

Con Alma Health Foundation

AUGUST 2012

Health Equity in New Mexico: A Roadmap for Grantmaking and Beyond



*The Heart & Soul of
Health in New Mexico*

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Message from Dolores E. Roybal, Executive Director

Recognizing that relevant, accurate healthcare information is critical to addressing the complex health-related issues that we face in New Mexico, the Board of Trustees of Con Alma Health Foundation embarked upon a landmark research project in 2006, “Closing the Health Disparity Gap in New Mexico: A Roadmap for Grantmaking,” designed to guide the Foundation’s grantmaking and program initiatives.

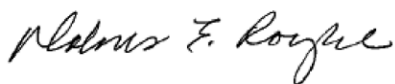
Based on our rapidly changing environment, we determined to update the report. The main differences in this 2012 report, “Health Equity in New Mexico: A Roadmap for Grantmaking and Beyond,” are: a focus on health equity as opposed to health disparities; the addition of community focus groups as a way to gain a deeper understanding of issues and solutions facing New Mexicans; updated secondary data; and the inclusion of current challenges and issues.

Since our last report in 2006, New Mexico has weathered a national recession, increased needs in our aging and veteran populations, and experienced a continued shift in cultural demographics, increasing the minority population, among other changes. Additionally, federal health care reform was implemented through the Patient Protection and Affordable Care Act, which was signed into law in 2010. The new law provides an opportunity for addressing racial and ethnic disparities, increasing coverage and access, and improving the quality of health care.

Con Alma made the decision to release this report to the public due to the significance of the findings and the potential for the information to serve as a resource for others working toward improving health in New Mexico. Here you find a basis for dialogue, not only within Con Alma, but within communities across our state. Its purpose is to assist Con Alma and the communities it serves in understanding the health issues facing New Mexico from a health equity perspective and to support grantmaking, program initiatives, and responsive policy development. This report challenges us to engage in further dialogue that will lead toward effective solutions and improved health outcomes.

Although one of the main purposes of the updated report is to inform the Foundation’s grantmaking, Con Alma’s assets go beyond the dollars with which it makes grants. Con Alma also serves as a convener and as a catalyst for positive, systemic change. Thus, the report will provide a roadmap for grantmaking and beyond.

Mil gracias,



DOLORES E. ROYBAL,
Executive Director

Acknowledgments

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- Sara Maria Araujo, Masters of Public Health, for collecting and updating the secondary data; Dionysios “Dennis” McCutcheon, Program Assistant and New Mexico Highlands University Social Work graduate student, for his assistance in updating the secondary data and charts; Catherine “Catie” Calder, University of New Mexico Masters of Public Health graduate student, for her help in researching; and Carla Roybal, who at the time was a University of New Mexico Masters of Public Health graduate student, for developing the community snapshots for the focus groups;
- Susan Cantor, for managing the production of this report; and
- Billie Blair, Editor, for her excellent work in formatting and editing the report;
- We also wish to thank Robert Archuleta, President, and Pamela Herndon, outgoing President, Board of Trustees; Jim Coates, Chair, Community Advisory Committee; and Dolores E. Roybal, Executive Director, Con Alma Health Foundation for their leadership and support.

THANK YOU ALL.

Executive Summary

Based on our rapidly changing environment, Con Alma Health Foundation determined to update its landmark research project of 2006, “Closing the Health Disparity Gap in New Mexico: A Roadmap for Grantmaking.” This 2012 report focuses on health equity, added community voices through focus groups, updated secondary data; and includes current challenges and issues such as federal health care reform.

Con Alma’s grantmaking has evolved and so has the Foundation’s role in engaging stakeholders in public policy issues, leveraging resources to increase philanthropic engagement and dollars for New Mexico, and promoting statewide initiatives. The Foundation’s assets go beyond the dollars with which it makes grants; Con Alma also serves as a convener and as a catalyst for positive, systemic change.

KEY FINDINGS SUMMARY

1. Improved conditions and policies that address Social Determinants of Health and advance health equity, especially among racially and ethnically diverse and underserved populations, can significantly improve health in New Mexico.
2. Access to quality and affordable health care services continues to be a barrier to good health, especially in rural New Mexico, communities of color, and underserved populations (e.g. elderly, immigrants, border communities, and veterans).
3. Prevention, nutrition, health promotion and holistic health are critical to improving health in New Mexico.
4. Our rapidly changing environment, including demographic shifts, will have major implications in health for the people and communities of New Mexico.

KEY FINDINGS

1. **Improved conditions and policies that address Social Determinants of Health and advance health equity, especially among racially and ethnically diverse and underserved populations, can significantly improve health in New Mexico.**
 - The correlation between poverty, educational attainment, and good health is evident when comparing health

outcomes for New Mexico’s children and others in the United States. New Mexico ranks 48 and 49 respectively in teen death and teen birth rates.

- Racial and ethnic minorities suffer higher rates of mortality and illness compared with other Americans, and receive a lower quality of health care.
 - New Mexico has the second highest poverty rate in the nation.
 - The number of households receiving food stamps has almost doubled during the recession, from 6 percent to 11 percent.
 - Children ages 0–5 are more likely to die: New Mexico experienced a 20 percent increase in youth death rates since 2000.
2. **Access to quality and affordable health care services continues to be a barrier to good health, especially in rural New Mexico, communities of color, and underserved populations (e.g. elderly, immigrants, border communities, and veterans).**
 - New Mexico has the second highest rate of uninsured in the nation (21.6 percent).
 - Hispanic and American Indian adults were over twice as likely to be without health insurance coverage as whites.
 - Native Americans lack a consistent health benefits package.
 - The health workforce is neither diverse nor culturally competent. Minorities make up 59 percent of the population, but only 11 percent of the nursing workforce.
 - Thirty-two of the state’s 33 counties are defined as Health Professional Shortage areas.
 - Substance abuse/dependence and/or mental disorders affect more than half a million people in New Mexico: 24.3 percent will need help from the publicly funded care system.
 - Returning veterans from Iraq and Afghanistan are expected to increase the number of veterans in New Mexico. Veterans, especially in rural areas, lack access to essential health care & behavioral services.

3. Prevention, nutrition, health promotion & holistic health are critical to improving health in New Mexico.

- Nationally, there has been a shift in the conversation about health care in the last decade to focus on prevention, access and alleviating equity boundaries.
- The percentage of obesity among the state's population doubled from 1990 to 2009. Obesity can lead to heart disease, stroke, diabetes, and some cancers.
- Preventative oral health is limited, especially in rural areas, which can result in impaired general health, particularly impacting the mortality rate due to heart disease at younger ages.
- Health care reform provides opportunities to implement prevention, and wellness programs.

4. Our rapidly changing environment, including demographic shifts, will have major implications in health for the people and communities of New Mexico.

- People of color in New Mexico comprise 58.7 percent of the population in the 2010 Census and fare far worse than their white counterparts across a range of health indicators.
- The New Mexico Hispanic population increased by 25 percent compared to a 13 percent increase in total population.
- New Mexico residents 18 and under account for almost one in five of the population (18 percent in 2010); and the Hispanic population under 18 years of age was 58 percent, the largest in the US.
- The largest percent increase from 2000 to 2010 was among those 60 years to 64 years, at 5.8 percent. By 2030, the state will rank fourth in the nation in percentage of population age 65 and older; currently New Mexico is 39th.
- Almost half of New Mexico's grandparents provide a home for their grandchildren.
- Minority child populations show the most dramatic shift: almost three in four children under five is African American (2 percent), Hispanic (59 percent) or Native American (12 percent).

RECOMMENDATIONS FOR GRANTMAKING

- Invest in communities
- Invest in health basics
- Leverage resources
- Invest in systems change

1) INVEST IN COMMUNITIES

The data and focus group responses point to the Con Alma's core mission to understand and respond to the health rights and needs of the culturally and demographically diverse peoples and communities of New Mexico. They also underscore Con Alma's core values to involve, collaborate and partner with New Mexico communities.

Recommendations:

- Support improved access to quality and affordable health care. This includes supporting programs that increase the scope of medical services in rural clinics, increase transportation to health facilities and enhance educational efforts that make Medicaid more understandable to the community user.
- Expand grantmaking to rural communities, including efforts that seek to link rural communities to health care resources from other areas such as tele-health and sharing means to implement best practices with limited resources.
- Strengthen outreach to Tribes, Pueblos, Apache Nation, and Navajo Nation.
- Fund programs that increase cultural and linguistic competency with providers trained to be culturally competent, that increase access to bilingual health and that support traditional uses such as *promotoras* and traditional healers.
- Support preservation and enhancement of cultural and spiritual assets.
- Give grants that increase and diversify the health workforce and support leadership development for people of color in health care professions.

2) INVEST IN HEALTH BASICS

Communities need the most basic of health care: sufficient access to primary care physicians and other health professionals, dental checkups and oral health, mental health services and preventative measures that alleviate undesired health care outcomes.

Recommendations:

- Continue to support organizations that promote wellness strategies such as prevention, nutrition, health promotion, holistic health, and spiritual health and well-being.
- Provide support for replications of basic health programs that have worked elsewhere.
- Give grants to nonprofit organizations that offer technical and capacity building skills.
- Continue general operating support to nonprofit, health-related organizations to support infrastructure and administrative overhead costs.
- Continue to fund organizations that serve preadolescent children (below age 10) to encourage healthy lifestyles (reducing youth risk behaviors such as obesity, diabetes, substance abuse, teen pregnancy and accidental deaths.)
- Support programs that provide mental health care in wrap-around approaches in rural communities.

3) LEVERAGE RESOURCES

Leverage Con Alma Health Foundation's human and financial resources to attract other resources for New Mexico; and support/encourage multi-sector collaboration.

Recommendations:

- Leverage Con Alma Health Foundation's resources to attract local, state and national funding and other resources to improve health in New Mexico.
- Continue to participate in advocacy networks that pool resources and ideas to lead to improved health policy making at the state and local levels.
- Support collaborations such as partnerships between public health departments and community-based health programs and organizations offering mentoring programs to tap underutilized community resources and strengthen social networks.
- Support organizational efforts to enhance coordination and multi-sector collaboration.

4) INVEST IN SYSTEMS CHANGE

Innovation, leadership, acting as an effective advocate and promoting change are all underpinnings of Con Alma's mission. While experience has shown there are no easy answers to the mission of health equity, Con Alma can continue to serve as a catalyst for positive, systemic change in New Mexico.

Recommendations:

- Support policies that advance health equity, especially among racially and ethnically diverse populations, and underserved populations/communities.
- Support policy development through research, evaluation and advocacy.
- Support programs that provide analysis of health data, policy issues and programs.
- Support workforce development that provides a pathway to health care professions. Inherent in this goal is encouraging organizations to use innovative models that blend traditional and nontraditional health and support cultural and linguistic competency.
- Support and strengthen nonprofits that seek to improve the health of underserved populations through community organizing and advocacy.
- Provide support and foster collaborations for organizations to educate legislators and policy makers on the work of nonprofits in New Mexico on strengthening health equity and on the impact of Medicaid and the Patient Protection and Affordable Care Act to the state's underserved populations.

BEYOND GRANTMAKING

Getting from here to health equity depends on a broad policy focus; collaboration to address social determinants; a multi-stakeholder and sector approach and support for the civic capacity of the community. Con Alma will continue to engage stakeholders in public policy issues, leverage resources to increase philanthropic engagement and dollars for New Mexico, and promote statewide initiatives to improve health. Con Alma Health Foundation's assets go beyond the dollars with which it makes grants; the Foundation will continue to serve as a convener and as a catalyst for positive, systemic change.

Introduction

Mission and History

Con Alma Health Foundation's mission is to be aware of and respond to the health rights and needs of the culturally and demographically diverse peoples and communities of New Mexico. Con Alma seeks to improve the health status and access to health care services for all, and advocates for a health policy which addresses the health needs of all New Mexicans.

Con Alma is New Mexico's largest foundation dedicated solely to health. Over the last 10 years, Con Alma has awarded \$10 million to more than 400 qualified 501 (c)(3) nonprofit, health related, community-based organizations serving New Mexico.

The Foundation was established in 2001 through the conversion of Blue Cross Blue Shield of New Mexico from a nonprofit organization to a for-profit company. The conversion provided charitable assets of \$20 million to benefit the health of New Mexicans, which was used to establish Con Alma Health Foundation (CAHF). Proceeds from a second conversion in 2002, the result of the sale of the Los Alamos Medical Center (LAMC), created the Northern New Mexico Health Grants Group (NNMHGG). The Hospital Auxiliary for LAMC and CAHF, working together as NNMHGG, distribute the investment income from those proceeds to populations traditionally served by LAMC. The Foundation's endowment currently stands at \$23 million, and its policy is to grant up to 5 percent each year in order to preserve the capacity to improve health care in New Mexico for years to come.

MISSION

Con Alma Health Foundation's mission is to be aware of and respond to the health rights and needs of the culturally and demographically diverse peoples and communities of New Mexico. Con Alma seeks to improve the health status and access to health care services for all and advocates for a health policy that addresses the health needs of all New Mexicans.

