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House Bill 19: Creating the NM Center for Health Workforce Analysis

The chancellor for health sciences of the University of New Mexico shall convene a health care work force work group that includes representatives of health care consumers; health care providers; organized groups representing physicians, physician assistants, nurses, nurse practitioners, dentists, dental hygienists and pharmacists; health care work force training institutions; the department of health; the public education department; the higher education department; and the boards.

The work group shall:

- A. devise an electronic survey, designed to be completed by applicants for licensure of renewal of licensure, which includes questions regarding the information required pursuant to Subsection C of Section 24-14C-5 NMSA 1978 and any other survey questions that the chancellor and the work group deem appropriate;
- B. analyze and make recommendations to the legislature regarding incentives to attract qualified individuals, including those from minority groups underrepresented among health care professions, to pursue health care education and practice in New Mexico;
- C. develop a short-term plan and a five-year plan to improve health care access, with a draft report on the plans to be submitted to the interim legislative health and human services committee by November 1, 2011. Beginning October 1, 2012, the work group shall make detailed annual reports to the legislative health and human services committee by October 1 of each year; and
- D. analyze the collected data and make recommendations to the legislature for building healthier communities and improving health outcomes.

New Mexico Health Workforce Committee
Richard Larson, Chair, Vice Chancellor HSC SOM Office of Research
Charlie Alfero, Hidalgo Medical Services
Jane Batson, Eastern NM University Roswell
Carolyn Bonham, UNM Department of Psychiatry
Britt Catron, Director of Office of Primary Care, NM Department of Health
Shauna Casaus, Board of Nursing
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Tres Schnell, NM Department of Health
Eric Spencer, Public Education Dept.
Leonard Thomas, USPHS Indian Health Service
Dale Tinker, Exec. Director, NM Pharmacy Assoc.
Birgit Trujillo
Beth Vasquez

Health Professional Licensure Data

From RLD

- Dentists (general and specialists)
- Dental Hygienists and Assistants
- Pharmacists, Pharmacy Clinicians, Pharmacy Techs
- Psychologists
- Social Workers
- Councilors and Therapists
- Nurses – NPs, RNs, LPNs (Through the BON)
- DOs
- PAs working with DOs

From DOH

- Lay Nurse Midwives
- Emergency medical personnel (Basic and Intermediate EMTs, Paramedics and Certified First Responders)
- School Counselors

From Medical Board

- Medical Doctors (primary care and specialists)
- Physician Assistants working with MDs

Data Elements:

- License location
- Licensee's age
- Licensee's gender

Center Categories of Activity

A. ELECTRONIC SURVEYS:

- i. MOUs signed with most Boards
- ii. Geographic Access Data System (GADS) data
- iii. County Health Report Cards

B. RECRUITMENT/RETENTION:

- i. Pipeline
- ii. BA/MD
- iii. HEROs, Academic Hubs
- iv. Incentives—Loan Repayment, Loan for Service, Scholarships

C. ACCESS:

- i. Address Shortages
- ii. Family Medicine
- iii. Ethnic Diversity of Workforce

D. HEALTHIER COMMUNITIES:

- i. Expand Primary Care
- ii. Addressing Social Determinants of Health and Disease
- iii. Team Care: Prim Care, MDs, RNs, Dentists, Pharms, Community Health Workers
- iv. Health-economic development multiplier

Electronic Survey Results (sample): MDs, NPs, Ethnicity, Practice Location**Licensed Physicians by County, New Mexico, 2011 (Updated 04/29/2013)**

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County	Population	Percent of Population	Number of Licensed Physicians	Percent of Licensed Physicians	Rate Per 1,000 Population
Bernalillo	670,968	32.2%	2,539	52.3%	3.78
Catron	3,733	0.2%	4	0.1%	1.07
Chaves	65,890	3.2%	113	2.3%	1.71
Cibola	27,658	1.3%	13	0.3%	0.47
Colfax	13,640	0.7%	17	0.3%	1.25
Curry	49,649	2.4%	63	1.3%	1.27
De Baca	1,945	0.1%	1	0.0%	0.51
Doña Ana	213,598	10.3%	349	7.2%	1.63
Eddy	54,152	2.6%	58	1.2%	1.07
Grant	29,380	1.4%	64	1.3%	2.18
Guadalupe	4,619	0.2%	2	0.0%	0.43
Harding	704	0.0%	1	0.0%	1.42
Hidalgo	4,861	0.2%	1	0.0%	0.21
Lea	65,423	3.1%	51	1.0%	0.78
Lincoln	20,454	1.0%	37	0.8%	1.81
Los Alamos	18,222	0.9%	58	1.2%	3.18
Luna	25,281	1.2%	25	0.5%	0.99
McKinley	73,664	3.5%	93	1.9%	1.26
Mora	4,773	0.2%	1	0.0%	0.21
Otero	65,703	3.2%	72	1.5%	1.10
Quay	9,026	0.4%	10	0.2%	1.11
Rio Arriba	40,446	1.9%	29	0.6%	0.72
Roosevelt	20,446	1.0%	11	0.2%	0.54
San Juan	128,200	6.2%	179	3.7%	1.40
San Miguel	29,301	1.4%	44	0.9%	1.50
Sandoval	134,259	6.4%	277	5.7%	2.06
Santa Fe	145,648	7.0%	589	12.1%	4.04
Sierra	11,943	0.6%	12	0.2%	1.00
Socorro	17,873	0.9%	17	0.3%	0.95
Taos	32,917	1.6%	84	1.7%	2.55
Torrance	16,345	0.8%	4	0.1%	0.24
Union	4,433	0.2%	4	0.1%	0.90
Valencia	77,070	3.7%	36	0.7%	0.47
New Mexico	2,082,224	100.0%	4,858	100.0%	2.33

