New Mexico
Rural Health Plan

Report of the Rural Health Planning Workgroup

June 30, 2019

Executive Summary

A **Rural Health Strategic Planning** effort for New Mexico was initiated with support from the National Conference of State Legislatures. The goal of the effort was to develop consensus recommendations for improving health status and health services in rural New Mexico.

A core planning group convened in Denver during the initial phase of the project. Members included New Mexico legislators, New Mexico Department of Health (NMDOH) staff, and representatives of key health service and health provider organizations. Preliminary plans were established for the initiative and NMDOH was asked to be the facilitator of the planning process. Following the initial meeting additional members were invited to participate as part of the Planning Workgroup. These additional members included representatives of health provider associations and health professional education institutions.

The rural health planning process had five separate stages. The Planning Workgroup:

- Established a **consensus definition of rural**;
- Conducted a **preliminary rural health priority assessment**;
- Conducted an in-depth **rural health status and health services assessment**;
- Collected input on **rural health priorities of local communities and stakeholders**; and
- Developed **specific program and policy recommendations**.

The Planning Workgroup and its committees conducted the planning process as outlined. After completing all assessments and collecting input from local communities and stakeholders the Planning Workgroup compiled the following set of consensus recommendations for improving health status and health services in rural New Mexico

- **Expand State Loan Repayment Program** to include behavioral health professionals.
- **Restore Rural Primary Health Care Act Program (RPHCA) funding** to previous appropriation level.
- **Expand funding for State Loan Repayment Program** awards.
- **Expand Rural Health Care Practitioner Tax Credit Program** to include additional behavioral health providers, including LISWs.
- **Implement and provide funding to support a statewide tele-behavioral health network**.
- Provide additional **funding under RPHCA to support substance use disorder services**.
- **Expand the number of behavioral health investment zones** and engage additional local governments in coordinated approaches to these needs.

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Introduction

A **Rural Health Strategic Planning** effort for New Mexico was initiated with support from the National Conference of State Legislatures. The aim of the effort was to develop consensus recommendations for improving health status and health services in rural New Mexico. A core planning group convened in Denver during the initial phase of the project. Members included New Mexico legislators, New Mexico Department of Health (NMDOH) staff, and representatives of key health service and health provider organizations. Preliminary plans were established for the initiative and NMDOH was asked to be the facilitator of the planning process.

Following the initial meeting additional members were invited to participate as part of the Planning Workgroup. These additional members included representatives of health provider associations and health professional education institutions. The **Attachments** include full listing of Planning Group participants as well as New Mexico Department of Health staff assigned to support the planning effort.

This report documents the planning process and the specific program and policy recommendations resulting from this planning. **Attachments** include details from different stages of the planning process.

Rural Health Planning Process

The rural health planning process had five separate stages. The Planning Group:

- Established a **consensus definition of rural**;
- Conducted a **preliminary rural health priority assessment**;
- Conducted an in-depth **rural health status and health services assessment**;
- Collected input on **rural health priorities of local communities and stakeholders**; and
- Developed **specific program and policy recommendations**.

Defining rural was an important first step in the planning process. There are multiple definitions of rural used by different agencies and programs. In their choice of a rural definition, the Planning group defined the target area for its subsequent program and policy recommendations. In defining different types of rural communities, the Planning group also demonstrated that disparities exist between rural communities – not just between rural and urban communities.

The **preliminary assessment of rural health priorities** sought to tap the extensive experience in rural health matters of Planning Group members. The assessment of Planning Group members' specific concerns helped provide a survey of the issues that should be addressed in the planning effort. Policymaking does not happen in a vacuum, and this step helped assure that the initiative drew on the experience of previous rural health improvement efforts.

The **rural health assessment** was the core activity of the planning effort. Data was compiled to identify key disparities between rural and urban communities as well as disparities between different types of rural communities. Disparities in health status, social determinants and health service availability were identified. The in-depth assessment gave Planning Group members a detailed evidence base for their policy and program recommendations.

The Planning Group recognized the importance of collecting the information on the **priorities of local rural communities** throughout the state. The Planning Group itself is largely composed of leaders with a statewide perspective. There can be differences between statewide and local perspectives on these matters. Exploring the rural health priorities of local communities allowed the final recommendations to be grounded in the perspectives of local people.

The final **program and policy recommendations** of the Planning Group provide a list of consensus priorities for the members. The recommendations show the approaches which have the widest support from rural health policy leaders in the state. The final recommendations show the consensus priorities for the broad range of rural health as well as for specific sub-areas of rural health policy such as health professional education and health services improvement.

The results of each of these planning stages are summarized in the subsequent sections of this report.

Defining Rural in New Mexico

The Rural Health Planning Workgroup explored several alternative definitions of 'rural' with the aim of selecting definitions that met the aims of the strategic planning effort. Some definitions define rural at a county level while others define it at sub-county levels. Demographic and social determinant data is largely available at a sub-county level, but much health status, health risk and health services data is available only on a county level.

After discussion, the Planning Group decided to use a county level rural definition for strategic planning purposes. It chose rural/urban definitions used by the NMDOH Indicator-Based Information System (IBIS). This is a multi-category definition which defines rural counties as non-MSA counties. It divides rural counties into two sub-categories – a small town rural category for counties containing towns no larger than 10,000 people, and a larger town rural category for counties containing towns larger than 10,000 people. This definition is delineated in the **Attachments**, including a map showing the different urban and rural categories.

Geographically, New Mexico is a largely rural state. Of its 33 counties, only 7 contain predominantly urban areas defined as part of Metropolitan Statistical Areas (MSAs).

- Bernalillo
- Sandoval
- Valencia
- Torrance
- Dona Ana
- Santa Fe
- San Juan.

The remaining 26 Non-Metropolitan counties are considered rural or frontier in nature. Non-Metro counties are differentiated by the size of the largest settlement within the county. 12 Non-Metro counties with a largest settlement under 10,000 population are categorized as mostly rural, and can be considered, for purposes of this plan Small Town Non-Metro Counties:

- Catron
- Colfax
- De Baca
- Guadalupe
- Harding
- Hidalgo
- Lincoln
- Mora
- Quay
- Sierra

- Socorro
- Union.

14 Non-Metro Counties have a largest settlement of more than 10,000 and can be considered, for purposes of this plan, Large Town Non-Metro Counties:

- Cibola
- Chaves
- Curry
- Eddy
- Grant
- Lea
- Los Alamos
- Luna
- McKinley
- Otero
- Rio Arriba
- Roosevelt
- San Miguel
- Taos.

These categories are useful for identifying disparities within rural parts of the state.

Metro counties are also differentiated by the size of the largest settlement within the MSA. The counties of the Albuquerque MSA, with a central settlement of more than 500,000, are considered Large Metro Counties. Counties in all other MSAs are considered Small Metro Counties.

It should be noted that there are locations within MSA counties that are largely rural or frontier. The very large size of New Mexico counties creates this situation. For example, Cuba and the very western parts of Sandoval County are more than 80 miles from the center of Albuquerque are in small census units that can be considered frontier. Nevertheless, they are lumped into a county that is considered a Large Metro County. Much of the most useful health assessment data is collected at the county level. The analysis contained in this plan will emphasize county-level disparities. Select measures will identify disparities in rural sub-county portions of Metro Counties.

The Planning Group recognized that the use of county-level definitions conforms to the likely manner in which rural health interventions will be implemented. While the Plan is primarily a blueprint for State level policy and programs, the Planning Group recognized that county government has an important responsibility in rural health. Counties administer Indigent Health Care Funds for hospitals and other health services. They also provide facilities for NMDOH public health offices.

Preliminary Rural Health Priority Assessment

The Planning Group includes many members with extensive knowledge and experience in rural health policy and programs. To capture this wealth of understanding a preliminary survey of Planning Group members was conducted. The survey asked open response questions soliciting from Planning Group members their rural health program and policy priorities. Questions explored seven different rural health issue areas:

- **Health Services**: Funding and policy changes for rural-focused health service programs.
- **Recruitment/Retention Incentives**: Funding, program and policy changes for rural-focused health professional programs.
- **Health Professional Training and Education**: Funding, program and policy changes for rural-focused health professional training/education programs.
- **Medicaid Policy**: Changes in funding and policy affecting rural health services.
- **Health Promotion**: Changes in programs and policy affecting health status improvement efforts in rural areas.
- **Health Insurance**: Changes in health insurance law, regulation, and policy affecting rural areas.
- **Health professional licensing/regulation**: Changes in professional practice guidance affecting rural areas.

The responses to the survey were very detailed and rich. The responses fell into 5 key areas of recommendation:

- **Appropriation Priorities:** priorities for changes in state funding for rural health related activities.
- **Program Change Priorities:** priorities for changes in the operation or administration of existing state programs.
- **New Program Priorities:** priorities for the establishment of new state programs.
- **Policy Change Priorities:** priorities for changes to existing state program policies.
- **Study/Planning Priorities**: priorities for future study by state agencies.

The survey questions and all responses are summarized in the **Attachments**. Priorities with the largest number of survey mentions are detailed below:

- **Appropriation Priorities**:
    - Restore state funding to important rural health programs, including the Rural Primary Health Care Act (RPHCA) program and the School-Based Health Center (SBHC) program.
    - Restore state funding to important health professional recruitment/retention programs, including the New Mexico Health

Professional Loan Repayment program, the New Mexico Health Service Corps Stipend (NMHSC) program, and the New Mexico Health Professional Recruitment and Retention Clearinghouse.
    - Recapitalize the New Mexico Primary Care Capital Fund.

- **Program Change Priorities**:

    - Expand categories of professionals who qualify for tax incentives under the New Mexico Rural Health Practitioners Tax Credit Program.
    - Modify priorities and evaluation of RPHCA program.
      Expand categories of professionals who qualify for NMHSC stipend program.

- **New Program Priorities**:

    - Re-establish authorization and appropriation for the New Mexico Nurse Advice Line.
    - Expand and provide state support to a Rural Based Family Practice Residency Program.
    - Develop new and expanded substance abuse and opioid treatment education and training.

- **Policy Change Priorities**:

    - Require Medicaid MCOs to utilize a universal credentialing system.
    - Provide Medicaid reimbursement to rural clinics for nurse advice triage calls.

- **Study/Planning Priorities**:

    - Study the feasibility of establishing a Uniform Credentialing System for health professionals to be used by all health coverage payors.
    - Study the potential for expanding/repurposing NMDOH Public Health Offices.

These responses were reviewed at an early meeting of the Planning Group and formed a baseline for further Plan discussions. There was substantial convergence in the responses, particularly around restoration of state funding for multiple rural-focused programs. These areas of agreement formed a baseline for the final recommendations of the Planning Group. It should be noted that the final consensus recommendations showed significant changes from preliminary participant priorities.

Rural Health Assessment: Introduction

The **rural health assessment** conducted for the Rural Health Plan was composed of multiple data reviews designed to identify the special health and health service needs of rural New Mexico. The assessment was conducted using the NM IBIS county-level definitions of rural, in line with the Planning Group decision to use these as a focus. This permitted a wide range of data from several sources to be used.

The rural health assessment analyzed the following health-related data:

- **Demographic Indicators**: reviewing differences in county populations
- **Socioeconomic Indicators**: reviewing differences key social determinant of
- **Health Status Indicators**: reviewing differences in direct measures of population health
- **Maternal and Child Health Indicators**: reviewing differences in measures of health related to pregnancy and childbirth
- **Mortality Indicators**: reviewing differences in the death rates for different causes of death
- **Health Professional Shortage Areas**: reviewing the Federal designation of areas with critical shortages of primary care, dental and mental health professionals/services.
- **Specialty Physician Shortages**: reviewing areas with shortages of key specialty physicians/services.
- **Acute Care Hospitals**: reviewing differences in the availability of acute care inpatient facilities.
- **State Rural Health Programs**: reviewing the current status of important state-funded programs designed to meet the health needs of rural New Mexico.

The primary aim of the assessment was to identify significant disparities between rural and urban counties. The analyses would provide the Planning Group with an evidence base for the development of new/modified rural health programs and policies. The secondary aim of the assessment was to identify significant disparities between Small-Town rural counties and Large-Town rural counties. Identification of these differences would allow the development of rural health programs and policies targeted to more discrete high need rural areas of New Mexico.

The next sections of the report provide summaries of the different analyses which composed the rural health assessment. Supporting data and more detailed findings are included in the **Attachments**.

Rural Health Assessment: Demographic Indicators

Rural Population Demographic Overview

As part of the assessment data was compiled on a range of key demographic indicators, including:

- Total population
- Population under age 5
- Population under age 18
- Population age 65 and over
- Age dependency ratio
- Population density
- Hispanic population
- Native American population
- Non-English-speaking population
- Non-Hispanic white population.

The analysis of these indicators for rural and urban areas is presented on tables in the Attachments and is summarized below.

Total Population: Bureau of the Census estimates for 2016 indicate that there are 698,987 residents of Non-Metro counties in New Mexico, representing about **one-third (33.2%) of the total population of the state**.

The population in Small Town Rural counties is estimated to be 94,142 - 4.5% of the total state population. The population in Large Town Rural counties is estimated to be 604,845 - 28.8% of the total state population. Tables summarizing demographic data for the rural population are contained in the **Attachments.**

Population Under Age 18: Bureau of the Census estimates for 2016 indicate that there are 171,688 residents of Non-Metro counties under the age of 18, representing about **a quarter (24.6%) of the total population** in those counties. This is higher than the 23.0% figure in Metro counties.

The population under age 18 in Small Town Rural counties is estimated to be 17,786 - only 18.9% of the total population in those counties. The population under age 18 in Large Town Rural counties is estimated to be 153,902 - 25.4% of the total population in that category of counties. The relative size of this age group in Small Town Rural counties is substantially lower than that in other categories of counties.

Population Under Age 5: Bureau of the Census estimates for 2016 indicate that there are 47,477 residents of **Non-Metro counties under the age of 5, representing 6.8% of the total population** in those counties. This is higher than the 6.0% figure in Metro counties.

The population under age 5 in Small Town Rural counties is estimated to be 4,603 - only 4.9% of the total population in those counties. In comparison the population under age 5 in Large Town Rural counties is estimated to be 42,874 - 7.1% of the total population in that category of counties. This relative size of this age group in Small Town Rural counties is substantially lower than that in other categories of counties. The relative size of this age group in Large Town Rural counties is substantially higher than in other categories of counties.

Population Age 65 and Over: Bureau of the Census estimates for 2016 indicate that there are 120,038 residents of **Non-Metro counties age 65 and over, representing just over a sixth (17.2%) of the total population** in those counties. This is higher than the 16.1% figure in Metro counties.

The population age 65 and over in Small Town Rural counties is estimated to be 24,135 - 25.6% of the total population in those counties. The population age 65 and over in Large Town Rural counties is estimated to be 95,903 - 15.9% of the total population in that category of counties. The relative size of this age group in Small Town Rural counties is substantially higher than that in other categories of counties.

Age Dependency Ratio: Bureau of the Census population estimates for 2016 can be used to calculate an age dependency ratio for different parts of the state. This ratio is calculated as the total of the population under age 15 and the population age 65 and over divided by the population age 16-64. It provides a rough picture of the population dependent upon others compared to the working population. This ratio is 60.3 for Non-Metro counties, substantially higher than the 54.1 ratio in Metro counties.

The ratio Small Town Rural counties is even higher - 69.9. The ratio in Large Town Rural counties is somewhat lower - 58.9.

Population Density: Non-metro counties have an average population density of **6.9 persons per square mile**. This is lower than the 68.5 figure in Metro counties and suggests one of the challenges in addressing rural health needs.

Small Town Rural counties have a much lower density - 2.0 persons per square mile - far below frontier area population density criteria. Large Town Rural counties have a population density of 11.0 persons per square mile.

Hispanic Population: The Hispanic percentage of the population in **Non-Metro counties is 46.5%, lower than the 49.4% figure in Metro counties.**

The percentage in Small Town Rural counties is slightly lower at 45.1%. The percentage in Large Town Rural counties is 46.7%. Both are lower than the 48.5% figure for the entire state.

Non-English Speaking Population: In Non-Metro counties the percentage of the population age 5 and over that does not speak English very well is **9.7% - lower than the percentage for Metro counties**.

In comparison, the percentage is somewhat lower in Small Town Rural counties is - 7.8%. The percentage in Large Town Rural counties is higher - 10.1%. This last percentage is also higher than the 9.3% figure for the entire state.

Native American Population: Native Americans comprise **11.9% of the population of Non-Metro counties**. This is significantly **higher than the 7.0% figure for Metro counties.**

In Small Town Rural counties, the percentage is much lower - 3.3%. **In Large Town Rural counties, it is higher - 13.2%.** This is higher than the 8.6% figure for the entire state.

Non-Hispanic White Population: In Non-Metro counties the non-Hispanic white population comprises 38.4% of the population, **slightly lower than the 39.4% percentage for Metro Counties**.

In **Small Town Rural counties, the percentage is substantially higher - 50.0%**. This is **significantly higher than the 39.0% figure for the entire state**. In Large Town Rural counties, the percentage is slightly lower - 36.6%.

Rural Population Demographic Disparities:

There are multiple demographic disparities between Metro and Non-Metro counties.

Listed below are indicators showing important disparities between Non-Metro and Metro counties. The largest indicator disparities, where they exist, are flagged with a double asterisk – those with more than a 50% difference in percentages or rates - or a single asterisk - those with more than a 20% difference in percentages or rates:

Non-Metro Higher than Metro:

- Population Age 65 and Over,
- Age Dependency Ratio,
- Native American Population Percentage (*),
- Non-Hispanic White Population Percentage,
- Population Under Age 18, and
- Population Under Age 5.

Detailed demographic comparisons between Small Town Rural counties and Large Town Rural counties are displayed on a **Health Status and Social Determinant Indicator Comparison Chart** included in the **Attachments**.

Rural Health Assessment: Socioeconomic Indicators

Rural Population Socioeconomic Overview

As part of the assessment data was compiled on a range of key socioeconomic indicators, including:

- Population below poverty
- Population under age 5 below poverty
- Population under age 18 below poverty
- Population age 65 and over below poverty
- Unemployment rate
- Population without health insurance.

The analysis of these indicators for rural and urban areas is presented on tables in the **Attachments** and is summarized below.

Population Below Poverty: The Bureau of the Census estimates that for the five-year period 2011-2015 **22.5% of the residents of Non-Metro counties** were below the Federal poverty level. This is higher than the 20.7% estimate for the poverty population for Metro counties.

19.6% of the population in Small Town Rural counties was estimated to be below poverty. In comparison **23.0% of the population in Large Town Rural counties** was estimated to be below poverty. This last figure is higher than the 21.0% for the entire state.

