



# THE HEALTH CARE WORKFORCE IN EIGHT STATES: EDUCATION, PRACTICE AND POLICY

Spring 2002

## NEW MEXICO

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# **The Health Care Workforce in Eight States: Education, Practice and Policy**

## **PROJECT DESCRIPTION**

Historically, both federal and state governments have had a role in developing policy to shape the health care workforce. The need for government involvement in this area persists as the private market typically fails to distribute the health workforce to medically underserved and uninsured areas, provide adequate information and analysis on the nature of the workforce, improve the racial and ethnic cultural diversity and cultural competence of the workforce, promote adequate dental health of children, and assess the quality of education and practice.

It is widely agreed that the greatest opportunities for influencing the various environments affecting the health workforce lie within state governments. States are the key actors in shaping these environments, as they are responsible for:

- financing and governing health professions education;
- licensing and regulating health professions practice and private health insurance;
- purchasing services and paying providers under the Medicaid program; and
- designing a variety of subsidy and regulatory programs providing incentives for health professionals to choose certain specialties and practice locations.

Key decision-makers in workforce policy within states and the federal government are eager to learn from each other. This initiative to compile in-depth assessments of the health workforce in 8 states is an important means of insuring that states and the federal government are able to effectively share information on various state workforce data, issues, influences and policies.

Products of this study include individual health workforce assessments for each of the eight states and a single assessment that compares various data and influences across the eight states. In general, each state assessment provides the following:

- 1) A summary of health workforce data, available resources and a description of the extent the state invests in collecting workforce data. [Part of this information has been provided by the Bureau of Health Professions];
- 2) A description of various issues and influences affecting the health workforce, including the state's legislative and regulatory history and its current programs, financing and policies affecting health professions education, service placement and reimbursement, planning and monitoring, and licensure/regulation;
- 3) An assessment of the state's internal capacity and existing strategies for addressing the above workforce issues and influences; and
- 4) An analysis of the policy implications of the state's current workforce data, issues, capacity and strategies.

The development of the project's data assimilation strategy, content and structure was guided by an expert advisory panel. Members of the advisory panel included both experts in state workforce policy (i.e., workforce planners, researchers and educators) and, more broadly, influential state health policymakers (i.e., state legislative staff, health department officials). The advisory panel has helped to ensure the workforce assessments have an appropriate content and effective format for dissemination and use by both state policymakers and workforce experts/officials.

# STUDY METHODOLOGY

## Study Purpose and Audience

Key decision-makers in workforce policy within states and the federal government are eager to learn from each other. Because states increasingly are being looked to by the federal government and others as proving grounds for successful health care reform initiatives, new and dynamic mechanisms for sharing innovative and effective state workforce strategies between states and with the federal government must be implemented in a more frequent and far reaching manner. This initiative to compile comprehensive capacity assessments of the health workforce in 8 states is an important means of insuring that states and the federal government are able to effectively share information on various state workforce data, issues and influences.

Each state workforce assessment report is not intended to be voluminous; rather, information is presented in a concise, easy-to-read format that is clearly applicable and easily digestible by busy state policymakers as well as by workforce planners, researchers, educators and regulators.

## Selection of States

NCSL, with input from HRSA staff, developed a methodology for identifying and selecting 8 states to assess their health workforce capacity. The methodology included, but was not limited to, using the following criteria:

- a. States with limited as well as substantial involvement in one or more of the following areas: statewide health workforce planning, monitoring, policymaking and research;
- b. States with presence of unique or especially challenging health workforce concerns or issues requiring policy attention;
- c. States with little involvement in assessing health workforce capacity despite the presence of unique or especially challenging health workforce concerns or issues requiring policy attention;
- d. Distribution of states across Department of Health and Human Services regions;
- e. States with Bureau of Health Professions (BHP) - supported centers for health workforce research and distribution studies;
- f. States with primarily urban and primarily rural health workforce requirements; and
- g. States in attendance at BHP workforce planning workshops or states that generally have interest in workforce modeling.

## Collection of Data

NCSL used various means of collecting information for this study. Methods exercised included:

- a. Phone and mail interviews with state higher education, professions regulation, and recruitment/retention program officials;
- b. Custom data tabulations by national professional trade associations and others (i.e., Quality Resource Systems, Inc.; Johns Hopkins University School of Public Health) with access to national data bases;
- c. Tabulations of data from the most recent edition of federal and state government databases (e.g., National Health Service Corps field strength);
- d. Site visit interviews with various officials in the ten profile states;
- e. Personal phone conversations with other various state and federal government officials;
- f. Most recently available secondary data sources from printed and online reports, journal articles, etc.; and
- g. Comments and guidance from members of the study's expert advisory panel.

## STATE SUMMARY

New Mexico is a predominantly rural state with over half of its population of minority or ethnic origin. About a quarter of the state's population are uninsured, a proportion that is nearly twice the national average and is growing.

New Mexico has major problems in the supply and distribution of its health care workforce. One-third of the population resides in a primary care health professional shortage area (HPSA), and the proportion of residents that live in a dental HPSA is nearly three times the national average. Just three New Mexico counties are not designated as a HPSA. The ratio of National Health Service Corps personnel per 10,000 population living in HPSAs is over twice the U.S. average. New Mexico's overall ratios of physicians, nurses, dentists and pharmacists per 100,000 population each are significantly below the national average. The state has one medical school and one pharmacy school, and no dental school. There are just 15 schools of nursing in New Mexico.

Despite evidence that the state has a significant health workforce shortage, few extraordinary efforts have been undertaken to address the problem with major results. In June 2001, the Secretary of Health convened a working forum of over 125 persons to develop comprehensive consensus strategies to improve New Mexico's health care system with a particular emphasis on workforce issues. The forum identified key issues, brainstormed potential solutions and outlined various programmatic and legislative recommendations. Quarterly workgroup meetings on such topics as financing, training and licensing were planned.

Over the years, the state has implemented various recruitment and retention strategies for physicians, nurses, physician assistants and other health professions practicing primary care in medically underserved rural areas, including several small scholarship and loan programs and a few special grant initiatives. The University of New Mexico Health Sciences Center has also operated for several years a physician relief or *locum tenens* support program for primary care physicians practicing in rural areas. These programs generally receive high marks from state officials for their effectiveness. However, such impact is limited, due to their small size.

The proportion of graduates of New Mexico's one publicly funded medical school going into primary care is much larger than the national average. Nearly a fifth of graduates enter a family medicine residency program. However, a proportion significantly less than the national average chose a family practice residency within the state. Despite the fact that over 97 percent of newly entering medical students are state residents, less than 30 percent of the state's practicing physicians completed their medical school and graduate medical education in-state.

