol (STP) on December 17, 2009. The STP assures that NM DOH and its employees are familiar with previously agreed-upon processes when the Department initiates programmatic actions that have tribal implications. Use of the protocol is an established policy at NM DOH.

NM DOH will also continue to support other requirements in SB196, such as maintaining a designated Tribal Liaison to monitor and track Indian health concerns. Ron Reid, Ph.D. has been NM DOH's Tribal Liaison since October 2006. Dr. Reid

meets with the Secretary of Health to discuss and formulate action plans to address Indian health concerns within the State.

A. Policy Applied:

NM DOH Developmental Disability Services Division (DDSD) had its first formal consultation in February 2011. The DDSD provides services through the Developmental Disabilities Waiver (DDW) which must be renewed with the Center for Medicare and Medicaid Services (CMS) every five years. New Mexico's current waiver expired on June 30, 2011 and the state had to submit a renewal application by March 31, 2011. Approximately, 450 American Indian individuals are served by this waiver program. One of CMS' requirements for the waiver renewal was to engage tribal communities in a State-Tribal Consultation, so that their concerns can be addressed in the waiver renewal process

To address this requirement, the Department's tribal liaison assisted in organizing a State/Tribal consultation between NM DOH's Developmental Disabilities Services Division and the 22 Tribes, Nations and Pueblos. A State/Tribal Team, consisting of appointed members from the 22 tribal communities and appropriate state agency staff, met three times to review and develop recommendations on the DDW renewal application. After consensus was reached by the State/Tribal Team, the Secretary of Health and Human Services Department called for an official Consultation with Tribal Leaders on February 22, 2011. This was a very successful partnership that was instrumental in developing culturally sensitive recommendations for American Indians receiving developmental disabilities services

Other successful examples illustrating invoking the STCA to improve our services and service delivery include the following:

- The Public Health Division's Immunization Program works with the tribes, pueblos and nations and the Indian Health Service on an on-going basis to strategize and discuss any vaccine issues/questions and potential collaborative efforts to improve immunization rates in tribal communities.
- Through the Native American Partnership, the Public Health Division's Diabetes Prevention and Control Program meets regularly with representatives from a variety of tribal diabetes programs to consult with them about what works best in their communities. At times, staff from Indian Health Service and CDC's Native Wellness Program have participated in these meetings. Funding has been allocated for future meetings and/or activities as determined by the work group.

B. Input Methods Used with Tribes:

On-going outreach and input opportunities are continually made available to tribes, pueblos, nations and off-reservation groups. NM DOH's tribal liaison continues to facilitate these activities and opportunities, communicates tribal needs and priorities identified to the Secretary of Health, and collaborates with NM DOH Division's and tribal communities to implement appropriate responses. A couple of examples of these activities include:

- The American Indian Health Advisory Committee (AIHAC) provides guidance to NM DOH regarding health disparities issues impacting tribal communities. AIHAC, which is facilitated by the Secretary of Health, is in the process of reorganizing. The leadership of the 22 tribes, nations and pueblos and off-reservation organizations has been invited to re-nominate members from their respective communities to this group. To date we have seven appointed members and need nine members for a quorum. This is currently in process.

- The Tribal Partnership Initiative involves visits by the Tribal Liaison to identify health disparities specific to that community and develop, in concert with the Tribes, interventions that address those health disparities. During this fiscal year, the Tribal Liaison visited several communities and has several others scheduled. From these visits, diabetes continues to be listed as either the number one priority or tied for the number one health priority for each of the pueblos. These visits are one of the many processes used to help identify and align state health resources that can help the tribes provide or improve the delivery of health services in their community.

- The Bernalillo County Off-Reservation Native American Health Commission provides a voice for the off-reservation community (over 450 different tribes, pueblos and nations), which has historically been over-looked by local and federal governments. This Commission has successfully completed their three year strategic plan, which is a comprehensive health care plan that examines existing resources to ensure they are used effectively, and identify and secure alternative resources to expand and strengthen the off-reservation health care delivery system. The Commission reports their progress directly to the Secretary of Health and the Department's Tribal Liaison sits as one of the nine Commissioners.

- NM DOH's Tribal Epidemiologist monitors and tracks health disparities trends, themes and patterns for the state in collaboration with the tribes, pueblos and nations. Through this vehicle, DOH has worked to share and look at best practice interventions that will work to reduce health disparities in tribal communities. Through State epidemiology data, American Indians have been indicated to have the worse rates with Prenatal Care-Late or No Care, Obesity among youth, Youth Suicide, Diabetes Death, Pneumonia and Influenza Deaths, Motor Vehicle Deaths and Alcohol Related Deaths. This information serves to guide the work of the Department and is also beneficial to the State and Tribes in identifying new funding resources to develop and strengthen programs in reducing tribal health disparities.

C. Notification Process with Tribes:

NM DOH Tribal Liaison monitors and tracks all tribal health related funding opportunities, grants, and training opportunities; this information is shared with key contacts in the 22 tribes, pueblos and nations and uses existing email groups through the New Mexico Indian Affairs Department and the University of New Mexico Center for Native American Health to share this information. This process has been a regular function for the NM DOH for several years.

D. Interagency Collaboration Efforts:

FY12 has been a busy year, one that has focused on critical collaborations towards improving several of the identified priorities for tribal communities. These include:

- Participating on a multiple agency team to plan a successful Indian Children's Conference, which has become an annual event. This year we had over 400 participants in this conference which was held at Buffalo Thunder Resort.

- The Secretary of Health successfully celebrated a State-Tribal Health Week with six tribes in October 2011; she is planning a second annual State-Tribal Health celebration with five tribes in October 2012.

- Partnering with UNM's Rural and Primary Behavioral Health Service support to provide technical assistance for Senate Bill 416 that creates a Suicide Clearinghouse, which is an important resource to the Tribes, Nations and Pueblos.

- The Secretary serves as a member of the Tribal Infrastructure Fund (TIF) Board, which provides funding to Tribal Governments for health-related planning projects, as well as brick and mortar funding to build, expand or improve systems and facilities to improve the quality of life of American Indians in their respective communities in New Mexico.

- The Office of General Counsel presented at two state tribal judicial consortium meetings regarding mental health issues and the Mental Health Code and has been invited to future meetings to continue discussions about the domestication of tribal commitment orders.

- The Bureau of Vital Records and Health Statistics has participated in outreach activities by making forms and processes more accessible and presenting on-site for the convenience of tribal members.

SECTION IV. CURRENT PROGRAMS AND PLANNED SERVICES FOR AMERICAN INDIANS/ ALASKA NATIVES

The Department of Health is organized into eight program areas (Administration, Public Health, Epidemiology and Response, Laboratory Services, Facilities Management, Developmental Disabilities Support Services and Health, Certification, Licensing and Oversight), Medical Cannabis, that represent nine Divisions (See Appendix for a brief description of each of the program areas). Most of the Department's services are free or low-cost and are accessible to all New Mexicans, including American Indians and Alaskan Natives.

A. Current programs and services from the 2012 Department of Health's American Health Services Directory:

<u>Advisory Committees and Health Councils</u>

American Indian Health Advisory Committee, (505) 827-2627

Services: Provide guidance to the New Mexico Department of Health in order to address health issues impacting American Indian populations residing in New Mexico. **Served FY12:** All tribes in New Mexico. **FY12 Estimated Expenditures:** No funding.

Office of Community Health Partnerships-Tribal Community Health Improvement Councils, (505) 827-0015
Services: Collaboration and partnership with community health improvement councils in five American Indian communities. These health councils mobilize and coordinate local efforts to identify, prioritize and address the health needs of the individuals and families in these communities. **Served FY12:** 9,648 members of five Tribal communities: ToHajiilee (1,649); Cochiti (1,502); Acoma (2,802); San Ildefonso (1,524); and Santa Clara (2,171). **FY12 Estimated Expenditures:** Unfunded

Public Health Division staff members are working with University of New Mexico Health Sciences Center for Native American Health (CNAH) on a community health assessment workshop for tribal communities. The CNAH sponsored event will promote community health planning in New Mexico's tribal communities. This is first of several planned workshops to be scheduled over the next several months. These sessions will emphasize the development and implementation of community health assessments. The initiative aspires to build tribal community capacity for identifying and prioritizing health resources.

New Mexico Cancer Council's Native American Work Group, (505) 841-5847
Services: Provide financial support for the New Mexico Cancer Council's Native American Work Group, coordinated by the University of New Mexico's Cancer Center. FY12 activities of the Work Group included development of a section to the New Mexico Cancer Plan 2012-2016, titled Considerations for Implementing the NM Cancer Plan in Native American Communities. **Served FY12:** Majority of workgroup members are American Indian (approximately 15-19 people). **FY12 Estimated Expenditures:** $20,300

Native American Partnership for Diabetes Prevention and Control, (505) 476-7615 or 1-888-523-2966
Services: The Native American Partnership for Diabetes Prevention and Control involves face-to-face meetings, workgroup teleconference calls and visits by the Diabetes Program's Tribal Liaison to identify community strengths and needs that impact diabetes prevention and control. These efforts help identify and align state health resources that can help the tribes provide or improve the delivery of health services in their community. **FY12 Estimated Expenditures**: undetermined

Office of Community Health Workers (OCHW), (505) 476-3082
Services: Develop a standardized, competency-based training program with an associated voluntary certification process. The compilation of a CHW/CHR Registry is also planned. Once established, the training and certification processes will be available to Tribal Community Health Representatives and programs. **Served FY12:** The Office is

still in developmental stage. **FY12 Estimated Expenditures:** The Office is currently unfunded.