Population Under Age 5 Below Poverty: The Bureau of the Census estimates that for the five-year period 2011-2015 **36.6% of the population of Non-Metro counties under age 5** were below the Federal poverty level. This is higher than the 32.4% estimate for the same age group in Metro counties.

34.8% of this age group in Small Town Rural counties was estimated to be below poverty. In comparison **36.8% of this age group in Large Town Rural counties** was estimated to be below poverty. Both figures are higher than the 33.9% of the age group that was below poverty for the entire state.

Population Under Age 18 Below Poverty: The Bureau of the Census estimates that for the five-year period 2011-2015 **31.0% of the population of Non-Metro counties under age 18** was below the Federal poverty level. This is higher than the 28.6% estimate for the same age group in Metro counties.

25.2% of this age group in Small Town Rural counties was estimated to be below poverty. In comparison **31.7% of this age group in Large Town Rural counties**

was estimated to be below poverty. This is higher than the 29.4% of the age group that was below poverty for the entire state.

Population Age 65+ Below Poverty: The Bureau of the Census estimates that for the five-year period 2011-2015 **13.7% of the population of Non-Metro counties age 65+** were below the Federal poverty level. This is higher than the 11.6% estimate for the same age group in Metro counties.

12.2% of this age group in Small Town Rural counties was estimated to be below poverty. In comparison **14.1% of this age group in Large Town Rural counties** was estimated to be below poverty. Both figures are higher than the 12.0% of the age group that was below poverty for the entire state.

Unemployment Rate: The 2016 estimate for the **unemployed percent of the civilian workforce in Non-Metro counties is 7.5%.** This is higher than the 6.4% estimate for the same age group in Metro counties.

6.8% of the civilian workforce in Small Town Rural counties was estimated to be unemployed. In comparison **7.6% of the civilian workforce in Large Town Rural counties** was estimated to be unemployed. Both figures are higher than the 6.7% of the unemployed civilian workforce in the entire state.

Population Under age 65 Without Health Insurance: The Bureau of the Census estimates that in 2016 **13.6% of the population under age 65 in Non-Metro counties had no health insurance**. This is higher than the 12.9% estimate for this population group in Metro counties. 1

3.0% of the population group in Small Town Rural counties was estimated to be without health insurance. In comparison, **an estimated 13.7% of the population group in Large Town Rural Counties was without health insurance**. This figure is higher than the 13.1% of the population group estimated to be without health insurance in the entire state.

Rural Population Socioeconomic Disparities:

There are multiple socioeconomic disparities between Metro and Non-Metro counties.

Listed below are indicators showing important disparities between Non-Metro and Metro counties. The largest indicator disparities, where they exist, are flagged with a double asterisk – those with more than a 50% difference in percentages or rates - or a single asterisk - those with more than a 20% difference in percentages or rates:

Non-Metro Higher or Worse than Metro:

- Population below poverty,
- Population under age 5 below poverty,

- Population under age 18 below poverty,
- Population age 65+ below poverty,
- Unemployment rate, and
- Population without health insurance.

Detailed socioeconomic comparisons between Small Town Rural counties and Large Town Rural counties are displayed on a **Health Status and Social Determinant Indicator Comparison Chart** included in the **Attachments**.

Rural Health Assessment: Health Status Indicators

Rural Population Health Status Overview

As part of the assessment data was compiled on a range of key Health Status indicators, including:

- Life Expectancy from Birth
- Life Expectancy from Age 65
- Years of Potential Life Lost (YPLL) Before Age 75
- Percent Population Disabled
- Percent Adult Population with Fair/Poor Health

The analysis of these indicators for rural and urban areas is presented on tables in the **Attachments** and is summarized below.

Life Expectancy from Birth: The life expectancy from birth for a resident in Non-Metro New Mexico counties is **76.7 years, a full 2.5 years less** than the 79.2 years expected for residents of Metro counties.

The life expectancy for residents of Small Town Non-Metro counties is 76.9 years. In comparison the life **expectancy in Large Town Non-Metro counties is 76.6 years**, substantially lower than the 78.4 years expected for the entire state.

Life Expectancy from Age 65: The life expectancy from age 65 for a resident in **Non-Metro New Mexico counties is 20.0 years,** less than the 20.9 years expected for residents of Metro counties.

The life expectancy for residents of Small Town Non-Metro counties is 20.7 years. In comparison the life **expectancy in Large Town Non-Metro counties is 19.9 years**, lower than the 20.6 years expected for the entire state.

YPLL Before Age 75: The estimated Years of Potential Life Lost Before Age 75 for residents in Non-Metro New Mexico counties is **9,475 per 100,000 population.** This is **more than 25% higher than the 7,430 estimate for residents of Metro counties.**

The figure for residents of **Small Town Non-Metro counties is 9,923 years**. In comparison the YPLL in Large Town Non-Metro counties is 9,405 years, substantially higher than the 8,117 years expected for the entire state.

Percent Population Disabled: The estimate for the **disabled percent of the civilian population in Non-Metro counties is 17.7%.** This is much higher than the 13.1% estimate for Metro counties.

23.2% of the civilian population in Small Town Rural counties was estimated to be disabled. In comparison 16.8% of the civilian population in Large Town Rural counties was estimated to be disabled. Both figures are higher than the 14.6% of the disabled civilian population in the entire state.

Percent Adult Population With Fair/Poor Health: An estimated **22.8% of the adult population in Non-Metro counties** self-reports their health as fair or poor (less than good). This is much higher than the 19.5% estimate for Metro counties.

22.9% of the adult population in Small Town Rural counties was self-reported fair or poor health. In comparison **22.9% of the adult population in Large Town Rural counties** reported fair or poor health. Both figures are higher than the 20.3% of the adult population with fair or poor health in the entire state.

Rural Population Health Status Disparities:

There are multiple health status disparities between Metro and Non-Metro counties.

Listed below are indicators showing important disparities between Non-Metro and Metro counties. The largest indicator disparities, where they exist, are flagged with a double asterisk – those with more than a 50% difference in percentages or rates - or a single asterisk - those with more than a 20% difference in percentages or rates:

Non-Metro Higher or Worse than Metro:

- Life Expectancy from Birth,
- Life Expectancy from Age 65,
- Years of Potential Life Lost (YPLL) Before Age 75 (*),
- Percent Population Disabled (*), and
- Percent Adult Population with Fair/Poor Health.

Detailed health status indicator comparisons between Small Town Rural counties and Large Town Rural counties are displayed on a **Health Status and Social Determinant Indicator Comparison Chart** included in the **Attachments**.

Rural Health Assessment: Maternal and Child Health Indicators

Rural Maternal and Child Health Overview

As part of the assessment data was compiled on a range of key Maternal and Child Health indicators, including:

- Percent Low/Very Low Birthweight Births
- Percent Pre-Term Births
- Adolescent Birth Rate
- Percent Births with First Trimester Prenatal Care.

The analysis of these indicators for rural and urban areas is presented on tables in the **Attachments** and is summarized below.

Percent Low/Very Low Birthweight Births: 8.8% of live births in Non-Metro counties are low or very low birthweight. This is higher than the 8.6% of births in Metro counties.

10.0% of live births in Small Town Rural counties were low or very low birthweight. This figure is higher than the 8.7% of births in the entire state. In comparison 8.7% births in Large Town Rural counties were low or very low birthweight.

Percent Pre-Term Births: 9.7% of live births in Non-Metro counties are pre-term births. This is higher than the 9.5% of births in Metro counties.

10.3% of live births in Small Town Rural counties were pre-term. This figure is higher than the 9.6% of births in the entire state. In comparison 9.6% births in Large Town Rural counties were pre-term.

Adolescent Birth Rate: In Non-Metro counties there were 52.1 births for every 1,000 girls age 15-19. This is much higher than the 33.8 adolescent birth rate in Metro counties.

In Small Town Rural counties there were 43.7 births for every 1,000 girls age 15-19. **In comparison in Large Town Rural counties the adolescent birth rate was 53.2.** This figure is higher than the 39.9 rate for the entire state.

Percent of Births with Prenatal Care in First Trimester: 60.4% of live births in Non-Metro counties received prenatal care in the first trimester of pregnancy. This is lower than the 63.9% of births in Metro counties.

59.5% of live births in Small Town Rural counties received prenatal care in the first trimester of pregnancy. In comparison 60.5% births in Large Town

Rural counties received prenatal care in first trimester. Both figures are lower than the 63.9% of births in the entire state.

Rural Maternal and Child Health Disparities:

There are multiple Maternal and Child Health disparities between Metro and Non-Metro counties.

Listed below are indicators showing important disparities between Non-Metro and Metro counties. The largest indicator disparities, where they exist, are flagged with a double asterisk – those with more than a 50% difference in percentages or rates - or a single asterisk - those with more than a 20% difference in percentages or rates:

Non-Metro Higher or Worse than Metro:

- Percent Low/Very Low Birthweight Births,
- Percent Pre-Term Births,
- Adolescent Birth Rate (**), and
- Percent Births with First Trimester Prenatal Care.

Detailed maternal and child health indicator comparisons between Small Town Rural counties and Large Town Rural counties are displayed on a **Health Status and Social Determinant Indicator Comparison Chart** included in the **Attachments**.

Rural Health Assessment: Mortality Indicators

Rural Population Mortality Overview:

As part of the assessment data was compiled on a range of key Mortality indicators, including:

- Mortality Rate – All Causes
- Mortality Rate – Heart Disease
- Mortality Rate – All Cancers
- Mortality Rate – Unintentional Injury
- Mortality Rate – COPD
- Mortality Rate – Stroke
- Mortality Rate – Diabetes
- Mortality Rate – Chronic Liver Disease
- Mortality Rate – Influenza and Pneumonia
- Mortality Rate – Alcohol-Related Chronic Disease
- Mortality Rate – Drug Overdose
- Mortality Rate – Suicide
- Mortality Rate – Motor Vehicle Injury.

The analysis of these indicators for rural and urban areas is presented on tables in the **Attachments** and is summarized below.

Mortality Rate – All Causes: In Non-Metro counties there were 812.6 deaths from all causes per 100,000 population in 2012-2016. This is higher than the 699.3 death rate in Metro counties.

In Small Town Rural counties there were 794.3 deaths from all causes per 100,000 population. **In comparison in Large Town Rural counties the all cause death rate was 818.3.** Both figures were higher than the 737.5 all cause death rate for the entire state.

Mortality Rate – Heart Disease: In Non-Metro counties there were 165.5 deaths from heart disease per 100,000 population in 2012-2016. This is higher than the 132.4 death rate in Metro counties.

In Small Town Rural counties there were 160.7 deaths from heart disease per 100,000 population. **In comparison in Large Town Rural counties the heart disease death rate was 168.1.** Both figures were higher than the 144.2 heart disease death rate for the entire state.

Mortality Rate – All Cancers: In Non-Metro counties there were 149.6 deaths from cancers per 100,000 population in 2012-2016. This is higher than the 137.8 death rate in Metro counties.

In **Small Town Rural counties there were 152.2 deaths from cancers per 100,000 population**. In comparison in Large Town Rural counties the death rate from cancers was 149.4. Both figures were higher than the 141.9 cancers death rate for the entire state.

Mortality Rate – Unintentional Injury: In Non-Metro counties there were 71.5 deaths from unintentional injury per 100,000 population in 2007-2016. This is higher than the 60.3 death rate in Metro counties.

In **Small Town Rural counties there were 74.8 deaths from unintentional injury per 100,000 population**. In comparison in Large Town Rural counties the death rate from unintentional injury was 71.0. Both figures were higher than the 63.9 unintentional injuries death rate for the entire state.

Mortality Rate – COPD: In Non-Metro counties there were 51.3 deaths from chronic obstructive pulmonary disease (COPD) per 100,000 population in 2007-2016. This is higher than the 41.9 COPD death rate in Metro counties.

In **Small Town Rural counties there were 55.1 deaths from COPD per 100,000 population**. In comparison in Large Town Rural counties the death rate from COPD was 50.5. Both figures were higher than the 45.3 COPD death rate for the entire state.

Mortality Rate – Stroke: In Non-Metro counties there were 32.5 deaths from Stroke per 100,000 population **in 2007-2016**. This is **lower than the 33.8 Stroke death rate in Metro counties**. Deaths rates from Stroke are one of the few causes of death where Non-Metro rates are lower than Metro rates.

In Small Town Rural counties there were 33.2 deaths from Stroke per 100,000 population. In comparison in Large Town Rural counties the death rate from Stroke was 32.4. **Both figures were lower than the 33.4 Stroke death rate for the entire state**.

Mortality Rate – Diabetes: In Non-Metro counties there were 33.7 deaths from diabetes per 100,000 population in 2007-2016. This is substantially higher than the 24.2 death rate in Metro counties.

In Small Town Rural counties there were 30.1 deaths from diabetes per 100,000 population. In comparison in Large Town Rural counties the death rate from diabetes was 34.6. Both figures were higher than the 37.5 diabetes death rate for the entire state.

Mortality Rate – Chronic Liver Disease: In Non-Metro counties there were 25.2 deaths from chronic liver disease per 100,000 population in 2007-2016. This is substantially higher than the 17.4 death rate in Metro counties.

In Small Town Rural counties there were 20.8 deaths from chronic liver disease per 100,000 population**.** In comparison in **Large Town Rural counties the death rate from chronic liver disease was 26.0.** This figure was higher than the 20.0 chronic liver disease death rate for the entire state.

Mortality Rate – Alzheimer's Disease: In Non-Metro counties there were 16.8 deaths from Alzheimer's Disease per 100,000 population **in 2007-2016**. This is **lower than the 19.38 Alzheimer's Disease death rate in Metro counties**. Deaths rates from Alzheimer's Disease are one of the few causes of death where Non-Metro rates are lower than Metro rates.

In Small Town Rural counties there were 12.6 deaths from Alzheimer's Disease per 100,000 population. In comparison in Large Town Rural counties the death rate from Alzheimer's Disease was 17.8. **Both figures were lower than the 18.4 Alzheimer's Disease death rate for the entire state**.

Mortality Rate – Influenza and Pneumonia: In Non-Metro counties there were 17.4 deaths from influenza and pneumonia per 100,000 population in 2007-2016. This is higher than the 14.0 death rate in Metro counties.

In Small Town Rural counties there were 16.8 deaths from influenza and pneumonia per 100,000 population**.** In comparison in **Large Town Rural counties the death rate from influenza and pneumonia was 17.6.** Both figures were higher than the 15.2 influenza and pneumonia death rate for the entire state.

Mortality Rate – Alcohol-Related Chronic Disease: In Non-Metro counties there were 32.0 deaths from alcohol-related chronic disease per 100,000 population in 2007-2016. This is higher than the 25.6 death rate in Metro counties.

In Small Town Rural counties there were 27.5 deaths from alcohol-related chronic disease per 100,000 population**.** In comparison in **Large Town Rural counties the death rate from alcohol-related chronic disease was 32.8.** This figure was higher than the 27.7 alcohol-related chronic disease death rate for the entire state.

Mortality Rate – Drug Overdose: In Non-Metro counties there were 24.3 deaths from drug overdose per 100,000 population in 2007-2016. This is higher than the 24.2 death rate in Metro counties.

In Small Town Rural counties there were 28.5 deaths from drug overdose per 100,000 population. This figure was **higher than the 24.3 drug overdose**

death rate for the entire state. In comparison in Large Town Rural counties the death rate from drug overdose was 23.7.

Mortality Rate – Suicide: In Non-Metro counties there were 23.0 deaths from suicide per 100,000 population in 2007-2016. This is higher than the 19.6 death rate in Metro counties.

In Small Town Rural counties there were 27.2 deaths from suicide per 100,000 population. In comparison in Large Town Rural counties the death rate from suicide was 22.3. Both figures were **higher than the 20.7 suicide death rate for the entire state**.

Mortality Rate – Motor Vehicle Injury: In Non-Metro counties there were 23.0 deaths from motor vehicle injury per 100,000 population in 2007-2016. This is substantially higher than the 13.8 death rate in Metro counties.

In Small Town Rural counties there were 22.8 deaths from motor vehicle injury per 100,000 population. In comparison in **Large Town Rural counties the death rate from motor vehicle injury was 23.1.** Both figures were **higher than the 16.9 motor vehicle injury death rate for the entire state**.

Rural Mortality Disparities:

There are multiple Mortality disparities between Metro and Non-Metro counties. Many of the leading causes of death in the state have significantly higher rates in Non-Metro areas.

Listed below are indicators showing important disparities between Non-Metro and Metro counties. The largest indicator disparities, where they exist, are flagged with a double asterisk – those with more than a 50% difference in percentages or rates - or a single asterisk - those with more than a 20% difference in percentages or rates:

Non-Metro Higher or Worse than Metro:

- Mortality Rate – All Causes,
- Mortality Rate – Heart Disease (*),
- Mortality Rate – All Cancers,
- Mortality Rate – Unintentional Injury,
- Mortality Rate – COPD (*),
- Mortality Rate – Diabetes (*),
- Mortality Rate – Chronic Liver Disease (*),
- Mortality Rate – Influenza and Pneumonia (*),
- Mortality Rate – Alcohol-Related Chronic Disease (*),
- Mortality Rate – Drug Overdose,
- Mortality Rate – Suicide, and

- Mortality Rate – Motor Vehicle Injury (**).

Detailed mortality indicator comparisons between Small Town Rural counties and Large Town Rural counties are displayed on a **Mortality Comparison Chart** included in the **Attachments**.

Rural Health Assessment: Health Professional Shortage Areas in New Mexico

Overview

The Health Resources and Service Administration (HRSA) of the Department of Health and Human Services uses its own methodology to identify areas and sub-populations with a shortage of key health professionals. It identifies places/sub-populations with shortages of primary medical care physicians, dentists, and mental health professionals. These area and sub-populations are estimated to have **less than half the supply** of professionals needed by the target population. HRSA designates these areas and sub-populations as Health Professional Shortage Areas (HPSAs). The designations are kept updated on a multiyear schedule.

HRSA designates 3 key types of primary care HPSA – Whole County, Subcounty and Low-Income Population. The Whole County HPSA is a shortage designation for the entire population of a county. The Subcounty HPSA is a shortage designation for a subcounty geographic area sub-population. The Low-Income Population designation is a shortage designation for the population of a county or subcounty that is below 200% of the Federal Poverty Level.

A complete analysis of HPSA designations in rural/urban counties in New Mexico, updated through 2017, is included in the **Attachments**. identified below. They are compiled by geographic area type.