By 2001, the legislative acknowledged the existence of a nursing workforce crisis in New Mexico. A 2001 study by the Consortium for Nursing Workforce Development provided clear evidence of changing nursing supply and demand trends across the state, showing a 18 percent shortage of registered nurses and over 1000 vacancies for nurses in hospitals statewide. Nurses in public health settings particularly are in short supply.

Efforts to increase the supply of dentists are problematic. Although New Mexico currently buys slots in six area state dental schools at the states' in-state tuition rates and graduates have an obligation to return to New Mexico to practice, there is a clear lack of interest by young persons in the state in becoming dentists. The state has just one (new) dental residency program that operates with limited funding. Reciprocity of license for dentists from other states interested in working in New Mexico is viewed as quite restrictive. The state only recently has begun to operate a dental loan repayment program to encourage graduating dentists to practice in the state's underserved communities. Much of the attention to dental education is focused on dental hygiene programs with many such programs struggling to stay open.

# I. WORKFORCE SUPPLY AND DEMAND

Arguably, it is most important initially to understand the marketplace for a state's health care workforce. How many health professionals are in practice statewide and in medically underserved communities? What are the demographics of the population served? How is health care organized and paid for in the state? This section attempts to answer some of these questions by presenting state-level data collected from various sources.

**Table I-a.**

POPULATION		NM	U.S.
Total Population (2000)		<b>1,819,046</b>	281,421,906
Sex (2000)	% Female	<b>50.8</b>	50.9
	% Male	<b>49.2</b>	49.1
Age (2000)	% less than 18	<b>28.0</b>	25.7
	% 18-64	<b>60.3</b>	61.9
	% 65 or over	<b>11.7</b>	12.4
% Minority/Ethnic (1997-1999)		<b>55.5</b>	29.1
% Metropolitan (2000)*		<b>56.9</b>	79.9

\* As defined by the U.S. Office of Management and Budget

Sources: U.S. Census Bureau, AARP.

**More than half of New Mexico's population are minorities and just under half live in non-metropolitan areas.**

**Table I-b.**

PROFESSION UTILIZATION	NM	U.S.
% Adults who Reported Having Routine Physical Exam Within Past Two Years (1997)	<b>79.9</b>	83.2 (Median)
Average # of Retail Prescription Drugs per Resident (1999)	<b>7.6</b>	9.8
% Adults who Made Dental Visit in Preceding Year by Annual Family Income (1999):		
Less than \$15,000	<b>45</b>	
\$15,000 - \$34,999	<b>63</b>	
\$ 35,000 or more	<b>77</b>	

Sources: CDC, AARP, GAO.

**Less than half of New Mexico adults with an annual family income under \$15,000 visited a dentist in 1999.**

**Table I-c.**

<b>ACCESS TO CARE</b>		<b>NM</b>	<b>U.S.</b>
% Non-elderly (under age 65) Without Health Insurance	1999-2000	<b>27</b>	16.0
	1997-1999	<b>26</b>	18.0
% Children Without Health Insurance	1999-2000	<b>24</b>	12.0
	1997-1999	<b>22</b>	14.0
% Not Obtaining Health Care Due to Cost (2000)		<b>12.6</b>	9.9
% Living in Primary Care HPSA (2001)		<b>32.5</b>	19.9
# Practitioners Needed to Remove Primary Care HPSA Designation (2001)		<b>67</b>	--
% Living in Dental HPSA (2001)*		<b>37.3</b>	13.7
# Practitioners Needed to Remove Dental HPSA Designation (2001)		<b>78</b>	--

HPSA = Health Professional Shortage Area

\* It is commonly believed that there are additional areas in the state that may be eligible to receive HPSA designation.

*Sources:* KFF, AARP, BPHC-DSD.

**New Mexico has a greater proportion of non-elderly and children without health insurance, a larger percentage of people living in primary care and dental HPSAs, and a greater proportion of people not obtaining health care due to cost than the U.S. average.**

**Table I-d.**

<b>PROFESSIONS SUPPLY</b>				
<b>Profession</b>	<b># Active Practitioners</b>	<b># Active Practitioners per 100,000 Population</b>		
		<b>NM</b>	<b>U.S.</b>	
Physicians (1998)	<b>2,951</b>	<b>170.2</b>	198	
Physician Assistants (1999)	<b>271</b>	<b>15.6</b>	10.4	
Nurses	RNs (2000)	<b>11,932</b>	<b>656</b>	782
	LPNs (1998)	<b>2,820</b>	<b>162.7</b>	249.3
	CNMs (2000)	<b>89</b>	<b>4.8</b>	2.1
	NPs (1998)	<b>574</b>	<b>33.1</b>	26.3
	CRNAs (1997)	<b>120</b>	<b>7.0</b>	8.6
Pharmacists (1998)	<b>1,000</b>	<b>57.7</b>	65.9	
Dentists (1998)	<b>556</b>	<b>32.1</b>	48.4	
Dental Hygienists (1998)	<b>1,020</b>	<b>58.8</b>	52.1	
% Physicians Practicing Primary Care		33.0 <b>(30.0 U.S.)</b>		
% Registered Nurses Employed in Nursing		87.0 <b>(81.7 U.S.)</b>		
% of MDs Who Are International Medical Graduates (IMGs)		12.0 <b>(24.0 U.S.)</b>		

RN= Registered Nurse, LPN= Licensed Practical Nurse, CNM= Certified Nurse Midwife, NP= Nurse Practitioner  
CRNA= Certified Registered Nurse Anesthetist

Source: HRSA-BHPr.

**New Mexico has a higher percentage of physicians practicing primary care and a higher percentage of registered nurses employed in nursing than the U.S. as a whole.**

**Table I-e.**

<b>NATIONAL HEALTH SERVICE CORPS (NHSC) FIELD STRENGTH</b>			
Total Field Strength (FY 2001) * Includes mental/behavioral health officials	% in Urban Areas	% in Rural Areas	# Per 10,000 Population Living in HPSAs
<b>72</b>	<b>8</b>	<b>92</b>	<b>1.22 (0.49 U.S.)</b>
<i>Field Strength by Profession</i>			
Physicians	<b>29</b>		
Nurses	<b>12</b>		
Physician Assistants	<b>4</b>		
Dentists/Hygienists	<b>13</b>		

HPSA= Health Professional Shortage Area

Source: BHPr-NHSC.