The OCHW provides trainings, workshops, and program support to the tribes across the state.

OCHW is in partnership with:

- I.H.S. Health Promotion Disease Prevention Council, collaborates, shares opportunities, resources, and determines how to better service our Native people.
- NAP (Native American Partnership) - Concentration on diabetes throughout Indian Country.
- UNM-NM CARES-research in Tribal communities.

Birth and Death Certificates

New Mexico Bureau of Vital Records and Health Statistics, (505) 827-0167
Services: : Provides tribal community members information for obtaining birth and death certificates, adoptions and acknowledgment of paternity, name change, and which required documents are needed for proof for obtaining vital records and the associated fees for these services at the State-Tribal Health Fair week with Isleta, Kewa, San Felipe, Santa Clara, Laguna and Tesuque Pueblos. The State Registrar and staff provided three full-day workshops in Santa Fe, Mescalero Apache Nation and Sandia Resort and Casino on electronic vital records filing and coding for Tribal Census Officers, funeral directors and physicians. Training in Gallup or Window Rock is being planned for FY12. The first ever Navajo-only mortality vital records dataset (2006-2010) with Navajo Chapters was provided to the Navajo Epidemiology Center under the signed 2010 Data Sharing Agreement with the Navajo Nation Division of Health.
Served FY12: All tribes in New Mexico. **FY12 Estimated Expenditures:** No dedicated funding.

Cancer

Breast and Cervical Cancer (BCC) Screening Program, (505) 841-5860
Services: Provide free breast and cervical cancer screening and related diagnostic follow-up care for American Indian/Alaska Native women residing in the state who meet program eligibility criteria. Medicaid Category 052 provides full Medicaid coverage (Salud-exempt) for women diagnosed through the BCC Program with breast or cervical cancer or some precancerous cervical conditions. Also available are public awareness activities, education and technical assistance to tribes interested in increasing community capacity for breast and cervical cancer control. **Served FY12:** Approximately 2,346 American Indian women 30 years of age or older, who live at or below 250% of the federal poverty threshold, and are uninsured/underinsured. These services are available through Indian Health Service clinics (Albuquerque Area Indian Health Service and the Navajo Area Indian Health Service) and hospitals, urban Indian clinics, and at more than 200 other federally qualified health centers and hospitals throughout the state. **FY12 Estimated Expenditure:** $367,783 federal, state and grant funds.

Colorectal Cancer Program, (505) 222-8601
Services: Provides free colorectal cancer screening and related diagnostic follow-up care for American Indian/Alaska Native men and women residing in the state who meet program eligibility criteria. These services are available through First Nations Community Health Services and at other federally qualified health centers and hospitals. Also available are public awareness activities, education and technical assistance to tribes interested in increasing community capacity for colorectal cancer control. **Served FY12:** 14 American Indians receiving colorectal cancer screening services; approximately 200 families participated in public awareness and education activities. **FY12 Estimated Expenditure:** $989.10 (provision of direct clinical care).

Comprehensive Cancer Program, (505) 841-5847
Services: Provide culturally tailored cancer prevention, risk reduction and screening education programs in partnership with several American Indian communities and organizations including the American Indian community outreach program in the Office of Community Partnerships and Cancer Health Disparities at the University of New Mexico Cancer Center, Alamo Band of the Navajo Nation, Isleta Pueblo, Jicarrilla Apache Tribe, Santa Clara Pueblo and Tesuque Pueblo. In addition, Comprehensive Cancer Program staff were involved in planning for Native American Health Week and participated in NAHW events at Isleta Pueblo, Laguna Pueblo, San Felipe Pueblo, Santa Clara Pueblo and Santo Domingo/Kewa Pueblo.
Comprehensive Cancer Program staff continues to respond to requests for presentations and technical assistance from American Indian communities interested in conducting cancer prevention and survivorship activities. **Served FY12:** Approximately 400 American Indian families received information and/or education in programs supported by the Comprehensive Cancer Program. **FY12 Estimated Expenditures:** $1,000.

Office of Oral Health, (505) 827-2837
Services: The Office of Oral Health conducts health education, screening, and fluoride varnish to Tesuque Pueblo Health Start, and has provided oral health education, screening, dental sealants to Native American elementary school children throughout the state. **Served FY12:** 412 **FY12 Estimated Expenditure**: $21,402

<u>Data and Epidemiology Services</u>

Adult Behavioral Risk Factor Surveillance System (BRFSS) Survey, (505) 476-3569
Services: BRFSS epidemiologist and YRRS epidemiologist sit on the Albuquerque Area Southwest Tribal Epidemiology Center (AASTEC) Tribal BRFSS advisory committee. Technical assistance is provided to AASTEC on an as needed basis and mutual collaboration on recruiting schools to participate in the state-wide survey to increase the sample size of the American Indian student population. The BRFSS epidemiologist has collaborated with the diabetes epidemiologist on a Native American diabetes dataset for questions asked to adults on the state-wide telephone survey. **Served FY12:** All tribes in New Mexico. **FY12 Estimated Expenditures:** No funding.

Agency for Healthcare Research and Quality (**AHRQ**) **Race, Ethnicity, and Tribal Data Improvement Grant, (505) 476-3575**
Services: Assist pilot hospitals with data analysis to demonstrate that their grant activities (formal training and educational resources) have improved the quality of race, ethnicity and tribal identifier hospitalization data. This initiative will result in better data for comparative effectiveness research on improving health care outcomes. **Served FY12:** All tribes in New Mexico. **FY12 Estimated Expenditures:** To be determined.

American Indian Health Disparities Report Card, (505) 827-2570
Services: Publish a special edition of the Racial and Ethnic Health Disparities Report Card that focuses on American Indian health that highlights information on eight indicators on which American Indians consistently have the highest (worst) disparities and on two indicators for which American Indians have the lowest (best) rates in New Mexico. **Served FY12:** All tribal communities. **FY12 Estimated Expenditures:** No dedicated funding.

Community Health Assessment Program, (505) 827-5274
Services: The community epidemiologist and the data librarian have included tribe-specific 2000 US Census data and Work Force Solutions employment data in NM's Indicator-Based Information System (NM-IBIS) for public health. Tribe-specific birth and death data was also added on a secured, password protected site to provide Tribal governments their data in a timely manner that also insured confidentiality. All 22 tribal governments and the Eastern Band of Navajo were able to obtain 2008-2009 birth data and 2006-2010 death data that was tribe-specific and formatted by their specifications in order to apply for more grant opportunities. Three NM-IBIS advisory meetings were held in which tribal perspectives on how to improve access, formatting, and usability of NM-IBIS was discussed by advisory members from the two Tribal Epidemiology Centers. **Served FY12:** All tribes in New Mexico. **FY12 Estimated Expenditures:** No dedicated funding.

Data Sharing Agreements, (505) 476-1788
Services: Cabinet Secretary Catherine D. Torres, MD signed the first ever data sharing agreement with the Albuquerque Area Indian Health Service to share in-patient hospitalization data which will be combined with the private hospitalization database to provide a more accurate picture of serious morbidity for Native Americans in New Mexico. **Served FY12:** All tribes in New Mexico. **FY12 Estimated Expenditures:** No dedicated funding.

National Tribal Epidemiology Activities, (505) 476-3575
Services: Lead the Council of State and Territorial Epidemiologists (CSTE) Tribal Epidemiology workgroup, which has completed national surveys of public health surveillance activities in Indian Country. **Served FY12:** All federally recognized U.S. tribes. **FY12 Estimated Expenditures:** No dedicated funding.