Primary Medical Care HPSAs in New Mexico

Rural counties in New Mexico have significantly greater primary care physician shortages than do urban counties. Analysis of Federally-designated HPSAs shows that:

- **All fourteen of New Mexico's Small Town Rural counties are designated** as primary care HPSAs. All HPSAs are whole county designations, reflecting a high level of need in these areas.
- **5 of New Mexico's 14 Large Town Rural counties are designated** as whole county primary care HPSAs. 1 additional county has 3 subcounty designations. The low-income population in 7 whole counties is designated.
- By comparison **only 1 of New Mexico's 3 Small Metro Counties is designated** as whole county primary care HPSA. 2 additional counties have subcounty designations. The low-income population in 1 subcounty is designated.
- Similarly, **only a portion of Bernalillo County**, the largest urban county, has a low-income population designation. 1 county – Sandoval – has a subcounty designation. 2 of the outlying counties in the Albuquerque MSA are designated as whole county HPSAs.

Federal Primary Care HPSA designation is given to the total population in the most rural of New Mexico's counties, highlighting the higher degree of shortage in these counties when compared to the state's urban counties.

Dental HPSAs in New Mexico

Rural counties in New Mexico have significantly greater dentist shortages than do urban counties. Analysis of Federally-designated HPSAs shows that:

- **12 of New Mexico's 14 Small Town Rural counties are designated as dental HPSAs**. 9 HPSAs are whole county designations, and the remaining 3 are low income county-wide designations.
- **4 of New Mexico's 14 Large Town Rural Counties are designated** as whole county dental care HPSAs. 1 additional county has a subcounty designation. **The low-income population in 9 whole counties is designated**.
- **1 of New Mexico's 3 Small Metro counties is partially designated as a shortage area** with three separate subcounty dental designations. A second county has one subcounty designation. 1 county has a county-wide low-income population designation, while another has a subcounty low-income population designation.
- **Bernalillo County is only marginally designated for dental shortage** with a subcounty low income population designation for one neighborhood. 2 additional counties are partially designated with subcounty designations. 1 of the outlying counties in the Albuquerque MSA is designated as a whole county dental HPSA.

As with Primary Care designation, Federal Dental HPSA designation is given to the total population in the most rural of New Mexico's counties, highlighting the higher degree of shortage in these counties when compared to the state's urban counties.

Mental Health HPSAs in New Mexico

Rural counties in New Mexico have significantly greater mental health professional shortages than do urban counties. Analysis of Federally-designated HPSAs shows that:

- **All fourteen of New Mexico's Small Town Rural counties** are designated as mental health HPSAs. All HPSAs are whole county designations, reflecting a high level of need in these areas.
- **All of New Mexico's 14 Large Town Rural Counties are designated** as Whole County Mental Health HPSAs. All HPSAs are whole county designations, reflecting a high level of need in these areas.
- **2 of New Mexico's 3 Small Metro counties are designated** as whole county Mental Health HPSAs. 1 other county has a whole county low income population designation.

- **Bernalillo County is partially designated** with a subcounty total population designation and a subcounty low-income population in two different neighborhoods. 2 of the outlying counties in the Albuquerque MSA are designated as whole county Mental Health HPSAs.

The large disparity between Rural and Urban designated Mental Health HPSA populations highlights the extreme need for mental health professionals in rural New Mexico.

Rural Health Assessment: Shortage of Key Physician Specialists

Overview:

Each year, the New Mexico Health Care Workforce Committee studies the supply and distribution of health care providers for an annual report to the Legislature. The data is compiled from surveys completed by health professionals as part of the licensing process. While this self-reported data is somewhat less definitive than HPSA designation data, it permits supplementary perspective on shortages of key physician specialties and dentists.

For purposes of the Plan, the assessment examined the relative distribution in rural/urban counties of five health professional categories:

- Primary Care Physicians
- Obstetrician/Gynecologists
- General Surgeons
- Psychiatrists
- Dentists.

The complete assessment is included in the **Attachments**. Findings are summarized below.

Distribution of Primary Care Physicians:

Rural/Urban Analysis: The supply of primary care physicians (MDs and DOs reporting specialties of family practice, family medicine, general practice, general pediatrics or general internal medicine) in 2016 in New Mexico's rural counties is below that of urban counties and falls below the national benchmark supply rate and the statewide rate. Both Small Town Rural counties and Large Town Rural counties fall below the national benchmark and Statewide rate. All categories of urban counties exceed the national benchmark.

Primary Care Physician data is summarized on the following table.

Primary Care Physicians per 10,000 Population
-- New Mexico - 2016

	Providers per 10,000 Population		Providers per 10,000 Population
Non-Metro	7.4	Rural	6.5
		Mixed	7.5
Metro	11.1	Small Metro	9.7
		Large Metro	11.9
State Total	9.9	Total	9.9

National Benchmark	7.9		7.9

Source: NM Health Care Workforce Committee 2017 Report

County Level Analysis: **10 of 12 Small Town Rural counties fall below the national benchmark** for primary care physicians and all fall below the statewide supply rate. One county reports no primary care physicians.

9 of 14 Large Town Rural counties fall below the national benchmark for primary care physicians and all but three of these counties fall below the state rate. All of these counties have some primary care physician workforce.

County level primary care physician workforce data is summarized on a table in the Attachments. It should be noted that Federally designated primary care medical shortage areas using a different dataset and a different definition of primary care specialties. It should also be noted that the Committee raised questions as to accuracy of the primary care self-identification of some physicians. The Committee questioned whether some hospitalists – physicians working solely in inpatient settings – were being counted inappropriately as primary care physicians in some counties. The findings of this analysis are important, however, even given these caveats.

Distribution of Obstetrician/Gynecologists:

Rural/Urban Analysis: The supply of obstetrician/gynecologist (OB/GYN) physicians in 2016 in New Mexico's rural counties is below that of urban counties and falls below the statewide rate. It is slightly above the national benchmark. Small Town Rural counties fall below the national benchmark and statewide rate. Large Town Rural counties slightly exceed the national benchmark by but fall below the statewide rate.

OB/GYN physician data is summarized on the following table.

OB/GYN Physicians per 10,000 Female Population -- New Mexico - 2016

	Providers per 10,000 Population		Providers per 10,000 Female Population
Non-Metro	2.2	Rural	1.9
		Mixed	2.3
Metro	2.7	Small Metro	1.8
		Large Metro	3.2
State Total	2.6	Total	2.6
National Benchmark	2.1		2.1

Source: NM Health Care Workforce Committee 2017 Report

County Level Analysis: 10 of 12 Small Town Rural counties fall below both the national benchmark for OB/GYN physicians and below the statewide supply rate. **9 of the 12 counties report no OB/GYN capacity**. 3 of 14 Large Town Rural counties fall below the national benchmark for primary care physicians and 8 of these counties fall below the state rate. All of these larger rural counties report some OB/GYN capacity. The shortage of OB/GYN capacity suggests the need for establishing regional referral arrangements and other systems needed to assure availability of these services to all rural residents.

County level OB/GYN physician workforce data is summarized on a table in the **Attachments**. It should be noted that several small counties have significantly higher rates of OB/GYN supply. This may reflect self-reporting anomalies with the survey – for example, physicians may be reporting that they do some gynecology. The data does not represent whether a physician is a Boarded OB/GYN. This suggests a focus for further study. Further analysis could also examine whether physicians are doing obstetrics and deliveries.

Distribution of General Surgeons:

Rural/Urban Analysis: The supply of general surgeons in 2016 in New Mexico's rural counties is above that of urban counties and above the national benchmark supply rate and the statewide rate. There are two national benchmarks - a minimum supply rate and an optimal rate. The rural county rate exceeds both. Small Town Rural counties and Large Town Rural counties exceed both national benchmarks and the statewide rate.

General Surgeon data is summarized on the following table.

General Surgeons per 100,000 Population
-- New Mexico - 2016

	Providers per 100,000 Population		Providers per 100,000 Population
Non-Metro	9.6	Rural	10.6
		Mixed	9.4
Metro	8.6	Small Metro	8.2
		Large Metro	8.8
State Total	8.9	Total	8.9
National Benchmark	6.0 Minimum		6.0 Minimum
National Benchmark	9.2 Optimal		9.2 Optimal

Source: NM Health Care Workforce Committee 2017 Report

County Level Analysis: **8 of 12 Small Town Rural counties fall below the minimum national benchmark** for general surgeons. 9 of 12 of these counties fall below the national optimal benchmark and the statewide supply rate. **8 of these counties report no general surgeons.** The lack of surgical capacity in some counties suggests a need to establish regional referral arrangements and other systems needed to assure availability of these services to all rural residents.

3 of 14 Large Town Rural counties fall below the national benchmark for general surgeons and 7 of these counties fall below the state rate. All of the Large Town Rural counties have some general surgeon workforce.

County level general surgeon workforce data is summarized on a Table in the **Attachments**. It should be noted that several small counties have significantly higher rates of general surgeon supply. This may reflect reporting anomalies and suggests a focus for further analysis.

Distribution of Psychiatrists:

Rural/Urban Analysis: The supply of psychiatrists for 2016 in New Mexico's rural counties is below that of urban counties and falls below the statewide rate. It is also below the national benchmark.

Small Town Rural counties fall substantially below both the national benchmark and Statewide rate. **Large Town Rural counties are also below** the national benchmark and statewide rates.

Psychiatrist data is summarized on the following table.

	Providers per 10,000 Population		Providers per 10,000 Population
Non-Metro	0.7	Rural	0.2
		Mixed	0.7
Metro	2.0	Small Metro	1.8
		Large Metro	2.2
State Total	1.6	Total	1.6
National Benchmark	1.5		1.5

Source: NM Health Care Workforce Committee 2017 Report

County Level Analysis: **All 12 Small Town Rural counties fall below** both the national benchmark for psychiatrists and below the statewide supply rate. **10 of the 12 counties report no psychiatrist capacity**.

12 of 14 Large Town Rural counties fall below both the national benchmark for psychiatrists and below the state rate. 2 of these larger rural counties report no psychiatrist capacity. The shortage of psychiatrists suggests the need for establishing regional referral arrangements and other systems needed to assure availability of these services to all rural residents.

County level psychiatrist workforce data is summarized on a table in the Attachments. It should be noted that several small counties have significantly higher rates of supply. This includes San Miguel County, home of the State Hospital. This may reflect reporting anomalies and suggests a focus for further analysis.

Distribution of Dentists:

Rural/Urban Analysis: The supply of Dentists for 2016 in New Mexico's rural counties is below that of urban counties and falls below the national benchmark supply rate and the statewide rate. **Both Small Town Rural counties and Large Town Rural counties fall below** the national benchmark and Statewide rate. All categories of urban counties exceed the national benchmark and state rate.

Dentist data is summarized on the following table.

Dentists per 10,000 Population
-- New Mexico - 2016

	Providers per 10,000 Population		Providers per 10,000 Population
Non-Metro	3.7	Rural	2.7
		Mixed	3.8
Metro	6.5	Small Metro	6.4
		Large Metro	6.6
State Total	5.6	Total	5.6

National Benchmark	4.0		4.0

Source: NM Health Care Workforce Committee 2017 Report

County Level Analysis: **9 of 12 Small Town Rural counties fall below the national benchmark** for dentists and all fall below the statewide supply rate. **4 of these counties report no dentists**. **9 of 14 Large Town Rural counties fall below** the national benchmark for dentists and all but one of these counties - Los Alamos - fall below the state rate. All of these counties have some dentist workforce.

County level dentist workforce data is summarized on a table in the **Attachments**.

Rural Health Assessment: Distribution of Acute Care Hospitals

Overview:

Inpatient hospital capacity in New Mexico is not evenly distributed. Some communities have no hospital services and are distant from the nearest facility. Other communities have some hospital capacity but may have only limited services available at that facility – lacking general surgical services or the ability to do deliveries. The lack of hospital services is a particular issue for rural communities in New Mexico and presents a challenge for the integration of health systems.

As part of the rural health assessment an inventory of hospitals in rural counties was conducted. The inventory focused on Critical Access Hospitals – hospitals with no more than 25 beds which operate under special requirements – and general acute care hospitals. The inventory did not include rehabilitation hospitals, psychiatric hospitals or other special purpose inpatient facilities. The inventory acknowledges Indian Health Service hospitals but recognizes that these have special focus and do not provide services to the general community. Tables showing the results of this inventory are included in the **Attachments**. A summary analysis of the inventory follows.

Hospitals in Small Town Rural Counties:

Small Town Rural counties have a limited supply of hospital services:

- 5 of 12 Small Town Rural counties have no hospitals, and all of these are at a significant distance from the nearest hospital.
- 6 of the 7 Small Town Rural counties with hospitals are Critical Access Hospitals with limited services.
- Only 1 of the hospitals is licensed as a general acute care hospital.

The limited inpatient services in all Small Town Rural counties highlights the need for systems of health care. Regional health systems are required - linking communities without hospitals to inpatient facilities and linking CAHs to upstream hospital services.

Hospitals in Large Town Rural Counties:

Large Town Rural counties have a greater supply of hospital services:

- All Large Town Rural counties in New Mexico have a hospital
- 3 of the 14 counties have Critical Access Hospitals and the remainder have general acute care hospitals.
- 7 of the 17 hospitals in Large Town Rural counties have 50 beds or fewer. 6 of the 17 hospitals in Large Town Rural counties have between 51-100 beds.4 of the 17 hospitals in Large Town Rural counties have more than 100 beds.

- 3 of the 14 counties have two hospitals while the reminder have only a single hospital. 1 county has two hospitals in the same town, while the other two counties have hospitals located in different communities.
- 5 of the 14 counties have Indian Health Service hospitals.

Not all Large Town Rural counties have a full range of multi-specialty services. Regional health systems need to assure that residents of these counties have access to all needed specialties.

Rural Health Assessment: State Rural Health Program Inventory

New Mexico has multiple programs which focus on the needs of rural underserved areas of the state. Several of these are exclusively state-funded. Others are federally-funded and coordinated by state agencies. Key programs include:

- **State Funded Programs**
    - Rural Primary Health Care Act (RPHCA) Program
    - Primary Care Provider Recruitment and Retention Clearinghouse
    - Primary Care Capital Fund
    - Rural Health Care Practitioner Tax Credit Program
    - School-Based Health Center Program
    - New Mexico Health Service Corps Community Practice Site Support Program
    - New Mexico Health Service Corps Stipend Program.
- **State Coordinated Programs**
    - Primary Care Cooperative Agreement
    - J-1 Visa Waiver (Conrad 30) Program
    - State Office of Rural Health Program
    - Medicare Rural Hospital Flexibility Program
    - Small Rural Hospital Improvement Program

These programs are described in greater detail in the **Attachments**.

There was a significant reduction of appropriations for State funded programs over several years. Refunding of existing programs was a major discussion focus for the Planning Group. Some improvement in rural health appropriations came out of the last Legislative session, but additional funding is needed before appropriations return to previous levels.

It should be noted that there are several health service payment programs, both federal and state, which are important for maintaining the financial viability of rural hospitals and health providers. For example, both Medicaid and Medicare provide higher rates of reimbursement to rural health clinics and federally-qualified health centers in underserved areas - many of which are rural. Medicare provides a differential payment to physicians in rural underserved areas and to Critical Access Hospitals in rural areas. These programs are not described in this section

Priority Health Issues: Local Communities

New Mexico has a planning infrastructure of representative county and tribal health councils. These councils conduct regular assessments of local health issues and help design responses that will improve both health status and health services. New Mexico's health councils recently completed a major assessment effort as part of the State Innovation Models grant. The Planning Group chose to tap the results of these assessments to provide local input for the Rural Health Plan.

Health councils explored a range of key health issues within local communities. An enumeration of these issues is included in the **Attachments**. After analysis of data and discussion, each health council prioritized the issues facing their communities. These priorities were summarized in individual health council reports for the SIM project.

The priority issues of health councils were compiled for rural health planning purposes. Lists of the issues identified by Small Town Rural, Large Town Rural, Metropolitan and Tribal health councils are presented in the **Attachments**, ranked by the number of priority mentions. There are significant differences in the highest priority issues identified in the different council categories:

- **Substance Abuse** was the highest priority issue identified by both Small Town Rural and Large Town Rural county councils. It was a much lower priority issue in Metro county councils.
- **Food/Nutrition/Obesity** issues were the second most important priority for Small Town Rural health councils. These were somewhat lower priority for Large Town Rural health councils. The Food issue was, interestingly enough, the top priority issue cited by Metro health councils.
- **Mental Health** issues were the second highest priority of Large Town Rural Health councils. This was a lower priority for other health councils.

A separate compilation was conducted separating the priorities of rural health councils in different regions of the state – Northwest, Northeast, Southwest and Southeast. There were distinct differences in priority issues identified by rural councils in these regions:

- **Food and Nutrition** issues were top priorities for the Southwest region's rural councils.
- **Substance Abuse** issues were top priority for both the Northwest and Northeast regions' rural councils.
- **Community capacity** was the top priority for rural councils in the Southeast region.

Tribal health councils had a distinct set of priority issues. Four issues received highest priority:

- **Alcohol Abuse**
- **Food**
- **Community Capacity**
- **Substance Abuse**.

A comparative table of the top rural priority issues is included in the **Attachments**.

Planning Group Recommendations

The Planning Group conducted its review of the rural health assessments as well as input from local communities and stakeholders on rural health priorities. Three committees were established to continue discussion of state rural health needs and to develop specific recommendations to be considered by the entire Planning Group for inclusion in the final Plan. The committees and their focus of discussion are listed below:

- **Rural Health Systems Committee** - exploring topics including:
  - Rural health services capacity/shortages.
  - Rural health services financial barriers.
  - Rural health systems integration.
  - Rural health coordinating services.
  - Rural safety net support.

- **Rural Health Professions Committee** - exploring topics including:
  - Rural health professional training and education.
  - Rural health professional recruitment/retention incentives/support.
  - Rural health professional practice quality improvement.

- **Rural Health Improvement Committee** - exploring topics including:
  - Rural health status disparities.
  - Rural health improvement efforts.
  - Coordination of health improvement/health service systems.

The Planning Group reviewed the recommendations from the committees and considered the addition of additional recommendations. A final set of potential recommendations was approved and compiled into a priority ranking survey. A copy of the survey is included in the **Attachments**.