Licensed Certified Nurse Practitioners by County, New Mexico, 2011

County	Population	Percent of Population	Number of Licensed Certified Nurse Practitioners	Percent of Licensed Certified Nurse Practitioners	Rate Per 1,000 Population
Bernalillo	670,968	32.2%	408	41.9%	0.61
Catron	3,733	0.2%	0	0.0%	0.00
Chaves	65,890	3.2%	27	2.8%	0.41
Cibola	27,658	1.3%	7	0.7%	0.25
Colfax	13,640	0.7%	8	0.8%	0.59
Curry	49,649	2.4%	18	1.8%	0.36
De Baca	1,945	0.1%	1	0.1%	0.51
Doña Ana	213,598	10.3%	101	10.4%	0.47
Eddy	54,152	2.6%	27	2.8%	0.50
Grant	29,380	1.4%	14	1.4%	0.48
Guadalupe	4,619	0.2%	2	0.2%	0.43
Harding	704	0.0%	1	0.1%	1.42
Hidalgo	4,861	0.2%	1	0.1%	0.21
Lea	65,423	3.1%	22	2.3%	0.34
Lincoln	20,454	1.0%	9	0.9%	0.44
Los Alamos	18,222	0.9%	8	0.8%	0.44
Luna	25,281	1.2%	10	1.0%	0.40
McKinley	73,664	3.5%	15	1.5%	0.20
Mora	4,773	0.2%	2	0.2%	0.42
Otero	65,703	3.2%	11	1.1%	0.17
Quay	9,026	0.4%	8	0.8%	0.89
Rio Arriba	40,446	1.9%	13	1.3%	0.32
Roosevelt	20,446	1.0%	5	0.5%	0.24
San Juan	128,200	6.2%	21	2.2%	0.16
San Miguel	29,301	1.4%	12	1.2%	0.41
Sandoval	134,259	6.4%	71	7.3%	0.53
Santa Fe	145,648	7.0%	85	8.7%	0.58
Sierra	11,943	0.6%	3	0.3%	0.25
Socorro	17,873	0.9%	8	0.8%	0.45
Taos	32,917	1.6%	23	2.4%	0.70
Torrance	16,345	0.8%	4	0.4%	0.24
Union	4,433	0.2%	3	0.3%	0.68
Valencia	77,070	3.7%	25	2.6%	0.32
New Mexico	2,082,224	100.0%	973	100.0%	0.47

Medical Doctors by Ethnicity, New Mexico, 2010-2012				
	Does Not Practice in New Mexico		Practice in New Mexico	
	Not Hispanic or Latino	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino
Count of Medical Doctors	2,452	197	3,586	579
Percent of Medical Doctors	92.6%	7.4%	86.1%	13.9%

New Mexico Center for Health Workforce Analysis

University of New Mexico/Health Sciences Center

Medical Doctors by Race, New Mexico, 2010-2012				
Race	Does Not Practice in New Mexico		Practice in New Mexico	
	Count	% of MDs	Count	% of MDs
American Indian or Alaska Native	28	1.1%	81	1.9%
Asian	228	8.6%	400	9.6%
Native Hawaiian or Pacific Islander	9	0.3%	21	0.5%
Black or African American	115	4.3%	131	3.1%
White	1,837	69.3%	2,918	70.1%
Other	275	10.4%	650	15.6%
Unknown	202	7.6%	59	1.4%
Total Races Selected	2,694		4,260	
Total Medical Doctors	2,649		4,165	
Note: survey requests respondents to select all races that apply; sum of percents >100%.				

Health Professional Shortages in Lea County

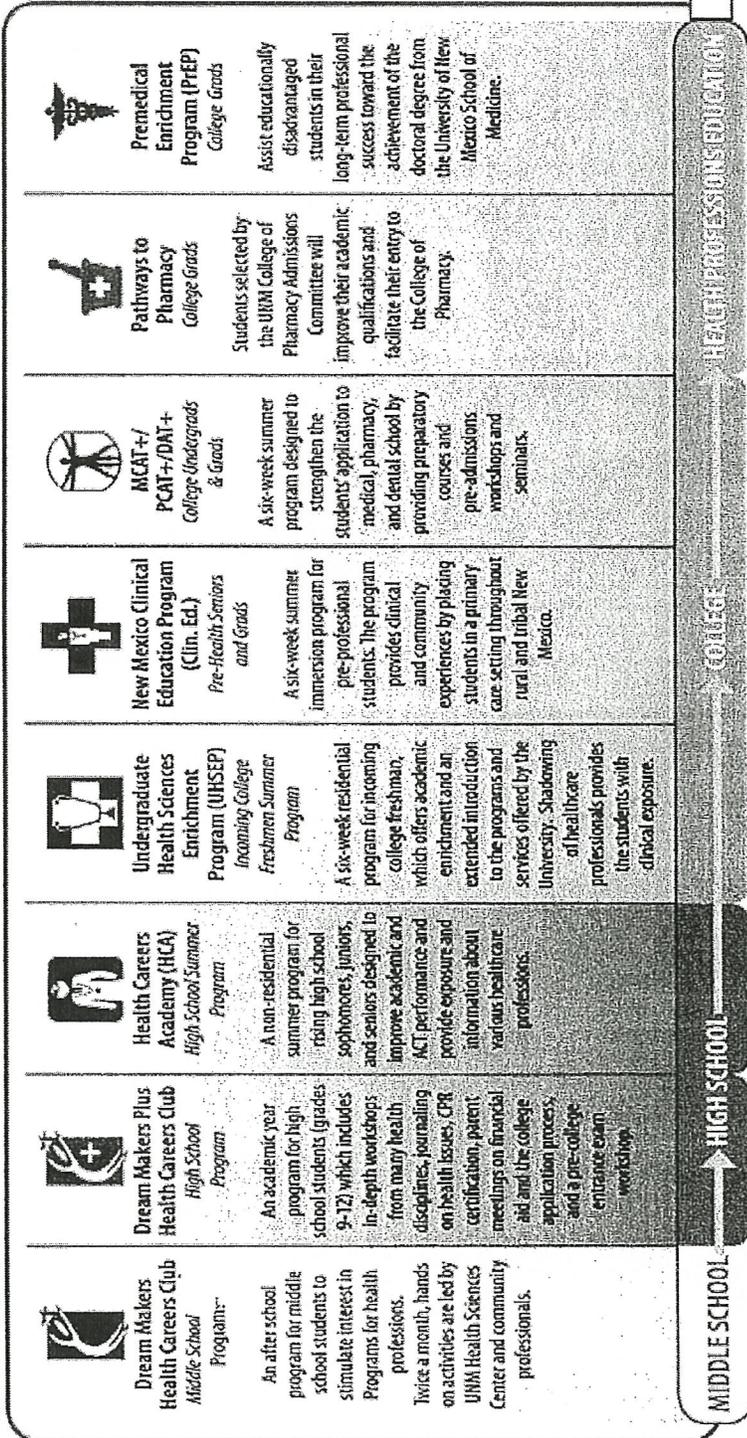
County Health Report Card: **5** Workforce Data Lea County