Diabetes

Coordinated Approach to Child Health (CATCH), (505) 476-7615 or 1-888-523-2966
Services: Provide a health promotion intervention in elementary schools throughout New Mexico. The intervention addresses healthy nutrition, increased physical activity, school food service and family and community support for behavior change.
Served FY12: 669 American Indian youth.
FY12 Estimated Expenditures: $18,607

Kitchen Creations Cooking School for People with Diabetes, (505) 476-7615 or 1-888-523-2966
Services: Provide a four-session series of cooking schools for people with diabetes and their families or care givers. The instructors teach appropriate meal planning and address food selection, portion control, techniques of food preparation and new products available to improve the diet of people with, or at risk for, diabetes.
Served FY12: 92 American Indians participated in 10 cooking schools in Zuni Pueblo, San Felipe Pueblo, Santa Ana Pueblo, Tesuque Pueblo, Navajo Nation in Shiprock area, Ramah Navajo, and Albuquerque Indian Health Center.
FY12 Expenditures: $15,874

Native American Partnership for Diabetes Prevention and Control, (505) 476-7615 or 1-888-523-2966
Services: Regular consultation meetings with Tribal Diabetes Programs. The goal of these sessions is to determine the most effective ways to prevent and control diabetes in American Indian communities in New Mexico. This is a key strategy for achieving the Diabetes Prevention and Control Program's long-term goal of eliminating diabetes-related health disparities.
Served FY12: Three meetings were held with approximately 59 participants, and one full-day data workshop on Tribal Collaboration on Data Management, with 44 participants.
FY12 Estimated Expenditures: $3,000.00

Education and Community Mobilization
Service: Provide educational presentations on diabetes and commercial tobacco to help individuals and local decision makers understand the link between commercial tobacco use and second hand smoke, including an increased risk for diabetes complications. **Served FY12:** 173 community members (Ramah Navajo, Southwest Tribal Tobacco Coalition, NM Community Health Workers Conference, Pojoaque Cessation Conference, Jicarilla Apache Men's Conference, and Santa Clara Substance-free conference.
FY 12 Estimated Expenditures: N/A (staff time only)

Family Planning

Family Planning, (505) 476-8882
Services: Provide comprehensive family planning services, including clinical reproductive health services, community education and outreach. Provide technical assistance and funding for the Teen Outreach Program, a service learning program for

preventing teen pregnancy and increasing school success, at Laguna Middle School and Laguna-Acoma Junior/Senior High School and To'Hajiilee Community School. **Served FY12:** Clinical services for 681 female and 217 male American Indians and educational services learning for 75 teens. **FY12 Estimated Expenditures:** $249,212.

Health Facility Licensing

Health Facility Licensing and Certification, (505) 476-9025
Services: Conduct surveys for facilities that receive Medicare or Medicaid funding that evaluate the quality of the services provided. **Served FY12:** Laguna Nursing Center and Mescalero Care Center. **FY12 Estimated Expenditures:** $23,308.

Immunizations

Immunization Advocacy, (505) 827-2898
Services: Collaborate and meet with the Indian Health Services several times a year to discuss vaccine issues, questions and/or develop collaborative efforts to improve immunization rates in tribal communities. One example of this collaboration occurred during the H1N1 2009/10 pandemic, the Immunization Program worked directly with New Mexico's tribes, pueblos and nations to arrange for receipt of H1N1 vaccine for mass immunizations statewide. **Served FY12:** All American Indians in New Mexico. **FY12 Estimated Expenditures:** No dedicated funding.

Vaccines for Children (VFC), (505) 827-2898
Services: Provide free childhood vaccinations to all American Indian children wherever they choose to receive health services including all Indian Health Services clinics, First Nations, public health clinics and private providers. **Served FY12:** Approximately 39,829 American Indian children ages birth through 18 years. **FY12 Estimated Expenditures: $3,472,180.**

Emergency Preparedness

Hospital and Healthcare Preparedness, (505) 476-8236
Services: Provided the Indian Health Services Hospitals with funding to support medical surge preparedness and planning - to expand surge capacity if hospitals become overwhelmed. **Served FY12:** All tribes in New Mexico. **FY12 Estimated Expenditures:** $150,000.

Medical Countermeasures Dispensing and Public Health Preparedness, (505) 476-8200
Services: Provided pueblos within the Albuquerque Metropolitan Statistical Area funding to support the development of medical countermeasure plans as part of the Centers for Disease Control and Prevention's Cities Readiness Initiative program.
Served FY12: All tribes in New Mexico. **FY12 Estimated Expenditures:** $21,000.

Emergency Public Health Preparedness Team, (505) 476-8200
Services: Collaborated with the University of Arizona's Mountain West Preparedness and Emergency Response Learning Center (MWPERLC) on a pilot program to increase community resiliency through capacity building for the Santa Clara Pueblo in New Mexico. This project will greatly assist the Santa Clara Pueblo in developing a comprehensive catalogue of public health preparedness resources (i.e. human, equipment, and facilities) that would be used in the event of a disaster. The MWPERLC will also be providing technical assistance in the completion of an evacuation plan.
Served FY12: Pueblo of Santa Clara members. **FY12: Estimated Expenditures:** $30,000.

Infectious Diseases

Infectious Disease Epidemiology Bureau, NM Emerging Infections Program, (505) 827-0006
Services: Two public health evaluations received IRB determinations from the Southwest IRB and the Navajo Nation Human Research Review Board to include Native American participants in the following surveillance projects: 1) Evaluating the Effectiveness of a 13-Valent Pneumococcal Conjugate Vaccine among Children; 2) Risk for Death from Influenza A (pH1N1) among American Indians and Alaska Natives (AI/AN). Midterm reports have been submitted to the three Health and two Navajo Agency Boards and questions and concerns have been followed up by the Principal Investigators on an ongoing basis for the duration of the projects. **Served FY12:** All tribes in New Mexico. **FY12 Estimated Expenditures:** To be determined.

AIDS/ARC Waiver, (505) 476-3618
Services: Serve individuals who have been diagnosed as having acquired immunodeficiency syndrome or AIDS-related conditions. The program provides case management, private duty nursing and home health aides. **Served FY12:** 0. **FY12 Estimated Expenditures:** $0.

First Nations Community Healthsource HIV/AIDS Services, Prevention (505) 262-6554, Care and Services (505) 293-1114
Services: Provide HIV prevention interventions, HIV testing, case management and support of services for persons living with HIV. **Served FY12:** 42 American Indian clients with HIV. **FY12 Estimated Expenditures:** $43,800 for HIV prevention and testing and $208,377 for HIV/AIDS case management and support services.

Healthcare-Associated Infections (HAI) Program, (505) 476-3520
Services: Collaboration with Crownpoint, Gallup Indian Medical Center, Mescalero, Northern Navajo Medical Center/Shiprock Service Unit, and Taos/Picuris hospitals to report healthcare personnel influenza vaccination rates, adult and pediatric Intensive Care Unit (ICU) central line-associated bloodstream infections (CLABSIs), non-ICU CLABSIs and/or *Clostridium difficile* infections on a voluntary basis through state supported electronic mechanisms. **Served FY12:** Mescalero Apache Nation, Navajo Nation, Taos and Picuris Pueblos. **FY12 Estimated Expenditures:** To be determined.

HIV Prevention Program, **(505) 476-3624**
Services: Contracts with three agencies to deliver culturally specific and tailored HIV prevention interventions to American Indians at risk including persons living with HIV/AIDS, transgender persons and gay/bisexual men: First Nations Community Healthsource, Navajo AIDS Network (NAN) and Santa Fe Mountain Center. Referrals and information about all statewide services for HIV, STD, Hepatitis and Harm Reduction can be found on a new searchable website: www.nmhivguide.org. **Served FY12:** Unable to determine. **FY12 Estimated Expenditures:** $131,000.

Infectious Disease Prevention Team - **Region One, (505) 722-4391**
Services: Provide sexually transmitted disease (STD), HIV, adult viral hepatitis and harm reduction services to at-risk persons in Region 1, with an emphasis on American Indians living on or near the Navajo Nation. Services include STD, HIV, hepatitis B and hepatitis C screening and testing; hepatitis A and B vaccines; HIV, STD, hepatitis and harm reduction prevention education; STD treatment, partner services and referrals; syringe exchange and overdose prevention services; and other disease investigation and follow-up services. **Served FY12:** Unable to determine. **FY12 Estimated Expenditures:** Unable to determine

Tuberculosis Program, (505) 827-2106
Services: Provide technical support and guidance in the provision of care for American Indians with active tuberculosis disease or latent tuberculosis infection (LTBI), contact investigations, professional training to service providers. **Served FY12:** 5 American Indians with active TB. **FY12 Estimated Expenditures:** In-kind services.

Nutrition Services

Women, Infants and Children (WIC) Program, (505) 476-8800
Services: Provide nutritious foods to supplement diets, nutrition information for healthy eating and referrals to healthcare providers and social services to eligible pregnant women, postpartum women, breastfeeding women, infants and children to age 5. In New Mexico, WIC Programs are available through Indian Tribal Organizations. NM DOH WIC serves any eligible Native American families who choose to come to a NM DOH WIC Clinic for convenience. **Served FY12:** Unable to determine. **FY12 Estimated Expenditures:** Unable to determine

Commodity Supplemental Food Program (CSFP), (505) 476-8803
Services: Provide U.S. Department of Agriculture (USDA) commodity foods to supplement the diets of lower income infants, children up to age 6; pregnant, postpartum and breastfeeding women; and persons 60 years of age or over. CSFP provides program participants with nutrition education and referrals to appropriate health and social service agencies. There are four CSFP food warehouses serving 55 tailgating sites around New Mexico. The CSFP food package includes cereal, cheese, dried beans, canned meat, fruit and vegetables and pasta, rice or potatoes. Some 90% of the participants in CSFP are elderly. CSFP is federally funded. **FY12 Served:** 1672 American Indian individuals. **FY12 Estimated Expenditures:** $1,176,809.00.