**New Mexico's ratio of National Health Service Corps professionals working in HPSAs is much larger than the national average.**

**Table I-f.**

<b>MANAGED CARE</b>				
Penetration Rate of Commercial and Medicaid HMOs (as % of total population), 2000			<b>NM</b>	<b>U.S.</b>
			<b>30.8</b>	28.1
Profession	MCOs required by state to include profession on their provider panel*	Profession allowed by state to serve as primary care provider in MCOs	Profession allowed by state to coordinate primary care as part of a standing referral	Profession allowed by state to engage in collective bargaining with MCOs
Physicians	<b>No</b>	<b>No</b>	<b>No</b>	<b>No</b>
Nurses	<b>No</b>	<b>No</b>	<b>No</b>	<b>No</b>
Pharmacies	<b>No</b>	<b>No</b>	<b>No</b>	<b>No</b>
Dentists	<b>No</b>	<b>No</b>	<b>No</b>	<b>No</b>
State requires certain individuals enrolled in MCOs to have direct access to certain specialty (OB/GYN, etc.) providers.				<b>Yes</b>
State requires certain individuals enrolled in MCOs to receive a standing referral to a specialist (OB/GYN, etc.).				<b>Yes</b>

MCOs = Managed Care Organizations HMOs = Health Maintenance Organizations OB/GYN = Obstetrician/Gynecologist

\* This requirement does not preclude MCOs from including additional professions on their provider panels.

Sources: HPTS, AARP.

**Thirty percent of New Mexico residents receive their health care from an HMO.**

**Table I-g.**

<b>REIMBURSEMENT OF SERVICES</b>					
	Profession	% Active Practitioners Enrolled	% Enrolled Receiving Annual Payments Greater Than \$10,000 <sup>1</sup>	Increase of 10% or More in Overall Payment Rates 1995-2000	Bonus or Special Payment Rate for Practice in Rural or Medically Underserved Area
<b>Medicaid</b>	Physicians	*	<b>3.73</b>	<b>Yes</b>	<b>No</b>
	NPs	*	<b>1</b>	<b>Yes</b>	<b>No</b>
	Dentists	*	<b>8.4</b>	<b>Yes</b>	<b>No</b>
	# of Enrolled Pharmacies				<b>550</b>
	% Change in Physician Fees (All Services), 1993-1998				<b>10.54</b>
	Recent State-Mandated Payment Increases				<b>Yes</b> (Professions unspecified)
	<b>Medicare</b>	# Active Practitioners Enrolled (2000)			
% Practitioners who Accept Fee as Full Payment (2001)				<b>91.1</b>	

<sup>1</sup> Generally seen as an indicator of significant participation in the Medicaid program.

<sup>2</sup> Denominator number from HRSA State Health Workforce Profile, December 2000.

\* Numerator data for physicians, nurse practitioners, and dentists from state Medicaid agencies were unusable: many professionals were apparently double-counted, perhaps due to varying participation in different health plans.

*Sources:* State Medicaid programs, Norton and Zuckerman "Trends", HPTS, AARP.

**Payment rates for New Mexico physicians, nurse practitioners and dentists increased by more than 10% between 1995 and 2000.**

## II. HEALTH PROFESSIONS EDUCATION

State efforts to help ensure an adequate supply of health professionals can be understood in part by examining data on the state’s health professions education programs—counts of recent students and graduates, amounts of state resources invested in education, and other factors. State officials can gauge how well these providers reflect the state’s population by also examining how many students and graduates are state residents or minorities. Knowing to what extent states are also investing in primary care education and how many medical school graduates remain in-state to complete residencies in family medicine is also important.

Table II-a.

UNDERGRADUATE MEDICAL EDUCATION			
<b># of Medical Schools</b> <i>(Allopathic and Osteopathic)</i>	1	<b>Public Schools</b>	1
		<b>Private Schools</b>	0
		<b>Osteopathic Schools</b>	0
<b># of Medical Students</b> <i>(Allopathic and Osteopathic)</i>	<b>1997-1998</b>	305	
	<b>1999-2000</b>	305	
<b># Medical Students per 100,000 Population<sup>1</sup></b>	<b>1999-2000</b>	16.8	
<b>% Newly Entering Students (Allopathic) who are State Residents, 1999-2000</b>		97.3	
<b>Requirement for Students in Some/All Medical Schools to Complete a Primary Care Clerkship</b>	<b>By the State</b>	No	
	<b>By Majority of Schools</b>	Yes	
<b># of Medical School Graduates</b> <i>(Allopathic and Osteopathic)</i>	<b>1998</b>	74	
	<b>2000</b>	86	
<b># Medical School Graduates per 100,000 Population<sup>1</sup></b>	<b>2000</b>	4.7	
<b>% Graduates (Allopathic) who are Underrepresented Minorities, 1994-1998</b>		16.76 (10.5 U.S.)	
<b>% 1987-1993 Medical School Graduates (Allopathic) Entering Generalist Specialties</b>		30.45 (26.7 U.S.)	
<b>State Appropriations to Medical Schools (Allopathic and Osteopathic), 1999-2000</b>	<b>Total</b>	\$ 42.2 million	
	<b>Per Student</b>	\$ 138,277	

<sup>1</sup> Denominator number is state population from 2000 U.S. Census.

Sources: AAMC, AAMC Institutional Goals Ranking Report, AACOM, Barzansky et al. “Educational Programs”, State higher education coordinating boards.

Ninety-seven percent of newly entering medical students in New Mexico are state residents.

Table II-b.

GRADUATE MEDICAL EDUCATION (GME)		
# of Residency Programs ( <i>Allopathic and Osteopathic</i> ), 1999-2000 <sup>1</sup>		44
# of Physician Residents ( <i>Allopathic and Osteopathic</i> ), 1999-2000 <sup>1</sup>		433
# Residents Per 100,000 Population, 1999-2000		24
% Allopathic Residents from In-State Medical School, 1999-2000		19.6
% Residents who are International <sup>2</sup> Medical Graduates, 1999-2000		11.8 (26.4 U.S.)
Requirement to Offer Some or All Residents a <i>Rural Rotation</i>	By the State	No
	By Most Primary Care Residencies	Yes
State Appropriations for Graduate Medical Education, 1996-1997 <sup>4,5</sup>	Total	Data not available
	Per Resident	Data not available
<i>Medicaid</i> Payments for Graduate Medical Education, 1998 <sup>3</sup>		<b>\$ 4.4 million</b>
	Payments as % of Total Medicaid Hospital Expenditures	<b>5.9</b> (7.4 U.S.)
	Payments Made Directly to Teaching Programs Under Capitated Managed Care	<b>Yes</b>
	Payments Linked to State Workforce Goals/ Goals of Improved Accountability	<b>Yes</b>
<i>Medicare</i> Payments for Graduate Medical Education, 1998 <sup>3</sup>		<b>\$ 9.66 million</b>

<sup>1</sup> Includes estimated number of osteopathic residencies/residents not accredited by the Accreditation Council for Graduate Medical Education.