	Estimated # of Hlth Professionals Needed per Population	Licensed Health Professional Residing in Lea County	Provider Gap
Physicians	108	60	48
Nurse Practitioners	54	17	37
Pharmacists	46		46
Physician Assistants	54	6	48
Occup. Therapists			
Physical Therapists	22	15	7
Dentists	39	7	32
Registered Nurses	466	379	87
LPNs		144	
Cert. Nur. Midwives			
Licensed Midwives			



H.E.A.L.T.H. NM

Hope, Enrichment, And Learning Transform Health in NM



RECIPROCAL INFORMATION CORRIDORS

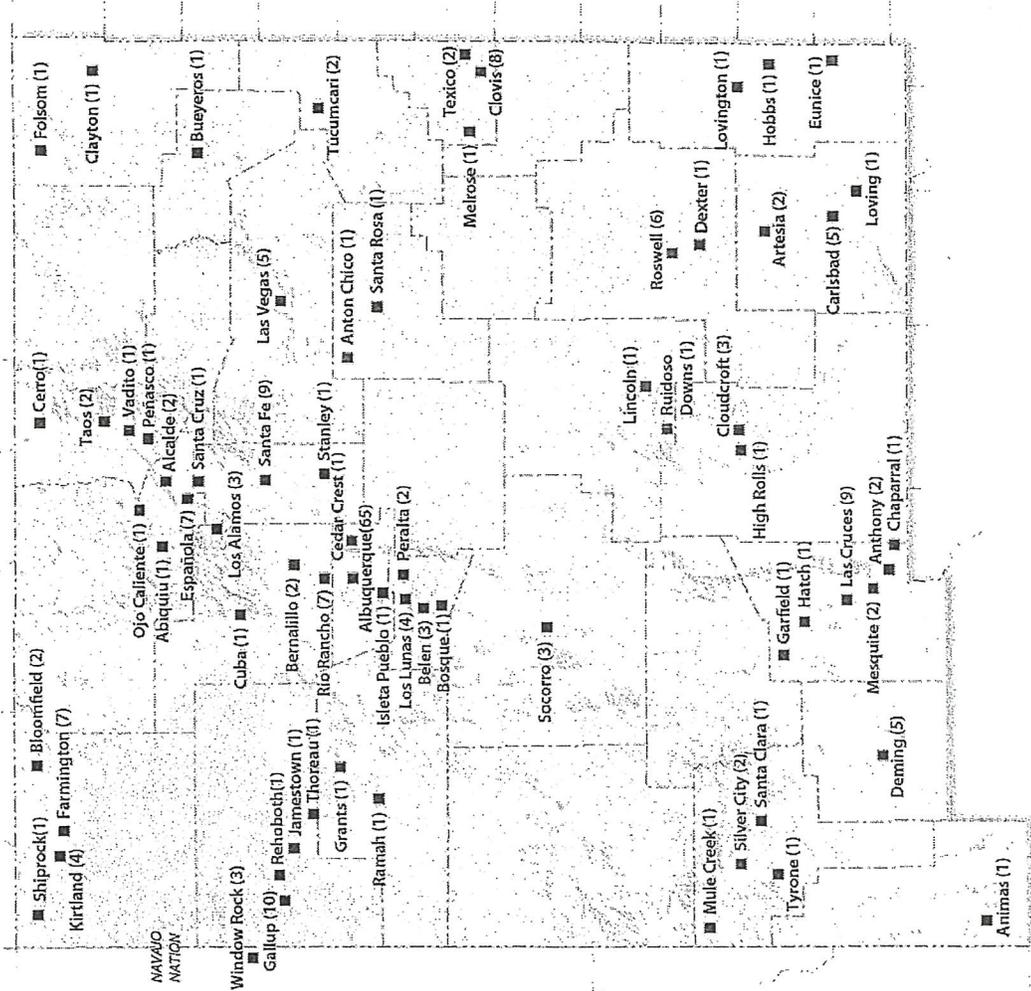
Information about Health and Education Knowledge Flows from Program Instructors, Sponsors, Community Partners to → Educational Pipeline Students to → Their Families, Especially their Moms → Feedback to Program