The results of the priority survey were reviewed and discussed by the Planning Group. A complete ranking of the final ranked recommendations is included in the **Attachments**. Seven of the recommendations received **highest overall priority** from the Planning Group. They include multiple rural health workforce and rural health systems recommendations. The scores associated with each recommendation are out of a maximum of 5. The higher scores reflect those recommendations with the highest consensus in the Planning Group:

- **Overall Planning Group Priority Recommendations**:

Expand State Loan Repayment Program to include behavioral health professionals.	**4.64**
Restore Rural Primary Health Care Act Program (RPHCA) funding to previous appropriation level.	**4.36**
Expand funding for State Loan Repayment Program awards.	**4.27**
Expand Rural Health Care Practitioner Tax Credit Program to include additional behavioral health providers, including LISWs.	**4.18**
Implement and provide funding to support a statewide tele-behavioral health network.	**4.09**
Provide additional funding under RPHCA to support substance use disorder services.	**4.09**
Expand the number of behavioral health investment zones and engage additional local governments in coordinated approaches to these needs.	**4.09**

The Planning Group recognized that the overall set of ranked recommendations would provide a guide for future rural health program and policy decisions. The Group felt, however, that there was value in seeing the ranked recommendations categorically within the three primary rural health topic areas – **Rural Health Systems, Rural Health Professions and Rural Health Improvement**. The top categorical recommendations in these areas are listed below:

- **Rural Health Systems Priority Recommendations:**

Restore Rural Primary Health Care Act Program (RPHCA) funding to previous appropriation level.	**4.36**
Provide additional funding under RPHCA to support substance use disorder services.	**4.09**
Establish Medicaid rates that are sufficient to ensure provider participation in the program - including reimbursement of behavioral health and dental providers.	3.91
Provide additional funding to NMDOH to adequately support administration of RPHCA Program.	3.73
Provide funding to support expanded services at existing school-based health centers, including behavioral health services. Include support for telemedicine services.	3.73
Examine and revise current RPHCA award and performance evaluation methods. Focus funding on need, quality and comprehensive services. Assure appropriate provider recruitment by contractors.	3.73
Update the 2013 Telehealth Parity law.	3.55

- **Rural Health Professions Priority Recommendations:**

Expand State Loan Repayment Program to include behavioral health professionals.	**4.64**
Expand funding for State Loan Repayment Program awards.	**4.27**
Expand Rural Health Care Practitioner Tax Credit Program to include additional behavioral health providers, including LISWs.	**4.18**
Implement and provide funding to support a statewide tele-behavioral health network.	**4.09**
Provide funding to support Loan Repayment Program operations and administration.	3.91
Move State Loan Repayment Program from NMHED to NMDOH.	3.55

- **Rural Health Improvement Priority Recommendations:**

Expand the number of behavioral health investment zones and engage additional local governments in coordinated approaches to these needs.	**4.09**
Evaluate and revise the existing Public Health Office infrastructure emphasizing responses to health promotion and social system deficits.	3.82

A complete listing of the ranked categorical recommendations is included in the **Attachments**.

Attachments

Planning Group Membership

New Mexico Rural Health Planning Group

Planning Group Members

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Representative Joanne Ferrary, New Mexico House of Representatives
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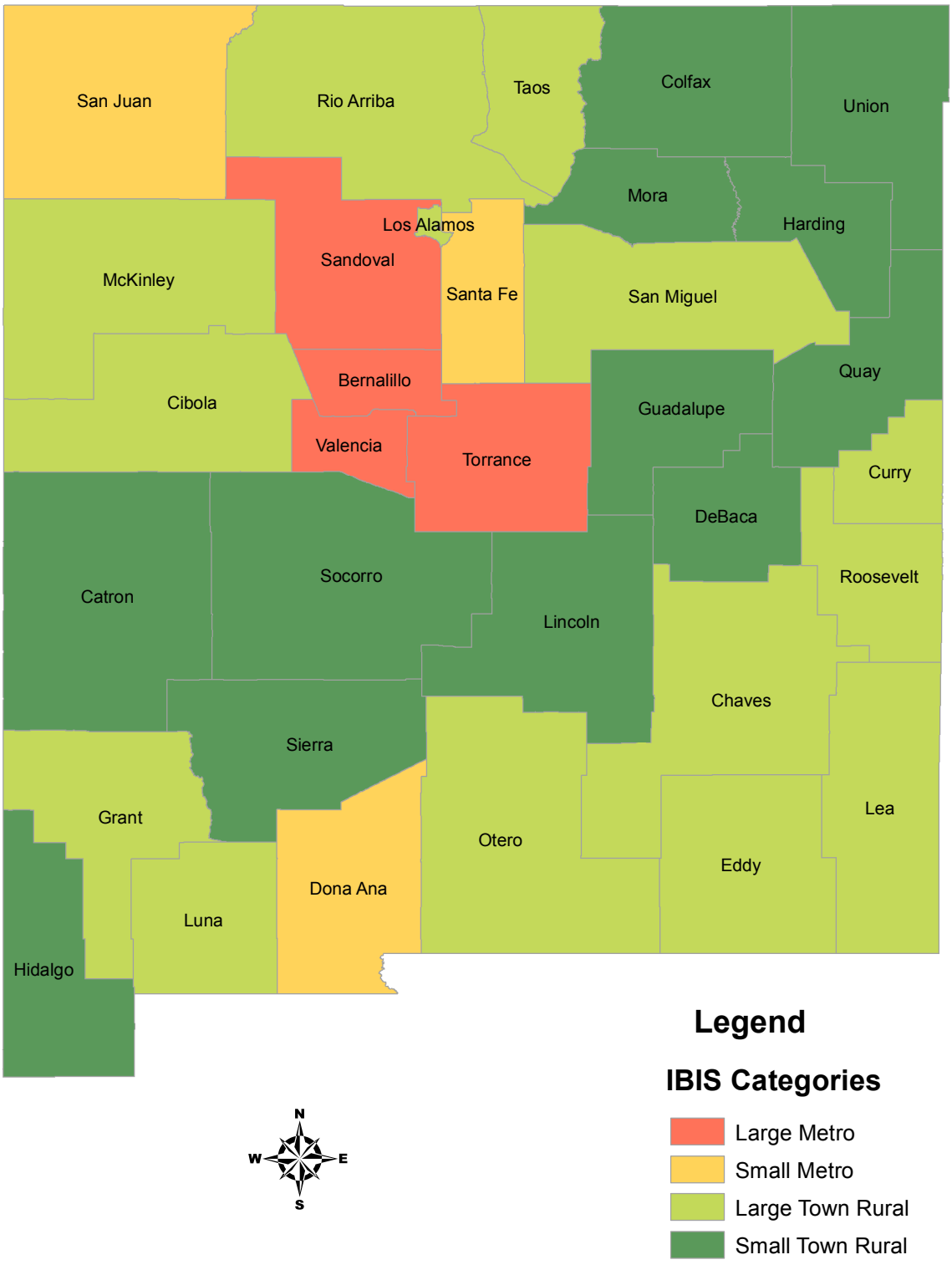
NM IBIS - Rural Definitions

New Mexico Counties - Rural-Urban Categories

Census Categories	NM IBIS Categories	County
Non-Metro	Small Town Rural	Catron County
		Colfax County
		De Baca County
		Guadalupe County
		Harding County
		Hidalgo County
		Lincoln County
		Mora County
		Quay County
		Sierra County
		Socorro County
		Union County
	Large Town Rural	Chaves County
		Cibola County
		Curry County
		Eddy County
		Grant County
		Lea County
		Los Alamos County
		Luna County
		McKinley County
		Otero County
		Rio Arriba County
		Roosevelt County
		San Miguel County
		Taos County
Metro	Small Metro	Dona Ana County
		San Juan County
		Santa Fe County
	Large Metro	Bernalillo County
		Sandoval County
		Torrance County
		Valencia County

New Mexico Rural and Urban Categories
IBIS Definitions



Preliminary Priority Assessment

Overview of Recommendations Survey Results

The responses to the Rural Health Plan Working Group Recommendations Survey are summarized in this report. There were 10 respondents to the survey making recommendations in 8 different areas:

- **Health Services**: Changes in program funding or policy for rural health service programs.
- **Recruitment/Retention Incentives**: Funding for rural-focused health professional programs.
- **Health Professional Training and Education**: Program funding or policy for rural-focused health professional training/education programs.
- **Medicaid Program**: Changes in policy affecting Medicaid reimbursement of rural health services.
- **Health Promotion**: Changes in health status improvement policy and programs in rural areas.
- **Health Insurance**: Changes in health insurance law, regulation, and policy affecting rural areas.
- **Health Professional Licensing/Regulation**: Changes in professional practice guidance affecting rural areas.
- **Infrastructure and Capital Investment**: Changes in program and policy affecting rural health system infrastructure and capital needs.
- **Other Rural Health Issues**.

Most respondents made recommendations in a subset of these areas.

The recommendations collected in the survey are organized into 5 different areas

- **Appropriation Recommendations**
- **Program Change Recommendations**
- **New Program Recommendations**
- **Policy Change Recommendations**
- **Study/Planning Recommendations**

All recommendations will be reviewed and discussed by the Working Group and there will be opportunity to append additional recommendations.

Several recommendations were mentioned by multiple respondents. These are bolded in the listings. While recommendations with multiple recommendations are listed first, the order of the recommendations does not reflect any prioritization. There will be a separate Working Group process to explore which recommendations might receive highest priority.

Several respondents provided extended **analysis and commentary** on key rural health issues. The full text of these submissions is summarized in a separate report. The issues raised are worthy of further discussion by the Working Group.

Appropriation Recommendations

Rural Health Services Support

- **Rural Primary Health Care Act Program (RPHCA).**
    - Restore funding to RPHCA
        - Restoration should be to previous appropriation levels of $14 million combined General Fund and County Supported Medicaid Fund appropriations.
        - Increase appropriation, as needed, to offset potential reductions of federal support.
    - Adequately staff DOH Office of Primary Care and Rural Health to effectively administer RPHCA Program

- **School-Based Health Centers Program.**
    - Restore General Fund support for this program. The restored appropriation should total $4 million.
    - Expand school health centers – expand both existing and new sites

- New Mexico Health Service Corps (NMHSC) Community Practice Site Support Program.
    - Restore General Fund support for this program. The restored appropriation should total $350,000.

- Preventive Dental Services for Children.
    - Provide expanded State support for child oral health prevention and treatment services. Target underserved and high need areas including Southern New Mexico.

- All Programs.
    - Increase funding of programs overall.

Health Professional Recruitment/Retention Incentives

- **New Mexico Health Professional Loan Repayment Program.**
    - Restore General Fund support for this program. The restored appropriation should total $1.5 million.
    - Increase state appropriation for this program. Sufficient funds should be appropriated to expand the program to support between 40 and 50 loan repayers.
    - Assure adequate staffing to competently administer this program.

- **New Mexico Health Services Corps (NMHSC) Stipend Program.**
    - Restore to previous annual appropriation level of $750,000.

- **New Mexico Health Professional Recruitment and Retention Clearinghouse.**
    - Restore General Fund appropriation for this program. The restored appropriation should total $500,000.
    - Increase state appropriation for support of the clearinghouse. Expand the clearinghouse scope to include critical specialists, behavioral health service providers and community health workers.

- New Mexico Rural Health Care Practitioner Tax Credit Program.
    - Assure state support for adequate staffing and effective administration of this program.

- New Mexico J-1 Visa Waiver Program for Physicians.
    - Assure adequate state supported staffing to effectively administer this program.

- All Programs.
    - Increase funding of programs overall.
    - Provide additional financial support for those incentive programs which are making a demonstrated difference.

Infrastructure and Capital Investment

- **Primary Care Capital Fund (PCCF)**:
    - Recapitalize the PCCF with the addition of $2 million of new non-reverting funds.

- Provide ongoing continuing capitalization with modest annual appropriations to the Fund.

Health Promotion Programs and Policy

- Restore Public Health Division Operational Capacity.

    - Provide sufficient appropriations to restore the Public Health Division workforce to previous levels. Reduce overall vacancy rates and extended position vacancy periods,. Assure that programs dealing directly with the public on a clinical basis have the tools and supplies required to do the work.

Program Change Recommendations

Rural Health Services Support

- **Rural Primary Health Care Act Program (RPHCA).**
    - Expand contract award/evaluation of RPHCA contractors so funding is based on need, quality and operational effectiveness/efficiency.
- School-Based Health Centers Program.
    - Encourage NM SBHCs to take on the School-Based Health Alliance's challenge for SBHCs to voluntarily adopt and report five standardized performance measures.

Health Professional Recruitment/Retention Incentives

- **New Mexico Rural Health Care Practitioner Tax Credit Program.**
    - Expand categories of professionals who qualify for tax incentives. This should include expansion to all licensed behavioral health professionals.
- **New Mexico Health Services Corps (NMHSC) Stipend Program.**
    - Expand categories of professionals who qualify for service corps. Include all licensed behavioral health provider students.
- **New Mexico Health Professional Loan Repayment Program.**
    - Move the State Loan Repayment Program out of NM Dept. of Higher Ed and into NM DOH, where other health workforce programs exist.
    - Increase the award amount available to nurse practitioner and physician assistant students.
    - Expand the program to include support and service obligation for all licensed behavioral health professionals including counselors.
    - Direct a specific proportion of incentives to hospital placements.
- All Programs.
    - Provide additional financial support for those incentive programs which are making a demonstrated difference. Expand categories of professionals qualifying for all health professional incentive programs.

Health Professional Training and Education

- Admissions to Health Professional Training and Education.
    - Change admission criteria and practices of key health professional training and education programs to assure participation of rural students and under-represented minorities.

- Expand/Redesign UNM Primary Care/Family Practice Residency Program.
    - Expand UNM Primary Care/Family Practice Residency Program slots.
    - Require all residents to complete rotations in a rural practice setting.
    - Provide financial support to rural practice sites providing rotations to residents.

- Redesign Health Professions Training/Education Programs.
    - Health professions-producing higher education institutions should design their training programs on the basis of what the state needs in which fields and in which geographic areas. DOH should monitor relative success in achieving these health professional training goals, identify best practices and share data and strategies with all institutions.

Health Promotion Programs and Policy

- Improve Health Promotion Program Coordination.
    - Formalize and expand collaboration between UNM Health Extension (HEROs) program and DOH's Health Promotion Specialists and Comprehensive Health Planning Councils. Involve other sectors to improve community health. For example UNM has formed an alliance with NMSU's College of Agriculture Cooperative Extension Service. Cooperative extension brings great, local resources in nutrition, youth development and family stabilization as well as economic development in the agriculture sector.

New Program Recommendations

Rural Health Services Support

- **Re-Establish New Mexico Nurse Advice Line**.
    - Recreate and support the state-based, statewide 24/7 nurse advice line service.
- Local Health System Integration Program:
    - NMDOH should develop local health systems integration support programs. These programs should include coordination of categorical health system funding into an overall plan for integrated local service systems. They should also include coordination of categorical health system funding with health councils and health status improvement efforts.
- Telehealth Demonstration Program.
    - Develop a multi-year state investment in pilot programs to demonstrate the effectiveness of telehealth in rural areas. Use the pilot to identify the best utilization of telehealth and the likely return on investment. Collaborate with the NM Telehealth Alliance in the development of this effort.

Health Professional Training and Education

- **Rural Based Family Practice Residency Program.**
    - Develop and support rural-based residency programs of this type to train and educate physicians interested in practicing in rural communities across the state.
- **Substance Abuse and Opioid Treatment Education and Training.**
    - Develop additional programs to train specialized substance abuse/opioid use treatment professionals. Programs should include the full range of behavioral health providers.
- Dental Therapist Training Programs.

- Develop dental therapist training programs. Closely monitor training programs, particularly for profit, to determine if they are producing quality and qualified professionals. Evaluate cost benefit ratio for public monies in these programs.

Medicaid Program

- Medicaid Value-Based Payment Demonstrations.

    - Expand value-based payment demonstrations. These models should provide incentives for evidence-based quality improvement in health care. State General funds could be used to demonstrate to provide quality performance incentives with safety net providers.

- Medicaid Population Health Payment Demonstrations.

    - Establish population-health reimbursement models in rural communities with willing rural hospitals and providers. This type of alternative payment model would have no downside risk to the providers during the first several years and would also provide for a shared savings opportunity for the providers and Medicaid. This model would encourage preventive care such as annual wellness visits and chronic care management to help reduce the overall costs of Medicaid patients.

Other Rural Related Issues

- New Mexico Health Policy Commission.

    - Restore funding for the New Mexico Health Policy Commission to examine larger health system issues. Include in Commission activities review of any scope of practice questions affecting rural health professionals.

Study/Planning Recommendations

Rural Health Services Support

- **All Programs - Federal Impact Contingency Planning**.
    - Develop contingency plans for the supporting the safety net should the percent of uninsured increase dramatically due to ACA repeals and rollbacks.
- Health Services Integration Planning.
    - The state should study and provide a forum for discussing desirable models for community level systems of care in both rural and urban communities. These should include relationships between NMDOH services and contractors with hospitals and other important providers of care. The models should identify a comprehensive range of services needed in both rural and urban communities as well as capacity targets to assure adequate access to health care for all residents.

Health Professional Recruitment/Retention Incentives

- New Mexico Rural Health Care Practitioner Tax Credit Program (NMRPTC):
    - Conduct a Memorial Study to explore the addition of new categories of eligible professionals under the NMRPTC. New categories could include pharmacists and additional classes of behavioral health professionals.
- NM Health Professional Loan Repayment Program.
    - The program should be evaluated to determine how many of those obligated graduate and return to service in the state after their educations – with a focus on the non-doctoral level disciplines.
- Behavioral Health Professionals.
    - Study ways to recruit and retain behavioral health clinicians.
- New Mexico J-1 Visa Waiver Program for Physicians.
    - Explore ways to increase the number of slots available under this program.

Health Professional Training and Education

- Physician Supply Planning.
    - Develop a plan for dealing with physician shortages, particularly in primary care (family medicine, pediatrics, and obstetrics/gynecology) for rural and frontier areas. This plan should include a strategy for developing residency training programs in concert with state needs.

- Study Responses to Physician Shortages.
    - Study ideas dealing with physician shortages, particularly in primary care (family medicine, pediatrics, and obstetrics/gynecology) for rural and frontier areas. Ideas could include which could include
        - How University of New Mexico medical school and Burrell College of Osteopathic Medicine at NMSU can cooperate to solve physician shortage.
        - How medical student and residency training consortiums could be developed to train medical students within New Mexico and import medical students from outside of the state to New Mexico.
        - Policy changes needed to support previous two ideas.

- Study Possible Responses for Other Health Professional Shortages.
    - Study ideas for similar consortium training for nursing, social work, and other professions. Ideas could include:
        - Community/University Health Partnership Consortium models to promote high quality training of physicians and other health care workers as well as encouragement of residents of New Mexico to enter these professions.
        - Such a partnership should include the two medical schools, hospitals, professional societies, public health entities, AHECs, federal programs such as VA and Indian Health Services, Medicaid, and other insurers in New Mexico.

- AHEC Model Study.
    - Evaluate New Mexico AHEC programs and study models in other states to identify changes that could improve NM AHEC effectiveness.

- Health Professions Training and Education Evaluation.