Obesity Prevention:
Nutrition and Physical Activity Program (505) 827-2520
Intervention: Partner with 3 tribal communities (Santa Clara, San Ildefonso and Zuni) to expand opportunities for healthy eating and active living for children where they live, learn and play. Healthy eating and physical activity and the two lifestyle behaviors that can prevent obesity. **Served FY 12:** Community-wide. **FY12 Estimated Expenditure:** $135,000.

Education: Developed the Health * Honor * Wisdom curriculum which provides hands-on activities to empower children with a holistic understanding that healthy eating and active living are interconnected with a healthy community and environment. It can be found on the HealthyKidsNM.org website. **Served FY 12:** Community-wide. **FY12 Estimated Expenditure:** included in the $135,000.

Surveillance: Established the NM childhood obesity surveillance system in 2010. Release annual report that includes state obesity prevalence rates for American Indian children attending NM public schools. **Served FY 12:** Community-wide. **FY12 Estimated Expenditure:** included in the $135,000.

Pregnancy Support

Pregnancy Support
Families FIRST, 1-877-842-4152
Services: Provides case management services to Medicaid eligible pregnant women and children 0-3 years. Among the services provided is assistance with the application process for Medicaid eligibility, screening for possible lead exposure, providing developmental screening, and providing education and educational materials related to pregnancy, and child development and safety. Services are provided in the home, in the local public health office and in other community settings. **Served FY12:** Services provided to approximately 113 American Indian families statewide. **FY12: Estimated Expenditures:** $31,075, Medicaid reimbursed.

School Based Health Centers

School-Based Health Centers (SBHCs), (505) 841-5889
Services: Provide integrated primary and behavior health care to school-aged children. All SBHCs serving American Indian youth are encouraged to address important cultural and traditional beliefs in their services. **Served FY12:** Twenty-three (23) sites that have a high number (some 100%) of American Indian youth: Ruidoso High School, Bernalillo High School, Highland High School, Wilson Middle School, Van Buren Middle School, Acoma Laguna Teen Center, Tohajille School, Navajo Prep, Taos High School, Taos Middle School, Mescalero Apache School, Native American Charter Academy, Española High School, Carlos Vigil Middle School, Quemado School District, Cobre Schools, Dulce High School, Jemez Valley School, Cuba Middle School, Laguna Middle School, Pojoaque High School, Gallup High School and Career Prep High School**. FY12 Estimated Expenditure:** $1,650,000.

Screening Programs

Newborn Genetic Screening Program, (505) 476-8868
Services: Require that all babies born in New Mexico receive screening for certain genetic, metabolic, hemoglobin and endocrine disorders. The New Mexico Newborn Screening Program offers screening for 27 disorders. **Served FY12:** All newborns are screened for genetic conditions prior to discharge from the hospital. This includes 3,057 American Indian children born in Indian Health Service Hospitals and those born in private or public hospitals. **FY12 Estimated Expenditures:** $272,113.

Newborn Hearing Screening Program, (505) 476-8868
Services: Assist families in accessing needed services when their infants require follow-up on their newborn's hearing screening. **Served FY12:** Approximately 214 American Indian children required follow-up services. **FY12 Estimated Expenditures:** $48,730.

Services for Persons at Risk for or With Existing Disabilities

Children's Medical Services (CMS), (505) 476-8868
Services: Provide medical coverage and care coordination to American Indian children with special health care needs that meet program eligibility requirements. Also provides the following multidisciplinary pediatric specialty clinics serving the Native American population in Northwest, Central and North Central areas of New Mexico. Clinics include: Cleft Lip and Palate, Genetic, Dysmorphology, Endocrine, Neurology and Pulmonary. **Served FY12:** 220 American Indian youth and children with special health care needs statewide. **FY12 Estimated Expenditures:** $25,000.

Developmental Disabilities Waiver, (505) 476-8973
Services: Serve individuals with intellectual disabilities or a related condition and a developmental disability occurring before the individual reaches the age of 22. The program provides an array of residential, habilitation, employment, therapeutic, respite and family support services. **Served FY12:** 461 American Indian clients. **FY12 Estimated Expenditures:** $36,004,123.

Family Infant Toddler (FIT) Program, (505) 476-8975
Services: Serve children from birth to age three with or at-risk for developmental delays and disabilities and their families. The FIT program provides an array of early intervention services, including physical therapy, speech therapy, special instruction, social work, service coordination, etc., and services are provided primarily in the home and other community settings. **Served FY12:** 1,352 American Indian children. **FY12 Estimated Expenditures:** $2,993,200 state and federal funds.

Medically Fragile Waiver, 1-877-696-1472
Services: Serve individuals, diagnosed before age 22, with a medically fragile condition and who are at risk for, or are diagnosed with, a developmental delay. This program provides nursing case management which coordinates private duty nursing, home health aides, physical, speech, and occupational therapy, psychosocial and nutritional

counseling and respite care. **Served FY12:** 22 American Indian clients. **FY12 Estimated Expenditures:** $176,345.

Mi Via Waiver, 505-841-5511
Services: Serve individuals qualified for the traditional Developmental Disability, Medically Fragile and AIDS/ARC Waivers who select Mi Via as an option to traditional waivers. Participants on the Mi Via Waiver are allowed more choice, control, flexibility and freedom in planning, budgeting and managing their own services/supports. **Served FY12:** 22 American Indian Clients. **FY12 Estimated Expenditures:** $713,020.

Staff That Work With Tribes

Department of Health Tribal Liaison
Services: Facilitate effective communication and relationships between the Department and tribes in order to develop policies and programs that improve the health of American Indian communities. **Served FY12:** All tribes in New Mexico. **FY12 Estimated Expenditures:** $80,000.

Tribal Epidemiologist, (505) 476-1788
Services: Leverage DOH epidemiology resources to analyze and disseminate health data, provide training in epidemiology and public health assessment, improve disease and injury surveillance and reporting systems, and advocate for utilization of American Indian health data and systems that can optimize the health of all American Indians in New Mexico. Four Quarterly Tribal Population Estimates meetings were held throughout the state for tribal health workers, planners, and tribal members to create their own tribal land GIS shape files to display their 2010 U.S. Census population data and housing units at the block level. Documented and responded to all 230 Native American health and social data requests. **Served FY12:** All tribes in New Mexico. **FY12 Estimated Expenditures:** $57,000.

Injury Prevention

Injury and Behavioral Health Bureau, (505) 827-6816
Services: In collaboration with the Albuquerque Area Indian Health Service Office of Injury Prevention and Tribal Law Enforcement officers, two injury prevention Mini-Grant training workshops were provided to tribal injury prevention specialists at the Southwest Indian Polytechnic Institute in Albuquerque and at the Ohkay Owingeh Hotel and Casino. Quarterly Injury Prevention Advisory meetings are held regionally with several Native American Committee Members. Numerous trainings from the Child Safety health educator, Elder Falls health educator, and Domestic Violence health educator are provided to tribal communities throughout the state. **Served FY12:** All tribes in New Mexico. **FY12 Estimated Expenditure:** No dedicated funding.

Suicide

New Mexico Crisis Line, (505) 841-5877
Services: Provide statewide toll-free crisis line services for all New Mexico youth. Served FY12: American Indian youth can and do access. **FY12 Estimated Expenditures:** $110,000.

New Mexico Suicide Intervention Project (NMSIP), (505) 222-8678
Services: Provide gatekeeper training on the signs of suicide for northern NM communities, schools and organizations, as well as support to schools and communities that have experienced a recent suicide**. Served FY12:** 575 Adults and 425 Youth**. FY12 Estimated Expenditures:** $70,000.

Suicide Prevention, (505) 222-8683
Services: Fund prevention activities to address the prevalence of youth suicide disproportionally impacting Native American Youth, including:
1) Jemez Valley School District Natural Helpers Program serving 9 communities, including Seven Springs, La Cueva, Sierra Los Pinos, Jemez Springs, Ponderosa, Cañon, Jemez Pueblo, San Ysidro and Zia Pueblo.
2) New Mexico Suicide Intervention Project Natural Helpers Program implemented at the Santa Fe Indian School.
3) Pojoaque Valley School District Natural Helpers Program serving four Pueblos, Nambe, Tesuque, San Ildefonso and Santa Clara.
4) Gallup Coalition for Healthy and Resilient Youth, a program to increase culturally relevant knowledge of signs of suicide, risk and protective factors and identification of resources among youth through implementing REZ Hope youth development curriculum at Gallup High School.
5) New Mexico Suicide Prevention Coalition, which will provide Question, Persuade, Refer and Gatekeeper trainings to tribal communities statewide. 6) OSAH Behavioral Health Team post-vention and trauma-informed school trainings to tribal communities statewide. **Served FY12:** 31 communities. **FY12 Estimated Expenditure:** $160,000.

Tobacco

Tobacco Use Prevention and Control Program (TUPAC), (505) 222-8618
Services: Provide activities and services to communities, schools and organizations to promote healthy, tobacco-free lifestyles among all New Mexicans. Does not include tobacco uses during religious or ceremonial events. **Served FY12:** Five Sandoval Indian Pueblos, Oso Vista Ranch Project, San Juan County Partnership. **FY12 Estimated Expenditures:** $108,750, tobacco settlement funds.