Pipeline: BA/MD

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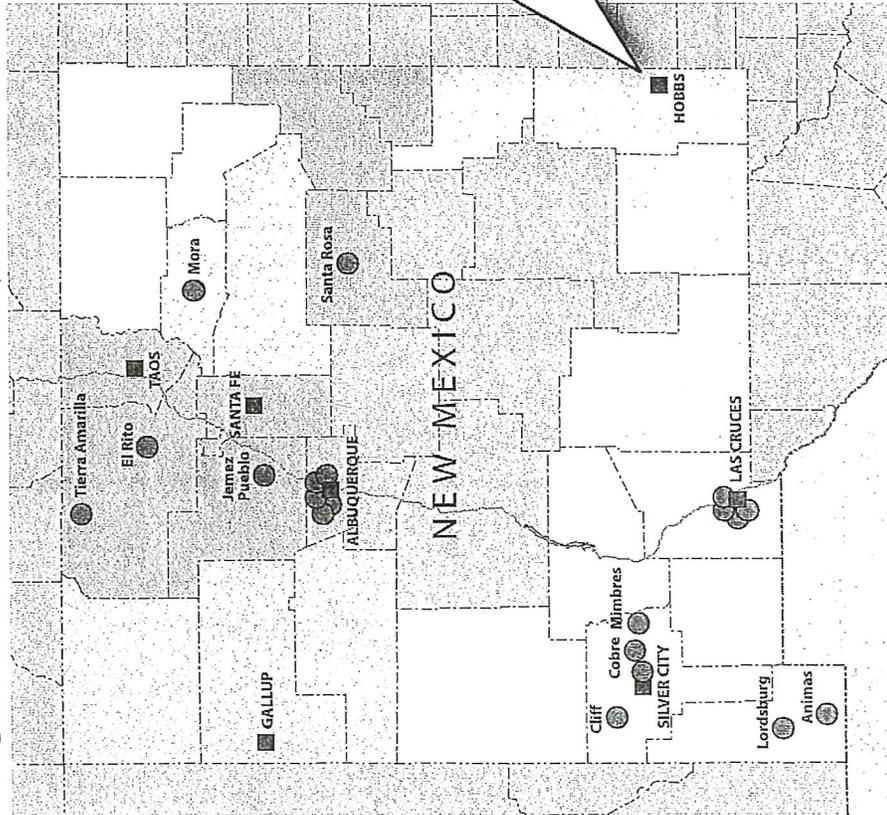


Combined BA/MD Program 2006-2013 Entry Class



Existing UNM HSC Health Extension Hubs

IMPACT-enrolled practice



Components of a UNM HSC Health Extension Hub

UNM HSC Resources
 Medical Library, Patient Records System Access, AHECs, Locum Tenens, Telehealth, CME, Physician Access Line Service, PBRN, Preceptorship

Local Community Resources
 Educational Institutions, Community Hospitals, Civic Organizations, FQHCs, and County Health Councils

HERO
 Health Extension Coordinators

External Partner Resources

Aligning Forces for Quality, Envision NM, HMS Center for Health Innovation/Natl. Ctr. for Frontier Communities, NM HIE and HITREC, Nurse Advice Line, NM, NM Primary Care Association, NM/DOH, NM/HSD, Medicaid MCOs

IMPACT-Enrolled Practices

HERO / ACADEMIC HUBS

Primary Care Shortage

- 40.5% of New Mexico's population lives in a Primary Care Health Professional Shortage Area
 - vs. 19.1% nationally
- Needed to remove shortage designation: +125
- Needed to achieve target ratio: (3000:1): 254



Nursing

- 19,685 registered nurses in New Mexico
- 740 per 100,000 population
 - 874 is U.S. ratio
- Need 2,325 additional nurses to meet U.S. average
- High demand counties (based on additional need):
 - >100: Rio Arriba, McKinley, Lea, San Juan and Cibola
 - >50: Luna, Valencia, Socorro, Roosevelt, Otero and Torrance
 - >20: Curry, Chaves, Hidalgo, Sierra and Quay



Dentists

- 978 licensed dentists in New Mexico

Specialty	Count
General Dentistry	851
Orthodontics	21
Oral and Maxillofacial Surgery	15
Prosthodontics	1
Other Specialties	26
Unknown Specialties	64

- 155 more dentists needed to meet target ratios
- Counties needing 10+ additional: Lea, Rio Arriba, Otero and McKinley



Family Medicine Residency re: Rural Workforce Data

As of 2013

- 76 FM residents in 3-years of training: ½ in the ABQ program, ½ in the 3 Rural Residency programs--Las Cruces, Santa Fe, and Roswell
- Silver City approved as 1+2 Residency and state's first Teaching Community Health Center
- Roswell program will end when Silver City begins June, 2013

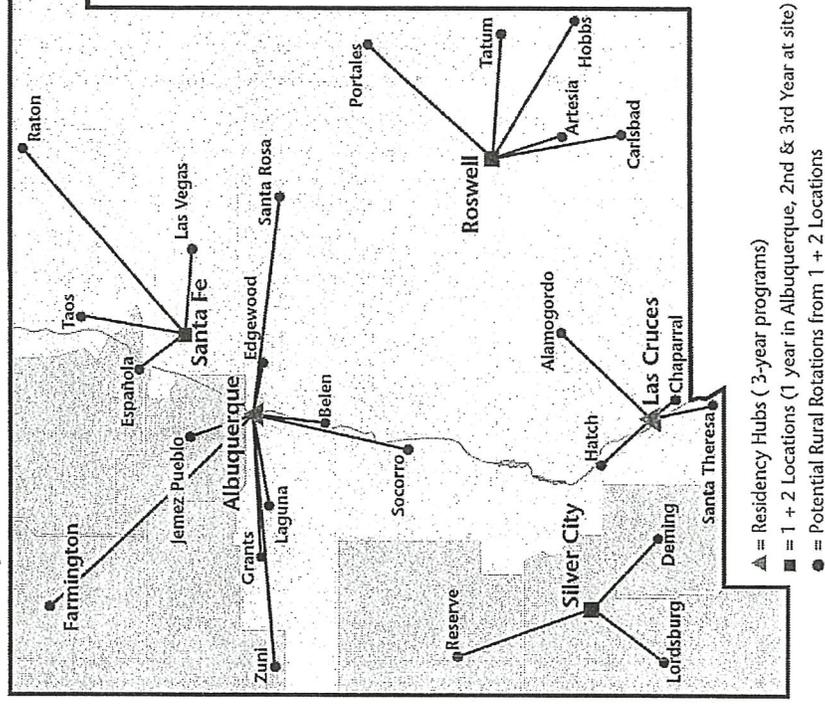
Outcomes

- >80% grads stay in NM
- ~70% of 3 Rural Residency grads practice in rural NM
- (until 2011) ~25% of ABQ Residency grads practice in rural NM
- (after 2011, all ABQ residents had mandatory rural blocks) 50% of 2012 and 2013 grads 11/22 now practicing in rural NM
 - a) 7 in rural, non-I.H.S. sites: Santa Rosa, Silver City, Las Vegas, Belen, Edgewood, Bernalillo
 - b) 4 in rural I.H.S. sites: Zuni, Crownpoint, Ft. Defiance)

FM resident Outcomes, Plans

- 76 Residents, half in ABQ, half in rural NM
- 25% of ABQ grads work in rural NM
- 70% of rural NM grads for in rural NM

Existing and Potential Training Locations for Family Medicine Residents in New Mexico





From the Association
of Departments of Family Medicine

Ann Fam Med 2005;3:000. DOI: 10.1370/afm.000.