- Conduct overall evaluation of state investments in these areas to determine how they can be improved with lessons learned to share between programs. Assess which programs should be expanded based upon their ROI to NM. Examination can include several foci, including:
  - Evaluate effectiveness of BA/MD program and, if appropriate, provide funding to expand slots.
  - Evaluate the feasibility of funding and developing one or two top notch expanded behavioral health Counseling training program(s) at major 4 year universities.
  - Evaluate effectiveness of Family/Pediatric Nurse Practitioner and Nurse Midwife Programs and if indicated expand programs and provide stipends / support / for rural practice commitment.

- Coordinated Planning of State-Funded GME Expenditures.
  - Establish a planning mechanism to target state investment in GME to the service needs of all New Mexico hospitals and service providers, including rural hospitals and providers. Develop residency allocation mechanism based upon this planning.

- Study of Certificated Health Service Training and Education.
  - Conduct study of needs for training of certificated health service staff including medical assistants, nurse assistants and community health workers. Assess current training capacity for these skilled service areas, identifying costs of available training sequences. Recommend development of additional certificate programs for state community colleges and branch colleges.

- Plan Expansion of Dental School Education.
  - Explore developing a dental school in New Mexico or partnering with an existing dental school with preference of NM residents to enter dental education.

Medicaid Program

- Study Reimbursement Rates and Medicaid Non-Participation.
  - Study Medicaid rates and their impact on provider participation in the Medicaid program. Include analysis of reimbursement rate impact on behavioral health professional participation.

Health Insurance Policy

- **Study Uniform Credentialing System**.
    - Examine the feasibility of implementing an NCQA-certified uniform credentialing system to streamline the credentialing and re-credentialing process for New Mexico health care providers.
- Study Rural/Urban Network Adequacy.
    - Examine the provider network adequacy in rural and urban areas of health plans offered in New Mexico. Identify any disparities and make policy recommendations.

Infrastructure and Capital Investment

- Pre-Hospital Care Infrastructure Assessment.
    - Evaluate the infrastructure needs of the pre-hospital care system with particular attention to its communication system. Assess its adequacy and operational effectiveness with consideration of needs during disasters.

Health Promotion Programs and Policy

- **Study Expansion/Repurposing of NMDOH Public Health Offices**.
    - Examine the refocusing of NMDOH Public Health operations in rural areas with an aim of reducing costs/duplication with other parts of the health system. Explore feasibility of repurposing DOH Public Health Funds and comingling then with additional Medicaid and Commercial insurance funds to develop and operate Rural care Coordination/ Health promotion/ and Navigation services . These would be uniform services to all residents in rural areas, regardless of carrier or insurance status.
    - Explore strategies to migrate existing public health services and support to existing rural providers to avoid duplication of services, fragmentation of services, and cost inefficiencies.

Policy Change Recommendations

Medicaid Program Policy

- **Nurse Advice Triage Line Services**.
    - Provide Medicaid reimbursement to rural clinics for nurse advice triage calls.
- **Medicaid Participation in Universal Credentialing Process**.
    - Require Medicaid MCOs to utilize universal credentialing system.
- Hospital Reimbursement.
    - Establish add-on or enhanced Medicaid payments to New Mexico's most isolated and vulnerable hospitals.
- Telehealth Reimbursement.
    - Provide reimbursement for “within system” telehealth - e.g. rural originating site to a primary care or specialty provider working for the same organization but located elsewhere, such as in an urban area.
- Medicaid Use of CHWs and Peer Counselors.
    - Require MCO utilization of community health workers (CHWs) and peer counselors as part of the Centennial Care 2.0 contracts. MCOs should employ these health professionals and deploy them in the community – embedded in primary care centers, emergency departments and jails.
- Medicaid Support for Expanded Physician Residencies.
    - Increase State funded Medicaid support of expanded physician residencies in all teaching hospitals. Revenues for increased support can come from intergovernmental transfers. Use this support to include teaching hospitals with fewer than 125 residents.
- Provider Due Process.
    - Enact due process procedures for participating providers.

- Managed Care Organization (MCO) Transparency.
    - Improve transparency of Centennial Care MCO operations.

Health Professional Licensing and Regulation

- Licensing Board Health Professional Data Surveys.
    - Encourage licensing boards to implement fully legislatively mandated surveys in uniform manners. Encourage UNM Workforce to reflect as accurately as possible the actual clinical FTEs practicing throughout the state as opposed to numerical licensee counts.
- Equal Scope of Practice.
    - Apply scope of practice for health professionals equally on a statewide basis, eliminating any difference in scope between rural and urban areas.

Rural Health Status Assessment Tables

Demographic Description

New Mexico Population - Rural and Urban -- 2016

	Population	PCT Population		Population	PCT Population
Non-Metro	698,987	33.2%	Small Town	94,142	4.5%
			Large Town	604,845	28.8%
Metro	1,404,599	66.8%	Small Metro	488,637	23.2%
			Large Metro	915,962	43.5%
Total	2,103,586	100.0%	Total	2,103,586	100.0%

New Mexico Population Age 0-17 - Rural and Urban -- 2016

	Number Age 0-17	Percent Age 0-17		Number Age 0-17	Percent Age 0-17
Non-Metro	171,688	24.6%	Small Town	17,786	18.9%
			Large Town	153,902	25.4%
Metro	322,849	23.0%	Small Metro	114,379	23.4%
			Large Metro	208,470	22.8%
Total	494,537	23.5%	Total	494,537	23.5%

Source: NM-IBIS - ACS Estimates

New Mexico Population Age 0-4 - Rural and Urban -- 2016

	Number Age 0-4	Percent Age 0-4		Number Age 0-4	Percent Age 0-4
Non-Metro	47,477	6.8%	Small Town	4,603	4.9%
			Large Town	42,874	7.1%
Metro	84,663	6.0%	Small Metro	30,838	6.3%
			Large Metro	53,825	5.9%
Total	132,140	6.3%	Total	132,140	6.3%

New Mexico Population Age 65 and Over - Rural and Urban -- 2016

	Number Age 65+	Percent Age 65+		Number Age 65+	Percent Age 65+
Non-Metro	120,038	17.2%	Small Town	24,135	25.6%
			Large Town	95,903	15.9%
Metro	226,134	16.1%	Small Metro	83,076	17.0%
			Large Metro	143,058	15.6%
Total	346,172	16.5%	Total	346,172	16.5%

Source: NM-IBIS - ACS Estimates

New Mexico Age Dependency Ratio - Rural and Urban -- 2016

	Ratio		Ratio
Non-Metro	60.3	Small Town	69.9
		Large Town	58.9
Metro	54.1	Small Metro	57.3
		Large Metro	52.5
Total	56.1	Total	56.1

New Mexico Population Density - Rural and Urban -- 2016

	Persons per Square Mile		Persons per Square Mile
Non-Metro	6.9	Small Town	2.0
		Large Town	11.0
Metro	68.5	Small Metro	43.5
		Large Metro	98.7
Total	17.3	Total	17.3

Source: NM-IBIS - ACS Estimates

New Mexico Hispanic Population - Rural and Urban -- 2016

	Percent of Population		Percent of Population
Non-Metro	46.5%	Small Town	45.1%
		Large Town	46.7%
Metro	49.4%	Small Metro	50.9%
		Large Metro	48.7%
Total	48.5%	Total	48.5%

New Mexico Native American Population - Rural and Urban -- 2016

	Percent of Population		Percent of Population
Non-Metro	11.9%	Small Town	3.3%
		Large Town	13.2%
Metro	7.0%	Small Metro	10.0%
		Large Metro	5.3%
Total	8.6%	Total	8.6%

Source: NM-IBIS - ACS Estimates

New Mexico Non-Hispanic White Population - Rural and Urban -- 2016

	Percent of Population		Percent of Population
Non-Metro	38.4%	Small Town	50.0%
		Large Town	36.6%
Metro	39.4%	Small Metro	36.6%
		Large Metro	40.9%
Total	39.0%	Total	39.0%

New Mexico Population Age 5+ Speaking English Less than 'Very Well' --Rural and Urban - 2016

	Percent of Population		Percent of Population
Non-Metro	9.7%	Small Town	7.8%
		Large Town	10.1%
Metro	9.1%	Small Metro	11.2%
		Large Metro	8.0%
Total	9.3%	Total	9.3%

Source: NM-IBIS - ACS Estimates

Socioeconomic Indicators

New Mexico - Percent Persons in Poverty - 2011-2015

	Non-Metro	Metro	New Mexico
Persons in Poverty	22.5%	20.7%	21.0%
Persons < 18 in Poverty	31.0%	28.6%	29.4%
Persons < 5 in Poverty	36.6%	32.4%	33.9%
Persons 65+ in Poverty	13.7%	11.6%	12.0%

New Mexico - Percent Persons in Poverty - 2011-2015

	Small Town	Large Town	Small Metro	Large Metro	New Mexico
Persons in Poverty	19.6%	23.0%	22.3%	20.5%	21.0%
Persons < 18 in Poverty	25.2%	31.7%	32.1%	26.6%	29.4%
Persons < 5 in Poverty	34.8%	36.8%	35.9%	30.4%	33.9%
Persons 65+ in Poverty	12.2%	14.1%	11.5%	11.6%	12.0%

Source: NM-IBIS Summary of American Community Survey - 5 Year Estimates

New Mexico Unemployment Rate -- 2016

	Percent Civilian Workforce		Percent Civilian Workforce
Non-Metro	7.5	Small Town	6.8
		Large Town	7.6
Metro	6.4	Small Metro	7.0
		Large Metro	6.1
Total	6.7	Total	6.7

New Mexico Uninsured Population -- 2015

	Percent Population Under Age 65		Percent Population Under Age 65
Non-Metro	13.6	Small Town	13.0
		Large Town	13.7
Metro	12.9	Small Metro	14.7
		Large Metro	12.0
Total	13.1	Total	13.1

Source: Bureau of Census - SAHIE

Health Status Indicators

New Mexico Life Expectancy From Birth -- 2014-2016

	Life Expectancy From Birth - Years		Life Expectancy From Birth - Years
Non-Metro	76.7	Small Town	76.9
		Large Town	76.6
Metro	79.2	Small Metro	80.0
		Large Metro	78.8
Total	78.4	Total	78.4

New Mexico Life Expectancy From Age 65 -- 2014-2016

	Life Expectancy From Birth - Years		Life Expectancy From Birth - Years
Non-Metro	20.0	Small Town	20.7
		Large Town	19.9
Metro	20.9	Small Metro	21.7
		Large Metro	20.5
Total	20.6	Total	20.6

Source: NM-IBIS

New Mexico YPLL Before Age 75 -- 2014-2016

	YPLL per 100,000 Population		YPLL per 100,000 Population
Non-Metro	9,475	Small Town	9,923
		Large Town	9,405
Metro	7,430	Small Metro	7,138
		Large Metro	7,587
Total	8,117	Total	8,117

New Mexico Percent Population Disabled -- 2011-2015

	Percent Civilian Population		Percent Civilian Population
Non-Metro	17.7	Small Town	23.2
		Large Town	16.8
Metro	13.1	Small Metro	12.3
		Large Metro	13.5
Total	14.6	Total	14.6

Source: Bureau of Census

New Mexico Adult Population Percent With Fair/Poor Health -- 2014-2016

	Percent Population Fair/Poor Health		Percent Population Fair/Poor Health
Non-Metro	22.8%	Small Town	22.7%
		Large Town	22.9%
Metro	19.5%	Small Metro	20.7%
		Large Metro	18.9%
Total	20.3%	Total	20.3%

Source: NM-IBIS

Maternal and Child Health Indicators

New Mexico Low/Very Low Birthweight Births -- 2007-2016

	Percent of Live Births		Percent of Live Births
Non-Metro	8.8%	Small Town	10.0%
		Large Town	8.7%
Metro	8.6%	Small Metro	8.1%
		Large Metro	9.0%
Total	8.7%	Total	8.7%

New Mexico Pre-Term Births -- 2007-2016

	Percent of Live Births		Percent of Live Births
Non-Metro	9.7%	Small Town	10.3%
		Large Town	9.6%
Metro	9.5%	Small Metro	8.3%
		Large Metro	10.2%
Total	9.6%	Total	9.6%

Source: NM-IBIS

New Mexico Adolescent Births -- 2011-2016

	Births per 1000 Girls 15-19		Births per 1000 Girls 15-19
Non-Metro	52.1	Small Town	43.7
		Large Town	53.2
Metro	33.8	Small Metro	40.6
		Large Metro	29.8
Total	39.9	Total	39.9

New Mexico Births With First Trimester Prenatal Care -- 2012-2016

	Percent of Live Births		Percent of Live Births
Non-Metro	60.4%	Small Town	59.5%
		Large Town	60.5%
Metro	65.9%	Small Metro	64.2%
		Large Metro	66.9%
Total	63.9%	Total	63.9%

Source: NM-IBIS

Mortality Indicators

New Mexico Age Adjusted Death Rate - All Causes -- 2012-2016

	Deaths per 100,000 Population		Deaths per 100,000 Population
Non-Metro	812.6	Small Town	794.3
		Large Town	818.3
Metro	699.3	Small Metro	666.9
		Large Metro	718.1
Total	737.5	Total	737.5

New Mexico Age Adjusted Death Rate - Heart Disease -- 2012-2016

	Deaths per 100,000 Population		Deaths per 100,000 Population
Non-Metro	166.5	Small Town	160.7
		Large Town	168.1
Metro	132.4	Small Metro	121.1
		Large Metro	138.6
Total	144.2	Total	144.2

Source: NM-IBIS

New Mexico Age Adjusted Death Rate - All Cancers -- 2012-2016

	Deaths per 100,000 Population		Deaths per 100,000 Population
Non-Metro	149.6	Small Town	152.2
		Large Town	149.4
Metro	137.8	Small Metro	130.9
		Large Metro	141.6
Total	141.9	Total	141.9

New Mexico Age Adjusted Death Rate - Unintentional Injury -- 2007-2016

	Deaths per 100,000 Population		Deaths per 100,000 Population
Non-Metro	71.5	Small Town	74.8
		Large Town	71.0
Metro	60.3	Small Metro	60.9
		Large Metro	60.0
Total	63.9	Total	63.9

Source: NM-IBIS

New Mexico Age Adjusted Death Rate - COPD -- 2007-2016

	Deaths per 100,000 Population		Deaths per 100,000 Population
Non-Metro	51.3	Small Town	55.1
		Large Town	50.5
Metro	41.9	Small Metro	37.8
		Large Metro	44.1
Total	45.3	Total	45.3

New Mexico Age Adjusted Death Rate - Stroke -- 2007-2016

	Deaths per 100,000 Population		Deaths per 100,000 Population
Non-Metro	32.5	Small Town	33.2
		Large Town	32.4
Metro	33.8	Small Metro	30.0
		Large Metro	36.0
Total	33.4	Total	33.4

Source: NM-IBIS

New Mexico Age Adjusted Death Rate - Diabetes -- 2007-2016

	Deaths per 100,000 Population		Deaths per 100,000 Population
Non-Metro	33.7	Small Town	30.1
		Large Town	34.6
Metro	24.2	Small Metro	24.2
		Large Metro	24.2
Total	27.5	Total	27.5

New Mexico Age Adjusted Death Rate - Chronic Liver Disease -- 2007-2016

	Deaths per 100,000 Population		Deaths per 100,000 Population
Non-Metro	25.2	Small Town	20.8
		Large Town	26.0
Metro	17.4	Small Metro	18.1
		Large Metro	17.0
Total	20.0	Total	20.0

Source: NM-IBIS

New Mexico Age Adjusted Death Rate - Alzheimer's Disease -- 2007-2016

	Deaths per 100,000 Population		Deaths per 100,000 Population
Non-Metro	16.8	Small Town	12.6
		Large Town	17.8
Metro	19.3	Small Metro	16.6
		Large Metro	20.7
Total	18.4	Total	18.4

New Mexico Age Adjusted Death Rate - Influenza and Pneumonia -- 2007-2016

	Deaths per 100,000 Population		Deaths per 100,000 Population
Non-Metro	17.4	Small Town	16.8
		Large Town	17.6
Metro	14.0	Small Metro	13.7
		Large Metro	14.1
Total	15.2	Total	15.2

Source: NM-IBIS

New Mexico Age Adjusted Death Rate - Alcohol-Related Chronic Disease -- 2007-2016

	Deaths per 100,000 Population		Deaths per 100,000 Population
Non-Metro	32.0	Small Town	27.5
		Large Town	32.8
Metro	25.6	Small Metro	24.6
		Large Metro	26.1
Total	27.7	Total	27.7

New Mexico Age Adjusted Death Rate - Drug Overdose -- 2007-2016

	Deaths per 100,000 Population		Deaths per 100,000 Population
Non-Metro	24.3	Small Town	28.5
		Large Town	23.7
Metro	24.2	Small Metro	20.5
		Large Metro	26.2
Total	24.3	Total	24.3

Source: NM-IBIS

New Mexico Age Adjusted Death Rate - Suicide -- 2007-2016

	Deaths per 100,000 Population		Deaths per 100,000 Population
Non-Metro	23.0	Small Town	27.2
		Large Town	22.3
Metro	19.6	Small Metro	19.6
		Large Metro	19.6
Total	20.7	Total	20.7

New Mexico Age Adjusted Death Rate - Motor Vehicle Injury -- 2007-2016

	Deaths per 100,000 Population		Deaths per 100,000 Population
Non-Metro	23.0	Small Town	22.8
		Large Town	23.1
Metro	13.8	Small Metro	15.9
		Large Metro	12.7
Total	16.9	Total	16.9

Source: NM-IBIS

Small-Town and Large-Town Rural Comparison Charts

Demographic and Socioeconomic Indicator Comparison Chart

Small Town Rural Counties Compared to Large Town Rural Counties

Small Town Rural Counties Compared to Metro Counties

	Higher or Worse	Lower or Better
Higher or Worse	**Indicators** **Demographic Indicators** **Population Age 65 and Over (**)** **Age Dependency Ratio (*)** **Non-Hispanic White Population Percentage (*)**	**Indicators** **Socioeconomic Indicators** Percentage Population Under 5 in Poverty Percentage Population 65 and Over in Poverty Percentage Civilian Workforce Unemployed Percentage Population Under 65 Uninsured
Lower or Better	**Indicators**	**Indicators** **Demographic Indicators** Population Under Age 18 Population Under Age 5 Hispanic Population Percentage Native American Population Percentage Limited English Speaking Ability **Socioeconomic Indicators** Percentage Population in Poverty Percentage Population Under 18 In Poverty

Single Asterisk- Rate more than 20% higher than Metro
Double Asterisk - Rate more than 50% higher than Metro