To achieve our mission, the Foundation lays emphasis on systemic change rather than on direct services. This holistic, expansive focus emphasizes meaningful and sustainable change. A "system" is defined as a collection of things that have some influence on one another, thus are interrelated. Con Alma Health Foundation recognizes that in order to change a system, we must invest in a variety of areas to comprehensively and effectively create positive outcomes.

Principles and Core Values That Guide Our Grantmaking

Con Alma adheres to core values to guide its policies, operations, and grantmaking. Consistent with the core values related to grantmaking, the Foundation:

- defines health broadly to include not only physical health, but also mental, emotional, behavioral, social, oral, environmental, economic, and spiritual health and well-being. This definition represents an approach to both individual and community well-being which impacts local and statewide health systems;
- focuses on the needs of the uninsured and the medically underserved;
- works to reduce health disparities by promoting greater access to health care and improved quality of health care—with a special emphasis on serving culturally diverse, rural, and tribal communities—in order to protect the rights of all New Mexicans to have adequate health care;
- makes grants that emphasize the importance of education, prevention, and personal responsibility while recognizing that the choices we make are limited by the choices we have;
- makes grants to build the capacity of grantees to more effectively accomplish their health missions;
- supports the identification, preservation and communication of traditional practices that maintain, foster, and improve health status; and
- supports community problem-solving, self-definition, and self-determination.

Changes Since 2006

Since our last report in 2006, “Closing the Health Disparities Gap in New Mexico: A Roadmap for Grantmaking,” New Mexico has weathered a national recession and its undefined costs in paying for joblessness, homelessness, uninvolved parents and lost educational opportunities. Our state’s aging population has accelerated, returning veterans from Iraq and Afghanistan are expected to sharply increase the number and need for services, and cultural demographics continue to shift, increasing the minority population to 58.7 percent in the 2010 Census. More of the state’s population is concentrated in urban areas, though rural residents account for a third of the state’s population compared to one fourth nationally. The New Mexico Human Services Department announced in February, 2012 plans to slow the dramatic growth in spending for state services.

In April, 2012 the New Mexico Human Services Department submitted a Centennial Care Plan, which is a Section 1115 Waiver on behalf of the state of New Mexico to the Center for Medicare and Medicaid Services (CMS). This plan proposes to combine all the Medicaid Waivers except for the Disabilities Waiver, which would reduce the number of Managed Care Organization contracts for Medicaid, and provide coverage to all adults at or below 138 percent of the Federal Poverty Level. The plan was withdrawn by Human Services Department. The Department re-submitted the Centennial Care Plan in late August 2012 after several public input sessions and Tribal consultations.

Yet health care reform is on the horizon. The Patient Protection and Affordable Care Act (PPACA) passed in 2010 already has several benefits in place. Several states waited for the Supreme Court Ruling before proceeding. In late June 2012 the Supreme Court decision mostly upheld the current

provisions of the law, which includes changes to Medicaid and Medicare, grants to states for health care finance and delivery innovations, and many provisions relating to health insurance regulation. The decision upholds the individual mandate, although the Supreme Court decided if a person chooses not to participate in buying health insurance, the penalty will be collected as a tax.

The biggest part of the decision that impacts New Mexicans is the change in Medicaid requirements. The decision holds that while Congress may offer states an enhanced federal match if they expand Medicaid to 138 percent of the federal poverty level, Congress may not penalize those states that do not expand Medicaid. If a state chooses to expand Medicaid it would receive 100 percent funding for it for the first 3 years starting in 2014. The fourth year federal funding would decline to 95 percent until 2020 when it would be reduced to 90 percent. The New Mexico Human Services Department at this time has not decided if it will resubmit the Centennial Care Plan or expand Medicaid under PPACA.

Although New Mexico has received multiple funding for planning a New Mexico Health Insurance Exchange (NMHIX), it has not moved forward with creating one. A plan for a Health Insurance Exchange needs to be submitted to the federal government by November 16, 2012. If a state does not submit a plan, that state will have a federal Health Insurance Exchange starting in 2014.

New Mexico was one of only seven grantees nationwide to learn in February, 2012 that it can receive up to \$70.4 million in loans to implement a nonprofit, consumer-governed health insurance plan. Known as a co-op plan, New Mexico Health Connections needs to be a carrier within a New Mexico Health Insurance Exchange in order to operate.

The Foundation does not “prescribe” the best methods and means for achieving community health and well-being. Rather, Con Alma Health Foundation supports community self-determination. We work with the community to support programs and initiatives that the community has identified.

In our 2006 Report, Con Alma targeted health disparities in New Mexico to achieve better health outcomes. This new 2012 report, “Health Equity in New Mexico: Grantmaking and Beyond,” has shifted its focus to achieving health equity, which aligns itself more appropriately with Con Alma Health Foundation’s mission, core values, broad definition of health, and emphasis on systems change. We have also highlighted areas that have not always been traditionally linked to health such as transportation and food sustainability. And we focus on underserved populations such as rural communities, the aging, veterans and immigrants.

The Foundation’s grantmaking has evolved and so has the Foundation’s role as a convener for engaging stakeholders in public policy issues, increasing philanthropic engagement and dollars for the state, and promoting statewide initiatives to improve health for New Mexicans.

Scope and Limitations

This report is not intended to be a definitive or comprehensive document on the status of health and health needs in New Mexico, but rather to help Con Alma Health Foundation focus its work and resources in areas consistent with the Foundation’s resources, mission and core values, and community needs. Con Alma Health Foundation made the decision to release this report to the public due to the significance of the findings and the potential for the information to serve as a resource for others working toward improving health in New Mexico.

Here you will find an update of state and local data, information on health equity and socioeconomic determinants of health, system challenges, and solutions to promote health equity in New Mexico.

Organization of the Report

The report is organized into the following sections:

- **Understanding Health Equity;**
- **Socioeconomic Determinants of Health:** updated state characteristics by age, sex, race/ethnicity, income and poverty, employment, education, foreign-born, and disability;
- **Diversity:** African American, Hispanic/Latino, Native American, Immigrant, and other;
- **Overall Health Report:** Strengths, challenges, behavioral health, childhood obesity, diabetes, low nutrition, obesity, oral health, suicide, teen births; and populations—aging, children and youth, border health, rural, veterans and other underserved populations such as women and LGBT;
- **Systemic Issues:** Insurance coverage, linguistic and cultural access, transportation, health care workforce shortage, Indian Health Services and veteran’s health care;
- **State Health Policy:** Patient Protection and Affordable Care Act (PPACA), insurance reform, Medicaid reform, and long-term care reform; and
- **Solutions:** Grantmaking in action, and grantmaking and beyond.

The Foundation’s Grantmaking continues to evolve, and the Foundation’s role as a convener for engaging stakeholders in public policy issues continues to expand, increasing the philanthropic engagement and dollars for the state, and promoting statewide initiatives to improve health for New Mexicans.

Understanding Health Equity

It is important in a majority/minority state such as New Mexico to understand what health equity means, its impact on the health of its residents and the means to bring down the barriers that prevent all our population from getting adequate health care.

Health equity concerns “those differences in health that can be traced to unequal economic and social conditions and are systemic and avoidable—and so essentially unjust and unfair.”¹ The terms “health disparity” and “health equity”

are sometimes used interchangeably. Although related, there are specific differences between the two concepts.²

Achieving health equity depends on a broad policy focus: we recognize the role of government and public policy to collaborate to address social determinants, approach issues utilizing multi-stakeholders and sectors (public/government, nonprofits/philanthropy and private/business), gain community understanding and participation and support the civic capacity of the community.

HEALTH DISPARITY	HEALTH EQUITY
Any difference in health between groups of people (based on geographic location, gender, socioeconomic status or ethnicity).	The term is based on the belief that everyone is entitled to a healthy life.
Some health disparities are NOT unjust or inequitable (e.g. innate biological differences resulting in different mortality rates between males and females).	Health equity pursues the elimination of health disparities.
However, most health disparities are avoidable, often the result of social or economic conditions or policies (e.g. obesity and smoking rates or the incidence of cancer between lower and upper income families).	Good health requires not only the traditional approach but must also focus attention to “address the broad policy and systems environment that influences health.”
Public health has traditionally attempted to reduce health disparities by targeting its interventions at individuals within vulnerable populations.	Health equity considers the status of the individual within a series of expanding contexts: family, religious/ethnic and other communities, geography, and the larger culture.

There is more to good health than lifestyle choices, genes and access to health care. Individual choices are often seen as a person’s own responsibility to make the right lifestyle choices. But ... the choices we make are limited by the choices we have.

– NEW MEXICO HEALTH EQUITY WORKING GROUP
PROJECT DESCRIPTION

¹ Unnatural Causes, <http://www.unnaturalcauses.org>

² Andress & Associates, LLC, Bridging the Health Gap, <http://www.bridgingthehealthgap.com>

Nationally, there has been a shift in the conversation about health care in the last decade to focus on prevention, access and alleviating equity boundaries. Health care in the United States has improved overall, though racial and ethnic minorities suffer higher rates of mortality and illness from asthma, diabetes and a range of other diseases, compared to other Americans.³ This population also tends to receive a lower quality of health care than non-minorities, even when access-related factors such as insurance status and income are controlled.⁴

An individual's income, education, employment, race/ethnicity, gender, age and language are critical components explaining health outcomes. There are multiple dimensions which explain inequities in health as illustrated by this socio-ecological model (see Figure 1).

Factors in this model include:

- **Family**, which can mediate risks and instill protective factors that influence adolescent substance abuse, early pregnancies or improved nutrition.
- **Geographic location:** The Robert Wood Johnson Foundation reports “our zip code may be more important

to our health than our genetic code.”⁵ People living in rural areas have fewer health care options, have transportation barriers to health care and fewer health care providers, especially in specialty medical areas.

- **Insurance status**, which determines whether individuals seek health care before medical problems are exacerbated.
- **Institutions that educate health professionals and institutions and organizations that deliver care.** If these institutions are culturally attuned to their service areas, more individuals are likely to seek treatment and outcomes are likely to be better.
- **Environmental and work conditions:** New Mexico's population that lives near polluted air or waters or work with materials such as asbestos and radiation are at greater health risk.
- **Neighborhood life** which is cohesive and non-violent, can enhance health outcomes.

The following sections provide a snapshot of the socioeconomic factors and the health systems barriers that affect the health and well-being of racially and ethnically diverse families and children in New Mexico.

Figure 1. Socio-Ecological Model to Thinking about Determinants of Health



Where we live, learn, work and play can have a greater impact on how long and how well we live than medical care.

– ROBERT WOOD JOHNSON ISSUE BRIEF 7, DECEMBER, 2009

³ Closing the Gap: Solutions to Race-Based Health Disparities (2005). Applied Research Center & Northwest Federal of Community Organizations.

⁴ Idem.

⁵ Robert Wood Johnson Issue Brief 7, December, 2009

Socioeconomic Determinants of Health

While New Mexico is world-renown for its multicultural heritage, beautiful landscapes and creativity in art and film, underneath this layer is a litany of ways in which our state has fallen behind:

- It has the second highest poverty rate in the nation.⁶ A family of four with less than \$22,341 annually is counted at the poverty level.⁷
- One out of three of our children live in poverty and more than half of them live in low-income households.⁸
- Almost half of New Mexico's grandparents provide a home for their grandchildren.⁹
- The number of households receiving food stamps (Support Nutritional Assistance Program) has almost doubled during the recession, from 6 percent to 11 percent.¹⁰
- Children ages 0–5 are more likely to die: New Mexico experienced a 20 percent increase in youth death rates since 2000.¹¹
- Only 2 out of 10 New Mexico 4th graders are proficient readers; New Mexico ranks 3rd in the nation for the percentage of teens who do not finish high school.¹²
- High school dropout rates result in low levels of educational attainment with just 25.5 percent of New Mexicans age 25 or older, the key age for entry into the work force, possessing a bachelor's degree.¹³
- Since the recession, more families live in households in which neither parent has had full-time, year-round employment in the last year.¹⁴ Raw unemployment numbers do not tell the whole story: joblessness has fluctuated, with annual 2011 seasonally adjusted numbers at 6.6 percent, which is 1.9 percent below the national average.¹⁵ New Mexico's highest unemployment peaked in 2003 at 5.9 percent, tracking the nation's 5.8 percent.¹⁶

While New Mexico values its diversity of residents, as a minority-majority state, we have among the highest percentage of Hispanics in the United States (46.3 percent based on 2010 census estimates), and 9.4 percent of our population is Native American. People of color fare far worse than their white counterparts across a range of health indicators, according to reports by the Joint Center for Political and Economic Studies.

Age and Sex

Between 2000 and 2010 New Mexico's population grew by 13.2 percent from 1.82 million to 2.01 million.¹⁷ Slightly more—51 percent of the population were female—and 49 percent were male. (See table.)¹⁸ New Mexico has been considered a young state, and, in fact, the number of residents 18 and under is growing to almost one in five of the population (18 percent in 2010).¹⁹

Yet New Mexican can anticipate a commensurate growth from the “age wave.” The largest percent increase from 2000–2010 was among those 60 years to 64 years, at 5.8 percent of the state's population, while those at 65 years and older are expected to grow at a faster rate.²⁰ New Mexico ranks 39th for the percentage of people age 65 or older and is projected to be fourth by 2030.²¹ (See Table 1.)