SERVING NATIVE AMERICAN COMMUNITIES

Academic departments have a shared purpose to better serve the local community, to bring diversity to our experience in training sites, and reflect the diversity of those who reside in our states. Nowhere is that mission better demonstrated than in the departments of family medicine based in states with large Native American populations. These departments have developed innovative programs to reach and collaborate with members of their Native American communities.

The University of North Dakota (UND) School of Medicine and Health Sciences Department of Family Medicine has residency programs in Bismarck and Minot involved with their local reservations. Faculty and residents from Minot travel weekly to provide maternity and women's health services to the Fort Berthold area. Both residency groups provide inpatient services at their main teaching hospitals. Several of the residents have gone on to work in these sites, which is one goal of the program. In addition, medical students have family medicine clinical experiences on the reservations at Indian Health Service (IHS) sites. Similarly, the physician's assistant (PA) program is working to attract students from the Native populations, enhance the PA student training in cultural issues, and improve care to Native American elders through a cooperative educational program with local elders.

The university regularly admits 7 Native American students yearly through the Indians into Medicine (INMED) Program; 5 students stay in North Dakota, and 2 go to the University of South Dakota (USD) for their clinical education. UND is also the recipient of a telemedicine grant to develop an annual eye screening program for Native Americans with diabetes.

The University of New Mexico Department of Family and Community Medicine has a long-standing commitment to serving Indian people. Three of the 5 founding department faculty worked in the Indian Health Service, and today, of the 46 faculty in the department, 28% have worked or are working with the IHS and 4 (9%) are American Indian. Strong links have been established between the Department and the Albuquerque IHS, including faculty appointments for the IHS physicians. Department faculty provide health services in rural and urban Indian communities,

faculty and residents admit referred Indian patients to the department's inpatient service, and residents train in IHS facilities.

Since 1998, 2 of 18 family medicine residents at New Mexico admitted each year are allowed to select the Albuquerque Indian Hospital for their required 3-year continuity clinic. A review of the outcome of this residency "track" shows that, of the 13 residents who have graduated after 3 years of continuity clinic training at the IHS, 7 (54%) were American Indian, 9 (69%) currently work in IHS, tribal, or urban Indian settings, and 4 (31%) work in non-Indian, underserved rural, urban or migrant health centers. Family medicine residency training in Native Indian communities has benefits for the Indian communities in terms of service, benefits for IHS in terms of recruitment of a stable health workforce, and benefits for the residency in terms of unique educational opportunities.

Finally, the USD School of Medicine and Health Sciences Department of Family Medicine has a central focus of reducing health disparities, especially for the American Indian population. This work is done through medical student rotations in preventive medicine, obstetrics-gynecology, and community health at IHS clinics and hospitals, medical student research projects addressing tribal and IHS priorities, faculty research and service grants/contracts with tribes, and an epidemiology contract through the Center for Rural Health Improvement with the Aberdeen Area Indian Health Service. Medical student projects include helping a tribe develop its own cancer plan, conducting a research survey of IHS provider screening habits and training needs for domestic violence, and a follow-up project the next year that provides ACOG domestic violence screening training CME to IHS providers. Department faculty and residents provide community lectures on educational opportunities in medicine and the health sciences to students in the communities where they work.

Like politics, health care is inherently a local issue, and the needs and concerns of local groups are as varied as the groups themselves. Academic departments must adapt to the local environment, build on local strengths, and respond to local needs. The programs described here represent only a small part of the diversity of departmental programs, but they are models of how departments have responded to their local conditions and built programs and systems that reach out to, collaborate with, and help those we seek to serve.

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The Impact on Rural New Mexico of a Family Medicine Residency

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Abstract

Purpose

To determine the impact on rural New Mexico of the large, decentralized University of New Mexico (UNM) family medicine residency.

Method

A cross-sectional study was conducted of all 317 residency's graduates from 1974 to 2004. Location of current practice was correlated with the residents' gender, ethnicity, medical school of origin, and whether most training took place in the urban program or one of three rural programs. The residency's impact on rural communities was assessed.

Results

There was no significant gender difference between graduates who went into urban or rural practice. Compared with nonminority graduates, a significantly greater percentage of ethnic minority graduates were in rural and urban New Mexico practices and fewer in out-of-state practices. A greater percentage of graduates who had been medical students in New Mexico practiced in both rural and urban New Mexico areas compared with graduates of out of state medical schools. Finally, a greater percentage of graduates from the three rural family medicine residencies remained in the state and practiced in rural areas compared with

graduates from the urban program. The graduates' contributions to the school of medicine and to rural New Mexico are described.

Conclusions

Graduates of UNM's family medicine residency have contributed significantly to the state's rural health workforce. Ethnic minority status, graduation from New Mexico's medical school, and training in one of the three rurally based residencies favored in-state and rural retention, while gender had no significant effect. The rural orientation of the residencies offered rural communities economic benefits.

Acad Med. 2005; 80:739-744.

The United States faces a growing shortage of physicians, and this shortage is more acute in rural areas.¹ In those areas, compared with urban areas, access to care is more limited, populations are sicker, physician and hospital reimbursements are lower, and barriers to retention of the health workforce are greater.² While the nation's rural population is growing, prospects for an adequate rural health workforce are threatened by a rapidly falling intake of rural applicants to medical school,³ reducing the likelihood that graduates will ultimately seek rural practice.