Training

Bilingual Navajo Medical Interpreter Training, (505) 827-2056
Services: Provide medical terminology training to Navajo speakers. The training includes a review of the Navajo clan system, regional Navajo language idioms, Cultural and Linguistically Appropriate Service standards, anatomy, verbal descriptions of pain, common illnesses and diseases, role playing and death and dying for Navajos. **Served FY12:** Forty-four participants from McKinley, San Juan, Cibola and Sandoval Counties.

FY12 Estimated Expenditures: $8,150.

Diabetes Professional Development and Provider Trainings, (505) 476-7615, 1-888-523-2966

Services: Provide free on-line trainings with continuing education units (CEUs), for diabetes educators and other providers, on the following topics:
1) Prediabetes
Served FY12: 52 American Indian health professionals.
FY12 Expenditures: See below
2) Diabetes and Depression
Served FY12: 6 American Indian health professionals.
FY12 Expenditures: See below
3) Diabetes and Smoking
Served FY12: 1 American Indian health professional
FY12 Expenditures: See below

FY12 Expenditures for all three on-line trainings: $5,495*
*Cost for the three on-line trainings is for all people trained, not just the American Indian trainees listed above. It is minimal because the trainings were already developed in previous fiscal years. The FY12 cost for all three includes course maintenance and CEU fees.

Implied Consent Training and Support, (505) 383-9086
Services: Provide classes to certify tribal law enforcement personnel as "operators" and "key operators" under the State Implied Consent Act. Also, provide certification for breath alcohol test devices used by tribal law enforcement of DWI/DUID programs. **Served FY12:** All tribes in New Mexico. **FY12 Estimated Expenditures:** Approximately $150,000.

New Mexico Indictor-Based Information System (NM-IBIS) Training, (505) 827-5274
Services: Continue to provide statewide training on using NM-IBIS (a Web-based structure query language database query system) at the University of New Mexico's Bureau of Business and Economic Research (BEBR) Data Users Conference in Albuquerque and for all Regional County meetings and one Tribal Quarterly Epidemiology meeting. **Served FY12:** All tribes in New Mexico. **FY12 Estimated Expenditures:** No dedicated funding.

<u>Water Testing</u>

Environmental Testing, Bureau of Indian Affairs and Navajo Tribal Utility Authority, (505) 383-9023
Services: Test drinking water for chemicals and bacteria under Federal Safe Drinking Water Act. **Served FY12:** Navajo Nation. **FY12 Estimated Expenditures:** $75,000.

Environmental Testing, Isleta Pueblo, (505) 383-9023

Services: Test drinking water for chemicals and bacteria under Federal Safe Drinking Water Act. **Served FY12:** Isleta Pueblo. **FY12 Estimated Expenditures** $25,000.

B. Planned programs and services for American Indians/Alaska Natives:

In a time of shrinking budgets, DOH is continually shifting resources and staff to address a variety of needs and priorities for all New Mexicans. American Indian health remains a priority and efforts will continue to support activities and help find new resources in the upcoming year.

One area of promise is resources availability to tribes and tribal organization as a result of the Affordable Health Care Act (AHCA). The Department is monitoring and tracking all health related funding and grants opportunities. DOH will be sharing AHCA grant announcements with the Indian Affairs Department, Indian Health Services, qualifying tribes, tribal organizations and off-reservation organizations as information becomes available. The Department will also be available to provide technical assistance, within resource constraints, as requested to support tribal grant applications and activities.

DOH is seeking Public Health Accreditation, a new voluntary status determined by the Public Health Accreditation Board, an independent accreditation body. Accreditation is awarded based on the department's ability to demonstrate through documentation compliance with 28 standards aligned with the 10 essential public health services provided by programs throughout the department. Although all essential services are relevant to Tribal partners, one stands out: "Engage with the community to identify and address health problems." This requirement is relevant to DOH's health improvement efforts in collaboration with its American Indian partners.

In addition, many of the programs listed above will continue in the next fiscal year. Some additional activities that are planned include:

SECTION V. TRAINING AND EMPLOYEE NOTIFICATION STCA Training Certification

SB196 requires that the State Personnel Office (SPO) develop and train all state employees on STCA. DOH was an active member of the workgroup that developed the "Train the Trainer" curriculum. The curriculum was piloted on May 25, 2010. DOH's Tribal Liaison and another key staff member participated in that training. The Department sent 91 staff to the SPO training in FY12.

VI. KEY NAMES AND CONTACT INFORMATION:

Following are the names, email addresses, and phone numbers for the individuals in DOH who are responsible for supervising, developing and/or implementing programs that directly affect American Indians or Alaskan Natives.

Division	Name/Title	Email	Phone
Office of the Secretary	Catherine D. Torres, Cabinet Secretary	Catherine.Torres@state.nm.us	(505) 827-2613
Office of the Secretary	Jim W.Green, Deputy Secretary	Jim.Green@state.nm.us	(505) 231-0163
Office of the Secretary	Brad McGrath, Chief Deputy Secretary	Brad.McGrath@state.nm.us	(505) 827-2613
Division of Health Disparities, Office of American Indian Health	Ron Reid, Tribal Liaison/Director	Ronald.Reid1@state.nm.us	(505) 827-2627
Office of Policy and Accountability	Tres Hunter Schnell, Director	Tres.schnell@state.nm.us	(505) 827-0562
Public Health Division	Michael Landen, MD Interim Director	Michael.Landen@state.nm.us	(505) 827-2389
Public Health Division	Maggi Gallaher, MD, Chief Medical Officer	Maggi.gallager@state.nm.us	(505) 827-2389
Public Health Division	Jane Peacock, Deputy Director	Jane.Peacock@state.nm.us	(505) 827-2504
Public Health Division	Christina Carrillo y Padilla, Bureau Chief, Health Systems	Christina. CarrilloyPadilla@state.nm.us	(505) 222-8671
Public Health Division	Judith Gabriele, Diabetes Program Manager	Judith.Gabriele@state.nm.us	(505) 476-7613

Division	Name/Title	Email	Phone
Public Health Division	Yolanda Cordova, Director, Office of School & Adolescent Health	Yolanda.Cordova@state.nm.us	(505) 841-5889
Public Health Division	Beth Pinkerton, Comprehensive Cancer Program manager	Beth.Pinkerton@state.nm.us	505-841-5847
Public Health Division	Karen Gonzales Acting Hepatitis Program Manager	Karen.Gonzales@state.nm.us	(505) 476-3076
Public Health Division	Jane Cotner, Immunization Program Manager	Jane.cotner@state.nm.us	(505)827-2463
Public Health Division	Gena Love, Head, Cancer Prevention and Control Section	Gena.love@state.nm.us	505-841-5859
Epidemiology and Response Division	Michael Landen, MD Acting State Epidemiologist and Director	Michael.landen@state.nm.us	(505) 476-3575
Developmental Disabilities Supports	Cathy Stevenson, Acting Division Director	Cathy.stevenson@state.nm.us	(505) 827-2574
Developmental Disabilities Supports	Andy Gomm, FIT Program Manager	Andy.Gomm@state.nm.us	(505) 476-8975
Scientific Laboratory Division – Environmental Testing	Dr. Phillip Adams, Chemistry Bureau Chief	Phillip.Adams@state.nm.us	(505) 383-9086
Scientific Laboratory	Dr. Rong Jen Hwang,	Rong.Hwang@state.nm.us	(505) 383-9086

Division	Name/Title	Email	Phone
Division – DWI	Toxicology Bureau Chief		

For a complete list of contact information, go to: http://www.health.state.nm.us/doh-phones.htm, www.nmhealth.org

SECTION VII. APPENDICES

A. Brief Description of the Department's Program Areas

PROGRAM AREA 1: ADMINISTRATION

The mission of the Administration Program is to provide leadership, policy development, information technology, administrative and legal support to the Department of Health so that the department achieves a high level of accountability and excellence in services provided to the people of New Mexico.

The Administration Program is responsible for all financial functions of the Department, including management of a $540 million annual budget and 4,200 employees, appropriation requests, operating budgets, the annual financial audit, accounts payable, revenue and accounts receivable, federal grants management, and financial accounting. It also provides human resources support services and assures compliance with the Personnel Act and State Personnel Board rules, training, key internal audits; information systems management for the Department, and legal advice and representation to assure compliance with state and federal laws.

PROGRAM AREA 2: PUBLIC HEALTH

The mission of the Public Health Division is to work with individuals, families and communities in New Mexico to improve health. The Division provides public health leadership by assessing health status of the population, developing health policy, sharing expertise with the community, assuring access to coordinated systems of care and delivering services to promote health and prevent disease, injury, disability and premature death.

The Public Health Division works to assure the conditions in which communities and people in New Mexico can be healthy. Performance measures and indicators in the Department's Strategic Plan and required by major federal programs are used continuously to monitor the status of specific activities, identify areas for improvement and serve as a basis for budget preparation and evaluation.