Table 1. Population by Gender and Age
Source: 2000 and 2010 U.S. Census Data

	2010	2000	CHANGE
NM Total Population	2,059,179	1,819,046	13.2 percent
Male	1,017,421	894,317	13.8 percent
Female	1,041,758	924,729	12.7 percent
Under 5 years	144,981	130,628	11.0 percent
5 to 9 years	143,308	141,171	1.5 percent
10 to 14 years	141,691	147,309	-3.8 percent
15 to 19 years	149,861	145,751	2.8 percent
20 to 24 years	142,370	121,291	17.4 percent
25 to 34 years	267,245	234,091	14.2 percent
35 to 44 years	248,523	282,009	-11.9 percent
45 to 54 years	242,009	245,819	-1.5 percent
55 to 59 years	120,580	87,140	38.4 percent
60 to 64 years	110,532	71,612	54.3 percent
65 to 74 years	153,794	117,745	30.6 percent
75 to 84 years	86,468	71,174	21.5 percent
85 years and over	31,993	23,306	37.3 percent
Median age (years)	36.7	34.6	6.1 percent

⁶ U.S. Census Bureau, American Community Survey poverty data for 2010

⁷ U.S. Census Bureau, 2010, interim report

⁸ Segal, Myra. Interactive briefing in Las Cruces, N.M., September 20, 2011.

⁹ U.S. Census Bureau, American Community Survey, 2008–2010, Table B10051

¹⁰ U.S. Census Bureau, American Community Survey 2008–2010, Table B10051

¹¹ Annie E. Casey Kids Count Data Book

¹² Segal, Myra. Interactive briefing in Las Cruces, New Mexico. September 20, 2011

¹³ U.S. Census Bureau, American Community Survey, Snapshot, Updated January, 2012

¹⁴ Annie E. Casey, Kids Count Data Center

¹⁵ Department of Labor, Bureau of Labor Statistics

¹⁶ New Mexico Department of Workforce Solutions

¹⁷ U.S. Census Bureau, American Community Survey, 2000–2010

¹⁸ Idem.

¹⁹ U.S. Census Bureau, American Community Survey, 2010

²⁰ Idem.

²¹ Idem.

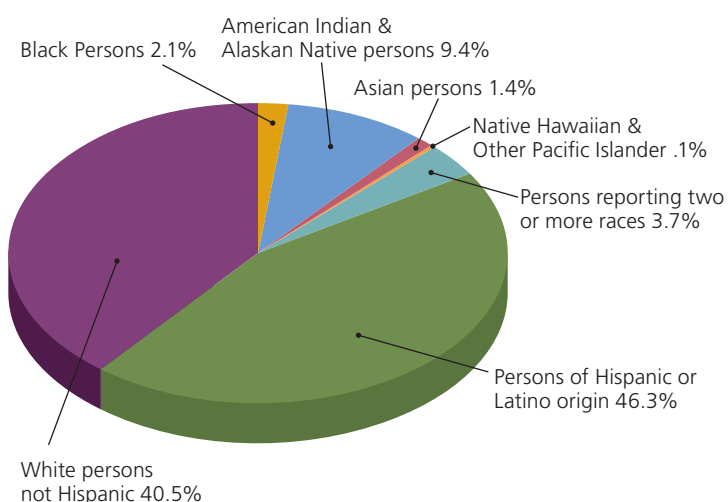
Race and Ethnicity

In 2010 U.S. Census projections, people of color comprised 58.7 percent of the population of the state: Hispanic/Latinos at 46.3 percent, American Indian at 9.4 percent, African American at 2.1 percent and Asian American at 1.4 percent.²² White non-Hispanics represented 40.5 percent of the population.²³ Between censuses, the Hispanic/Latino population was the fastest growing: 24.6 percent. From 2005–2008, the American Indian population had a 5.8 percent growth.²⁴ (See Figure 2.)

It is significant that persons reporting two or more races in New Mexico (2010 Census) was 3.7 percent compared to 2.9 percent in the U.S. overall. The 2010 Census Briefs, Overview of Race and Hispanic Origin: 2010, provides the nation's changing and racial diversity. Findings include:

- More than half of the growth in the total population of the United States from 2000 to 2010 was due to the increase in the Hispanic population.
- Among American children, the multiracial population has increased almost 50 percent, to 4.2 million, since 2000, making it the fastest growing youth group in the country.
- In what experts view as a significant change from 2000, the most common racial combination is black

Figure 2. New Mexico Resident Population by Race & Ethnicity 2010



and white. Ten years ago, it was white and “some other race,” a designation overwhelmingly used by people of Hispanic origin, which is considered by the government to be an ethnicity not a race.

- There are 57 racial combinations on the census. But of the population that chose more than one race, most chose one of the four most common combinations: 20.4 percent marked black and white; 19.3 percent chose white and “some other race.” The third most common pairing was Asian and white, followed by American Indian and white. These four combinations account for three fourths of the total mixed race population.

New Mexico is home to a multicultural population with two large minorities: Hispanics 46.4 percent and Native Americans 9.4 percent. However, because the state has such a small population of other racial/ethnic groups such as African Americans (2.1 percent), Asians (1.4 percent), and other racial/ethnic groups, data is often not collected and many health needs and issues go undiagnosed and untreated.

There is also a growing refugee population in New Mexico, especially the Albuquerque area. From 2000–2008, 2,332 refugees from 28 countries were resettled in Albuquerque. Historically, the majority of refugees were from Cuba and Vietnam. However, recent global events have created an influx of refugees from Iraq, Bhutan, Somalia, and the Democratic Republic of Congo. While Cuban and Vietnamese refugees have the support of a large Spanish-speaking population and an established Vietnamese community, refugees from the Middle East, Central Asia, and Africa have no similar support system and have encountered additional linguistic and cultural challenges to resettlement. These new populations tend to be large, intact families, often with three or more children. This demographic alone presents a new health care challenge with increased needs for gynecological and pediatric care.

²² U.S. Census Bureau, American Community Survey 2010, Quick Facts, updated January, 2012.

²³ Idem.

²⁴ U.S. Census Bureau, American Community Survey, 2005–2009 5 year estimates

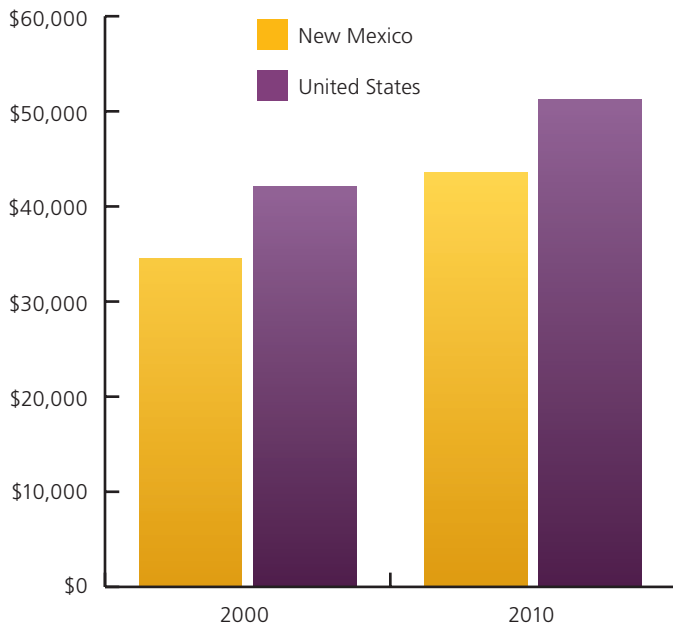
Income and Poverty

New Mexico median household income was well below national income in both 2000 and 2010. The state for 2010 was \$43,569;²⁵ the national median income was \$49,445. (See Figure 3.) Median income is not to be confused with “average household income.” It is considered by statisticians to be the best indicator and reflects households divided into two equal segments with the first half earning less than the median and the other half earning more. Income showed improvement in 2010 when the state median income was 88.1 percent of the United States figure, a gain of 4.5 percentage points over five years.²⁶ In 2010, almost one in five (19 percent) of New Mexico’s population was classified below the poverty level;²⁷ 10 percent of families in the state received food stamps, up from 5 percent in 2008.²⁸

Poverty is the elephant in the room.

– LAS CRUCES FOCUS GROUP PARTICIPANT

Figure 3. Median Household Income 2000 and 2010 New Mexico and U.S.



²⁵ U.S. Census Bureau, American Community Survey 2008–2010 Table B19013

²⁶ U.S. Census Bureau, 2005–2009 American Community Survey 5 year Estimates

²⁷ U.S. Census Bureau, American Community Survey, 2008-2010, Table S1701

²⁸ U.S. Census Bureau, American Community Survey, 2008-2010, Table C22002

²⁹ New Mexico Department of Workforce Solutions, Labor Force Employment and Unemployment, August, 2009

³⁰ Idem.

³¹ Idem.

Employment

A slow but far from reliable recovery in the job market is not keeping pace with the growth in the state’s population. From 2001 to 2010, total employment growth in New Mexico increased by 7.6 percent. Yet, New Mexico’s population increased 13.2 percent between 2000 and 2009.²⁹ By comparison, New Mexico is not growing nearly as fast as neighboring Sunbelt states: Arizona’s population grew by 28.7 percent and Texas’ population grew by 18.8 percent, suggesting that factors identified by the focus groups, such as low educational standards, lack of land use plans and the entrepreneurial climate affect the state’s growth.

According to the New Mexico Department of Labor, the unemployment rate stood at 6.6 percent for 2011 compared to 8.5 in the United States. (See Figure 4.) In New Mexico, 59,297 people were classified as unemployed in 2010, a decrease from 68,546 in 2009.³⁰ New Mexico ranks 17th in the nation, but county unemployment varies greatly, with Luna (16.1 percent) and Mora (12.9 percent) having the highest unemployment rates. Los Alamos County had the lowest unemployment rate at 3.5 percent.³¹

Figure 4. Unemployment Rate 2000 and 2011 New Mexico and U.S.

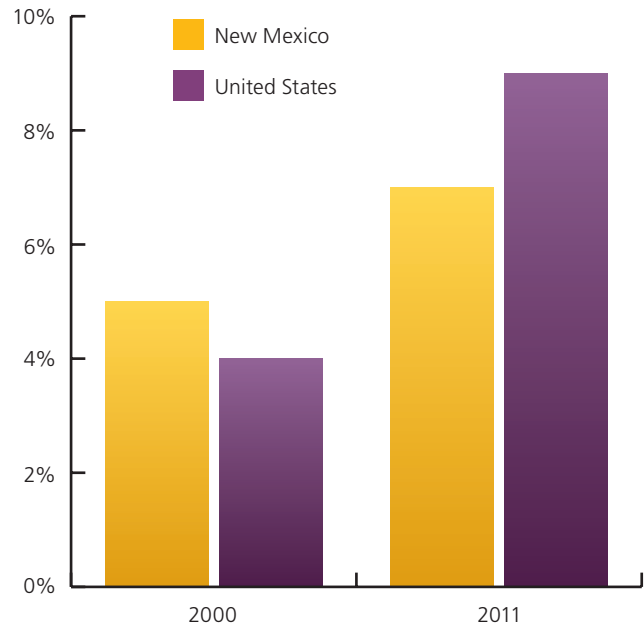
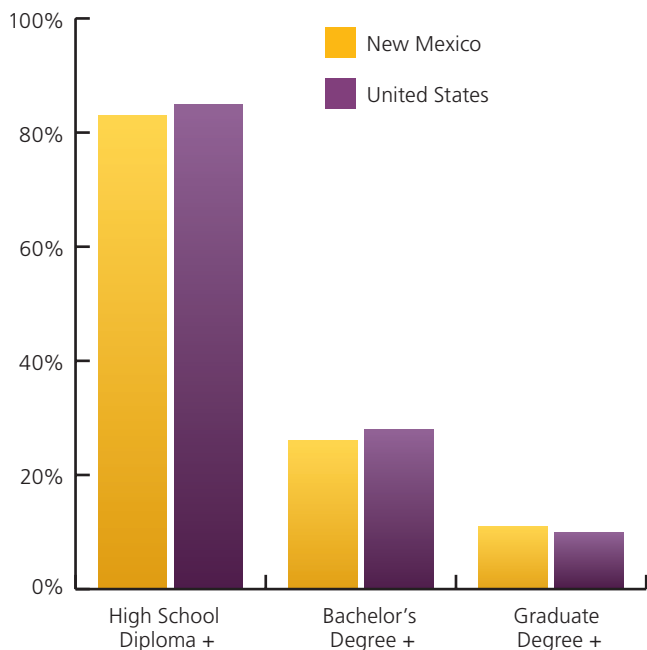


Figure 5. Educational Attainment in Percent of Persons 25 Years and Over By Type of Diploma/Degree New Mexico and U.S.



Education

Though the number of New Mexico's 25-year-olds with high school diplomas and college degrees compare fairly favorably to national statistics, high school dropout rates continue to confound educators. A formula that gives New Mexico students five years to graduate from high school showed 33.8 percent of students dropped out in 2008 before getting a diploma.³² New Mexico ranks slightly below the national percentages of persons 25 years and older with: high school diplomas (82.7 percent in New Mexico compared to 85 percent in the United States); bachelors or higher level degrees (25.5 percent compared to 27.9 percent in the nation).³³ (See Figure 5.)