New Mexico is the fifth largest state and is sparsely populated. Sixty percent of its 1.8 million residents live in rural counties, where only 40% of the state's health workforce practices. While the

state is enriched by its cultural diversity (a little over half of its population are members of ethnic minorities—40% Latino, 10% Native American, and 2% African American), this diversity challenges the health care system to address the linguistic and cultural factors that can create barriers to adequate services. The state is poor, with one of the highest rates of medically uninsured (25.6% under age 65 years), and with 29 of its 33 counties designated as U.S. Health Professions Shortage Areas. The New Mexico Department of Health reports substantial disparities in health by ethnicity, with Latinos, Native Americans, and African Americans having lower immunization rates, more instances of delayed prenatal care, and higher rates of teen pregnancy, hepatitis C, and violent death.⁴

An accessible primary health care system decreases the adverse influence of economic disparities on the health of the poor, especially in communities where economic disparities are great.⁵ This finding is especially relevant to states like New Mexico with wide health and economic disparities. An inadequate

supply of rural primary care physicians in the state exacerbates inequities in health status among its diverse populations. Finally, the economies of rural communities in New Mexico are fragile. The ability to attract and retain physicians is economically critical to these communities, allowing them to keep their hospitals open, create health-related jobs, and thereby attract businesses and retirees to settle there.⁶⁻⁸

New Mexico has only one medical school, and all family medicine training programs in the state are affiliated with it. Since 1974, the University of New Mexico (UNM) School of Medicine's Department of Family and Community Medicine has attempted to address rural health care access by implementing community-based educational strategies for medical students.^{9,10} In parallel, the department has been working with its legislative and community partners to fashion a family medicine residency that addresses the health needs of rural New Mexicans. The residency has implemented four strategies to address these needs:

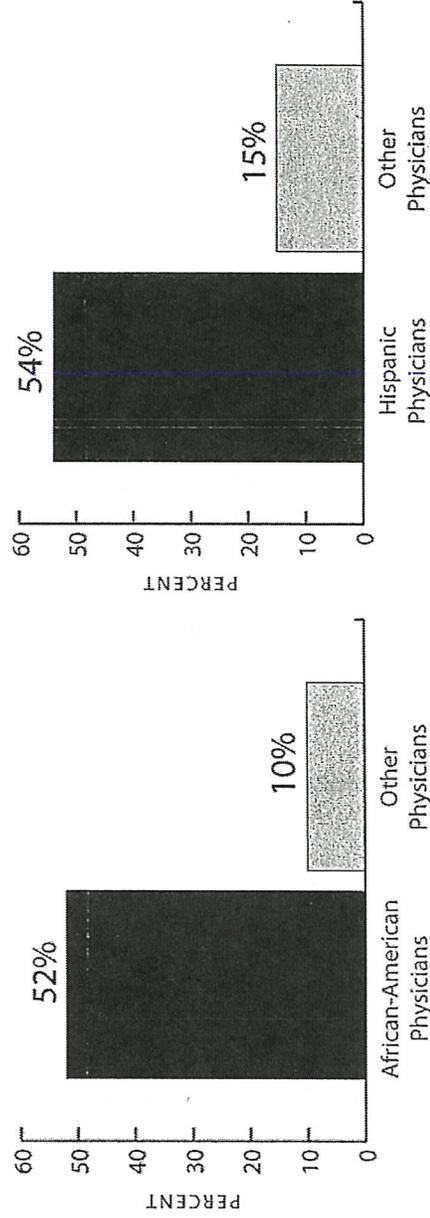
Please see the end of this report for information about the authors.

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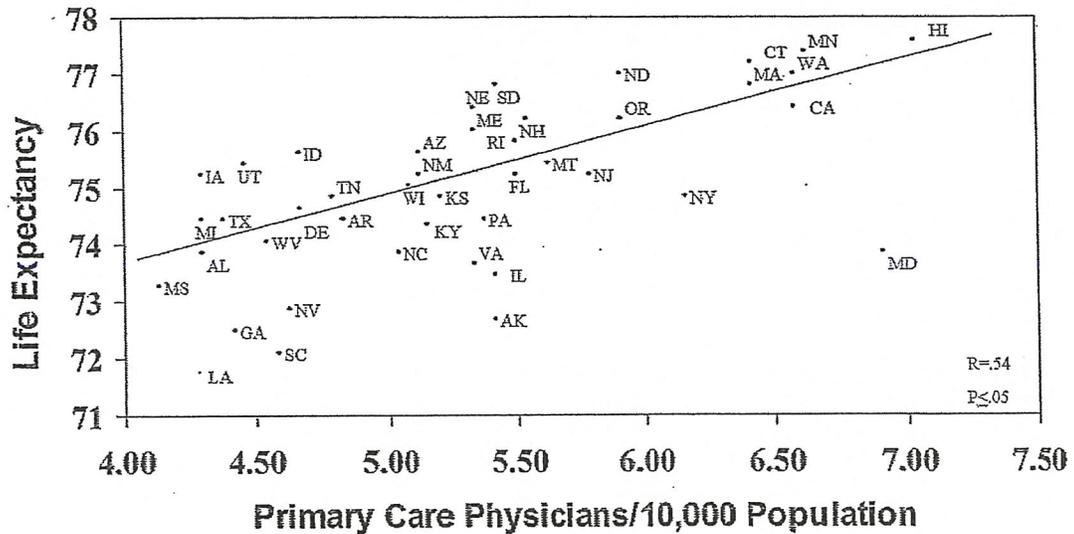
Access and Ethnicity

- Population is becoming more ethnically diverse
- But U.S. medical students from more upper income families
- Impact of ethnicity on access:

Likelihood of African-American or Hispanic Physicians to Treat Patients of the Same Race or Ethnicity



State Level Analysis: Primary Care and Life Expectancy



Source: Shi et al, J Fam Pract 1999; 48:275-84.

Starfield 07/07
WCUS 3766 n

In the United States, an increase of 1 primary care doctor is associated with 1.44 fewer deaths per 10,000 population.

The association of primary care with decreased mortality is greater in the African-American population than in the white population.