Demographic and Socioeconomic Indicator Comparison Chart

Large Town Rural Counties Compared to Small Town Rural Counties

Large Town Rural Counties Compared to Metro Counties	Higher or Worse	Lower or Better
Higher or Worse	**Indicators** **Demographic Indicators** **Native American Population Percentage (**)** Population Under Age 18 Population Under Age 5 Limited English Speaking Ability **Socioeconomic Indicators** **Percentage Population 65 and Over in Poverty (*)** Percentage Population in Poverty Percentage Population Under 18 In Poverty Percentage Population Under 5 in Poverty Percentage Civilian Workforce Unemployed Percentage Population Under 65 Uninsured	**Indicators**
Lower or Better	**Indicators** **Demographic Indicators** Hispanic Population Percentage	**Indicators** **Demographic Indicators** Population Age 65 and Over Non-Hispanic White Population Percentage

Single Asterisk- Rate more than 20% higher than Metro
Double Asterisk - Rate more than 50% higher than Metro

Health Status and MCH Indicator Comparison Chart

Small Town Rural Counties Compared to Large Town Rural Counties

Small Town Rural Counties Compared to Metro Counties

	Higher or Worse	Lower or Better
Higher or Worse	**Indicators** **Health Status Indicators** **Percent Population Disabled (**)** **YPLL Before Age 75 (*)** **Maternal and Child Health Indicators** Percentage Births Without First Trimester PNC Percentage Low/Very Low Birthweight Births Percent Pre-Term Births	**Indicators** **Health Status Indicators** Life Expectancy from Birth Life Expectancy from Age 65 **Maternal and Child Health Indicators** **Adolescent Birth Rate (*)**
Lower or Better	**Indicators**	**Indicators**

Single Asterisk- Rate more than 20% higher than Metro
Double Asterisk - Rate more than 50% higher than Metro

Health Status and MCH Indicator Comparison Chart

Large Town Rural Counties Compared to Small Town Rural Counties

Large Town Rural Counties Compared to Metro Counties	Higher or Worse	Lower or Better
	Indicators **Health Status Indicators** Life Expectancy from Birth Life Expectancy from Age 65 **Maternal and Child Health Indicators** **Adolescent Birth Rate (**)**	**Indicators** **Health Status Indicators** **YPLL Before Age 75 (*)** **Percent Population Disabled (*)** Age Dependency Ratio **Maternal and Child Health Indicators** Percentage Births Without First Trimester PNC Percentage Low/Very Low Birthweight Births Percent Pre-Term Births
Higher or Worse		
Lower or Better	**Indicators**	**Indicators**

Single Asterisk- Rate more than 20% higher than Metro
Double Asterisk - Rate more than 50% higher than Metro

Mortality Indicator Comparison Chart

Small Town Rural Counties Compared to Large Town Rural Counties

Small Town Rural Counties Compared to Metro Counties

	Worse	**Better**
Worse	**Indicators** **Mortality - COPD (*)** **Mortality - Suicide (*)** **Mortality - Unintentional Injury (*)** **Mortality - Drug Overdose (*)** Mortality - All Cancer	**Indicators** **Mortality - Motor Vehicle Injury (**)** **Mortality - Diabetes (*)** **Mortality - Influenza and Pneumonia (*)** **Mortality - Alcohol-Related Chronic Disease (*)** Mortality - All Causes Mortality - Heart Disease Mortality - Chronic Liver Disease
Better	**Indicators** Mortality - Stroke	**Indicators** Mortality - Alzheimer's Disease

Single Asterisk- Rate more than 20% higher than Metro

Double Asterisk - Rate more than 50% higher than Metro

Mortality Indicator Comparison Chart

Large Town Rural Counties Compared to Small Town Rural Counties

Large Town Rural Counties Compared to Metro Counties	Large Town Rural Counties Compared to Small Town Rural Counties: Worse	Large Town Rural Counties Compared to Small Town Rural Counties: Better
Worse	**Indicators** **Mortality - Motor Vehicle Injury (**)** **Mortality - Heart Disease (*)** **Mortality - Diabetes (*)** **Mortality - Influenza and Pneumonia (*)** **Mortality - Alcohol-Related Chronic Disease (*)** Mortality - All Causes Mortality - Chronic Liver Disease	**Indicators** **Mortality - COPD (*)** Mortality - All Cancer Mortality - Suicide Mortality - Unintentional Injury
Better	**Indicators** Mortality - Alzheimer's Disease	**Indicators** Mortality - Stroke Mortality - Drug Overdose

Single Asterisk- Rate more than 20% higher than Metro
Double Asterisk - Rate more than 50% higher than Metro

Rural Health Service Assessment

Health Professional Shortage Areas in New Mexico - Primary Care

Overview

The Health Resources and Service Administration (HRSA) of the Department of Health and Human Services uses its own methodology to identify areas and sub-populations with a shortage of primary medical care services. These area and sub-populations are estimated to have less than half the supply of primary medical care services needed by the target population. HRSA designates these areas and sub-populations as Health Professional Shortage Areas (HPSAs). The designations are kept updated on a multiyear schedule.

HRSA designates 3 key types of primary care HPSA – Whole County, Subcounty and Low-Income Population. The Whole County HPSA is a shortage designation for the entire population of a county. The Subcounty HPSA is a shortage designation for a subcounty geographic area sub-population. The Low-Income Population designation is a shortage designation for the population of a county or subcounty that is below 200% of the Federal Poverty Level.

Primary Care HPSA designations for New Mexico, updated through 2017, are identified below. They are compiled by geographic area type.

Small Town Rural County HPSAs

New Mexico Primary Care Health Professional Shortage Areas - 2017
-- Small Town Rural Counties

County	PC HPSA Type	PC HPSA Name
Catron	Whole County	Catron County
Colfax	Whole County	Colfax County
De Baca	Whole County	De Baca County
Guadalupe	Whole County	Guadalupe County
Harding	Whole County	Harding County
Hidalgo	Whole County	Hidalgo County
Lincoln	Whole County	Lincoln County
Mora	Whole County	Mora County
Quay	Whole County	Quay County
Sierra	Whole County	Sierra County
Socorro	Whole County	Socorro County
Union	Whole County	Union County

All fourteen of New Mexico's Small Town Rural counties are designated as primary care HPSAs. All HPSAs are Whole County designations, reflecting a high level of need in these areas.

Large Town Rural County HPSAs

New Mexico Primary Care Health Professional Shortage Areas - 2017
-- Large Town Rural Counties

County	PC HPSA Type	PC HPSA Name
Chaves	Whole County	Chaves County
Cibola	Whole County	Cibola County
Lea	Whole County	Lea County
McKinley	Whole County	McKinley County
Roosevelt	Whole County	Roosevelt County
Rio Arriba	Subcounty	Combined TA - Chama
Rio Arriba	Subcounty	Western Rio Arriba
Rio Arriba	Subcounty	Dixon/Chimayo
Luna	Population	Low Income - Luna County
Eddy	Population	Low Income - Eddy County
San Miguel	Population	Low Income - San Miguel County
Grant	Population	Low Income - Grant County
Curry	Population	Low Income - Curry County
Otero	Population	Low Income - Otero County
Taos	Population	Low Income - Taos County

5 of New Mexico's 14 Large Town Rural Counties are designated as Whole County primary care HPSAs. 1 additional county has 3 subcounty designations. The low income population in 7 whole counties is designated.

Small Metro County HPSAs

New Mexico Primary Care Health Professional Shortage Areas - 2017
-- Small Metro Counties

County	PC HPSA Type	PC HPSA Name
San Juan	Whole County	San Juan County
Dona Ana	Subcounty	Hatch
Dona Ana	Subcounty	Southern Dona Ana
Santa Fe	Subcounty	Cerrillos/Madrid/Edgewood
Santa Fe	Population	Low Income - Santa Fe/La Familia

1 of New Mexico's 3 Small Metro Counties is designated as Whole County primary care HPSA. 2 additional counties have subcounty designations. The low income population in 1 subcounty is designated.

Large Metro County HPSAs

New Mexico Primary Care Health Professional Shortage Areas - 2017
-- Large Metro Counties

County	PC HPSA Type	PC HPSA Name
Torrance	Whole County	Torrance County
Valencia	Whole County	Valencia County
Sandoval	Subcounty	Cuba
Sandoval	Subcounty	Southern Sandoval
Bernalillo	Population	Low Income - South East Heights

2 of the outlying counties in the Albuquerque MSA are designated as whole county HPSAs. 1 county – Sandoval – has a subcounty designation. Only a portion of Bernalillo County, the largest urban county, has a low-income population designation.

Health Professional Shortage Areas in New Mexico - Dental Care

Overview

The Health Resources and Service Administration (HRSA) of the Department of Health and Human Services uses its own methodology to identify areas and sub-populations with a shortage of dental care services. These area and sub-populations are estimated to have less than half the supply of dental services needed by the target population. HRSA designates these areas and sub-populations as Health Professional Shortage Areas (HPSAs). The designations are kept updated on a multiyear schedule.

HRSA designates 3 key types of dental HPSA – Whole County, Subcounty and Low-Income Population. The Whole County HPSA is a shortage designation for the entire population of a county. The Subcounty HPSA is a shortage designation for a subcounty geographic area sub-population. The Low-Income Population designation is a shortage designation for the population of a county or subcounty that is below 200% of the Federal Poverty Level.

Dental HPSA designations for New Mexico, updated through 2017, are identified below. They are compiled by geographic area type.

Small Town Rural County HPSAs

New Mexico Dental Health Professional Shortage Areas - 2017 -- Small Town Rural Counties

County	Type	Dental HPSA Name
Catron	Whole County	Catron County
Guadalupe	Whole County	Guadalupe County
Harding	Whole County	Harding County
Hidalgo	Whole County	Hildago County
Mora	Whole County	Mora County
Quay	Whole County	Quay County
Sierra	Whole County	Sierra County
Socorro	Whole County	Socorro County
Union	Whole County	Union County
Colfax	Population	Low Income - Colfax County
De Baca	Population	Low Income - De Baca County
Lincoln	Population	Low Income - Lincoln County

12 of New Mexico's 14 Small Town Rural counties are designated as dental HPSAs. 9 HPSAs are whole county designations, and the remaining 3 are low income county-wide designations.

Large Town Rural County HPSAs

New Mexico Dental Health Professional Shortage Areas - 2017
-- Large Town Rural Counties

County	Type	Dental HPSA Name
Cibola	Whole County	Cibola County
Lea	Whole County	Lea County
Luna	Whole County	Luna County
Otero	Whole County	Otero County
Rio Arriba	Subcounty	North/Western Rio Arriba
Chaves	Population	Low Income - Chaves County
Curry	Population	Low Income - Curry County
Eddy	Population	Low Income - Eddy County
Grant	Population	Low Income - Grant County
McKinley	Population	Low Income - McKinley County
Rio Arriba	Population	Low Income - Espanola
Roosevelt	Population	Low Income - Roosevelt County
San Miguel	Population	Low Income - San Miguel County
Taos	Population	Low Income - Taos County

4 of New Mexico's 14 Large Town Rural Counties are designated as Whole County dental care HPSAs. 1 additional county has a subcounty designation. The low income population in 9 whole counties is designated.

Small Metro County HPSAs

New Mexico Dental Health Professional Shortage Areas - 2017
-- Small Metro Counties

County	Type	Dental HPSA Name
Dona Ana	Subcounty	Dona Ana Hill Service Area
Dona Ana	Subcounty	Southern Dona Ana
Dona Ana	Subcounty	Hatch
Santa Fe	Subcounty	Cerrillos/Madrid/Edgewood
San Juan	Population	Low Income - San Juan County
Santa Fe	Population	Low Income - La Familia

1 of New Mexico's 3 Small Metro Counties has three separate Subcounty dental designations. A second county has one Subcounty designation. 1 county has a county-wide Low Income Population designation, while another has a subcounty Low-Income Population designation.

Large Metro County HPSAs

New Mexico Dental Health Professional Shortage Areas - 2017
-- Large Metro Counties

County	Type	Dental HPSA Name
Torrance	Whole County	Torrance County
Bernalillo	Subcounty	Southwest Valley Service Area
Sandoval	Subcounty	Cuba (North Sandoval)
Bernalillo	Population	Low Income - North Valley
Valencia	Population	Low Income - Valencia County

1 of the outlying counties in the Albuquerque MSA is designated as Whole County dental HPSA. 2 additional Large Metro counties have subcounty designations. The sub-county low income population in 2 Large Metro counties is designated.

Health Professional Shortage Areas in New Mexico - Mental Health

Overview

The Health Resources and Service Administration (HRSA) of the Department of Health and Human Services uses its own methodology to identify areas and sub-populations with a shortage of mental health services. These area and sub-populations are estimated to have less than half the supply of services needed by the target population. HRSA designates these areas and sub-populations as Health Professional Shortage Areas (HPSAs). The designations are kept updated on a multiyear schedule.

HRSA designates 3 key types of Mental Health HPSA – Whole County, Subcounty and Low-Income Population. The Whole County HPSA is a shortage designation for the entire population of a county. The Subcounty HPSA is a shortage designation for a subcounty geographic area sub-population. The Low-Income Population designation is a shortage designation for the population of a county or subcounty that is below 200% of the Federal Poverty Level.

Mental Health HPSA designations for New Mexico, updated through 2017, are identified below. They are compiled by geographic area type.

Small Town Rural County HPSAs

New Mexico Mental Health Health Professional Shortage Areas - 2017 -- Small Town Rural Counties

County	Type	MH HPSA Name
Catron	Whole County	Border Catchment Area - Catron
Colfax	Whole County	Colfax County
De Baca	Whole County	Plains Mental Health Service Area - De Baca
Guadalupe	Whole County	Plains Mental Health Service Area - Guadalupe
Harding	Whole County	Plains Mental Health Service Area - Harding
Hidalgo	Whole County	Border Catchment Area - Hidalgo
Lincoln	Whole County	Southeastern Catchment Area - Lincoln
Mora	Whole County	Mora County
Quay	Whole County	Plains Mental Health Service Area - Quay
Sierra	Whole County	South Central Catchment Area - Sierra
Socorro	Whole County	South Central Catchment Area - Socorro
Union	Whole County	Plains Mental Health Service Area - Union

All fourteen of New Mexico's Small Town Rural counties are designated as mental health HPSAs. All HPSAs are Whole County designations, reflecting a high level of need in these areas.

Large Town Rural County HPSAs

New Mexico Mental Health Health Professional Shortage Areas - 2017 -- Large Town Rural Counties		
County	**Type**	**MH HPSA Name**
Chaves	Whole County	Southeastern Catchment Area - Chaves
Cibola	Whole County	Cibola County
Curry	Whole County	Plains Mental Health Service Area - Curry
Eddy	Whole County	Southeastern Catchment Area - Eddy
Grant	Whole County	Border Catchment Area - Grant
Lea	Whole County	Southeastern Catchment Area - Lea
Luna	Whole County	Border Catchment Area - Luna
McKinley	Whole County	Catchment Area 1 - McKinley
Otero	Whole County	Southeastern Catchment Area - Otero
Rio Arriba	Whole County	Rio Arriba County
Roosevelt	Whole County	Plains Mental Health Service Area -Roosevelt
San Miguel	Whole County	San Miguel County
Taos	Whole County	Taos County

All of New Mexico's 14 Large Town Rural Counties are designated as Whole County Mental Health HPSAs. All HPSAs are Whole County designations, reflecting a high level of need in these areas.

Small Metro County HPSAs

New Mexico Mental Health Health Professional Shortage Areas - 2017 -- Small Metro Counties		
County	**Type**	**MH HPSA Name**
Dona Ana	Whole County	Dona Ana County
San Juan	Whole County	Catchment Area 1 - San Juan
Santa Fe	Population	Low Income - Santa Fe County

2 of New Mexico's 3 Small Metro counties are designated as Whole County Mental Health HPSAs. 1 other county has a Whole County Low Income Population designation.

Large Metro County HPSAs

New Mexico Mental Health Health Professional Shortage Areas - 2017 -- Large Metro Counties

County	Type	MH HPSA Name
Torrance	Whole County	Torrance County
Valencia	Whole County	Valencia County
Bernalillo	Subcounty	Southwest Valley
Bernalillo	Population	Low Income - North Valley

2 of the outlying counties in the Albuquerque MSA are designated as whole county Mental Health HPSAs. Bernalillo County is partially designated with a subcounty total population designation and a subcounty low-income population in two different neighborhoods.

Distribution of Primary Care Physicians

Rural/Urban Analysis: The supply of primary care physicians (MDs and DOs reporting specialties of family practice, family medicine, general practice, general pediatrics or general internal medicine) in 2016 in New Mexico's rural counties is below that of urban counties and falls below the national benchmark supply rate and the statewide rate. Both Small Town Rural counties and Large Town Rural counties fall below the national benchmark and Statewide rate. All categories of urban counties exceed the national benchmark.

Primary Care Physician data is summarized on the following table.

Primary Care Physicians per 10,000 Population
-- New Mexico - 2016

	Providers per 10,000 Population		Providers per 10,000 Population
Non-Metro	7.4	Rural	6.5
		Mixed	7.5
Metro	11.1	Small Metro	9.7
		Large Metro	11.9
State Total	9.9	Total	9.9
National Benchmark	7.9		7.9

Source: NM Health Care Workforce Committee 2017 Report

County Level Analysis: 10 of 12 Small Town Rural counties fall below the national benchmark for primary care physicians and all fall below the statewide supply rate. One county reports no primary care physicians.

9 of 14 Large Town Rural counties fall below the national benchmark for primary care physicians and all but three of these counties fall below the state rate. All of these counties have some primary care physician workforce.

County level primary care physician workforce data is summarized on the following table. It should be noted that Federally designated primary care medical shortage areas using a different dataset and a different definition of primary care cover additional areas not identified in this workforce analysis. This is discussed in a separate section of this report.

Primary Care Physicians per 10,000 Population
-- New Mexico Counties - 2016

County	Providers per 10,000 Population
Bernalillo	13.9
Sandoval	7.8
Torrance	1.3
Valencia	3.5
Large Metro	11.9
Doña Ana	8.5
San Juan	7.0
Santa Fe	13.6
Small Metro	9.7
Chaves	9.5
Cibola	7.6
Curry	7.1
Eddy	6.3
Grant	13.4
Lea	5.2
Los Alamos	16.9
Luna	3.2
McKinley	8.0
Otero	5.2
Rio Arriba	6.5
Roosevelt	6.6
San Miguel	6.7
Taos	10.2
Mixed	7.5
Catron	5.5
Colfax	5.5
De Baca	5.4
Guadalupe	4.5
Harding	0.0
Hidalgo	2.2
Lincoln	6.0
Mora	2.2
Quay	7.1
Sierra	9.7
Socorro	9.2
Union	4.6
Rural	6.5
State Total	9.9
National Benchmark	7.9

Distribution of Obstetrician/Gynecologists

Rural/Urban Analysis: The supply of obstetrician/gynecologist (OB/GYN) physicians in 2016 in New Mexico's rural counties is below that of urban counties and falls below the statewide rate. It is slightly above the national benchmark. Small Town Rural counties fall below the national benchmark and statewide rate. Large Town Rural counties slightly exceed the national benchmark by but fall below the statewide rate.