<sup>2</sup> Does not include residents from Canada.

<sup>3</sup> Explicit payments for both direct and indirect GME cost.

<sup>4</sup> Funds largely are for graduate education.

<sup>5</sup> Dollar amounts refer largely to funding for family medicine training programs. However, these funds that flow directly to teaching hospitals are not necessarily earmarked by the state for graduate medical education.

Sources: AMA, AMA State-level Data, AACOM, State higher education coordinating boards, Henderson "Funding", Oliver et al. "State Variations."

**About 20% of allopathic physician residents in New Mexico are from an in-state medical school.**

**Table II-c.**

FAMILY MEDICINE RESIDENCY TRAINING			
# of Residency Programs, 2001	5	# Residencies Located in Inner City	0
		# Residencies Offering Rural Fellowships or Training Tracks	4
# of Family Medicine Residents, 1999-2000			16
# Family Medicine Residents per 100,000 Population, 1999-2000 <sup>1</sup>			0.88
% Graduates ( <i>from state's Allopathic and Osteopathic medical schools</i> ) who were First Year Residents in Family Medicine, 1995-2000			22.6 (14.8 U.S.)
% Graduates ( <i>from state's Allopathic medical schools</i> ) Choosing a Family Medicine Residency Program Who Entered an In-State Family Medicine Residency, 1995-2000			33.3 (48.1 U.S.)
State Appropriations for Family Medicine Training, <sup>2</sup> 1996-1997		Total	\$ 1.87 million
		Per Residency Slot	\$ 110,253

<sup>1</sup> Denominator number is state population from 2000 U.S. Census.

<sup>2</sup> Dollar amounts refer largely to funding family medicine training programs. However, these funds that flow directly to teaching hospitals are not necessarily earmarked by the state for graduate medical education.

Sources: AAFP, AAFP State Legislation, Kahn et al., Pugno et al. and Schmittling et al. "Entry of U.S. Medical School Graduates".

**One-third of New Mexico graduates choosing a family medicine residency program enter an in-state residency.**

**Table II-d.**

<b>NURSING EDUCATION</b>				
<b># of Nursing Schools</b>	15	<b>Public Schools</b>	15	
		<b>Private Schools</b>	0	
<b># of Nursing Students<sup>1</sup></b> 1998-2000	1,562	<b># Associate Degree, 1998-1999</b>	932	
		<b># Baccalaureate Degree</b>	<b>1998-1999</b>	603
			<b>1999-2000</b>	519
		<b># Masters Degree</b>	<b>1998-1999</b>	27
			<b>1999-2000</b>	167
		<b># Doctoral Degree</b>	<b>1998-1999</b>	0
	<b>1999-2000</b>		0	
<b># Per 100,000 population<sup>2</sup></b>		85.9		
<b># of Nursing School Graduates<sup>1</sup></b> 1999-2000	672	<b># Associate Degree, 1999</b>	453	
		<b># Baccalaureate Degree</b>	<b>1999</b>	219
			<b>2000</b>	249
		<b># Masters Degree</b>	<b>1999</b>	50
			<b>2000</b>	43
		<b># Doctoral Degree</b>	<b>1999</b>	0
	<b>2000</b>		0	
<b># Per 100,000 population<sup>2</sup></b>		36.9		
<b>State Appropriations to Nursing Schools</b> <i>(Baccalaureate, Masters and Doctoral), 1998-1999</i>		<b>Per Student: \$ 5,825</b> <i>(1 school reporting)</i>		

<sup>1</sup> Annual figure for Associate, Baccalaureate, Masters and Doctoral students/graduates for most recent years available.

<sup>2</sup> Denominator number is the state population from the 2000 U.S. Census.

Sources: NLN, AACN, State higher education coordinating boards.

Enrollment for master's degree nursing programs rose dramatically between 1999 and 2000.

Table II-e.

PHARMACY EDUCATION			
# of Pharmacy Schools	1	Public Schools	1
		Private Schools	0
# of Pharmacy Students, 2000-2001	312	# Baccalaureate Degree	0
		# Doctoral Degree ( <i>PharmD</i> )	312
	# Per 100,000 population*	17.2	
# of Pharmacy Graduates, 2000	115	# Baccalaureate Degree	75
		# Doctoral Degree ( <i>PharmD</i> )	40
	# Per 100,000 population*	2.2	

\* Denominator number is state population from 2000 U.S. Census.

Source: AACP.

Table II-f.

PHYSICIAN ASSISTANT EDUCATION		
# of Physician Assistant Training Programs, 2000-2001		2
# of Physician Assistant Program Students, 2000-2001		44
# Physician Assistant Program Students per 100,000 Population <sup>1</sup>		2.4
# of Physician Assistant Program Graduates, 2001		9 (1 program)
# Physician Assistant Program Graduates per 100,000 Population <sup>1</sup>		0.49
State Appropriations for Physician Assistant Training Programs, 2000-2001 <sup>2</sup>	Total	0
	Per Student	0
	As % of Total Program Revenue	0

<sup>1</sup> Denominator number is state population from 2000 U.S. Census.

<sup>2</sup> In general, state appropriations are not directly earmarked for these programs, but rather to their sponsoring institutions.

Sources: APAP, APAP Annual Report.

Table II-g.

DENTAL EDUCATION			
# of Dental Schools	0	Public Schools	0
		Private Schools	0
# of Dental Students, 2000-2001	0		
# Dental Students per 100,000 Population*	0		
# of Dental Graduates, 2000	0		
# Dental Graduates per 100,000 Population*	0		
State Appropriations to Dental Schools, 1998-1999	Per Student: 0		

\* Denominator number is state population from 2000 U.S. Census.

Source: ADA.

Table II-h.

DENTAL HYGIENE EDUCATION			
# of Dental Hygiene Training Programs	2	Public Schools	2
		Private Schools	0
# of Dental Hygiene Program Students, 1997-1998	49		
# Dental Hygiene Program Students per 100,000 Population*	2.7		
# of Dental Hygiene Program Graduates, 1998	48		
# Dental Hygiene Program Graduates per 100,000 Population*	2.6		

\* Denominator number is state population from 2000 U.S. Census.