³² New Mexico Education Department

³³ U.S. Census Bureau, American Community Survey, Quick Facts revised January, 2012

³⁴ Migration Policy Institute, citing 2010 American Community Survey

³⁵ Idem.

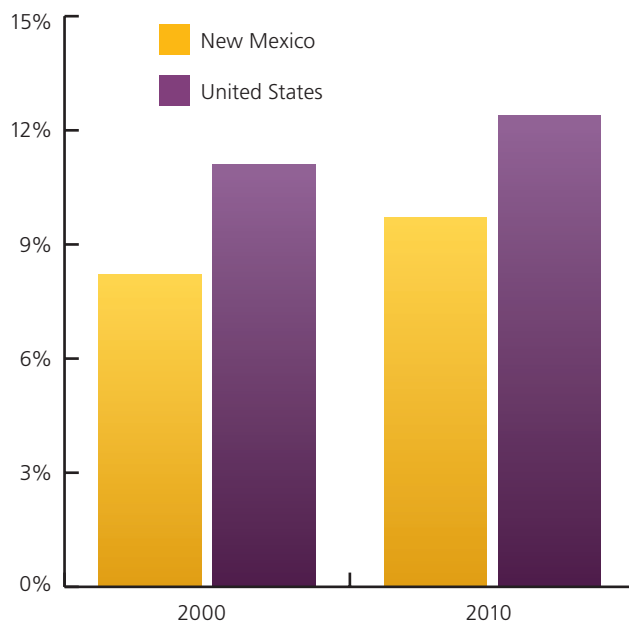
³⁶ Idem.

³⁷ New Mexico Department of Health, New Mexico County Impact; Developmental Disabilities Support Division, January, 2009

³⁸ New Mexico Department of Health, Developmental Disabilities Support Division, New Mexico Community Impact, 2009.

³⁹ Idem.

Figure 6. Percent Foreign-Born Population New Mexico and United States



Foreign-Born

The percentage of the state's population that was foreign-born increased between the censuses, rising from 8.2 percent of the population to 9.9 percent.³⁴ Nationally, the foreign-born population was proportionately larger in the most recent final census: 12.9 percent in 2010, up from 11.1 percent in 2000.³⁵ Among the 50 states and the District of Columbia, New Mexico had the 17th highest percentage of foreign-born persons in 2010, up from a rank of 18th in 2000.³⁶ (See Figure 6.)

Disability

Some 13.6 percent or 269,338 of adult, non-institutionalized New Mexicans report having a disability.³⁷ Age is an important factor in disability, with older age groups having a higher burden of disability than younger age groups. Among those with disabilities requiring assistance, white, non-Hispanic have the highest need at 24.9 percent, followed by Native Americans at 17.1 percent, and Hispanic/Latinos at 15.8 percent.³⁸ About 20 percent of New Mexicans that report a disability have a developmental or cognitive disability.³⁹

Our state is diverse in many ways, including people's health status and the type of health care they receive. Understanding how age, gender, race/ethnicity, education level, and income impact health status is one of the most complex interactions among these and can help explain why some people are healthier than others. Hispanics, Native Americans and African Americans are less likely to access these health services:

- Preventative care: the percentage of adults over age 50 who have received a colonoscopy, sigmoidoscopy, proctoscopy or fecal occult blood test.⁴⁰
- Mental health care: "Staying Healthy," a national report, cites cultural beliefs, the stigma attached to getting care for mental illness, access to competent care and language barriers.⁴¹

The results of the 2009 Adult Behavior Risk Factors and Health Conditions in New Mexico show that:

Hispanic and American Indian adults were over twice as likely to be without health insurance coverage as whites (26.4 percent and 40.9 percent compared to 10.9 percent).⁴² Asian adults also had high coverage, with only 14.5 percent reporting a lack of coverage. Cost was more likely to have prevented African Americans, Hispanics or American Indians than whites from obtaining needed medical care in the past 12 months (26.4 percent, 21.0 percent and 23.6 percent compared to 9.8 percent).⁴³

American Indian adults were more likely to be cigarette smokers than white adults (24.9 percent compared to 16.3 percent).⁴⁴ There was no measurable difference between other groups. The prevalence of tobacco use among American Indian adults has increased significantly in recent years. In 2005, only 15 percent of American Indian adults were current smokers.⁴⁵ Hispanic (67.4 percent) and American Indian (68.0 percent) adults were more likely to be overweight or obese than white (56.7 percent) and Asian/Native Hawaiian and Other Pacific Islander (NHOPI) (49.7 percent).⁴⁶

In no other area is New Mexico showing a more dramatic shift than in the number of children from minority populations: almost three in four children under five is either African American (2 percent), Hispanic/Latino (59 percent) or Native American (12 percent).⁴⁷ We ignore these demographic changes at our peril; the future of the state of our health will be determined by how effectively we prioritize and respond to the culturally and demographically diverse people of New Mexico.

African Americans

New Mexico's African American population is relatively small, comprising only 2.2 percent of the total population.⁴⁸ Among the largest health equity issues affecting African Americans, according to the New Mexico Department of Health's "Racial and Ethnic Health Disparities Report Card" are HIV/AIDS and infant mortality.⁴⁹ African Americans in New Mexico have the highest rate of HIV/AIDS rates at 27.1 per 100,000 as compared to whites' rates of 5.2 per 100,000.⁵⁰ Infant mortality rates are also highest at 13.4 deaths per 1,000, triple the rate of whites at 4.1 per 1,000.⁵¹ Obesity amongst African Americans is also at a higher rate than Native Americans and Hispanics in New Mexico at 34.8 per 100 compared to 33.6 for Native Americans and 28.6 for Hispanics.⁵² It should be noted that data on African Americans in New Mexico is limited and much of the existing data is outdated. The lack of meaningful data could in itself be considered a disparity.

CULTURAL VIEW:

African Americans see opportunities in culturally competent medical care in which assumptions are not made based upon the patient's color or dress. People in this focus group also spoke of including alternative medicine in health care: acupuncture, massage therapy and other forms of treatment typically associated with the white or Asian communities.

⁴⁰ National Quality Report, Agency for Health Care Research and Quality, U.S. Department of Health and Human Services, 2000

⁴¹ Idem.

⁴² Honey, Wayne A., New Mexico Epidemiology, Volume 2011 November, January, 2011.

⁴³ Idem.

⁴⁴ Idem.

⁴⁵ Idem.

⁴⁶ Idem.

⁴⁷ U.S. Census Bureau, American Community Survey B101001.

⁴⁸ U.S. Census Bureau, American Community Survey, 2008–2010 estimates

⁴⁹ New Mexico Department of Health, Racial and Ethnic Disparities Report Card, September, 2011

⁵⁰ Ibid, p. 15.

⁵¹ Ibid, p. 5.

⁵² Ibid, p. 9.

Hispanic/Latinos

Hispanic/Latinos comprise more than 46.3 percent of the New Mexico's total population. More than 83 percent of Hispanic/Latinos are native to the state.⁵³ New Mexico's Hispanics have had a unique history of colonization, which has created a mestizo culture (or mixed race) consisting of Spanish and indigenous roots. This rich, yet tragic complexity of history dates back to the occupation of New Mexico by Spaniards up through contemporary economic and immigration policies and contentious U.S.-Mexico border relations. Today, New Mexican Hispanic/Latinos choose to identify and name themselves in many ways: Hispanic or Spanish Americans, Latinos, Chicanos, Mexicanos.

The Hispanic/Latino population in New Mexico is younger than the rest of the nation, and they are highly concentrated in the border region:

Hispanic/Latino population:

- United States: 15 percent⁵⁴
- New Mexico: 45.5 percent⁵⁵
- New Mexico border region: 55 percent⁵⁶

Hispanic/Latino Youth population:

- United States: 34.6 percent⁵⁷
- New Mexico: 30.8 percent⁵⁸
- New Mexico border region: 32.5 percent⁵⁹

In 2008, 21.3 percent of Hispanic/Latinos were living in poverty as compared to 10.5 percent of whites.⁶⁰ New Mexico's Hispanic/Latinos had a median family income in 2009 of \$36,282 as compared to \$51,405 for whites and \$38,366 for blacks.⁶¹

Educational attainment for the 25 year and older population that identified as Hispanic or Latino in New Mexico was:⁶²

- 15.1 percent with less than ninth grade
- 14.8 percent ninth to 12th grade, no diploma
- 30.2 percent high school graduates
- 20.5 percent with some college, no degree
- 6.1 percent associates degree
- 8.8 percent bachelor's degree, and
- 4.4 percent with graduate or professional degree

According to the New Mexico Department of Health's Racial and Ethnic Health Disparities Report Card, the Hispanic/Latino population had the highest rates for chlamydia, teen births and drug-induced death rates.⁶³ All three rates have shown a decrease from previous years. However, they remain significantly higher than other ethnic groups. Nationally, the rate of new HIV/AIDS cases was more than three times as high for Hispanics as for non-Hispanic whites.⁶⁴

CULTURAL VIEW:

A common thread that ran through the description of each priority was the opportunity to address the Hispanic/Latino community in a culturally competent manner to promote people's use of services. Participants noted that the attitudes toward behavioral health issues make it difficult for Hispanics/Latinos to seek help and recommended that behavioral health should be available and integrated with services at community clinics that serve Hispanics/Latinos. A higher mortality rate for those with HIV/AIDS is also due to a reluctance to seek early intervention. Cultural traditions of "looking after our own" and using traditional healing/medicines mean different approaches, more home-based care, respite, etc., and more training and use of *promotoras* and *curanderas*.

Though data would have us believe that Hispanics/Latinos underutilize long-term/residential care for the elderly and over-utilize home care, these terms reflect a judgment based on assumptions that are culturally inappropriate for Hispanic/Latino families where home care is a community tradition/norm. Respite care and other ways to make home-based care effective and efficient are culturally appropriate. Preventative outreach to Hispanic/Latino peoples can be effective through collaborations with churches, ESL classes, fiestas or other venues where people gather.

⁵³ 2009 Population Estimates; U.S. Census Bureau

⁵⁴ U.S. Census Bureau, 2009 American Community Survey

⁵⁵ U.S. Census Bureau, 2009 American Community Survey

⁵⁶ U.S. Census Bureau, 2005–2009 American Community Survey; Grant, Hidalgo, Luna, Doña Ana, Sierra, Otero

⁵⁷ U.S. Census Bureau, 2009 American Community Survey; age <18

⁵⁸ Idem.

⁵⁹ U.S. Census Bureau, 2005–2009 American Community Survey; same 6 border counties, age <18

⁶⁰ U.S. Census Bureau, 2005–2009 American Community Survey 5 year Estimates

⁶¹ Idem.

⁶² U.S. Census Bureau, 2009 Population Estimate

⁶³ New Mexico Department of Health "Racial and Ethnic Health Disparities Report Card", August, 2010, p. 3.

⁶⁴ National Quality Report, Agency for Health Care Research and Quality, U.S. Department of Health and Human Services, 2000

Immigrants

Almost one in 10 of New Mexico's population is foreign-born (9.5 percent) and that number is expected to increase. Among the border counties of New Mexico, 16.7 percent of the population is foreign-born.⁶⁵ The border counties of New Mexico include, Doña Ana, Grant, Hidalgo, Luna, Otero, and Sierra counties. All border counties are located within 100 miles of the New Mexico/Mexico border. A large majority of the foreign-born population from the border counties of New Mexico (86 percent) are from Latin America.⁶⁶ The second largest group is from Europe (7.7 percent) and then Asia (4.5 percent).⁶⁷ The foreign-born population experiences large health disparities in New Mexico. Of the people that are in the border states of New Mexico, 35.1 percent live below 100 percent of the poverty level.⁶⁸

In New Mexico, most of the foreign-born population is from the world regions of Latin America (78.3 percent), Asia (9.5 percent), and Europe (7.9 percent).⁶⁹ While the median age of all foreign-born population in New Mexico was 40.7 in 2009, it is expected to decrease.⁷⁰ The median age for those entered 1990 to 1999 was 35.2 years and the median age for those entered 2000 or later was 29.0 years.⁷¹ About 18.9 percent of the foreign-born population in New Mexico has a high school degree or its equivalency.⁷² One third of the foreign-born population in New Mexico works in service occupations, followed by construction, maintenance, and repair occupations.⁷³ Of the immigrant population in New Mexico, 25.9 percent live below 100 percent of the poverty level.⁷⁴

Research on Hispanic/Latino health status demonstrates that the more acculturated Latinos become, their health tends to worsen. This is considered the "Latino Paradox," an irony about Hispanic/Latino immigrants that is still being teased out by the U.S. Centers for Disease Control and Prevention. As a group, arriving immigrants tend to be healthier with lower rates of heart disease, cancer and stroke, the biggest killers of people in the United States.

Thus, funding health interventions that promote the health and well-being of Hispanic/Latino communities should take these sub-cultural variations and acculturation into consideration.