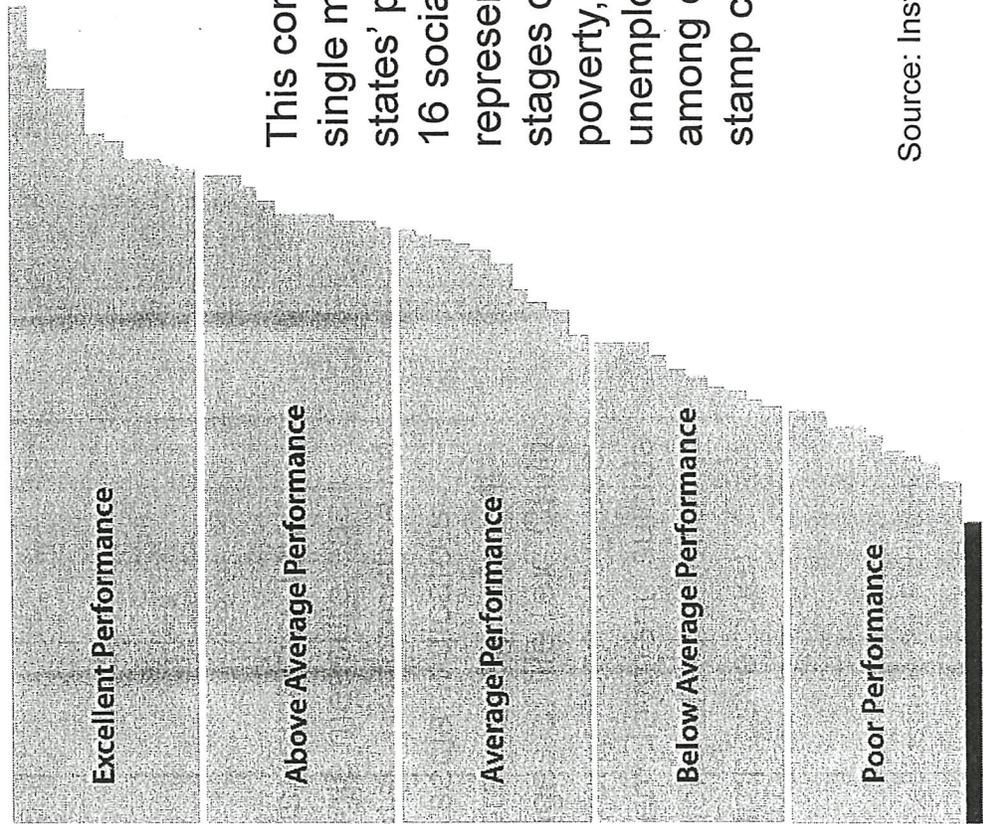
Quality Care is Not Enough ex. Diabetes in Native Americans

- Recommended Preventive Services:
 - Native Americans have best rates
- Deaths from Diabetes:
 - Native Americans have highest rates

New Mexico Dept of Health 2010 Report on Ethnic
Disparities in Health



The Social Health of the Fifty States: Where is New Mexico?



This combines in a single measure each states' performance on 16 social indicators representing different stages of life (ex. Child poverty, teen drug use, unemployment, suicide among elderly, food stamp coverage)

Source: Institute for Public Health



CASE STUDY

The Health Commons and Care of New Mexico's Uninsured

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Conflicts of interest: none reported

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ABSTRACT

PURPOSE A seamless system of social, behavioral, and medical services for the uninsured was created to address the social determinants of disease, reduce health disparities, and foster local economic development in 2 inner-city neighborhoods and 2 rural counties in New Mexico.

METHODS Our family medicine department helped urban and rural communities that had large uninsured, minority populations create Health Commons models. These models of care are characterized by health planning shared by community stakeholders; 1-stop shopping for medical, behavioral, and social services; employment of community health workers bridging the clinic and the community; and job creation.

RESULTS Outcomes of the Health Commons included creation of a Web-based assignment of uninsured emergency department patients to primary care homes; reducing return visits by 31%; creation of a Web-based interface allowing partner organizations with incompatible information systems to share medical information; and creation of a statewide telephone Health Advice Line offering rural and urban uninsured individuals access to health and social service information and referrals 24 hours a day, 7 days a week. The Health Commons created jobs and has been sustained by attracting local investment and external public and private funding for its products. Our department's role in developing the Health Commons helped the academic health center (AHC) form mutually beneficial community partnerships with surrounding and distant urban and rural communities.

CONCLUSIONS Broad stakeholder participation built trust and investment in the Health Commons, expanding services for the uninsured. This participation also fostered marketable innovations applicable to all Health Commons' sites. Family medicine can promote the Health Commons as a venue for linking complementary strengths of the AHC and the community, while addressing the unique needs of each. Overall, our experience suggests that family medicine can play a leadership role in building collaborative approaches to seemingly intractable health problems among the uninsured, benefiting not only the community, but also the AHC.

Ann Fam Med 2006;4(Suppl 1):S22-S27. DOI: 10.1370/afm.539.

INTRODUCTION

Intractable health problems in our society, such as health disparities between economic and ethnic groups, poor access to care, and alarming increases in uninsured populations, have as their root cause social determinants.¹ The Health Commons is a conceptual model developed by the University of New Mexico (UNM) Department of Family and Community Medicine (the Department) in collaboration with its safety net stakeholders. This model attempts to address social determinants through integration and collaboration among many community stakeholders, pooling resources to address community-prioritized health needs. Funded by the W.K. Kellogg Foundation and the Health

NM Center for Health Workforce Analysis: Sample Requests

- Nursing: projected need for each field of nursing (Doctorate, Masters, NP, CNW, Bachelors, LPN) per county
- Nursing: projected supply for each health profession from each University, Branch Campus, Community College, Tribal College
- Pharmacy: projected need per county, projected supply
- DOH--County: current workforce, projected need, projected capacity
- Analysis of factors favoring health professions graduates recruitment into most needed health fields in most needed geographic areas (ex. high school, college, venue of learning, ethnicity, socioeconomic background)
- Analysis of factors favoring retention in state, retention in most needed geographic areas
- What are national and state benchmarks for “adequate” supply and geographic distribution of primary care and specialty physicians?
- What is projected impact on health services demand of Affordable Care Act, of Team-Based Care, of investment in prevention?