Sources: ADHA, AMA Health Professions.

### III. PHYSICIAN PRACTICE LOCATION

The following tables examine in-state physician practice location from two different vantage points: (1) of all physicians who were trained (went to medical school or received their most recent GME training) in the state between 1975 and 1995, and (2) of all physicians who are now practicing in the state, regardless of where they were trained. Compiled from the American Medical Association's 1999 Physician Masterfile by Quality Resource Systems, Inc., the data importantly illustrates to what extent physician graduates practice in many of the state's small towns, using the rural-urban continuum developed by the U.S. Department of Agriculture.

#### PRACTICE LOCATION (URBAN/ RURAL) OF PHYSICIANS WHO RECEIVED THEIR ALLOPATHIC MEDICAL SCHOOL TRAINING IN NEW MEXICO BETWEEN 1975 AND 1995.

Table III-a.

NEW MEXICO		
Number of physicians who were trained in NM and who are now practicing in NM as a percentage of all physicians practicing in NM.		<b>21.67</b>
Number of physicians who were trained in NM and are practicing in NM, by practice location (metro code <sup>1</sup> ), as a percentage of all physicians practicing in NM.	#00	0.00
	#01	0.00
	#02	23.36
	#03	19.69
	#04	21.62
	#05	16.08
	#06	21.33
	#07	23.08
	#08	50.00
#09	33.33	
Number of physicians who were trained in NM and who are now practicing in NM as a percentage of all physicians who were trained in NM.		<b>36.09</b>
Number of physicians who were trained in NM and are practicing in NM, by practice location (metro code <sup>1</sup> ), as a percentage of all physicians trained in NM.	#00	0.00
	#01	0.00
	#02	61.70
	#03	37.50
	#04	27.59
	#05	51.40
	#06	33.33
	#07	31.82
	#08	25.00
#09	40.00	

<sup>1</sup> 1995 Rural/Urban Continuum Codes for Metro and Nonmetro Counties. Margaret A. Butler and Calvin L. Beale. Agriculture and Rural Economy Division, Economic Research Service, U.S. Department of Agriculture.

Codes # 00-03 indicate metropolitan counties:

- 00: Central counties of metro areas of 1 million or more
- 01: Fringe counties of metro areas of 1 million or more
- 02: Counties with metro areas of 250,000 - 1 million
- 03: Counties in metro areas of less than 250,000

NA: Not Applicable; no counties in the state are in the R/U Continuum Code

Codes # 04-09 indicate non-metropolitan counties:

- 04: Urban population of 20,000 or more, adjacent to metro area
- 05: Urban population of 20,000 or more, not adjacent to metro area
- 06: Urban population of 2,500-19,999, adjacent to metro area
- 07: Urban population of 2,500-19,999, not adjacent to metro area
- 08: Completely rural (no place w population > 2,500), adjacent to metro area
- 09: Completely rural (no place w population > 2,500), not adjacent to metro area

**PRACTICE LOCATION (URBAN/ RURAL) OF PHYSICIANS WHO RECEIVED  
THEIR MOST RECENT GME TRAINING IN NEW MEXICO  
BETWEEN 1978 AND 1998.**

**Table III-b.**

NEW MEXICO		
Number of physicians who received their most recent GME training in NM and who are now practicing in NM as a percentage of all physicians practicing in NM.		<b>27.57</b>
Number of physicians who received their most recent GME training in NM and are practicing in NM, by practice location (metro code <sup>1</sup> ), as a percentage of all physicians practicing in NM.	#00	0.00
	#01	0.00
	#02	35.56
	#03	18.70
	#04	2.63
	#05	11.80
	#06	22.78
	#07	19.79
	#08	0.00
	#09	33.33
Number of physicians who received their most recent GME training in NM and who are now practicing in NM as a percentage of all physicians who were trained in NM.		<b>42.76</b>
Number of physicians who received their most recent GME training in NM and are practicing in NM, by practice location (metro code <sup>1</sup> ), as a percentage of all physicians trained in NM.	#00	0.00
	#01	0.00
	#02	70.32
	#03	35.05
	#04	3.70
	#05	40.00
	#06	41.86
	#07	23.46
	#08	0.00
	#09	66.67

<sup>1</sup> 1995 Rural/Urban Continuum Codes for Metro and Nonmetro Counties. Margaret A. Butler and Calvin L. Beale. Agriculture and Rural Economy Division, Economic Research Service, U.S. Department of Agriculture.

*Codes # 00-03 indicate metropolitan counties:*

- 00: Central counties of metro areas of 1 million or more
- 01: Fringe counties of metro areas of 1 million or more
- 02: Counties with metro areas of 250,000 - 1 million
- 03: Counties in metro areas of less than 250,000

*Codes # 04-09 indicate non-metropolitan counties:*

- 04: Urban population of 20,000 or more, adjacent to metro area
  - 05: Urban population of 20,000 or more, not adjacent to metro area
  - 06: Urban population of 2,500-19,999, adjacent to metro area
  - 07: Urban population of 2,500-19,999, not adjacent to metro area
  - 08: Completely rural (no place w population > 2,500), adjacent to metro area
  - 09: Completely rural (no place w population > 2,500), not adjacent to metro area
- NA: Not Applicable; no counties in the state are in the R/U Continuum Code.*

## IV. LICENSURE AND REGULATION OF PRACTICE

States are responsible for regulating the practice of health professions by licensing each provider, determining the scope of practice of each provider type and developing practice guidelines for each profession. The tables below illustrate the licensure requirements for each of the health professions covered in this study as well as additional information on recent expansions in scope of practice or other novel regulatory measures taken by the state.

**Table IV-a.**

<b>PHYSICIANS</b>	
LICENSURE REQUIREMENTS	Graduation from a New Mexico board-approved medical college or school that has been approved by the Liaison Committee on Medical Education (LMCE) and the Association of American Medical Colleges (AAMC), or is on the approved list of the California State Medical Board; successfully pass examinations.
LICENSURE REQUIREMENTS: <b>INTERSTATE TELE-CONSULTATION</b>	<b>Full license</b> (through statute), though temporary licenses may be granted for physicians who wish to teach, conduct research, or perform specialized diagnostic and treatment procedures.
STATE MANDATES INDIVIDUAL PROFESSION PROFILES TO BE PUBLICLY ACCESSIBLE	No.

Sources: State licensing board, HPTS.