CULTURAL VIEW:

A focus group was held in southern New Mexico with members of the immigrant community. They spoke of people's fear of seeking treatment, lack of access to government programs and a cultural divide between native Hispanic/Latinos and immigrants that manifests in local clinics. One advocate told of immigrants living in apartment complexes with mold and mildew, whose children have respiratory issues, yet they are reluctant to get help. Advocates also spoke of the opportunity for immigrants to create better relationships with existing populations.

Native Americans

Historical trauma is a phrase associated with Native Americans. This means the social consequences of U.S. policies and practices of genocide, slavery and forced assimilation have created an intergenerational phenomena affecting health.⁷⁵ It has been documented that historical trauma and oppression, along with chronic under-funding of the Indian Health Services have had a detrimental impact on the health and well-being of indigenous peoples.^{76 77 78}

Native Americans in New Mexico comprise 9.4 percent of the population.⁷⁹ Native Americans are composed of diverse sub-groups with distinct languages, customs and beliefs and are located in both rural and urban communities. In Bernalillo County, for example, there are more than 400 tribal affiliations.⁸⁰ Populations within tribal communities range from fewer than 50 individuals counted as living at Picuris Pueblo to more than 40,000 people on the Navajo Nation in New Mexico.⁸¹ (See Figure 7.)

⁶⁵ U.S. Census Bureau, 2005–2009 American Community Survey 5 year Estimates

⁶⁶ Idem.

⁶⁷ Idem.

⁶⁸ Idem.

⁶⁹ Idem.

⁷⁰ Idem.

⁷¹ Idem.

⁷² Idem.

⁷³ Idem.

⁷⁴ Idem.

⁷⁵ Maria Yellow Horse Brave Heart, Models for Healing Multicultural Survivors of Historical Trauma, December 7–11, 2004, Albuquerque, N.M. Sponsored by the Takini Network.

⁷⁶ Duran, E. and Duran, B. (1995). *Native American Postcolonial Psychology*. Albany: State University of New York Press.

⁷⁷ Yellow Horse Brave Heart, M. & DeBryun, L.M. (1998). The American Indian Holocaust: Healing Historical Unresolved Grief. *American Indian and Alaska Native Mental Health Research*, 8 (2), p. 56–78.

⁷⁸ Yellow Horse Brave Heart, M. (2003). The historical Trauma Response Among Natives and Its Relationship with Substance Abuse: A Lakota Illustration. *Journal of Psychoactive Drugs*. 35 (1), p. 7–13.

⁷⁹ U.S. Census Bureau, 2009 Population Estimates

⁸⁰ New Mexico BluePrint for Health

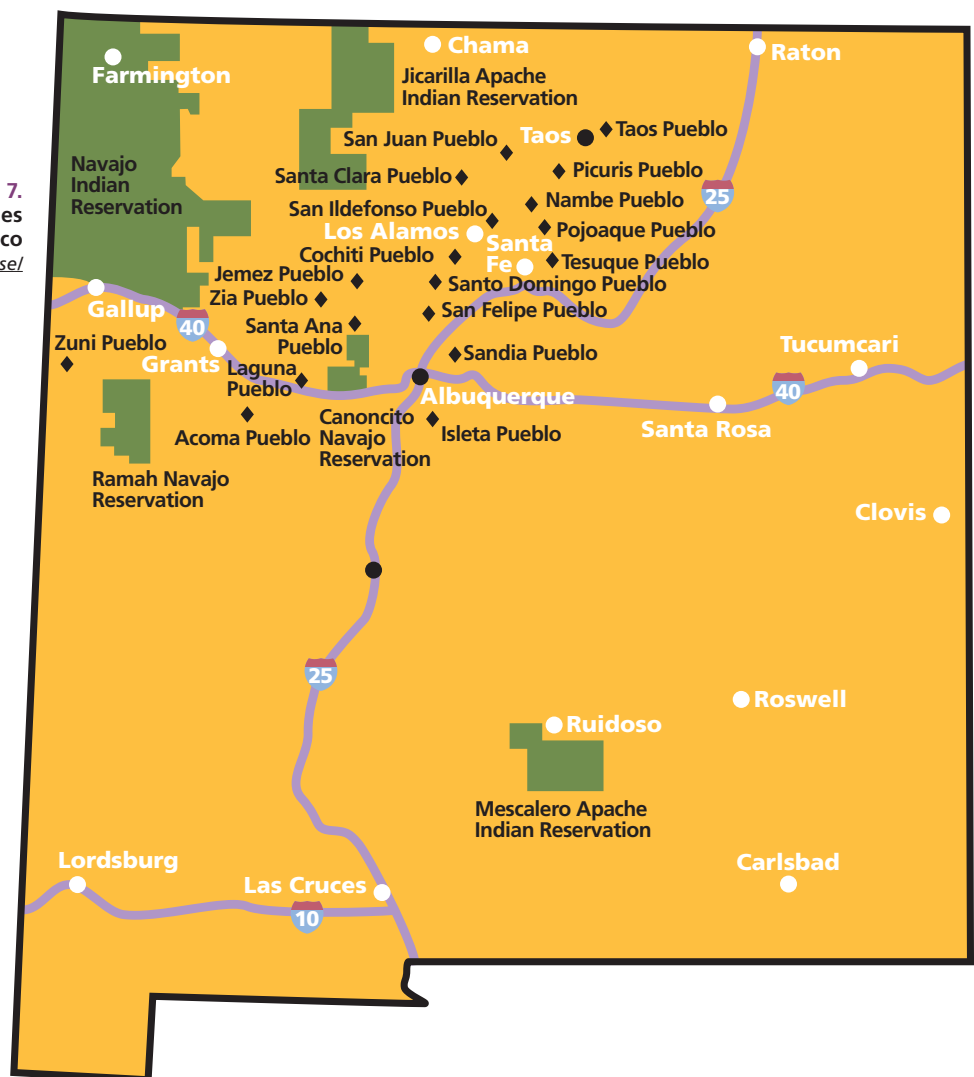
⁸¹ Native American Children in New Mexico: Snapshots from the U.S. Census (2005) Revised 2008. A Kid's Count Special Report, New Mexico Voices for Children.

- In 2008, Native Americans were 50 percent more likely to die from alcoholism, 20 percent more likely to die from diabetes and 150 percent more likely to have an accidental death than the rest of the United States.⁸²
- Native Americans have the highest prevalence of type 2 diabetes in the world, which is a significant threat to Native children.⁸³
- Heart disease is the number one cause of death among Native Americans.⁸⁴
- Sudden Infant Death Syndrome (SIDS) was the leading cause of infant death among children born to American Indian and Alaska Native mothers who live in Urban Indian Health Organization service areas.⁸⁵
- Twenty-seven percent of all Native American children live under federal poverty level.⁸⁶

- The median income of Native American families is half that of non-Hispanics in New Mexico.⁸⁷
- Native Americans suffered the highest rates of diabetes death, pneumonia/influenza death, alcohol-related death, motor vehicle injury death, shigellosis, adolescent driving under the influence, adolescent illicit drug use, and adolescent overweight status; and a large increase in the adult smoking rate.⁸⁸
- Native Americans suffered the greatest disparity changes for pneumonia/influenza death and diabetes death, for which disparities increased, and hepatitis A and shigellosis, for which disparities decreased.⁸⁹
- Native American youth are almost twice as likely to commit suicide.⁹⁰

Figure 7.
Tribal Communities
in New Mexico

Source: <http://www.ihs.gov/albuquerque/newsunrise/>



⁸² Indian Health Service Fact Sheet. U.S. Department of Health and Human Services: Indian Health Service. <http://info.ihs.gov/Disparities.asp>. Updated June, 2008.

⁸³ U.S. Census 2009.

⁸⁴ Idem.

⁸⁵ Idem.

⁸⁶ Centers for Disease Control and Prevention, 2008 National Vital Statistics Report

⁸⁷ Idem.

⁸⁸ Centers for Disease Control and Prevention, 2008 National Vital Statistics Report

⁸⁹ Idem.

⁹⁰ New Mexico Indian Health Disparities Report Card, 2010

CULTURAL VIEW:

Native Americans in our focus groups cited issues of “power and privilege” in New Mexico’s Pueblos, implying that some tribal members receive better treatment in all areas, including health care, than others. Tribal members cautioned that tobacco statistics should be viewed through the lens of their traditional use in religious ceremonies. They are concerned about high rates of poverty, alcoholism and suicide, the lack of safe and adequate housing, and the preponderance of single mothers and veterans. On a positive note, they told how traditional Feast Days have evolved so that more vegetables and healthy foods are served and that guests are encouraged to eat less by “taking a small piece of food, bless it and eat it.” They also said that by reflecting upon how ancestors might have dealt with sociological or health issues, people of Native American heritage have opportunities to find “answers within.”

*The healthy lifestyle
is in our prayer.*

– NATIVE AMERICAN FOCUS GROUP PARTICIPANT

GRANTMAKING IN ACTION

Alamo Navajo School Board received a Con Alma Health Foundation \$45,000 multi-year grant to support leadership training and wellness activities in the Alamo Navajo Community, one of the poorest and most rurally isolated Native communities in New Mexico.

Additional Ethnic Groups

As has been the tradition in our nation, New Mexico has become a home for diverse cultures that come seeking economic opportunities or freeing oppression. Asians account for the largest number of these groups at 1.4 percent, though there are also Tibetans (Santa Fe is a Tibetan refugee site), Sri Lankans and many other ethnic groups. While their numbers may be far less than 1 percent, each has its own special needs and challenges that require attention, and the health care system must recognize that each has culturally specific needs. Further emphasizing this increasing dichotomy are those in New Mexico who chose to identify as two or more races in the 2006–2010 U.S. Census: 3.7 percent.⁹¹

⁹¹ U.S. Census Bureau, American Community Survey, 2010

Overall Health Report

In 2010, New Mexico ranked 33rd in overall health out of the 50 states according to the United Health Foundation, *America's Health Rankings*.⁹² Since 2000, New Mexico has ranked between 28th and 38th in the United States, with an average ranking of 33rd.⁹³ Therefore, it would be inaccurate to say New Mexico is advancing in its overall health.

New Mexico is a large and diverse state; it is ranked fifth in the United States in area, covering 121,589 square miles.⁹⁴ This makes the strengths and challenges vary by race/ethnicity and area of New Mexico.

Strengths

New Mexico was ranked as the top state in healthy living and seventh in the well-being index based on a Gallup Poll analysis in 2009, joining other Western states that demonstrate healthy behavior patterns due to a clean environment.⁹⁵ The research evaluated lifestyle, healthy behaviors, work environment, physical health, emotional health, and access to basic necessities.

Because of its low population, relationships tend to be closer, and individuals are more likely to receive personal support in an effort to meet their health care needs. Cultural values also tend to support personalized health care and openness to alternative care. The high number of nonprofits focused on health care provides opportunities for enhanced care and for health care reform.

GRANTMAKING IN ACTION

New Mexico Center on Law and Poverty was awarded a Con Alma Health Foundation multi-year grant of \$40,000 to increase access to health care for underserved New Mexicans statewide.

Fewer New Mexicans are likely to die of heart disease and cancer and fewer infants will die before the age of one than in the United States as a whole:

- The cardiovascular death rate was 241.6 deaths per 100,000 population in 2009.⁹⁶
- The death rate due to cancer was 161.7 deaths per 100,000 population in 2009.⁹⁷
- Infant mortality for children under the age of one was down in 2010 from 2008: 5.0 from 5.1 respectively, as compared to the national number of 6.8.⁹⁸
- Children are receiving their recommended vaccinations: 84 percent of children aged 24-35 months have received the recommended vaccine series of 4 DTaP, 3 Polio, 1 MMR, 3 HepB, 3 Hib, and 1 Varicella by their second birthday in 2010.⁹⁹

The United Health Foundation Health Rankings of 2009 state that New Mexico strengths also include: high public health funding at \$132 per person, low levels of air pollution at 6.5 micrograms of fine particulate per cubic meter and a low prevalence of binge drinking at 11.9 percent of the population.¹⁰⁰ Focus group participants see opportunities to expand health care through the high number of two-year and four-year higher educational institutions located in their communities.

*One of our greatest strengths
is our people.*

– ESTANCIA FOCUS GROUP PARTICIPANTS

Challenges

Though New Mexico's clean air and lifestyle may result in some positive health outcomes, educational attainment and access to care continue to pose challenges. Among these is limited access to adequate prenatal care with 73 percent of pregnant women receiving adequate prenatal care, a high rate of uninsured population at 26.7 percent, and children in poverty at 25.2 percent of individuals under age 18.¹⁰¹ Focus groups identified socioeconomic issues such as the cycle of poverty that results in high school dropout rates, which leads to underemployment.

According to the 2009 United Health Foundation Health Rankings, New Mexico challenges also include: a high violent crime rate at 650 offenses per 100,000 population and high geographic disparity of health care within the state at 15.7 percent.¹⁰²

⁹² American Health Rankings, United Health Foundation, 2010

⁹³ Idem.

⁹⁴ U.S. Census 2009

⁹⁵ Gallup-Healthways Well-Being Index and Life Evaluation Index data from Jan, 2008–Apr, 2009

⁹⁶ Bureau of Vital Records and Health Statistics

⁹⁷ New Mexico Department of Health, Selected Health Statistics Annual Report

⁹⁸ Bureau of Vital Records and Health Statistics.