PROGRAM AREA 3: EPIDEMIOLOGY AND RESPONSE

The mission of Epidemiology and Response is to monitor health, provide health information, prevent disease and injury, promote health and healthy behaviors, respond

to public health events, prepare for health emergencies and provide emergency medical and vital registration services to New Mexicans.

PROGRAM AREA 4: LABORATORY SERVICES

The mission of the Scientific Laboratory Division (SLD) is to provide analytical laboratory services and scientific advisement services for tax-supported agencies, groups, or entities administering health and environmental programs for New Mexicans.

PROGRAM AREA 6: FACILITIES MANAGEMENT

The Office of Facilities Management mission is to provide oversight of Department of Health facilities which provide mental health, substance abuse, nursing home care, and rehabilitation programs in facility and community-based settings to New Mexico resident who need safety net services.

PROGRAM AREA 7: DEVELOPMENTAL DISABILITIES SUPPORT SERVICES

The mission of the Developmental Disabilities Supports Division is to effectively administer a system of person-centered community supports and services that promotes positive outcomes for all stakeholders with a primary focus on assisting individuals with developmental disabilities and their families to exercise their right to make choices, grow and contribute to their community.

PROGRAM AREA 8: HEALTH CERTIFICATION, LICENSING AND OVERSIGHT

The mission of the Division of Health Improvement is to conduct health facility licensing and certification surveys, community-based oversight and contract compliance surveys and a statewide incident management system so that people in New Mexico have access to quality health care and that vulnerable population are safe from abuse, neglect and exploitation.

B. Any agency-specific and applicable/relevant state or federal statutes or mandates related to providing services to American Indians/Alaska Natives (AI/AN)

The State Maternal and Child Health Plan Act created community health councils within county governments. In 2007, this act was amended to allow allocation of funds for both county and tribal governments to create health councils to address their health needs within their communities.

C. List of DOH Agreements, MOUs/MOAs with tribes that are currently in effect.

Tribe	Agency	Broad Activity	Agreement Name	Current Status	Contact	Phone #
Nation of	DOH	EBT WIC	NMDOH –	In effect	Brenda	(918) 453-5291

Tribe	Agency	Broad Activity	Agreement Name	Current Status	Contact	Phone #
Oklahoma		Support	CNO MOA		Carter	
Pueblo of Isleta	DOH	EBT WIC Support	NMDOH – POI MOA	In effect	Mary Dominguez	(505) 924-3181
Pueblo of Laguna	DOH	Family Infant Toddler Program	Provider Agreement	In effect	Andy Gomm	(505) 476-8975
Mescalero Apache	DOH	Family Infant Toddler Program	Provider Agreement	In effect	Andy Gomm	(505) 476-8975
Navajo Nation	DOH	Family Infant Toddler Program	MOA	In Process – Should be in effect as of 9/09	Andy Gomm	(505) 476-8975
Navajo Nation	DOH	Tuberculosis direct-observed therapy	MOA	In effect	Diana Fortune	(505) 827-2473
Navajo Nation	DOH	STD Investigation and control	Operational partnership		Dan Burke	(505) 476-1778
Mescalero Apache Schools	DOH	Primary & behavioral health care in school-based health center	MOA	In effect	Jim Farmer	(505) 222-8682
Navajo Preparatory School	DOH	Primary & behavioral health care in school-based health center	MOA	In effect	Jim Farmer	(505) 222-8682
Pueblo of San Felipe	DOH	Primary & behavioral health care in	MOA	In effect	Jim Farmer	(505) 222-8682

Tribe	Agency	Broad Activity	Agreement Name	Current Status	Contact	Phone #
		school-based health center				
Pueblo of Laguna Dept. of Education	DOH	Teen Pregnancy Education	MOA	In effect	Valerie Fisher Shannon Barnes	(505) 476-8876
Pueblo Isleta	DOH	WIC services	MOU	In Effect	Deanna Torres	(505) 476-8814
Mescalero Apache Tribe	DOH	WIC services	MOA	In effect	Barbara Garza	(505) 528-5135
Pueblo of Laguna	DOH	Cancer prevention and survivorship	MOA	In effect	Beth Pinkerton	(505) 841-5847
Navajo Area Indian Health Service	DOH	Receipt, Storage and Staging site for the Strategic National Stockpile program	MOA	In Effect	Eric Category	(505) 476-8217
IHS ABQ Area	DOH	Breast and Cervical Cancer Screening and DX	PA	In Effect	Gena Love	505-841-5859
IHS Navajo Area	DOH	Breast and Cervical Cancer Screening and DX	PA	In Effect	Gena Love	505-841-5859
Alamo Navajo School Board	DOH	Breast and Cervical Cancer	PA	In Effect	Gena Love	505-841-5859

Tribe	Agency	Broad Activity	Agreement Name	Current Status	Contact	Phone #
		Screening and DX				
Jemez Pueblo	DOH	Breast and Cervical Cancer Screening and DX	PA	In Effect	Gena Love	505-841-5859
Pueblo of Sandia Health Center	DOH	Breast and Cervical Cancer Screening and DX	PA	In Effect	Gena Love	505-841-5859
Ramah Navajo School Board	DOH	Breast and Cervical Cancer Screening and DX	PA	In Effect	Gena Love	505-841-5859
Mescalero Apache Indian Health Services	DOH	Influenza Surveillance	PA	In Effect	Katie Avery	(505) 827-0083
Dulce Jicarilla Indian Health Services	DOH	Influenza Surveillance	PA	In Effect	Katie Avery	(505) 827-0083
Taos-Picuris Indian Health Services	DOH	Influenza Surveillance	PA	In Effect	Katie Avery	(505) 827-0083
Acoma-Canoncito-Laguna Indian Health Services	DOH	Influenza Surveillance	PA	In Effect	Katie Avery	(505) 827-0083

D. DOH's Tribal Collaboration and Communication Policy

New Mexico Department of Health
State-Tribal Consultation, Collaboration and Communication Policy

Section I. Background

A. In 2003, the Governor of the State of New Mexico and 21 out of 22 Indian Tribes of New Mexico adopted the *2003 Statement of Policy and Process* (Statement), to "establish and promote a relationship of cooperation, coordination, open communication and good will, and [to] work in good faith to amicably and fairly resolve issues and differences." The Statement directs State agencies to interact with the Tribal governments and provides that such interaction "shall be based on a government-to-government relationship" aimed at furthering the purposes of meaningful government-to-government consultation.

B. In 2005, Governor Bill Richardson issued Executive Order 2005-004 mandating that the Executive State agencies adopt pilot tribal consultation plans with the input of the 22 New Mexico Tribes.

C. The New Mexico Health and Human Services Tribal Consultation meeting was held on November 17-18, 2005 to carry out Governor Richardson's Executive Order 2005-004 calling for a statewide adoption of pilot tribal consultation plans to be implemented with the 22 Tribes within the State of New Mexico. This meeting was a joint endeavor of the five executive state agencies comprised of the Aging and Long-Term Services Department, the Children, Youth and Families Department, the Department of Health, the Human Services Department and the Indian Affairs Department. A State-Tribal Work Plan was developed and sent out to the Tribes on June 7, 2006 for review pursuant to the Tribal Consultation meeting.

D. On March 19, 2009, Governor Bill Richardson signed SB 196, the State Tribal Collaboration Act (hereinafter "STCA") into law. The STCA reflects a statutory commitment of the state to work with Tribes on a government-to-government basis. The STCA establishes in state statute the intergovernmental relationship through several interdependent components and provides a consistent approach through which the State and Tribes can work to better collaborate and communicate on issues of mutual concern.

E. In Fall 2009, the Healthy New Mexico Group, comprised of the Aging and Long Term Services Department, the Children, Youth and Families Department, the Department of Health, the Department of Veterans' Services, the Human Services Department, the Indian Affairs Department, and the Office of African American Affairs, met with representatives from the Tribes to develop an overarching Policy that, pursuant to the STCA:

1. Promotes effective collaboration and communication between the Agency and Tribes;

2. Promotes positive government-to-government relations between the State and Tribes;

3. Promotes cultural competence in providing effective services to American Indians/Alaska Natives; and

4. Establishes a method for notifying employees of the Agency of the provisions of the STCA and the Policy that the Agency adopts.

F. The Policy meets the intent of the STCA and defines the Agency's commitment to collaborate and communicate with Tribes.

Section II. Purpose

Through this Policy, the Agency will seek to improve and/or maintain partnerships with Tribes. The purpose of the Policy is to use or build-upon previously agreed-upon processes when the Agency initiates programmatic actions that have tribal implications.

Section III. Principles

A. Recognize and Respect Sovereignty – The State and Tribes are sovereign governments. The recognition and respect of sovereignty is the basis for government-to-government relations and this Policy. Sovereignty must be respected and recognized in government-to-government consultation, communication and collaboration between the Agency and Tribes. The Agency recognizes and acknowledges the trust responsibility of the Federal Government to federally-recognized Tribes.