**Table IV-b.**

<b>PHYSICIAN ASSISTANTS</b>	
LICENSURE REQUIREMENTS	Graduation from accredited PA program; Current National Commission on Certification of Physician Assistants (NCCPA) certificate; Bachelor's degree or two years work experience as certified PA.
RECENT STATE MANDATED EXPANSIONS IN SCOPE OF PRACTICE	<p><b><i>PRESCRIPTIVE AUTHORITY</i></b>  <b>Yes.</b> Limited prescriptive authority for drugs in board approved formulary.</p> <p><b><i>PHYSICIAN SUPERVISION</i></b>  Physician not required to be physically present at time and place where PA performs services.</p>

Source: State licensing board.

**Table IV-c.**

NURSES	
LICENSURE REQUIREMENTS	<p><b>Registered Nurses (RNs)</b> Successfully complete an approved program of nursing for licensure as a registered nurse and pass the national licensing examination for registered nurses.</p> <p><b>Advanced Practice Nurses (APNs)</b> Is already a registered nurse, has successfully completed the appropriate advanced practice education program, and is certified by a national nursing organization.</p> <p><b>Licensed Practical Nurses (LPNs)</b> Successfully complete an approved program of nursing for licensure as a licensed practical and pass the national licensing examination for licensed practical nurses.</p>
LICENSURE REQUIREMENTS: <i>FOREIGN-TRAINED NURSES</i>	Graduation from an approved nursing program or a nursing program which is equivalent to an approved program of nursing in the United States. Initial licensure by passing a national licensure examination in English. Registered nurse (RN) and practical nurse (PN) graduates from non-U.S. nursing programs must request an evaluation of their nursing education credentials be sent to the New Mexico board of nursing directly from a board-recognized educational credentialing agency. RN and PN graduates in non-U.S. nursing programs may submit a copy, certified by a notary, of the commission on graduates of foreign nursing schools' (CGFNS) examination certificate in lieu of an evaluation of the educational credentials.
LICENSURE REQUIREMENTS: <i>INTERSTATE TELE-CONSULTATION</i>	Full License.
RECENT STATE MANDATED EXPANSIONS IN SCOPE OF PRACTICE	<p><b><i>PRESCRIPTIVE AUTHORITY</i></b> NP, CNS can prescribe scheduled II-V.</p> <p><b><i>PHYSICIAN SUPERVISION</i></b> NPs can practice independently and make decisions regarding health care needs of the individual, family or community and carry out health regimens. CRNAs must collaborate with the licensed physician, osteopathic physician, dentist or podiatrist concerning the anesthesia care of the patient.</p>
RECENT STATE REQUIREMENTS TO IMPROVE WORKING CONDITIONS IN CERTAIN INSTITUTIONS	None.
STATE MANDATES INDIVIDUAL PROFESSION PROFILES TO BE PUBLICLY ACCESSIBLE	Yes, available on web.

Sources: State licensing board, AANA, ACNM, Pearson "Annual Legislative Update", HPTS.

**Table IV-d.**

DENTISTS	
LICENSURE REQUIREMENTS	Graduated from an accredited school of dentistry; Passed national examination and written exam from board.
LICENSURE REQUIREMENTS: <i>INTERSTATE TELE-CONSULTATION</i>	<b>Full License.</b>

Source: State licensing board.

**Table IV-e.**

PHARMACISTS	
LICENSURE REQUIREMENTS	Graduation from a school or college of pharmacy approved by the board, not less than one year of experience under the direction of a pharmacist in accordance with the programs of supervised training established by regulation of the board, and passing score on an examination approved by the board.
RECENT STATE MANDATED EXPANSIONS IN SCOPE OF PRACTICE	<b>Yes,</b> have limited prescriptive authority with supervising practitioner and can provide immunizations.
STATE MANDATES INDIVIDUAL PROFESSION PROFILES TO BE PUBLICLY ACCESSIBLE	No.

Source: State licensing board.

**Table IV-f.**

DENTAL HYGIENISTS	
LICENSURE REQUIREMENTS	Graduated from an accredited school dental hygiene program; Passed national examination and written exam from board.
RECENT STATE MANDATED EXPANSIONS IN SCOPE OF PRACTICE	<b><i>PRESCRIPTIVE AUTHORITY</i></b> No.  <b><i>DENTIST SUPERVISION</i></b> Dental hygienist may enter collaborative practice based on a written agreement between the dental hygienist and one or more consulting dentist(s). Collaborative practice agreement must contain protocols for care.

Source: State licensing board, ADHA.

## **Glossary of Acronyms**

CNM: Certified nurse midwife.

CRNA: Certified registered nurse anesthetist.

NP: Nurse practitioner.

## V. IMPROVING THE PRACTICE ENVIRONMENT

States have the challenge of not only helping to create an adequate supply of health professionals in the state, but also ensuring that those health professionals are distributed evenly throughout the state. Various programs and incentives are used by states to encourage providers to practice in rural and other underserved areas. The tables in this section describe New Mexico's programs as well as the perceived effectiveness of these programs.

### RECRUITMENT/ RETENTION INITIATIVES

**Table V-a.**

INITIATIVE	In Use	Perceived or Known Impact (1= high, 5= low)	Health Professions Affected					
			Physicians	Nurses	Pharmacists	Dentists	Dental Hygienists	Physician Assistants
FOCUSED ADMISSIONS / RECRUITMENT OF STUDENTS FROM RURAL OR UNDERSERVED AREAS	No							
SUPPORT FOR HEALTH PROFESSIONS EDUCATION (stipends, preceptorships) IN UNDERSERVED AREAS	Yes	3	X	X				
RECRUITMENT / PLACEMENT PROGRAMS FOR HEALTH PROFESSIONALS	Yes	1	X	X				X
PRACTICE DEVELOPMENT SUBSIDIES (i.e., start-up grants)	No							
MALPRACTICE PREMIUM SUBSIDIES	No							
TAX CREDITS FOR RURAL/ UNDERSERVED AREA PRACTICE	No							
PROVIDING SUBSTITUTE PHYSICIANS ( <i>locum tenens</i> support)	Yes	2	X					
MALPRACTICE IMMUNITY FOR PROVIDING VOLUNTARY OR FREE CARE	No							
PAYMENT BONUSES / OTHER INCENTIVES BY MEDICAID OR OTHER INSURANCE CARRIERS	No							
MEDICAID REIMBURSEMENT OF TELEMEDICINE	No							

*Source: State health officials.*

Placement programs for physicians, nurses, and physician assistants receive a high impact rating from state health officials.