⁹⁹ New Mexico Department of Health, Indicator Based Information System

¹⁰⁰ 2009 America's Health Rankings, United Health Foundation

¹⁰¹ U.S. Census Bureau, Current Population Survey, 2009

¹⁰² 2009 America's Health Rankings, United Health Foundation

Other challenges are highlighted as follows, in alphabetical order:

BEHAVIORAL HEALTH

Substance abuse/dependence and/or mental disorders affect more than half a million individuals in New Mexico or about one in four—24.3 percent—of the state’s total population.¹⁰³ Between 25 and 35 percent of people with substance abuse and/or mental health disorders will need services from the publicly funded system of care (Medicaid, Medicare, HIS, other sources of state and federal payment).¹⁰⁴

Eight of the 10 leading causes of death in New Mexico are at least partially caused by the abuse of alcohol, tobacco, or other drugs.¹⁰⁵

The New Mexico Human Services Department’s 2006 Needs Assessment estimated that 9,025 youth and 131,112 adults (including 3,047 individuals in state’s jails and prisons) have substance abuse disorders.¹⁰⁶ In New Mexico, the death rate due to alcohol is 19 deaths per 100,000 people, and the death rate due to drugs is 22.3 deaths per 100,000 people.¹⁰⁷

Typically, mental health providers rely on government contracts for a major source of funding, despite significant cuts in recent years. As new policies further narrow the eligibility to access health and human services, it is possible that fewer public dollars will be available to support these programs. Funding provided for health and substance abuse services in New Mexico is currently inadequate to meet the behavioral health needs of New Mexico’s residents. In addition, there are inadequate numbers of licensed practitioners in the state as a whole, and particularly outside Albuquerque and Santa Fe.

Focus group participants identified these additional opportunities:

- Psychiatric care is limited: current mental health services should be mapped to determine if they are adequate.
- New Mexico’s high levels of obesity and diabetes are linked to behavioral health and should be co-treated.
- Substance abuse is co-occurring with mental illness and could be treated together.

- Gambling addiction is more prevalent and is viewed as a behavioral health issue, which can be treated.
- Behavioral health should be available and integrated with services at community clinics that serve Hispanics/Latinos (and other communities of color) in a culturally competent way.
- We need more training for medically and behavioral health-appropriate interpretation services.

Some health ‘authorities’ report that Hispanics under-utilize long-term/residential care for the elderly and “over-utilize” home care. These terms reflect a judgment based on assumptions that are culturally inappropriate for Hispanic/Latino families. Home care is a community tradition/norm. Respite care and other ways to make home-based care effective and efficient are culturally appropriate.

– HISPANIC FOCUS GROUP PARTICIPANT

CHILDHOOD OBESITY

Nationally, childhood obesity is a growing health epidemic, which has a spiraling effect into adulthood. In 2008, more than one third of children and adolescents in the United States were overweight or obese. The New Mexico Department of Health found in 2012 that more than one in five third graders are obese and weigh an average of 102 pounds. More than one third of Native American third graders are obese.¹⁰⁸ The Department calls these massive weight gains at an early age a contradiction to the widely held belief that obesity occurs at later ages.¹⁰⁹ In New Mexico, childhood obesity rates climbed 3.3 points in four years, with 13.5 percent of children reporting obesity in 2009.¹¹⁰ The Centers for Disease Control and Prevention reported in 2011 that from 1980 to 2008 the percentage of adolescents aged 12–19 years who are obese more than tripled and that these individuals are at greater risk for type 2 diabetes, bone

¹⁰³ New Mexico Human Services Department (2006). Needs Assessment, Resource Inventory & Demographic Data.

¹⁰⁴ Idem.

¹⁰⁵ New Mexico Department of Health, New Mexico Substance Abuse Epidemiology Report, October, 2010

¹⁰⁶ Quick Facts 2010, New Mexico Health Policy Commission, December 2009, p.117–118.

¹⁰⁷ New Mexico Selected Health Statistics Annual Report 2007; The State Center for Health Statistics, Bureau of Vital Records and Health Statistics

¹⁰⁸ Oliver Uytterbrouck, Albuquerque Journal, “8-year-olds Tipping Scales at 100 Pounds, February 25, 2012

¹⁰⁹ Idem.

¹¹⁰ New Mexico Department of Health Indicator Based Information System

and joint problems, sleep apnea, and social and psychological problems such as stigmatization and poor self-esteem. A child born to overweight parents, either mother or father, has a genetic predisposition to diabetes.¹¹¹

Overweight and obesity are the result of “caloric imbalance”—too few calories expended for the amount of calories consumed—and are affected by various genetic, behavioral, and environmental factors. A leading environmental factor is the use of television, video games, other digital devices, lack of outdoor activities and the decline in school-based exercise. For example, only 30.2 percent of New Mexico children had daily physical education classes in 2009.¹¹²

Physicians play an important role in encouraging children’s healthy eating. The American Academy of Pediatrics recommends that pediatricians discuss and promote healthy diets with their young patients.

What’s happened to riding bikes? Now it’s cool if you smoke and eat at McDonald’s.

— ALBUQUERQUE FOCUS GROUP PARTICIPANT

DIABETES

Not only is diabetes costly to the state: \$1 billion a year, according to the New Mexico Department of Health, but diabetes complications are costly to individual well-being and include premature death, cardiovascular disease, blindness, end stage kidney disease and lower extremity amputations. People with diabetes are two to four times more likely to develop cardiovascular disease and stroke. The costs of diabetes extend beyond medical costs, such as lower productivity, disability and premature death.¹¹³

Diagnosed diabetes rates were 8.3 percent in the United States in 2009, compared to 7.9 percent of New Mexicans.¹¹⁴ Diabetes shows racial/ethnic variables in New Mexico:¹¹⁵

- Native Americans: 14.9 percent
- African Americans: 14.2 percent
- Hispanic/Latinos: 12 percent
- White/non-Hispanics: 5.9 percent

Close to 220,000 people in New Mexico likely have diabetes, reports the New Mexico Department of Health. That is because 174,000 were under treatment in 2007–2009 and an estimated one third of people (42,700) with diabetes do not yet know they have it.¹¹⁶

LOW NUTRITION

If we eat right, we are more likely to stay healthy. Appropriate nutritional intake reduces poor health outcomes, such as diabetes, obesity and heart disease. Yet, nationally half of children do not get health provider advice about healthy eating habits. Between 2001–2005 the number rose for children ages 6–17: from 45.4 percent to 52.1 percent.

In New Mexico and the United States, the percentage of adults who reported consuming five or more fruits and vegetables each day is increasing, while still inadequate to insure health outcomes. From 2005 to 2009, those who eat fruits and vegetables each day have increased from 21.5 percent to 23.2 percent in New Mexico.¹¹⁷ In the United States, the number has increased from 23.2 percent to 23.4 percent.¹¹⁸ In New Mexico, there is a significant difference between men and women in fruit and vegetable nutritional habits: 19.8 percent of men report consuming five or more fruits and vegetables each day, while 24.8 percent of women report consuming five or more fruits and vegetables each day.¹¹⁹ Among high school adolescents in New Mexico, in 2009, 20.9 percent report consuming five or more fruits and vegetables each day.¹²⁰ In the United States, about 22.3 percent report consuming five or more fruits and vegetables each day.¹²¹

Finding fresh, healthy food is an issue for many because of the distance from farm to table. Farmers’ markets in New Mexico are open seasonally throughout the state, and some residents have home gardens. Some 50 unique farmers’ markets are available, reflecting the particular character of local cultures and vegetation.¹²² Nevertheless, focus group participants reported that markets are not open year round and that efforts to farm locally are thwarted by a changing lifestyle that includes time demands at work, lack of interest in traditional acequia irrigation by the younger population, increased subdividing of rural lands and lack of space to garden for apartment dwellers.

¹¹¹ Centers for Disease Control and Prevention

¹¹² New Mexico Department of Health Indicator Based Information System Report

¹¹³ New Mexico Department of Health Indicator Based Information System, Updated November, 2011

¹¹⁴ New Mexico Department of Health Indicator Based Information System, Updated August, 2011

¹¹⁵ Idem.

¹¹⁶ New Mexico Department of Health Indicator Based Information System.

¹¹⁷ Bureau of Vital Records & Health Statistics, 2009

¹¹⁸ Idem.

¹¹⁹ Idem.

¹²⁰ Idem.

¹²¹ Idem.

¹²² www.farmersmarketsnm.org, retrieved March 1, 2011.

Our school lunches are appalling, and by the time we get fruits and vegetables here, they're no good to eat.

– SILVER CITY FOCUS GROUP PARTICIPANT

OBESITY

The percentage of obesity among the total population of New Mexico doubled from 1990 to 2009; it was 25.6 percent in 2009.¹²³ Obesity is associated with an increased risk for a number of chronic diseases, including heart disease, stroke, diabetes, and some cancers. More New Mexico adolescents are obese: 12 percent, compared to the national 13 percent, putting them at high risk for diabetes, high blood pressure, and other preventable diseases.¹²⁴

There are variables among racial/ethnic groups:¹²⁵

- Native Americans: 33.7 percent obese
- Hispanics: 28.7 percent obese
- White/non-Hispanic: 20.4 percent obese
- African Americans: 34.8 percent obese

Focus group participants were well aware of the obesity epidemic and attributed it to a changing lifestyle in which children are rarely asked to do chores—certainly not farm chores as in the past—and in which adults eat inappropriately, including a reliance on “fast food” chains.

Opportunities groups identified:

- Holistic approach to diabetes care
- Return to rural gardening
- More active use of farmers’ markets

ORAL HEALTH

Poor oral health may result not only in potential tooth loss, but also in poor nutrition and impaired general health, particularly impacting the mortality rate due to heart disease at younger ages. Almost one in five people over 65, 18.1 percent of the population, have lost all their teeth,

while 41.2 percent has lost six or more teeth.¹²⁶ Among the younger population, more than one third (37 percent) of third grade students have untreated tooth decay.¹²⁷

Some 64 percent of New Mexico’s population visited the dentist or dental clinic within the past year based upon a 2008 measurement, and 64.3 percent had their teeth cleaned by a dentist or a dental hygienist in that time period.¹²⁸ Other oral health care data for 2008:

- 1,247 people received dental screenings by a state program
- Dental sealants and fluoride varnishes were provided to 5,786 children
- Oral Health Education and Promotion services were provided to 13,832 people¹²⁹

New Mexico ranks in the middle of the nation for people receiving fluoridated water, with 77.0 percent of the population on public water systems providing fluoridated water.¹³⁰ New Mexico ranks 25th among all states for the numbers of people receiving fluoridated water.¹³¹

The state is home to three dental hygiene schools¹³² and 36 community-based low-income dental clinics.¹³³

The New Mexico state Medicaid program has limited dental benefits, though pregnant women receive comprehensive dental benefits. The New Mexico SCHIP program does not have adult dental benefits. These programs do not always reach the rural areas in New Mexico where dental care is most needed. The majority of dental care is utilized in Bernalillo and Santa

ORAL HEALTH INITIATIVE

With funding support from the W.K. Kellogg Foundation, Con Alma Health Foundation partnered with community based nonprofit organizations to explore the feasibility and public will to increase the dental workforce through a mid-level oral health practitioner model in New Mexico. Information on the initiative is outlined in the Foundation’s [“Key Findings Report on New Mexico’s Oral Health Gap, 2009–2010.”](#)

¹²³ New Mexico Department of Health Indicator Based Information System.

¹²⁴ Idem.

¹²⁵ Idem.

¹²⁶ BRFSS 2008, from Center for Disease Control Health Resources

¹²⁷ State Oral Health Survey, New Mexico Department of Health, Office of Dental Health 2003; Centers for Disease Control and Prevention Oral Health Resources

¹²⁸ Centers for Disease Control and Prevention, Oral Health Resources, BRFSS 2008

¹²⁹ Idem.

¹³⁰ Centers for Disease Control and Prevention Water Fluoridation Reporting System, 2008 Water Fluoridation Statistics

¹³¹ Idem.

¹³² State Dental Program Information, reported by New Mexico State Dental Director, 2009 Centers for Disease Control and Prevention National Oral Health Surveillance System, State Oral Health Profile

¹³³ Idem.