B. Government-to-Government Relations – The Agency recognizes the importance of collaboration, communication and cooperation with Tribes. The Agency further recognizes that Agency programmatic actions may have tribal implications or otherwise affect American Indians/Alaska Natives. Accordingly, the Agency recognizes the value of dialogue between Tribes and the Agency with specific regard to those programmatic actions.

C. Efficiently Addressing Tribal Issues and Concerns – The Agency recognizes the value of Tribes' input regarding Agency programmatic actions. Thus, it is important that Tribes' interests are reviewed and considered by the Agency in its programmatic action development process.

D. Collaboration and Mutual Resolution – The Agency recognizes that good faith, mutual respect, and trust are fundamental to meaningful collaboration and communication policies. As they arise, the Agency shall strive to address and mutually resolve concerns with impacted Tribes.

E. Communication and Positive Relations – The Agency shall strive to promote positive government-to-government relations with Tribes by: (1) interacting with Tribes in a spirit of mutual respect; (2) seeking to understand the varying Tribes' perspectives; (3) engaging in communication, understanding and appropriate dispute resolution with Tribes; and (4) working through the government-to-government process to attempt to achieve a mutually-satisfactory outcome.

F. Informal Communication – The Agency recognizes that formal consultation may not be required in all situations or interactions. The Agency may seek to communicate with and/or respond to Tribes outside the consultation process. These communications do not negate the authority of the Agency and Tribes to pursue formal consultation.

G. Health Care Delivery and Access – Providing access to health care is an essential public health responsibility and is crucial for improving the health status of all New Mexicans, including American Indians/Alaska Natives in rural and urban areas. American Indians/Alaska Natives often lack access to programs dedicated to their specific health needs. This is due to several factors prevalent among American Indians/Alaska Natives, including but not limited to, lack of resources, geographic isolation, and health disparities. The Agency's objective is to work collaboratively with Tribes to ensure adequate and quality health service delivery in all tribal communities, as well as with individual American Indians/Alaska Natives in urban areas or otherwise outside tribal communities.

H. Distinctive Needs of American Indians/Alaska Natives – Compared with other Americans, American Indians/Alaska Natives experience an overall lower health status and rank at, or near, the bottom of other social, educational and economic indicators. American Indians/Alaska Natives have a life expectancy that is four years less than the overall U.S. population and they have higher mortality rates involving diabetes, alcoholism, cervical cancer, suicide, heart disease, and tuberculosis. They also experience higher rates of behavioral health issues, including substance abuse. The Agency will strive to ensure with Tribes the accountability of resources, including a fair and equitable allocation of resources to address these health disparities. The Agency recognizes that a community-based and culturally appropriate approach to health and human services is essential to maintain and preserve American Indian/Alaska Native cultures.

I. Establishing Partnerships – In order to maximize the use of limited resources, and in areas of mutual interests and/or concerns, the Agency seeks partnerships with Tribes and other interested entities, including academic institutions and Indian organizations. The Agency encourages Tribes to aid in advocating for state and federal funding for tribal programs and services to benefit all of the State's American Indians/Alaska Natives.

J. Intergovernmental Coordination and Collaboration-

1. Interacting with federal agencies. The Agency recognizes that the State and Tribes may have issues of mutual concern where it would be beneficial to

coordinate with and involve federal agencies that provide services and funding to the Agency and Tribes.

2. Administration of similar programs. The Agency recognizes that under Federal tribal self-governance and self-determination laws, Tribes are authorized to administer their own programs and services which were previously administered by the Agency. Although the Agency's or Tribe's program may have its own federally approved plan and mandates, the Agency shall strive to work in cooperation and have open communication with Tribes through a two-way dialogue concerning these program areas.

K. Cultural and Linguistic Competency – The Agency shall strive for its programmatic actions to be culturally relevant and developed and implemented with cultural and linguistic competence.

Section IV. Definitions

A. The following definitions shall apply to this Policy:

1. American Indian/Alaska Native – Pursuant the STCA, this means:
    a) Individuals who are members of any federally recognized Indian tribe, nation or pueblo;
    b) Individuals who would meet the definition of "Indian" pursuant to 18 USC 1153; or
    c) Individuals who have been deemed eligible for services and programs provided to American Indians and Alaska Natives by the United States public health service, the bureau of Indian affairs or other federal programs.

2. Collaboration – Collaboration is a recursive process in which two or more parties work together to achieve a common set of goals. Collaboration may occur between the Agency and Tribes, their respective agencies or departments, and may involve Indian organizations, if needed. Collaboration is the timely communication and joint effort that lays the groundwork for mutually beneficial relations, including identifying issues and problems, generating improvements and solutions, and providing follow-up as needed.

3. Communication – Verbal, electronic or written exchange of information between the Agency and Tribes.

4. Consensus – Consensus is reached when a decision or outcome is mutually-satisfactory to the Agency and the Tribes affected and adequately addresses the concerns of those affected. Within this process it is understood that consensus, while a goal, may not always be achieved.

5. Consultation – Consultation operates as an enhanced form of communication that emphasizes trust and respect. It is a decision making method for

reaching agreement through a participatory process that: (a) involves the Agency and Tribes through their official representatives; (b) actively solicits input and participation by the Agency and Tribes; and (c) encourages cooperation in reaching agreement on the best possible decision for those affected. It is a shared responsibility that allows an open, timely and free exchange of information and opinion among parties that, in turn, may lead to mutual understanding and comprehension. Consultation with Tribes is uniquely a government-to-government process with two main goals: (a) to reach consensus in decision-making; and (b) whether or not consensus is reached, to have considered each other's perspectives and honored each other's sovereignty.

6. Cultural Competence – Refers to an ability to interact effectively with people of different cultures. Cultural competence comprises four components: (a) awareness of one's own cultural worldview, (b) appreciation of cultural differences, (c) knowledge of different cultural practices and worldviews, and (d) honing cross-cultural skills. Developing cultural competence improves one's ability to understand, communicate with, provide services and resources to, and effectively interact with people across cultures.

7. Culturally Relevant – Describes a condition where programs or services are provided according to the clients' cultural backgrounds.

8. Government-to-Government – Describes the intergovernmental relationship between the State, Tribes and the Federal government as sovereigns.

9. Indian Organizations –Organizations, predominantly operated by American Indians/Alaska Natives, that represent or provide services to American Indians and/or Alaska Natives living on and/or off tribal lands and/or in urban areas.

10. Internal Agency Operation Exemption – Refers to certain internal agency operations and processes not subject to this Policy. The Agency has the authority and discretion to determine what internal operations and processes are exempt from this Policy.

11. Internal Tribal Government Operations Exemption – Refers to certain internal tribal government operations not subject to this Policy. Each Tribe has the authority and discretion to determine what internal operations and processes are exempt from this Policy.

12. Linguistic Competence – Refers to one's capacity to communicate effectively and convey information in a manner that is understood by culturally diverse audiences.

13. Participation – Describes an ongoing activity that allows interested parties to engage one another through negotiation, compromise and problem solving to reach a desired outcome.

14. Programmatic Action – Actions related to the development, implementation, maintenance or modification of policies, rules, programs, services, legislation or regulations by the Agency, other than exempt internal agency operations, that are within the scope of this Policy.

15. Tribal Advisory Body – A duly appointed group of individuals established and organized to provide advice and recommendations on matters relative to Agency programmatic action.

16. Tribal Implications – Refers to when a programmatic action by the Agency will have substantial direct effect(s) on American Indians/Alaska Natives, one or more Tribes, or on the relationship between the State and Tribes.

17. Tribal Liaison – Refers to an individual designated by the Agency, who reports directly to the Office of the Agency Head, to:
    a) assist with developing and ensuring the implementation of this Policy;
    b) serve as a contact person responsible for maintaining ongoing communication between the Agency and affected Tribes; and
    c) ensure that training is provided to staff of the Agency as set forth in Subsection B of Section 4 of the STCA.

18. Tribal Officials – Elected or duly appointed officials of Tribes or authorized intertribal organizations.

19. Tribes– Means any federally recognized Indian nation, tribe or pueblo located wholly or partially within the boundaries of the State of New Mexico. It is understood that “Tribes” in the plural form means that or those tribe(s) upon which programmatic actions have tribal implications.

20. Work Groups –Formal bodies and task forces established for a specific purpose through joint effort by the Agency and Tribes. Work Groups can be established to address or develop more technical aspects of programmatic action separate or in conjunction with the formal consultation process. Work groups shall, to the extent possible, consist of members from the Agency and participating Tribes.

Section V. General Provisions

A. Collaboration and Communication

To promote effective collaboration and communication between the Agency and Tribes relating to this Policy, and to promote cultural competence, the Agency shall utilize, as appropriate: Tribal Liaisons, Tribal Advisory Bodies, Work Groups and Informal Communication.