**LOAN REPAYMENT/ SCHOLARSHIP PROGRAMS \***

**Table V-b.**

Program Type	Number of Programs	Number of Annual Participants	Average Retention Rate	Eligible Health Professions					
				Physicians	Nurses	Pharmacists	Dentists	Dental Hygienists	Physician Assistants
LOAN REPAYMENT	1	50	Not Available	X	X		X		
SCHOLARSHIP	0	0	N/A*						

\* Includes only state-funded programs which require a service obligation in an underserved area. (NHSC state loan repayment programs are included since the state provides funding.)

N/A\* = Data is not applicable

Source: State health officials.

## WORKFORCE PLANNING ACTIVITIES\*

Table V-c.

ACTIVITY	In Use	Health Professions Affected					
		Physicians	Nurses	Pharmacists	Dentists	Dental Hygienists	Physician Assistants
COLLECTION / ANALYSIS OF PROFESSIONS SUPPLY DATA:  FROM <u>PRIMARY</u> SOURCES (e.g., licensure renewal process; other survey research)  FROM <u>SECONDARY</u> SOURCES (e.g., state-based professional trade associations)	Yes	X	X				X
	No						
PRODUCTION OF RECENT STUDIES OR REPORTS THAT DOCUMENT / EVALUATE THE SUPPLY, DISTRIBUTION, EDUCATION OR REGULATION OF HEALTH PROFESSIONS	Yes	X					
RECENT REGULATORY ACTIONS INTENDED TO REQUIRE OR ENCOURAGE COORDINATION OF POLICIES AND DATA COLLECTION AMONG HEALTH PROFESSIONS GROUPS OR LICENSING BOARDS	No						

\* One state health official supplied these responses. Therefore, data may be limited and may not accurately reflect all current workforce-planning activities in the state.

**New Mexico collects and analyzes statewide supply data for physicians, nurses, and physician assistants.**

## VI. EXEMPLARY WORKFORCE LEGISLATION, PROGRAMS AND STUDIES

The following abstracts describe several of New Mexico's recent endeavors to understand and describe the status of the state's current health care workforce.

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### Legislation and Programs

#### **S-42 (2002)**

Appropriates \$50,000 to the Board of Nursing in fiscal years 2002 through 2003 to contract for a statewide study to examine the need for additional nurses and the types of education and training necessary to meet New Mexico's health care demands.

#### **H-265 (1999)**

Allows dental hygienists to work in "collaborative practice" with dentists and requires licensure by credentials for dentists and hygienists that are duly licensed by clinical examination in another state.

#### **Senate Joint Memorial 21: Final Report**

*Health Policy Commission, October 1999*

In 1998, the Legislature asked the Health Policy Commission to conduct a comprehensive analysis of primary oral health care access (SJM 21). The report discusses the commission's findings regarding access to oral health services and recommended initiatives needed to improve access to dental care.

Recommended legislative changes include:

- Legislation establishing a synergistic system for health professional supply and distribution in the state;
- Assessment and recommendations on establishing an essential community health professional designation to provide support for health professionals serving underserved communities or populations;
- Establishment of an education program in dental schools to meet state needs;
- Implementation of an oral health professional career ladder;

Recommendations for enhancing dental education include:

- Expanding Western Interstate Commission for Higher Education (WICHE) slots for dental students and non-WICHE dental school contracts;
- Explore procuring slots for New Mexicans in dental schools;
- Work with Dental Association and WICHE to establish rural clinical /practical rotations;
- Establish a NM based general dentistry program.

#### **The University of New Mexico Locum Tenens Program**

*University of New Mexico Center for Community Partnerships*

The University of New Mexico Health Sciences Center has been working since 1993 to provide primary care practitioners in rural area with practice relief by having others serve in their place. The university was awarded \$200,000 per year by the state to initiate and support the program. Participants include primary care faculty and residents from primary care departments. The program has been able to provide 2,000 days of coverage for physicians in rural and underserved areas and thirty resident physician graduates were placed into rural practices where they had provided coverage.

## Studies

### **Dental Professional Workforce Inventory Survey**

*New Mexico Health Policy Commission, 2001*

Survey of dentists and dental hygienists in the state asks questions about practice location and Medicaid participation.

### **Health Care in New Mexico: Quick Facts 2001**

*New Mexico Policy Commission, 2001*

This fact book provides statistical information on health care in the state. The book breaks down statistics on health care access by geographic area and supply and demand of health care professionals.

### **Workforce Conference Recommendations/Strategies**

*New Mexico Department of Health, Fall 2001*

This forum met in 2001 to identify key workforce issues and develop potential solution to workforce problems in the state. The group looked at the health care practice environment, the supply of health professionals, health care financing, and the socioeconomic environment and made recommendations to address these issues.

### **State of the Nursing Workforce in New Mexico**

*Donea Shane, New Mexico Consortium for Nursing Workforce Development, July 2001*

This study assesses the supply and demand of nurses in the state and details focus group conclusions on addressing the nursing shortage in New Mexico. The report has admission, enrollment, and graduation rates for nursing students in the state.

### **University of New Mexico School of Medicine: MD Recipients and Former Residents**

*Location Report, 2001*

This report provides facts about physician recipients and former residents from the University of New Mexico (UNM) School of Medicine. Key statistics are:

- 28% of all physician recipients are licensed to practice in New Mexico
- 48% of those licensed in New Mexico are in primary care specialties.
- Over the last 6 years, the number of UNM-trained physicians practicing in the state has increased 49%
- Of all licensed physicians in the state, 35% are physician recipients or former residents of the UNM School of Medicine

### **HRSA State Health Workforce Profile**

*Bureau of Health Professions, December 2000*

The State Health Workforce Profiles provide current data on the supply, demand, distribution, education and use of health care professionals in each state. Each state profile has an overview of the health status of state residents and health services within the state. In addition the profiles have breakdowns of health care employment by place of work and profession.

<http://bhpr.hrsa.gov/healthworkforce/profiles/default.htm>

## VII. POLICY ANALYSIS

Organizations with Significant Involvement in Health Workforce Analysis/Development

- **New Mexico Department of Health**
- **University of New Mexico Health Sciences Center**
- **New Mexico Health Resources**
- **New Mexico Health Policy Commission**
- **New Mexico Consortium for Nursing Workforce Development**

**Evidence of Collaboration: Minimal to Moderate (associated with physician and nursing workforce data collection and training program development, and physician recruitment and retention activities)**

New Mexico is a predominantly rural state with over half of its population of minority or ethnic origin. About a quarter of the state's population are uninsured, a proportion that is nearly twice the national average and is growing.