Fe counties, which receive about 55 percent of the state's total dental care.¹³⁴ However, these two counties represent only 39 percent of New Mexico's total population.¹³⁵

The state is experiencing a dental care shortage. In 15 of the 33 counties of New Mexico, there are 5 or fewer dentists. There are zero dentists in Guadalupe, Harding, Hidalgo, Mora, and Union counties.¹³⁶ Of particular concern are Cibola, Colfax, Roosevelt, Socorro, Torrance, and especially Rio Arriba County, which have a higher disparity of per capita dentists. Rio Arriba County had a population of 44,167 in 2009 and five dentists.¹³⁷

SUICIDE

Suicide rates in New Mexico are considerably higher than those in the rest of the United States at 19.5 deaths per 100,000 people.¹³⁸ Our state is one of seven in the nation that showed a significant increase in the number of suicide deaths from 1999–2005.¹³⁹ Suicide is the second leading cause of death, behind traffic and other accidents, of people ages 15–24.¹⁴⁰

The reasons for suicide are complex, but may include depression, lack of access to medical services, alcohol and substance abuse, and access to firearms. Suicide rates are higher in rural, western states. Suicide rates among young people may be related to stress, confusion and depression from situations occurring in their families, schools and

communities. Such feelings can overwhelm young people and lead them to consider suicide as a “solution.” Few schools and communities have suicide prevention plans that include screening, referral and crisis intervention. Suicide rates increase with age and are very high among those 65 years of age and older, because older adults are more likely to be suffering from a physical illness and be divorced or widowed.¹⁴¹

TEEN BIRTH RATES

Though teen birth rates have been declining in New Mexico for many years, in 2009 New Mexico ranked second highest in the nation for teen birth rates with only Mississippi reporting more births to teens 15–19 years old.¹⁴³ Some 63.9 births per 1,000 in New Mexico in 2009 were to mothers ages 15–19. Teen mothers are less likely to receive adequate pre-natal care, putting them at risk for high blood pressure, gestational diabetes and other disorders.¹⁴⁴ Focus group participants spoke of even younger populations becoming pregnant, including elementary school students, and of cultural acceptance of teen pregnancies. The infants born to these mothers are at risk for a number of health problems, including low birth weight, neonatal death and Sudden Infant Death Syndrome. Most young teen mothers are less likely to get or stay married or complete high school. They are also more likely to have a lower income and require public assistance.

A side effect of teen pregnancy is that more grandparents have become caregivers for children. Kids Count 2012 Report cites that up to half of grandchildren living with their grandparents are also being cared for by them. In New Mexico, the prevalence of grandparent householders responsible for their own grandchildren under 18 years was 65.9 percent in 2008 and 52.1 percent in 2009.¹⁴⁵ While this is a significant decrease, New Mexico's prevalence is high compared to other states. In the United States, the prevalence of grandparent householders responsible for their own grandchildren under 18 years was 54.7 percent in 2008 and 40.3 percent in 2009.¹⁴⁶ This can put a significant financial burden on grandparents raising grandchildren, where 20.5 percent of this population is below the poverty level.¹⁴⁷

You immunize your children against illness and disease; why not immunize them against suicide by asking tough questions early on.

— APRYL MILLER, CLINICAL DIRECTOR,
NEW MEXICO SUICIDE INTERVENTION PROJECT'S
SKY CENTER¹⁴²

¹³⁴ 2009 Geographic Access Data System Selected Healthcare Professionals in New Mexico; New Mexico Health Policy Commission, Revised May 2010

¹³⁵ U.S. Census 2009

¹³⁶ New Mexico Health Policy Commission, 2009 GADS Report, revised September, 2010

¹³⁷ 2009 Geographic Access Data System Selected Healthcare Professionals in New Mexico; New Mexico Health Policy Commission, revised May 2010

¹³⁸ New Mexico Selected Health Statistics Annual Report 2007; The State Center for Health Statistics, Bureau of Vital Records and Health Statistics

¹³⁹ National Health Care Disparities Report, U.S. Department of Health and Human Services, AHRQ Pub. No. 09-0002

¹⁴⁰ Ibid.

¹⁴¹ Ibid., p. 56

¹⁴² Robert Nott, “Schools, Agencies and Peers Aim to Prevent Teen Suicides,” *Santa Fe New Mexican*, February 12, 2012.

¹⁴³ Centers for Disease Control and Prevention, National Vital Stats Report, updated November, 2011

¹⁴⁴ Agency for Health Care Research and Quality 2008 Health Care Quality Report

¹⁴⁵ U.S. Census Bureau, 2005–2009 American Community Survey 5 year Estimates

¹⁴⁶ Idem.

¹⁴⁷ Idem.

Populations

Aging

By the year 2030, New Mexico will experience a baby boomer boom. The state will rank fourth in the nation in percentage of population age 65 and older; currently New Mexico is thirty-ninth.¹⁴⁸ New Mexico's growing number of older adults reflects the aging of its own population, as well as the continuing migration of retirees and so-called "Lone Eagles," older individuals who can do their business anywhere, to western states. In the year 2030, older New Mexicans will out-number those under age 18, who will account for only 21.7 percent of the population. This will put pressure on at-home caregivers, as nearly 10 percent of the state's population served in this role in 2006 at an estimated economic value of \$1.6 billion.¹⁴⁹ Health status is self-reported to be "fair" or "poor" among 34.4 percent of the population age 75 years and older.¹⁵⁰ The most important physical issues that the population over 65 must address are diabetes, injury, heart disease and neurological illness. The highest rate of diabetes by age group was among the 65 years and older group (26.6) while the lowest rate occurred among those less than 15 years of age (4.0).¹⁵¹ The highest rate of injury-related hospital discharges was found in the 65 years and older age group at 146.1 per 10,000.¹⁵² People aged 65 years and older experienced 86 percent of hip fracture hospitalizations with a rate of 58.8 per 10,000 population.¹⁵³ For traumatic brain injury, including stroke, the highest hospitalization rate occurred in the 65 years and older age group at 13.1 per 10,000 population.¹⁵⁴ The number one cause of death

The graying of New Mexico will have a significant effect on the state, ranging from changing demands on government services, such as health care to increased political involvement and advocacy on the part of elders.

– NEW MEXICO AGING AND LONG-TERM SERVICES

for the aging in New Mexico is heart disease, at 7,679.1 deaths per 100,000 for people age 85 and older.¹⁵⁵ The number two cause of death for this population is malignant neoplasms, or cancer, at 3,053.8 deaths per 100,000 population for people 65 and older.¹⁵⁶

In addition, the aging increase demand on behavioral health services as this population is more prone to depression, suicide, substance abuse, alcoholism, and Alzheimer's disease, and to experience food insecurity, thus leading to poor nutrition. Disabilities among the elderly will double: by the year 2030, 22.6 percent of people from 75–85 and 54.6 percent of people over 85 will have a disability.¹⁵⁷ The most common disabilities include hearing difficulties (20.4 percent) and ambulatory difficulties (27.3 percent).¹⁵⁸

Border Health

If the U.S.-Mexico border area were its own state, it would rank last in access to health care; third in death rates due to hepatitis; fifth in deaths related to diabetes; last in per capita income; and first in the percentage of children uninsured.¹⁵⁹

This vast area stretches 2,000 miles from the southern tip of Texas to California, touching New Mexico at Doña Ana, Luna, Hidalgo, Grant, Otero and Sierra counties. The population of the entire border area is expected to double by the year 2025.

My average client is a woman, 70–80 years old, who moved into Torrance County 30 years ago. Her husband has died and she lives alone in a mobile home with rickety steps, no handicap ramp and uses a walker. She lacks transportation to her doctor appointments, to the grocery store, to church and the drug store.

– ESTANCIA FOCUS GROUP PARTICIPANT

¹⁴⁸ New Mexico Aging and Long-Term Services

¹⁴⁹ New Mexico Agency on the Elderly

¹⁵⁰ Health Behaviors and Conditions of Adult New Mexicans, 2007, Behavioral Risk Factor Surveillance System Survey Data, p. 3.

¹⁵¹ 2009 HIDD Report NM Health Policy Commission

¹⁵² Idem.

¹⁵³ Idem.

¹⁵⁴ Idem.

¹⁵⁵ New Mexico Selected H Stats Annual Report Volume 2, 2007, pg. 53

¹⁵⁶ Idem.

¹⁵⁷ New Mexico Aging and Long-Term Services Department

¹⁵⁸ U.S. Census Bureau, American Community Survey, 2009

¹⁵⁹ At the Cross Roads: U.S./Mexico Counties in Transition; U.S./Mexico Border Counties Coalition 2006; University of Texas at El Paso.

While a 2011 study by the City of El Paso and Paso del Norte Foundation shows border counties outperforming New Mexico and the United States as a whole on preventative care, the numbers are far from stellar: 35.8 percent childhood immunization rate and 74 teen births per 1,000 in Doña Ana County and 95 per 1,000 in Luna County.

A relatively new issue is a lack of affordable pharmaceuticals since the increase in drug cartel violence in Ciudad Juarez, which is the Mexican border city where many people bought their medicines.

Environmental issues, including polluted water and air sources, sewer and sanitation inadequacies and lead in soils, are a growing concern among New Mexico's counties bordering Mexico. As a result, many border residents suffer from environmental health problems, including waterborne and respiratory diseases, gastrointestinal conditions and skin diseases. The elderly and children are especially at risk. Rural communities are sometimes at a greater risk, as they are more likely to have inadequate water supply and treatment systems.¹⁶⁰

The agricultural industry in New Mexico's border counties poses a number of hazards that put workers at risk of exposure to pesticides and other agro-chemicals, as well as injuries and sun and heat exposure. Although there are laws to protect agricultural workers, there are limited resources to ensure that the laws are enforced. In most of the United States, including New Mexico, agricultural injuries are not reported.

Along the border, the health care workforce shortage is more pronounced. Here is the percent of licensed providers, compared to New Mexico as a whole:¹⁶¹

- **Physicians:** 10.5 percent of the 227.6 per 100,000 New Mexico residents
- **Nurses:** 14.8 percent of the 851.0 per 100,000 New Mexico residents
- **Dentists:** 12.4 percent of the 46.0 for every 100,000 New Mexico residents

Children and Youth

For children, health issues arise from not getting comprehensive care from conception onward; for youth, health issues are related to societal pressures that may lead to substance abuse, victimization by bullying or death by accident. (See also Challenges: Childhood obesity, Suicide, Teen Births and the section on youth health under Populations: Rural.)

The correlation between poverty, educational attainment, and good health is evident when comparing health outcomes for New Mexico's children and others in the United States. New Mexico ranks 48 and 49 respectively in teen death and teen birth rates.¹⁶²

While New Mexico's children rank high for immunization rates, they tend to have slightly lower birth weights, infant mortality rates and child death rates than their national peers.¹⁶³ Their mothers are less likely to receive pre-natal care (74.7 percent compared to the national norm of 83.2 percent in 2006).¹⁶⁴

Infant mental health, defined as ages birth to three, is receiving increasing attention because of new research in infant development, early brain development, and attachment theory.¹⁶⁵ Toddlers who do not receive appropriate childcare are at higher risk for behavioral problems and mental health disorders, including traumatic stress disorders, regulatory or adjustment disorders, disorders of mood and relationship disorder, which will affect their success in school and life.

Hunger is also a problem. One in five New Mexico children are food insecure, defined as not knowing the source of their next meal. During the 2011–12 school year, 67.7 percent of children were eligible for the federal free or reduced price lunch program.¹⁶⁶ The federal reimbursement at \$2.77 per meal does not cover the costs. Though an additional 6 cents per meal was authorized to start in 2013, it will still not cover the costs of meeting the new Child Nutrition Act regulations.

¹⁶⁰ www.epa.gov/usmexicoborder/issues.html, EPA, U.S.-Mexico Border 2012: Environmental Issues, Last updated January, 2011.

¹⁶¹ 2009 Geographic Access Data System Selected Healthcare Professionals in New Mexico; New Mexico Health Policy Commission (revised May, 2010)

¹⁶² U.S. Census Bureau, American Community Survey, 2008–2010

¹⁶³ Annie E. Casey Foundation, Kids Count Data Book

¹⁶⁴ Kaiser Family Foundation State Health Facts.org

¹⁶⁵ New Mexico Infant Toddler (FIT) Program, The Integration of Infant Mental Health Approaches Position Paper 2005

¹⁶⁶ New Mexico Public Education Department, 2012.

Suicide is the second leading cause of death among New Mexico youth.¹⁶⁷ Bullying is associated with increases in suicide risk in young people as well as increases in depression. Some of this stems from the fact that New Mexico teenagers are more likely to be out of school and lack full time work (32 percent).¹⁶⁸

Added to these health issues is the fact that 12 percent of children under 19 do not have health insurance.¹⁶⁹

Other Underserved Populations

WOMEN

While many women's health issues may be related to their biology (childbirth, contraception, menopause, etc.), they also include medical situations where there is gender-differentiated access to medical treatment. The New Mexico Department of Health reports:¹⁷⁰

- **Heart disease** kills 500,000 American women per year—50,000 more women than men, though it is considered a man's disease. Women are more likely than men to have a second heart attack within a year of the first one.
- **Depression:** Women are two to three times more likely than men to suffer from depression because their brains secrete less serotonin.
- **Osteoporosis:** Women comprise 80 percent of the national population with this condition, which is attributable to a higher rate of lost bone mass.
- **Smoking** has a more negative effect on the cardiovascular health in women than men. Women are less successful in quitting smoking and have more severe withdrawal symptoms.
- **STDs:** Women are two times more likely than men to contract a sexually transmitted disease and more likely to experience drops in body weight, which can lead to wasting syndrome.