1. The Role of Tribal Liaisons. To promote State-Tribe interactions, enhance communication and resolve potential issues concerning the delivery of Agency services to Americans Indians/Alaska Natives, Tribal Liaisons shall work with Tribal Officials and Agency staff and their programs to develop policies or implement program changes. Tribal Liaisons communicate with Tribal Officials through both formal and informal methods of communication to assess:
    a) issues or areas of tribal interest relating to the Agency's programmatic actions;
    b) Tribal interest in pursuing collaborative or cooperative opportunities with the Agency; and
    c) the Agency's promotion of cultural competence in its programmatic actions.

2. The Role of Tribal Advisory Bodies. The Agency may solicit advice and recommendations from Tribal Advisory Bodies to collaborate with Tribes in matters of policy development prior to engaging in consultation, as contained in this Policy. The Agency may convene Tribal Advisory Bodies to provide advice and recommendations on departmental programmatic actions that have tribal implications. Input derived from such activities is not defined as this Policy's consultation process.

3. The Role of Work Groups. The Agency Head may collaborate with Tribal Officials to appoint an agency-tribal work group to develop recommendations and provide input on Agency programmatic actions as they might impact Tribes or American Indians/Alaska Natives. The Agency or the Work Group may develop procedures for the organization and implementation of work group functions. (See, e.g., the sample procedures at Attachment A.)

4. Informal Communication.
    a) Informal Communication with Tribes. The Agency recognizes that consultation meetings may not be required in all situations or interactions involving State-Tribal relations. The Agency recognizes that Tribal Officials may communicate with appropriate Agency employees outside the consultation process, including with Tribal Liaisons and Program Managers, in order to ensure programs and services are delivered to their constituents. While less formal mechanisms of communication may be more effective at times, this does not negate the Agency's or the Tribe's ability to pursue formal consultation on a particular issue or policy.

    b) Informal Communication with Indian Organizations. The State-Tribal relationship is based on a government-to-government relationship. However, in certain instances, communicating with Indian Organizations can benefit and assist the Agency, as well. Through this Policy, the Agency recognizes that it may solicit recommendations, or otherwise collaborate and communicate with these organizations.

B. Consultation

Consultation shall be between the Agency Head and Tribal Officials or their delegated representatives who possess authority to negotiate on their behalf.

1. Applicability – Tribal consultation is most effective and meaningful when conducted before taking action that impacts Tribes and American Indians/Alaska Natives. The Agency acknowledges that a best case scenario may not always exist, and that the Agency and Tribes may not have sufficient time or resources to fully consult on a relevant issue. If a process appropriate for consultation has not already begun, through this Policy, the Agency seeks to initiate consultation as soon as possible thereafter.

2. Focus – The principle focus for government-to-government consultation is with Tribes through their Tribal Officials. Nothing herein shall restrict or prohibit the ability or willingness of Tribal Officials and the Agency Head to meet directly on matters that require direct consultation. The Agency recognizes that the principle of intergovernmental collaboration, communication and cooperation is a first step in government-to-government consultation, and is in accordance with the STCA.

3. Areas of Consultation – The Agency, through reviewing proposed programmatic actions, shall strive to assess whether such actions may have Tribal Implications, as well as whether consultation should be implemented prior to making its decision or implementing its action. In such instances where Tribal Implications are identified, the Agency shall strive to pursue government-to-government consultation with relevant Tribal Officials. Tribal Officials also have the discretion to decide whether to pursue and/or engage in the consultation process regarding any proposed programmatic action not subject to the Internal Agency Operation Exemption.

4. Initiation – Written notification requesting consultation by an Agency or Tribe shall serve to initiate the consultation process. Written notification, at the very least, should:
    a) Identify the proposed programmatic action to be consulted upon.
    b) Identify personnel who are authorized to consult on behalf of the Agency or Tribe.

5. Process – The Agency, in order to engage in consultation, may utilize duly-appointed work groups, as set forth in the previous section, or otherwise the Agency Head or a duly-appointed representative may meet directly with Tribal Officials, or set forth other means of consulting with impacted Tribes as the situation warrants.
    a) Consultation shall be between the Agency Head and Tribal Officials or their delegated representatives with authority to negotiate on their behalf.
    b) The Agency will make a good faith effort to invite for consultation all perceived impacted Tribes.

6. Limitations on Consultation –
    a) This Policy shall not diminish any administrative or legal remedies otherwise available by law to the Agency or Tribe.
    b) The Policy does not prevent the Agency and Tribes from entering into Memoranda of Understanding, Intergovernmental Agreements, Joint Powers Agreements, professional service contracts, or other established administrative procedures and practices allowed or mandated by Federal, State or Tribal laws or regulations.
    c) Final Decision Making Authority: The Agency retains the final decision-making authority with respect to actions undertaken by the Agency and within Agency jurisdiction. In no way should this Policy impede the Agency's ability to manage its operations.

Section VI. Dissemination of Policy

Upon adoption of this Policy, the Agency will determine and utilize an appropriate method to distribute the Policy to all its employees.

Section VII. Amendments and Review of Policy

The Agency shall strive to meet periodically with Tribes to evaluate the effectiveness of this Policy, including the Agency's promotion of cultural competence. This Policy is a working document and may be revised as needed

Section VIII. Effective Date
This Policy shall become effective upon the date signed by the Agency Head.

Section IX. Sovereign Immunity
The Policy shall not be construed to waive the sovereign immunity of the State of New Mexico or any Tribe, or to create a right of action by or against the State of New Mexico or a Tribe, or any State or Tribal official, for failing to comply with this Policy. The Agency shall have the authority and discretion to designate internal operations and processes that are excluded from the Policy, and recognizes that Tribes are afforded the same right.

Section XI. Closing Statement/ Signatures
The Department of Health hereby adopts the State-Tribal Consultation, Collaboration and Communication Policy.

Date _____12/17/2009_____
Alfredo Vigil, MD
Cabinet Secretary
Department of Health

ATTACHMENT A

Sample Procedures for State-Tribal Work Groups

DISCLAIMER: The following illustration serves only as sample procedures for State-Tribal Work Groups. The inclusion of this Attachment does not mandate the adoption of these procedures by a work group. Whether these, or alternative procedures, are adopted remains the sole discretion of the Agency Head and/or as duly-delegated to the Work Group.

A. Membership – The Work Group should be composed of members duly appointed by the Agency and as appropriate, participating Tribes, for specified purpose(s) set forth upon the Work Group's conception. Continued membership and replacements to Work Group participants may be subject to protocol developed by the Work Group, or otherwise by the designating authority or authorities.

B. Operating Responsibility – The Work Group should determine lines of authority, responsibilities, definition of issues, delineation of negotiable and non-negotiable points, and the scope of recommendations it is to disseminate to the Agency and Tribes to review, if such matters have not been established by the delegating authority or authorities.

C. Meeting Notices – Written notices announcing meetings should identify the purpose or agenda, the Work Group, operating responsibility, time frame and other relevant tasks. All meetings should be open and publicized by the respective Agency and Tribal offices.

D. Work Group Procedures – The Work Group may establish procedures to govern meetings. Such procedures can include, but are not limited to:

1. Selecting Tribal and Agency co-chairs to serve as representatives and lead coordinators, and to monitor whether the State-Tribal Consultation, Collaboration and Communication Policy is followed;
2. Defining roles and responsibilities of individual Work Group members;
3. Defining the process for decision-making,
4. Drafting and dissemination of final Work Group products;
5. Defining appropriate timelines; and
6. Attending and calling to order Work Group meetings.

E. Work Group Products – Once the Work Group has created its final draft recommendations, the Work Group should establish a process that serves to facilitate implementation or justify additional consultation. Included in its process, the Work Group should recognize the following:

1. Distribution – The draft recommendation is subjected for review and comment by the Agency, through its Agency Head, Tribal Liaison, and/or other delegated representatives, and participating Tribes, through their Tribal Officials.

2. Comment – The Agency and participating Tribes are encouraged to return comments in a timely fashion to the Work Group, which will then meet to discuss the comments and determine the next course of action. For example:
   a) If the Work Group considers the policy to be substantially complete as written, the Work Group can forward the proposed policy to the Agency and participating Tribes for finalization.
   b) If based on the comments, the Work Group determines that the policy should be rewritten; it can reinitiate the consultation process to redraft the policy.
   c) If the Agency and participating Tribes accept the policy as is, the Work Group can accomplish the final processing of the policy.

F. Implementation – Once the collaboration or consultation process is complete and the Agency and Tribes have participated in, or have been provided the opportunity to participate in, the review of the Work Group's draft recommendations, the Work Group may finalize its recommendations. The Work Group co-chairs should distribute the Work Group's final recommendations to the Agency, through its delegated representatives, and to participating Tribal Officials. The Work Group should record with its final recommendation any contrary comments, disagreements and/or dissention, and whether its final recommendation be to facilitate implementation or pursue additional consultation.

G. Evaluation – At the conclusion of the Work Group collaboration or consultation process, Work Group participants should evaluate the work group collaboration or consultation process. This evaluation should be intended to demonstrate and assess cultural competence of the Agency, the Work Group, and/or the process itself. The evaluation should aid in measuring outcomes and making recommendations for improving future work group collaboration or consultation processes. The results should be shared with the Agency, through its delegated representatives, and participating Tribal Officials.