CENTER NEEDS:

- i. HB 19 moving health workforce data from DOH to UNM HSC came with a mandate but without funding
- ii. Requests keep growing from different interested parties for Health Workforce Reports, projections re: needs per county, needs per tribe, supply from each higher ed institutions, the Center is only able to address ~ 25%
- iii. Faculty/Staff time reallocated to collect and analyze the data, generate reports to the state legislature as per HB 19
- iv. 2015 UNM HSC legislative priority request is for \$265,000 to support staffing for the Center to fulfill its broader role in NM (Still working way through UNM system)

HSC Legislative Requests FY15

Center for Health Workforce Analysis: \$265,000

Signed by the Governor in February 2012, the Health Care Workforce Data Collection, Analysis, and Policy Act authorized the transfer of health professional licensure and survey data from the Department of Health to the UNM Health Sciences Center.

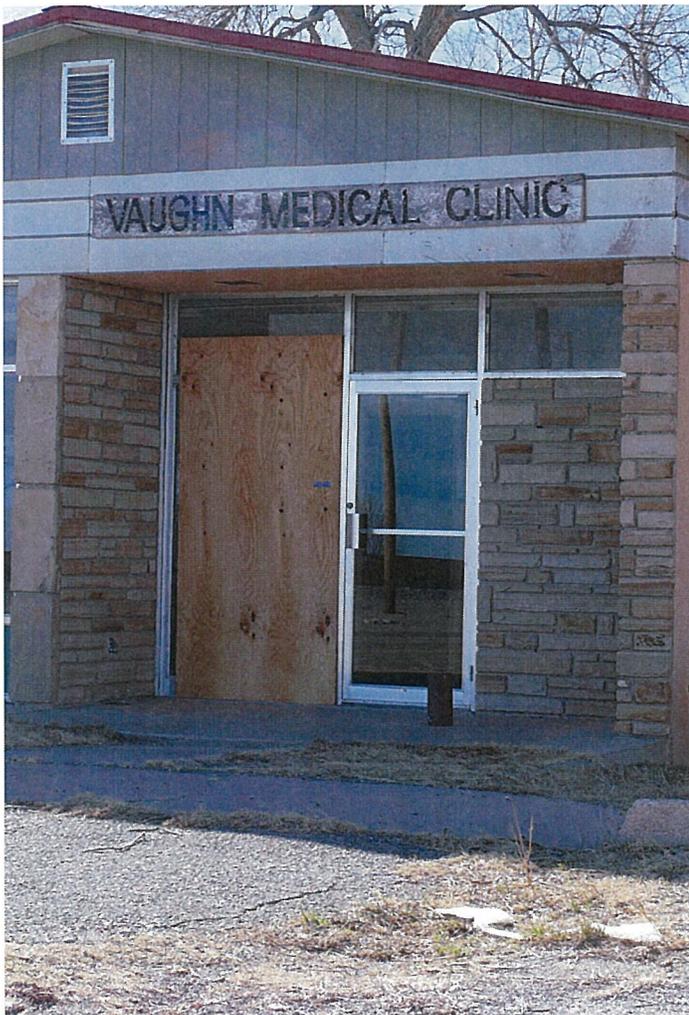
The creation of a Center for Health Workforce Analysis (Center) is an important opportunity to address NM's health care needs. By locating the Center within the state's largest health professions education programs, the state is leveraging the unique position of the HSC. Increasing the health workforce in needed areas of the state will lower the cost of care by improving the overall health of the population. Maintaining a healthy workforce has an

economic benefit to local businesses. Communities see economic benefit as well — each added physician brings \$1 million in business per year, while hiring 18 people directly or indirectly.

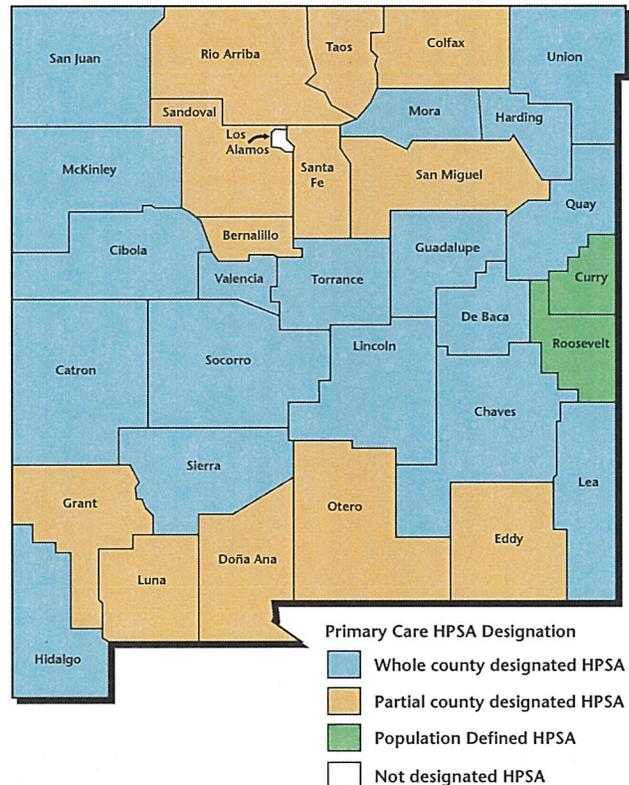
The Center has a reporting function — providing information to legislators and other stakeholders. It also has a workforce policy development function within UNM HSC and higher education.

- In order to be operational under the provisions of the Act, we are proposing the Center be staffed including database and software expenses.*

* This request is still going through UNM's internal process and not an official request at this time.



2009 DATA
New Mexico Health Professional Shortage Areas:
Primary Care Professionals



Source: US Dept. of Health and Human Services, HRSA, Bureau of Health Professions/National Center for Health Workforce Analysis (Does not include FQHC and Certified Rural Health Clinics)