New Mexico has major problems with the supply and distribution of its health care workforce. One-third of the population resides in a primary care health professional shortage area (HPSA), and the proportion of residents that live in a dental HPSA is nearly three times the national average. Just three New Mexico counties are not designated as a HPSA. The ratio of National Health Service Corps personnel per 10,000 population living in HPSAs is over twice the U.S. average. New Mexico's overall ratios of physicians, nurses, dentists and pharmacists per 100,000 population each are significantly below the national average. The state has one medical school and one pharmacy school, and no dental school. There are just 15 schools of nursing in New Mexico.

Despite evidence that the state has a significant health workforce shortage, few extraordinary efforts have been undertaken to address the problem with major results. More incrementally, the state has in recent years:

- Mandated modest Medicaid fee increases, primarily for physicians and dentists. Less than 10 percent of Medicaid-enrolled physicians and dentists in the state provide a significant amount of care to Medicaid beneficiaries.
- Funded various studies to document health professional workforce supply and demand and to analyze access to the health workforce.
- Directed development of a geographic access data system that provides a single source of health care system data and analysis for policy development. As part of this data initiative, the state health policy commission attempts to collaborate with the state's health profession licensing boards to periodically survey practicing physicians, nurses and dentists statewide as part of the relicensure process.

In 1996, a joint legislative memorial asked the New Mexico Health Policy Commission to convene a task force to develop options that address the supply and distribution of the state's health care workforce. Among other things, the Commission called for a clearer link between state funds and the ability of state family medicine residencies to graduate physicians versed in community-based primary care in rural and underserved areas.

In June 2001, the Secretary of Health convened a working forum of over 125 persons to develop comprehensive consensus strategies to improve New Mexico's health care system with a particular emphasis on workforce issues. The forum identified key issues, brainstormed potential solutions

and outlined various programmatic and legislative recommendations. Following the forum, quarterly workgroup meetings on such topics as financing, training and licensing were planned.

Over the years, the state has implemented various recruitment and retention strategies for physicians, nurses, physician assistants and other health professions practicing primary care in medically underserved rural areas, including several small scholarship and loan programs and a few special grant initiatives. The University of New Mexico Health Sciences Center has also operated for several years a physician relief or *locum tenens* support program for primary care physicians practicing in rural areas. These programs generally receive high marks from state officials for their effectiveness. However, such impact is limited, due to their small size.

### **Physicians**

The proportion of graduates of New Mexico's one publicly funded medical school going into primary care is much larger than the national average. Nearly a fifth of graduates enter a family medicine residency program. However, a proportion significantly less than the national average chose a family practice residency within the state. Despite the fact that over 97 percent of newly entering medical students are state residents, less than 30 percent of the state's practicing physicians completed their medical school and graduate medical education in-state.

In recognition of the loss of graduating physicians to New Mexico and to the state's rural areas, the Legislature in recent years has funded family medicine education to focus on community-based training in rural settings shown to be in greatest need of physician services. The medical school has established a decentralized, community-based experience in primary care in several rural communities throughout the state. Recent studies show that 80 percent of graduates of the state's rural family practice residencies go into practice in rural New Mexico. The state Medicaid program's support for graduate medical education also supports the idea of such a training experience. Since 1997, under the state Medicaid managed care program, GME payments are allowed to go for primary care training in rural, non-hospital settings.

### **Nursing**

By 2001, the legislature acknowledged the existence of a nursing workforce crisis in New Mexico. A 2001 study by the Consortium for Nursing Workforce Development provided clear evidence of changing nursing supply and demand trends across the state, showing a 18 percent shortage of registered nurses and over 1000 vacancies for nurses in hospitals statewide. Nurses in public health settings particularly are in short supply. Hospital nurse executives across the state are looking at sharing resources by establishing a regional nurse recruitment network with Arizona.

Shortage of nurse faculty and lack of clinical training sites are top concerns of nurse educators in the state. This group has been effective in addressing their concerns by virtue of its ability to operate with a united voice. The School of Nursing at the University of New Mexico received extra funds from the legislature in 2001 for training additional nurses. In coming years, plans by the group call for efforts to encourage the Legislature to expand the training capacity of many of the smaller nursing schools that train associate degree as well as baccalaureate degree nurses. In 2002, the Legislature appropriated funds to study the need for additional nurses and types of education and training necessary to meet nursing needs in the state. Enrollment in baccalaureate degree nursing programs have declined or remained flat in recent years.

Interest in establishing a statewide nursing research center similar to those proposed in other states remains an agenda item for the Legislature. In 2001, the Board of Nursing did not support such legislation because funds to create the center came from their operating budget. Recent efforts to fund such a center are focused on accessing state tobacco settlement funds.

## **Dentists**

As evidenced from the above data, the state faces a major crisis in oral health. A 1999 report by the state health policy commission for the Legislature indicates that the state has an acute and growing shortage of dentists. Twenty-four of the state's 33 counties are dental HPSAs. Significant retirements by aging dentists are expected in the next five to ten years.

Efforts to increase the supply of dentists are problematic. The state has no dental school and no serious interest by the state in funding one exists. Although New Mexico currently buys slots in six area state dental schools at the states' in-state tuition rates, and graduates have an obligation to return to New Mexico to practice, there is a lack of interest by young persons in becoming dentists. The state has just one dental residency program that operates with limited funding. With no penalty for doing so, many students end up buying out their service obligation. In addition, reciprocity of license for dentists from other states interested in working in New Mexico, a method using historically to limit the state's supply of dentists, is viewed as quite restrictive. The state only recently has begun to operate a dental loan repayment program to encourage graduating dentists to practice in the state's underserved communities. Much of the attention to dental education is focused on dental hygiene programs with many such programs struggling to stay open.

Effective October 2000, new collaborative practice arrangements between dentists and dental hygienists were instituted, allowing hygienists to practice in a different location than dentists for certain activities. This new model of practice for hygienists is perceived as potentially effective in educating and screening low-income children. However, Medicaid and private insurers do not reimburse hygienists directly for such services. To date, there are about four such arrangements in existence (two in rural areas). Despite some modest increases in Medicaid payment rates in recent years, it is estimated that only about a fifth of the state's practicing dentists accept Medicaid patients, and (as noted earlier) only a small percentage of these providers provide a significant level of care to these patients.

## **Pharmacists**

The supply of pharmacists is not viewed as major problem yet in New Mexico. However, occasional shortages of pharmacists in rural hospitals have always been a problem. The state's one pharmacy school now trains only doctoral degree students. All practicing pharmacists under law now have limited prescriptive authority.

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