OB/GYN physician data is summarized on the following table.

OB/GYN Physicians per 10,000 Female Population
-- New Mexico - 2016

	Providers per 10,000 Population		Providers per 10,000 Female Population
Non-Metro	2.2	Rural	1.9
		Mixed	2.3
Metro	2.7	Small Metro	1.8
		Large Metro	3.2
State Total	2.6	Total	2.6
National Benchmark	2.1		2.1

Source: NM Health Care Workforce Committee 2017 Report

County Level Analysis: 10 of 12 Small Town Rural counties fall below both the national benchmark for OB/GYN physicians and below the statewide supply rate. 9 of the 12 counties report no OB/GYN capacity. 3 of 14 Large Town Rural counties fall below the national benchmark for primary care physicians and 8 of these counties fall below the state rate. All of these larger rural counties report some OB/GYN capacity. The shortage of OB/GYN capacity suggests the need for establishing regional referral arrangements and other systems needed to assure availability of these services to all rural residents.

County level OB/GYN physician workforce data is summarized on the following table. It should be noted that several small counties have significantly higher rates of OB/GYN supply. This may reflect reporting anomalies and suggests a focus for further analysis.

OB/GYN Physicians per 10,00 Female Population
-- New Mexico Counties - 2016

County	Providers per 10,000 Female Population
Bernalillo	4.1
Sandoval	1.0
Torrance	0.0
Valencia	0.0
Large Metro	3.2
Doña Ana	2.4
San Juan	1.0
Santa Fe	1.7
Small Metro	1.8
Chaves	2.1
Cibola	2.2
Curry	2.1
Eddy	2.5
Grant	2.0
Lea	2.1
Los Alamos	3.3
Luna	1.6
McKinley	2.4
Otero	2.5
Rio Arriba	2.5
Roosevelt	1.0
San Miguel	2.1
Taos	2.9
Mixed	2.3
Catron	0.0
Colfax	6.3
De Baca	0.0
Guadalupe	0.0
Harding	0.0
Hidalgo	0.0
Lincoln	2.0
Mora	0.0
Quay	0.0
Sierra	0.0
Socorro	3.5
Union	0.0
Rural	1.9
State Total	2.6
National Benchmark	2.1

Distribution of General Surgeons

Rural/Urban Analysis: The supply of general surgeons in 2016 in New Mexico's rural counties is above that of urban counties and above the national benchmark supply rate and the statewide rate. There are two national benchmarks - a minimum supply rate and an optimal rate. The rural county rate exceeds both. Small Town Rural counties and Large Town Rural counties exceed both national benchmarks and the statewide rate.

General Surgeon data is summarized on the following table.

General Surgeons per 100,000 Population -- New Mexico - 2016

	Providers per 100,000 Population		Providers per 100,000 Population
Non-Metro	9.6	Rural	10.6
		Mixed	9.4
Metro	8.6	Small Metro	8.2
		Large Metro	8.8
State Total	8.9	Total	8.9
National Benchmark	6.0 Minimum		6.0 Minimum
National Benchmark	9.2 Optimal		9.2 Optimal

Source: NM Health Care Workforce Committee 2017 Report

County Level Analysis: 8 of 12 Small Town Rural counties fall below the minimum national benchmark for general surgeons. 9 of 12 of these counties fall below the national optimal benchmark and the statewide supply rate. 8 of these counties report no general surgeons. The lack of surgical capacity in some counties suggests a need to establish regional referral arrangements and other systems needed to assure availability of these services to all rural residents.

3 of 14 Large Town Rural counties fall below the national benchmark for general surgeons and 7 of these counties fall below the state rate. All of the Large Town Rural counties have some general surgeon workforce.

County level general surgeon workforce data is summarized on the following table. It should be noted that several small counties have significantly higher rates of general surgeon supply. ***This may reflect reporting anomalies and suggests a focus for further analysis***.

General Surgeons per 100,000 Population
-- New Mexico Counties - 2016

County	Providers per 100,000 Population
Bernalillo	11.0
Sandoval	4.2
Torrance	0.0
Valencia	0.0
Large Metro	8.8
Doña Ana	6.0
San Juan	8.2
Santa Fe	11.4
Small Metro	8.2
Chaves	6.0
Cibola	10.8
Curry	17.8
Eddy	13.9
Grant	6.9
Lea	2.9
Los Alamos	27.2
Luna	4.0
McKinley	12.2
Otero	3.0
Rio Arriba	7.5
Roosevelt	10.1
San Miguel	7.1
Taos	14.9
Mixed	9.4
Catron	0.0
Colfax	23.5
De Baca	0.0
Guadalupe	0.0
Harding	0.0
Hidalgo	0.0
Lincoln	0.0
Mora	0.0
Quay	23.5
Sierra	8.8
Socorro	23.0
Union	0.0
Rural	10.6
State Total	8.9
National Benchmark	6.0 Minimum

Distribution of Psychiatrists

Rural/Urban Analysis: The supply of psychiatrists for 2016 in New Mexico's rural counties is below that of urban counties and falls below the statewide rate. It is also below the national benchmark.

Small Town Rural counties fall substantially below both the national benchmark and Statewide rate. Large Town Rural counties are also below the national benchmark and statewide rates.

Psychiatrist data is summarized on the following table.

	Providers per 10,000 Population		Providers per 10,000 Population
Non-Metro	0.7	Rural	0.2
		Mixed	0.7
Metro	2.0	Small Metro	1.8
		Large Metro	2.2
State Total	1.6	Total	1.6

National Benchmark	1.5		1.5

Source: NM Health Care Workforce Committee 2017 Report

County Level Analysis: All 12 Small Town Rural counties fall below both the national benchmark for psychiatrists and below the statewide supply rate. 10 of the 12 counties report no psychiatrist capacity.

12 of 14 Large Town Rural counties fall below both the national benchmark for psychiatrists and below the state rate. 2 of these larger rural counties report no psychiatrist capacity. The shortage of psychiatrists suggests the need for establishing regional referral arrangements and other systems needed to assure availability of these services to all rural residents.

County level psychiatrist workforce data is summarized on the following table. It should be noted that several small counties have significantly higher rates of supply. This includes San Miguel County, home of the State Hospital. This may reflect reporting anomalies and suggests a focus for further analysis.

Psychiatrists per 10,000 Population
-- New Mexico Counties - 2016

County	Providers per 10,000 Population
Bernalillo	2.7
Sandoval	0.7
Torrance	0.0
Valencia	0.8
Large Metro	2.2
Doña Ana	1.0
San Juan	0.9
Santa Fe	3.6
Small Metro	1.8
Chaves	0.6
Cibola	0.0
Curry	0.6
Eddy	0.5
Grant	1.0
Lea	0.6
Los Alamos	1.6
Luna	0.4
McKinley	0.8
Otero	0.5
Rio Arriba	0.2
Roosevelt	0.0
San Miguel	3.5
Taos	1.2
Mixed	0.7
Catron	0.0
Colfax	0.0
De Baca	0.0
Guadalupe	0.0
Harding	0.0
Hidalgo	0.0
Lincoln	0.0
Mora	0.0
Quay	1.2
Sierra	0.0
Socorro	0.6
Union	0.0
Rural	0.2
State Total	1.6
National Benchmark	1.54

Distribution of Dentists

Rural/Urban Analysis: The supply of Dentists for 2016 in New Mexico's rural counties is below that of urban counties and falls below the national benchmark supply rate and the statewide rate. Both Small Town Rural counties and Large Town Rural counties fall below the national benchmark and Statewide rate. All categories of urban counties exceed the national benchmark and state rate.

Dentist data is summarized on the following table.

Dentists per 10,000 Population
-- New Mexico - 2016

	Providers per 10,000 Population		Providers per 10,000 Population
Non-Metro	3.7	Rural	2.7
		Mixed	3.8
Metro	6.5	Small Metro	6.4
		Large Metro	6.6
State Total	5.6	Total	5.6
National Benchmark	4.0		4.0

Source: NM Health Care Workforce Committee 2017 Report

County Level Analysis: 9 of 12 Small Town Rural counties fall below the national benchmark for dentists and all fall below the statewide supply rate. 4 of these counties report no dentists. 9 of 14 Large Town Rural counties fall below the national benchmark for dentists and all but one of these counties - Los Alamos - fall below the state rate. All of these counties have some dentist workforce.

County level dentist workforce data is summarized on the following table. It should be noted that Federally designated primary dental care shortage areas using a different dataset and a different definition of primary care cover additional areas not identified in this workforce analysis. This is discussed in a separate section of this report.

Dentists per 10,000 Population
-- New Mexico Counties - 2016

County	Providers per 10,000 Population
Bernalillo	7.4
Sandoval	4.9
Torrance	1.3
Valencia	2.7
Large Metro	6.6
Doña Ana	4.9
San Juan	7.2
Santa Fe	8.1
Small Metro	6.4
Chaves	4.2
Cibola	3.2
Curry	5.3
Eddy	3.3
Grant	4.5
Lea	3.3
Los Alamos	7.6
Luna	3.2
McKinley	3.9
Otero	2.6
Rio Arriba	3.5
Roosevelt	2.5
San Miguel	3.2
Taos	4.8
Mixed	3.8
Catron	2.7
Colfax	3.1
De Baca	0.0
Guadalupe	4.5
Harding	0.0
Hidalgo	0.0
Lincoln	4.0
Mora	4.3
Quay	1.2
Sierra	2.6
Socorro	2.3
Union	0.0
Rural	2.7
State Total	5.6
National Benchmark	4.0

Hospital Capacity in NM Small Town Rural Counties - 2017

County	Hospital Name	Town	Hospital Type	Beds
Catron County				
Colfax County	MINERS' COLFAX MEDICAL CENTER	RATON	Critical Access Hospital	25
De Baca County				
Guadalupe County	GUADALUPE COUNTY HOSPITAL	SANTA ROSA	Short Term Acute Care	12
Harding County				
Hidalgo County				
Lincoln County	LINCOLN COUNTY MEDICAL CENTER	RUIDOSO	Critical Access Hospital	25
Mora County				
Quay County	DR DAN C TRIGG MEMORIAL HOSPITAL	TUCUMCARI	Critical Access Hospital	25
Sierra County	SIERRA VISTA HOSPITAL	T OR C	Critical Access Hospital	15
Socorro County	SOCORRO GENERAL HOSPITAL	SOCORRO	Critical Access Hospital	24
Union County	UNION COUNTY GENERAL HOSPITAL	CLAYTON	Critical Access Hospital	25

Hospital Capacity in NM Large Town Rural Counties - 2017

County	Hospital Name	Town	Hospital Type	Beds
Chaves County	EASTERN NEW MEXICO MEDICAL CENTER	ROSWELL	Short Term Acute Care	162
Chaves County	LOVELACE REGIONAL HOSPITAL - ROSWELL	ROSWELL	Short Term Acute Care	26
Cibola County	CIBOLA GENERAL HOSPITAL	GRANTS	Critical Access Hospital	25
Curry County	PLAINS REGIONAL MEDICAL CENTER	CLOVIS	Short Term Acute Care	106
Eddy County	ARTESIA GENERAL HOSPITAL	ARTESIA	Short Term Acute Care	38
Eddy County	CARLSBAD MEDICAL CENTER	CARLSBAD	Short Term Acute Care	116
Grant County	GILA REGIONAL MEDICAL CENTER	SILVER CITY	Short Term Acute Care	68
Lea County	LEA REGIONAL MEDICAL CENTER	HOBBS	Short Term Acute Care	250
Lea County	NOR-LEA HOSPITAL DISTRICT	LOVINGTON	Critical Access Hospital	25
Los Alamos County	LOS ALAMOS MEDICAL CENTER	LOS ALAMOS	Short Term Acute Care	53
Luna County	MIMBRES MEMORIAL HOSPITAL	DEMING	Critical Access Hospital	49
McKinley County	REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE SERVICES	GALLUP	Short Term Acute Care	69
Otero County	GERALD CHAMPION REGIONAL MEDICAL CENTER	ALAMOGORDO	Short Term Acute Care	94
Rio Arriba County	PRESBYTERIAN ESPANOLA HOSPITAL	ESPANOLA	Short Term Acute Care	80
Roosevelt County	ROOSEVELT GENERAL HOSPITAL	PORTALES	Short Term Acute Care	22
San Miguel County	ALTA VISTA REGIONAL HOSPITAL	LAS VEGAS	Short Term Acute Care	62
Taos County	HOLY CROSS HOSPITAL A DIV OF TAOS HEALTH SYSTEMS	TAOS	Short Term Acute Care	42

NM Rural Health Program Inventory

Inventory of Key State Rural Health Programs

Overview

New Mexico has multiple programs which focus on the needs of rural underserved areas of the state. Several of these are exclusively state-funded. Others are federally-funded and coordinated by state agencies. Several of the key programs are outlined below. State-funded and state-coordinated programs are listed separately.

It should be noted that there are several health service payment programs, both federal and state, which are important for maintaining the financial viability of rural hospitals and health providers. For example, both Medicaid and Medicare provide higher rates of reimbursement to rural health clinics and federally-qualified health centers in underserved areas - many of which are rural. Medicare provides a differential payment to physicians in rural underserved areas and to Critical Access Hospitals in rural areas. These programs are not described in this section

State-Funded Activities

- **The Rural Primary Health Care Act (RPHCA) Program**:
    - **Description**: This program provides financial support for the operations of 100 community-based primary care clinic sites throughout the state ensuring the provision of basic health care. RPHCA emphasizes the provision of primary medical care, but also provides support for some dental, behavioral health and care coordination services. Many RPHCA-supported sites also receive financial support from other sources including federal grants and generated revenues. RPHCA coordinates its funding of clinical operations with these other sources. This provides substantial leverage to the impact of the state investment.
    - **Impact**: RPHCA-supported clinics reported more than 370,000 patients and over 1,100,000 primary care encounters in state fiscal year 2017 (FY17). RPHCA supported clinics provide care to both rural and urban underserved communities with the majority of sites in rural areas.
    - **Funding**: Overall RPHCA funding has declined significantly over the last several fiscal years. Appropriations for RPHCA come from both the General Fund and the County Supported Medicaid Fund (CSMF). CSMF funding derives from a statutory formula and is subject to annual budget appropriation. Unexpended CSMF balances remain dedicated to RPHCA uses. In addition to reductions in General Fund RPHCA appropriations, balances in the CSMF, originally dedicated to RPHCA purposes were transferred to the General Fund and used to respond to overall state budget shortfalls.

- **Primary Care Provider Recruitment and Retention Clearinghouse**:

    - **Description**: State funds support, under contract with New Mexico Health Resources, a clearinghouse for recruitment and retention for primary care providers in underserved and rural areas of the state.
    - **Impact**: 50 health professionals were placed in 16 counties and 21 different communities during FY17. This includes placements of medical, dental and behavioral health clinicians. In the period FY 2011 - FY 2016 the Clearinghouse made 312 permanent placements, more than 60% of which were in rural areas. The balance of placements went to community health centers in underserved urban areas.
    - **Funding**: Currently the Clearinghouse receives General Fund support for its core primary care recruitment and retention efforts. Federal and other funds supplement the core effort of the clearinghouse, providing assistance for the support of Critical Access Hospitals and the placement of specialists in shortage areas. Overall RPHCA General Fund support for the core primary care purpose of the Clearinghouse has declined over the last several fiscal years.

- **Primary Care Capital Fund (PCCF)**:

    - **Description**: The New Mexico Department of Health, in cooperation with the New Mexico Finance Authority, administers a low-interest capital loan fund for community-based primary care centers and hospices. It is a revolving fund established with an initial $6 million-dollar appropriation. All loan payments return to the fund for use in additional loans. Loan recipients can reduce the amount of their loan payments by providing services to uninsured, Medicaid and Medicare patients.
    - **Impact**: There were 10 active loans for primary care center facilities in FY17.
    - **Funding**: No new capitalization of the program has been made. Approximately 1-2 new loans are extended in each year based upon available funds accumulated through repayments. In previous years part of the PCCF balances were transferred to the General Fund and used to respond to overall state budget shortfalls.

- **New Mexico Rural Health Care Practitioner Tax Credit Program (NMRPTC)**:

    - **Description**: This program provides a state income tax credit to eligible health care providers working in rural, underserved areas. Tax credits of $5,000 per year are available to full-time doctoral level clinicians. Tax credits of $3,000 per year are available to other eligible clinicians working full-time in rural underserved areas. Tax credits of half the full award amount are available to eligible clinicians who work at least half-time in rural underserved areas. Unused tax credits can be rolled forward by participants for several years. The Department of Health reviews applications from

clinicians and issues certificates to those who meet all eligibility criteria. These certificates are filed as part of participant individual tax returns and make filers eligible for tax credits issued by the Taxation and Revenue Department.
  - **Impact**: For tax year 2016, 1,952 rural health care providers were determined eligible for the NMRPTC. All were practicing in rural areas.
  - **Funding**: Tax credits totaling over six million dollars were issued to these participants. No state operational funds are dedicated to the administration of this program. Its operation of this program is conducted with staff time assigned from other federal and state programs.

- **School-Based Health Center (SBHC) Program**:

  - **Description**: This program supports the development and operation of school-based health centers throughout the state. These centers provide comprehensive primary care and behavioral health services by using a multi-disciplinary health team.
  - **Impact**: New Mexico has more than 80 SBHCs bringing health care to where students are – in the school. SBHCs provide comprehensive health services, so students can avoid health-related absences and get support to succeed in school. Many of the health centers are located in rural areas.
  - **Funding**: SBHC program funding has declined over the last several fiscal years.

- **New Mexico Health Service Corps (NMHSC) Community Practice Site Support Program**:

  - **Description**: This program provides financial support to eligible community-based practice sites in underserved areas to support their efforts to recruit and retain clinicians.
  - **Funding**: In FY 17 there was no financial support available under this program. In previous years the NMHSC Community Practice Site Support Program made awards to multiple practice sites, the majority of which were rural.

- **New Mexico Health Service Corps (NMHSC) Stipend Program**:

  - **Description**: This program provides financial stipends to primary care providers and paramedics during their training in exchange for a commitment to work full time at approved rural, medically underserved locations upon completion of training. Eligible professionals include primary care physicians in residency, physician assistants, nurse practitioners, nurse midwives, dentists, dental hygienists and paramedics.
  - **Impact**: There are dozens of Stipend recipients in training and working in underserved locations, the majority of which are rural.

- **Funding**: NMHSC Stipend Program funding has declined over the last several fiscal years.

State Coordinated Programs

- **Primary Care Cooperative Agreement (PCO)**:

  - **Description**: This federally-funded activity supports the coordination of state primary care program activities with those of the federal Health Resources and Services Administration (HRSA). Under the PCO agreement the Office of Primary Care and Rural Health (OPCRH) of the New Mexico Department of Health works to foster collaboration, provide technical assistance, assess needs, and develop workforce in primary care shortage areas in the state. The OPCRH helps coordinate federal National Health Service Corps (NHSC) placements at primary care centers and other safety net programs in the state.
  - **Impact**: There are 203 NHSC clinicians serving at 107 sites in the state of New Mexico in FY17 – more than half of them in rural areas.
  - **Funding**: This program is funded entirely with federal support. No state matching funds are associated with its operation.

- **J-1 Visa Waiver (Conrad 30) Program**:

  - **Description**: This program allows the Department of Health (NMDOH) to recommend to the U.S. Department of State that foreign physicians be permitted to extend their residency in the United States while they practice in underserved areas of New Mexico. The NMDOH can support requests for up to 30 candidates per federal fiscal year.
  - **Impact**: More than 88 physicians were serving in New Mexico with an obligation under this program in FY 17, the majority in rural areas.
  - **Funding**: There is no funding, state or federal, attached to this program. Its operation is conducted with staff time assigned from other federal and state programs.

- **State Office of Rural Health Program (SORH:**

  - **Description:** This program supports the coordination of state rural health activities with those of HRSA. It assures effective use of federal and state resources for rural safety net agencies by strengthening state, local, and federal partnerships in rural health.
  - **Impact**: Under this program the OPCRH provided 156 in-depth technical assistance encounters to 156 clients (academic institutions, associations, clinics, hospitals, and providers) in FY17.
  - **Funding**: This effort is supported entirely with federal funding. Other state expenditures under the RPHCA Program count as a local match for the federal funding.

- **Medicare Rural Hospital Flexibility Program (FLEX**:

    - **Description**: This program supports the development of rural health care networks and the conversion of eligible rural hospitals to Critical Access Hospital (CAH) status. CAH status qualifies hospitals to receive a higher level of reimbursement from Medicare, improving their financial viability. The OPRCH helps hospitals convert to CAH status and improve operation as CAHs.
    - **Impact**: Ten New Mexico hospitals had CAH certification in FY17. All are in rural areas.
    - **Funding**: This effort is supported entirely with federal funding. No state match is required.

- **Small Rural Hospital Improvement Program (SHIP)**:

    - **Description**: This program supports improved systems development and quality management in eligible rural hospitals statewide. The OPCRH provides small financial contracts to participating hospitals to support these improvement efforts.
    - **Impact**: In New Mexico, eleven rural hospitals were participating in the program to improve operations during FY17.
    - **Funding**: This effort is supported entirely with federal funding. No state match is required. OPCRH staff supported by state and other federal programs administer this effort.

Local Rural Community Input

Priority Health Issues - Health Issues in Small Town Rural Counties

Health Issue	Councils Prioritizing Issue
Substance Abuse: reduce substance abuse	7
Food: increase availability and consumption of healthy food	5
Nutrition: improve nutrition	5
Obesity/Diabetes: reduce obesity and diabetes	5
Alcohol Abuse: reduce alcohol abuse	4
Community Capacity: improve community capacity building	4
Child and Adolescent Health: improve child and adolescent health	3
Mental Health: improve mental and behavioral health	3
Suicide: reduce suicides	3
Child Abuse: reduce child abuse/neglect	2
Health Service Access: improve access to health care including mental health	2
School Health: health education and services in schools	2
Elder Health: improve health of older adults	1
Sexual Violence: reduce sexual violence/assault	1
Social Disparities: reduce race, social and economic injustices impact on population health	1
Transportation: improve accessible transportation	1
Veterans: improve the health of veterans	1
Cancer: reduce cancer deaths	0
Healthy Lifestyles: promote healthy lifestyles	0
Housing: improve availability of safe housing	0
Maternal and Infant Health: improve maternal and infant health	0
Physician Supply: improve physician recruitment and retention	0
Prisons: improve availability of health services for the incarcerated	0
SIM: continue accountable communities initiative	0
Teen Pregnancy: reduce unwanted teen pregnancy	0
Tobacco: reduce tobacco use and its health impacts	0
Violence: reduce interpersonal violence and homicides	0

Priority Health Issues - Health Issues in Large Town Rural Counties

Health Issue	Councils Prioritizing Issue
Substance Abuse: reduce substance abuse	9
Mental Health: improve mental and behavioral health	7
Obesity/Diabetes: reduce obesity and diabetes	7
Child and Adolescent Health: improve child and adolescent health	6
Community Capacity: improve community capacity building	6
Food: increase availability and consumption of healthy food	6
Nutrition: improve nutrition	6
Alcohol Abuse: reduce alcohol abuse	5
School Health: health education and services in schools	5
Suicide: reduce suicides	3
Elder Health: improve health of older adults	2
Health Service Access: improve access to health care including mental health	2
Physician Supply: improve physician recruitment and retention	2
Social Disparities: reduce race, social and economic injustices impact on population health	2
Cancer: reduce cancer deaths	1
Child Abuse: reduce child abuse/neglect	1
Housing: improve availability of safe housing	1
Maternal and Infant Health: improve maternal and infant health	1
Prisons: improve availability of health services for the incarcerated	1
Sexual Violence: reduce sexual violence/assault	1
Teen Pregnancy: reduce unwanted teen pregnancy	1
Violence: reduce interpersonal violence and homicides	1
Healthy Lifestyles: promote healthy lifestyles	0
SIM: continue accountable communities initiative	0
Tobacco: reduce tobacco use and its health impacts	0
Transportation: improve accessible transportation	0
Veterans: improve the health of veterans	0

Priority Health Issues - Health Issues in Urban Counties

Health Issue	Councils Prioritizing Issue
Food: increase availability and consumption of healthy food	7
Alcohol Abuse: reduce alcohol abuse	4
Child and Adolescent Health: improve child and adolescent health	4
Community Capacity: improve community capacity building	4
Nutrition: improve nutrition	4
Substance Abuse: reduce substance abuse	4
Mental Health: improve mental and behavioral health	3
Obesity/Diabetes: reduce obesity and diabetes	3
Suicide: reduce suicides	3
Health Service Access: improve access to health care including mental health	2
School Health: health education and services in schools	2
Child Abuse: reduce child abuse/neglect	1
Elder Health: improve health of older adults	1
Healthy Lifestyles: promote healthy lifestyles	1
Maternal and Infant Health: improve maternal and infant health	1
Physician Supply: improve physician recruitment and retention	1
Sexual Violence: reduce sexual violence/assault	1
SIM: continue accountable communities initiative	1
Social Disparities: reduce race, social and economic injustices impact on population health	1
Tobacco: reduce tobacco use and its health impacts	1
Violence: reduce interpersonal violence and homicides	1
Cancer: reduce cancer deaths	0
Housing: improve availability of safe housing	0
Prisons: improve availability of health services for the incarcerated	0
Teen Pregnancy: reduce unwanted teen pregnancy	0
Transportation: improve accessible transportation	0
Veterans: improve the health of veterans	0

Priority Health Issues - Health Issues in Tribal Health Councils

Health Issue	Councils Prioritizing Issue
Alcohol Abuse: reduce alcohol abuse	3
Community Capacity: improve community capacity building	3
Food: increase availability and consumption of healthy food	3
Substance Abuse: reduce substance abuse	3
Child and Adolescent Health: improve child and adolescent health	2
Health Service Access: improve access to health care including mental health	2
Nutrition: improve nutrition	2
Obesity/Diabetes: reduce obesity and diabetes	2
School Health: health education and services in schools	2
Suicide: reduce suicides	2
Healthy Lifestyles: promote healthy lifestyles	1
Mental Health: improve mental and behavioral health	1
Tobacco: reduce tobacco use and its health impacts	1
Cancer: reduce cancer deaths	0
Child Abuse: reduce child abuse/neglect	0
Elder Health: improve health of older adults	0
Housing: improve availability of safe housing	0
Maternal and Infant Health: improve maternal and infant health	0
Physician Supply: improve physician recruitment and retention	0
Prisons: improve availability of health services for the incarcerated	0
Sexual Violence: reduce sexual violence/assault	0
SIM: continue accountable communities initiative	0
Social Disparities: reduce race, social and economic injustices impact on population health	0
Teen Pregnancy: reduce unwanted teen pregnancy	0
Transportation: improve accessible transportation	0
Veterans: improve the health of veterans	0
Violence: reduce interpersonal violence and homicides	0

Comparison of Top Priority Issues – Rural and Urban Counties

Top Priority Health Issues Small Town Rural Counties	
Substance Abuse	7
Food	5
Nutrition	5
Obesity/Diabetes	5
Alcohol Abuse	4
Community Capacity	4

Top Priority Health Issues Large Town Rural Counties	
Substance Abuse	9
Mental Health	7
Obesity/Diabetes	7
Child and Adolescent Health	6
Community Capacity	6
Food	6
Nutrition	6

Top Priority Health Issues Urban Counties	
Food	7
Alcohol Abuse	4
Child and Adolescent Health	4
Community Capacity	4
Nutrition	4
Substance Abuse	4
Mental Health	3
Obesity/Diabetes	3
Suicide	3

Comparison of Top Priority Issues – Regional Rural Counties

Top Priority Health Issues Southwest Rural Counties	
Food	4
Nutrition	4
Mental Health	3
Substance Abuse	3
Suicide	3
Alcohol Abuse	1
Community Capacity	1

Top Priority Health Issues Southeast Rural Counties	
Community Capacity	8
Obesity/Diabetes	6
Alcohol Abuse	5
Food	5
Nutrition	5
School Health	5

Top Priority Health Issues Northwest Rural Counties	
Substance Abuse	3
Child and Adolescent Health	2
Mental Health	2
Obesity/Diabetes	2
School Health	2
Alcohol Abuse	1
Community Capacity	1
Food	1
Nutrition	1
Physician Supply	1
Social Disparities	1
Suicide	1

Top Priority Health Issues Northeast Rural Counties	
Substance Abuse	6
Health Service Access	4
Obesity/Diabetes	4
Child and Adolescent Health	3
Mental Health	3

Final Recommendations

Rural Health Plan Recommendations: Prioritization

Instructions: Listed below are the recommendations developed by the Rural Health Plan Work Group's three committees. Please rate each recommendation, indicating your opinion of its relative importance. Check the box to the right reflecting your rating.

How would you rate the importance of each of the following rural health workforce recommendations:						
		Not at All Important	Slightly Important	Moderately Important	Very Important	Extremely Important
1	Move State Loan Repayment Program from NMHED to NMDOH.	☐	☐	☐	☐	☐
2	Provide funding to support Loan Repayment Program operations and administration.	☐	☐	☐	☐	☐
3	Expand funding for State Loan Repayment Program awards.	☐	☐	☐	☐	☐
4	Expand State Loan Repayment Program to include behavioral health professionals .	☐	☐	☐	☐	☐
5	Provide funding to support rural health professional training track.	☐	☐	☐	☐	☐
6	Implement and provide funding to support operation of the SIM integrated Hub model - including training component.	☐	☐	☐	☐	☐
7	Implement and provide funding to support a telemedicine network - including support for behavioral health.	☐	☐	☐	☐	☐
8	Expand Rural Health Care Practitioner Tax Credit Program to include additional behavioral health providers, including LISWs.	☐	☐	☐	☐	☐

How would you rate the importance of each of the following rural health systems recommendations:						
		Not at All Important	Slightly Important	Moderately Important	Very Important	Extremely Important
1	Restore Rural Primary Health Care Act Program (RPHCA) funding to previous appropriation level.	☐	☐	☐	☐	☐
2	Provide additional funding under RPHCA to support substance use disorder services.	☐	☐	☐	☐	☐
3	Provide additional funding to NMDOH to adequately support administration of RPHCA Program.	☐	☐	☐	☐	☐
4	Implement and provide funding to support a program of annual child oral health screenings and prevention services.	☐	☐	☐	☐	☐
5	Re-establish and provide funding to support the state-based, statewide 24/7 nurse advice line service.	☐	☐	☐	☐	☐
6	Update the 2013 Telehealth Parity law.	☐	☐	☐	☐	☐
7	Provide multi-year State funding for pilot programs that demonstrate effective, replicable and scalable telemedicine in rural areas.	☐	☐	☐	☐	☐
8	Establish Medicaid rates that are sufficient to ensure provider participation in the program - including reimbursement of behavioral health and dental providers.	☐	☐	☐	☐	☐
9	Provide funding to support expanded services at existing school-based health centers, including behavioral health services. Include support for telemedicine services.	☐	☐	☐	☐	☐
10	Examine and revise current RPHCA award and performance evaluation methods. Focus funding on need, quality and comprehensive services. Assure appropriate provider recruitment by contractors.	☐	☐	☐	☐	☐

How would you rate the importance of each of the following rural health improvement recommendations:						
		Not at All Important	Slightly Important	Moderately Important	Very Important	Extremely Important
1	Evaluate and revise service delivery model at co-located, publicly funded service sites such as health commons.	☐	☐	☐	☐	☐
2	Evaluate and revise the existing Public Health Office infrastructure emphasizing responses to health promotion and social system deficits.	☐	☐	☐	☐	☐
3	Create model for collaboration between HEROs, Health Promotion, Cooperative Extension Service, Health Councils, AHECs and the NMDOH. Develop formal agreement based upon this model.	☐	☐	☐	☐	☐
4	Expand the number of behavioral health investment zones to engage additional local governments in coordinated approaches to these needs.	☐	☐	☐	☐	☐

Overall Recommendation Scoring - Combined Categories

		Score
Expand State Loan Repayment Program to include behavioral health professionals.	**4.64**	**RHW**
Restore Rural Primary Health Care Act Program (RPHCA) funding to previous appropriation level.	**4.36**	**RHS**
Expand funding for State Loan Repayment Program awards.	**4.27**	**RHW**
Expand Rural Health Care Practitioner Tax Credit Program to include additional behavioral health providers, including LISWs.	**4.18**	**RHW**
Implement and provide funding to support a statewide tele-behavioral health network.	**4.09**	**RHW**
Provide additional funding under RPHCA to support substance use disorder services.	**4.09**	**RHS**
Expand the number of behavioral health investment zones and engage additional local governments in coordinated approaches to these needs.	**4.09**	**RHI**
Provide funding to support Loan Repayment Program operations and administration.	3.91	**RHW**
Establish Medicaid rates that are sufficient to ensure provider participation in the program - including reimbursement of behavioral health and dental providers.	3.91	**RHS**
Evaluate and revise the existing Public Health Office infrastructure emphasizing responses to health promotion and social system deficits.	3.82	**RHI**
Provide additional funding to NMDOH to adequately support administration of RPHCA Program.	3.73	**RHS**
Provide funding to support expanded services at existing school-based health centers, including behavioral health services. Include support for telemedicine services.	3.73	**RHS**
Examine and revise current RPHCA award and performance evaluation methods. Focus funding on need, quality and comprehensive services. Assure appropriate provider recruitment by contractors.	3.73	**RHS**
Move State Loan Repayment Program from NMHED to NMDOH.	3.55	**RHW**
Update the 2013 Telehealth Parity law.	3.55	**RHS**

Provide funding to support rural health professional training track.	3.45	**RHW**
Implement and provide funding to support a program of annual child oral health screenings and prevention services.	3.45	**RHS**
Evaluate and revise service delivery model at co-located, publicly funded service sites such as health commons.	3.45	**RHI**
Provide multi-year State funding for pilot programs that demonstrate effective, replicable and scalable telemedicine in rural areas.	3.36	**RHS**
Create model for collaboration between HEROs, Health Promotion, Cooperative Extension Service, Health Councils, AHECs and the NMDOH. Develop formal agreement based upon this model.	3.27	**RHI**
Implement and provide funding to support operation of the SIM integrated Hub model - including training component.	3.00	**RHW**
Re-establish and provide funding to support the state-based, statewide 24/7 nurse advice line service.	3.00	**RHS**

Legend	
RHW	**Rural Health Workforce**
RHS	**Rural Health Systems**
RHI	**Rural Health Improvement**

How would you rate the importance of each of the following rural health workforce recommendations?	
	Score
Expand State Loan Repayment Program to include behavioral health professionals.	4.64
Expand funding for State Loan Repayment Program awards.	4.27
Expand Rural Health Care Practitioner Tax Credit Program to include additional behavioral health providers, including LISWs.	4.18
Implement and provide funding to support a statewide tele-behavioral health network.	4.09
Provide funding to support Loan Repayment Program operations and administration.	3.91
Move State Loan Repayment Program from NMHED to NMDOH.	3.55
Provide funding to support rural health professional training track.	3.45
Implement and provide funding to support operation of the SIM integrated Hub model - including training component.	3.00

How would you rate the importance of each of the following rural health improvement recommendations?	
	Score
Expand the number of behavioral health investment zones and engage additional local governments in coordinated approaches to these needs.	4.09
Evaluate and revise the existing Public Health Office infrastructure emphasizing responses to health promotion and social system deficits.	3.82
Evaluate and revise service delivery model at co-located, publicly funded service sites such as health commons.	3.45
Create model for collaboration between HEROs, Health Promotion, Cooperative Extension Service, Health Councils, AHECs and the NMDOH. Develop formal agreement based upon this model.	3.27

How would you rate the importance of each of the following rural health systems recommendations?	
	Score
Restore Rural Primary Health Care Act Program (RPHCA) funding to previous appropriation level.	4.36
Provide additional funding under RPHCA to support substance use disorder services.	4.09
Establish Medicaid rates that are sufficient to ensure provider participation in the program - including reimbursement of behavioral health and dental providers.	3.91
Provide additional funding to NMDOH to adequately support administration of RPHCA Program.	3.73
Provide funding to support expanded services at existing school-based health centers, including behavioral health services. Include support for telemedicine services.	3.73
Examine and revise current RPHCA award and performance evaluation methods. Focus funding on need, quality and comprehensive services. Assure appropriate provider recruitment by contractors.	3.73
Update the 2013 Telehealth Parity law.	3.55
Implement and provide funding to support a program of annual child oral health screenings and prevention services.	3.45
Provide multi-year State funding for pilot programs that demonstrate effective, replicable and scalable telemedicine in rural areas.	3.36
Re-establish and provide funding to support the state-based, statewide 24/7 nurse advice line service.	3.00