On the plus side, some pain medications (known as kappa-opiates) are more effective in relieving pain in women than in men. Also, a Kaiser Family Foundation report ranks New Mexico in the top 19 states for women who report healthy outcomes, including feeling well and not missing activities or work because of illness.¹⁷¹

In New Mexico, women are less likely to die of heart disease, lung cancer and all types of cancer than men, though they are more likely to experience arthritis and asthma. When breast cancer is detected in the early stages, there is a high survival rate for New Mexico's population: 98 percent.¹⁷²

Women are more likely than men to be the victims of domestic abuse and in New Mexico one third of adult females (32 percent) will experience domestic abuse. The New Mexico Department of Health reports that almost one in five homicides (18 percent) are related to domestic abuse.¹⁷³

Like other diversity issues, women's health must be viewed through the lens of gender differences. Clinical trials, for example, did not include women until the late 1980s and 1990s, making evidence-based research lacking. Services for women are fragmented, and socioeconomic status affects how women use health care.

LESBIAN, GAY, BISEXUAL, TRANSGENDER (LGBT)

Close to 5 percent of New Mexico's population (4.9 percent) identified as lesbian or gay in the 2005 American Community Survey, though recent research would tend to indicate that number is higher. New Mexico was fifth in the nation in the number of same sex couples in the 2000 census at 9.8 per 1,000 residents.¹⁷⁴ There are no significant differences in the distribution of racial/ethnic groups of sexual orientation. For purposes of this report and others, health information is drawn from people who self-identify to the Behavioral Risk Factor Surveillance System, an anonymous telephone survey, which began to capture this data in 2005. There is no specific New Mexico data on LGBT youth, though other states have compiled information.

Lesbian, gay and bisexual adults in New Mexico have a higher percentage for some adverse health outcomes, including tobacco use, alcohol use, excessive alcohol use, suicide, depression, intimate partner violence, obesity, asthma and life

¹⁶⁷ New Mexico Epidemiology Report 2006

¹⁶⁸ Anne E. Casey Foundation Kids Count Data Book

¹⁶⁹ New Mexico Voices for Children, Kids Count Data Book, 2012

¹⁷⁰ http://nmhealth.org/dpp/womens_health.shtml

¹⁷¹ Putting Women's Health Disparities on the Map, Kaiser Family Foundation, June, 2009

¹⁷² New Mexico's Health Indicator Report, New Mexico Department of Health

¹⁷³ Idem.

¹⁷⁴ Santa Fe Community Foundation, Fall 2001 Issues Guide

dissatisfaction.¹⁷⁵ Many of these behaviors are risk factors for chronic diseases such as cardiovascular disease, diabetes, and some cancers. Lesbian women are more likely to develop breast cancer, though they are more likely than their straight counterparts to get regular mammograms. Lesbians, gays and bisexuals are more likely than straight adults to engage in sufficient physical activity and have had an HIV test. There are no significant differences for fruit and vegetable consumption, diabetes, cancer screening or lack of health insurance. Nationally, LGBT youth are four times more likely to attempt suicide.

Studies indicate that a multi-faceted approach with improved cultural competencies needs to be taken to address lesbian, gay, bisexual and transgender health. This also includes people who are queer, questioning, two-spirited or intersex.¹⁷⁶

Rural Health

Spreading across its four corners with 121,298 square miles, New Mexico has a population density of 17 per square mile—up by only one per square mile since the last census. That makes the state the sixth-most sparsely inhabited U.S. state. A “rural” area encompasses all population, housing, and territory, not including areas having 50,000 or more people (as defined by the U.S. Census 2010). With this definition, all of New Mexico may be considered “rural” excluding the Albuquerque, Las Cruces, Rio Rancho, and Santa Fe areas. While the most significant problem of rural communities is access to health care, there are also the problems of accidental injuries, pollution and other poor health outcomes for youth and those with chronic diseases that result from long distance travel.

RURAL SNAPSHOT:

While one might think of rural areas as rich in farmlands and food production, the bulk of New Mexico’s agricultural production, dairy and cattle at \$2.5 billion per year, is

primarily shipped out of state. While the amount of organic farming has increased, the amount in food crops was at 44,602 acres for the 2008–2010 Census report, and New Mexico is 21st of the states in vegetable production.¹⁷⁷ More New Mexicans live in urban areas than the national average.¹⁷⁸ The number of rural residents in New Mexico is declining, from 36.9 percent of the population in 2000 to 33 percent in 2010 as people move to urban areas seeking jobs.¹⁷⁹ Rural residents earn less than their urban counterparts (\$30,664 per capita compared to \$34,908), are less likely to finish high school and report a higher unemployment rate at 8.2 percent.¹⁸⁰ In the focus groups, rural residents report they often are overlooked when it comes to health care programming and that they see opportunities in increased investment in prevention and early childhood.

- **Accidental injuries:** Although only one-third of all motor vehicle accidents occur in rural areas, two-thirds of the deaths attributed to these accidents occur on rural roads.¹⁸¹ Rural residents are nearly twice as likely to die from unintentional injuries other than motor vehicle accidents as urban residents. Death and serious injury accidents account for 60 percent of total rural accidents versus 48 percent of urban.¹⁸² One reason for this increased rate of morbidity and mortality is that in rural areas prolonged delays can occur between a crash, the call for EMS, and the arrival of an EMS provider. National average response time from motor vehicle accident to EMS arrival in rural areas was 18 minutes, or eight minutes greater than in urban areas.¹⁸³
- **Pollution:** Rural communities often have high levels of air pollutants and asthma. These high rates of asthma may be related to the air quality of adjacent larger population centers, agricultural pesticides and animal production. In New Mexico, the particularly high levels of asthma occur in the Southeast counties where there are more ranches and orchards. In New Mexico, the asthma hospitalization rate is 10.2 visits per 10,000 population.¹⁸⁴ In Lea County, the hospitalization rate is significantly higher with 35.6 visits per 10,000 population.¹⁸⁵ In Curry County, the hospitalization rate is 63.3 visits per 10,000 population.¹⁸⁶ Asthma rates may also be related to other characteristics such as parental smoking, race/ethnicity, or how asthma outcomes may be influenced by health insurance. Urban children nationally were twice as likely

¹⁷⁵ New Mexico’s Progress in Collecting Lesbian, Gay, Bisexual and Transgender Health Data and Its Implications for Additional Health Disparities. April, 2010.

¹⁷⁶ Idem.

¹⁷⁷ USDA, Economic Research Service

¹⁷⁸ U.S. Census Bureau

¹⁷⁹ Idem.

¹⁸⁰ Idem.

¹⁸¹ Rural Healthy People 2010 “Healthy People 2010: A Companion Document for Rural Areas”; Office of Rural Health Policy; HRSA

¹⁸² Idem.

¹⁸³ Idem.

¹⁸⁴ 2004–2006 New Mexico Health Policy Commission, Hospital Inpatient Discharge Data.

¹⁸⁵ Idem.

¹⁸⁶ Idem.

as rural children to see an asthma specialist (5 percent compared to 2.5 percent), 2.7 times as likely to receive asthma care in an emergency department (19 percent compared to 7 percent), and 1.4 times as likely to receive oral steroids (16 percent compared to 12 percent).¹⁸⁷ This hardship on patients can be particularly demanding in some illnesses in which treatment requires regular long distance travel.

- **Youth health:** Smoking, alcohol abuse and traffic accidents are health concerns for youth, and poor behaviors are more prevalent in rural areas. Though smoking is the leading preventable cause of death, one in four youth smoke in New Mexico.¹⁸⁸ Rural eighth graders are twice as likely to smoke cigarettes (26.1 percent compared to 12.7 percent in large metro areas).¹⁸⁹ The rate of DUI arrests is significantly greater in non-urban counties. Forty percent of rural 12th graders reported using alcohol while driving compared to 25 percent of their urban counterparts.¹⁹⁰
- **Chronic health:** Preventable conditions, including cerebrovascular disease, hypertension, and diabetes, are more common in rural areas. They are less treatable due to lack of medical resources.¹⁹¹ In addition, there is often less access to community resources that may prevent these conditions, such as fresh produce, safe community centers, and easy access to ambulatory care clinics. Medicare patients with acute myocardial infarction (AMI) who were treated in rural hospitals were less likely than those treated in urban hospitals to receive recommended treatments, and had significantly higher adjusted 30-day post AMI death rates from all causes than those in urban hospitals.¹⁹²

Most noteworthy is access to health care in rural areas where there is a serious lack, or mal-distribution, of medical resources. This may include health care facilities, health care workforce, substance abuse care, and pharmacies. Provider data is as follows:

PHYSICIANS:¹⁹³

- Of the 4,689 New Mexico licensed physicians (not to be confused with practicing physicians in the Systemic Issues section), more than half (51.9 percent) were licensed with a Bernalillo County address, which accounts for 32 percent of the population.
- Bernalillo and Santa Fe counties had the highest rates of licensed physicians per 1,000 population at 3.74.
- There were no licensed physicians with a Hidalgo County address.

REGISTERED NURSES:¹⁹⁴

- The rural area of San Miguel County had the highest rate of licensed RNs per 1,000 population at 11.28.
- The number of registered nurses is growing, and the median age of RNs is decreasing. This is promising as more clinics may be maintained with more full-time registered nurses.
- The majority of New Mexico licensed RNs (35.2 percent) were 25–44 years of age.

DENTISTS:¹⁹⁵

- Of the 961 New Mexico licensed dentists, 41.9 percent were licensed with a Bernalillo County address.
- There were no licensed dentists with a Guadalupe, Harding, Hidalgo, Mora or Union County address.
- Just over half (50.8 percent) of New Mexico licensed dentists were age 55 and over.¹⁹⁶ This older group of dentists may actually reflect a decreasing number of dentists in New Mexico as more retire or decrease their number of patients.

PHARMACIES:

Catron, Guadalupe, Harding and Hidalgo County addresses have no registered pharmacies.¹⁹⁷

¹⁸⁷ Do Rural and Urban Children have Comparative Asthma Care Utilization; Journal of Rural Health; Vol. 17, Issue 1, p.32–39, January, 2001

¹⁸⁸ New Mexico Department of Health Indicator, Updated November, 2011.

¹⁸⁹ Rural Healthy People, 2010: “Healthy People 2010: A Comparison Document for Rural Areas,” Office of Rural Health Safety Policy; HRSA

¹⁹⁰ Idem.

¹⁹¹ Idem.

¹⁹² WWAMI Rural Health Research Center study, Office of Rural Policy, HRSA, 2004.

¹⁹³ 2009 Geographic Access Data System Selected Healthcare Professionals in New Mexico; New Mexico Health Policy Commission, Revised May 2010

¹⁹⁴ Idem.

¹⁹⁵ Idem.

¹⁹⁶ Idem.

¹⁹⁷ New Mexico Health Policy Commission, 2009 GADS Report, revised September, 2010

PARAMEDICS:¹⁹⁸

Catron and Guadalupe counties have no registered licensed paramedics, and between 57–90 percent of first responders in rural areas are volunteers.

Focus group participants in rural areas recommended:

- Utilizing mobile health care units to provide specialized treatment
- Increased use of tele-health technologies
- Providing mental health and substance abuse services in the public schools
- Enhancing early childhood care
- Identifying high school students in rural communities to pursue health care careers with incentives to return home

Veterans' health

While the U.S. Census Bureau lists 177,740 veterans in New Mexico in its 2006–2010 report,¹⁹⁹ returning veterans from Iraq and Afghanistan are expected to have sharply increased that number. Not only do veterans, especially in rural areas, lack access to essential health care, but they are more likely to suffer from behavioral issues such

as post-traumatic stress disorder and more likely to be unemployed. The unemployment rate for veterans of Gulf War-era II (September 2001 forward) was 11.5 percent in 2010, 4.9 percent higher than the state's population as a whole.²⁰⁰ About 25 percent of Gulf War-era II veterans reported having a service-connected disability in July 2010, compared with about 13 percent of all veterans.

The U.S. military has often been ahead of the general population in adapting to diversity and differing cultural groups. It is suggested by the National Alliance on Mental Health that veterans of culturally diverse populations are often affected differently by their military experience.²⁰¹ For example, Latinos in the military may be at a higher risk of developing PTSD and experience more severe PTSD symptoms. The Alliance postulates, however, that this may be due to a higher exposure to combat experience, previous exposure to trauma or culturally-specific differences in reporting symptoms.

Women account for 15,407 of the state's veteran population, and that number is expected to double by 2035 while the general veteran population drops sharply.²⁰² Issues such as homelessness, single parenting, employment, as well as the usual challenges veterans find in the transition from military to civilian life, are especially difficult for women.²⁰³

¹⁹⁸ New Mexico Health Policy Commission, 2009 GADS Report, revised May 2010

¹⁹⁹ U.S. Census Bureau, American Community Survey, 2010

²⁰⁰ Idem.

²⁰¹ <http://www.nami.org>; Section Multicultural Issues

²⁰² http://www.ywca-nm.org/Womens_Veterans.aspx

²⁰³ Idem.

Systemic Issues

Insurance Coverage

More than one in five (21.6 percent) of New Mexico's population has no health insurance coverage.²⁰⁴ The less income, the less likely someone in the state is to have insurance. One in four families of four earning less than \$31,809 (defined as 138 percent of the poverty level), has no insurance.²⁰⁵ The lack of coverage continues to be a growing concern with serious negative consequences and economic costs, not just for the uninsured and their families but for the state and country.²⁰⁶ Adequate access to health care services can significantly influence health care use and health care outcomes. Without coverage, the uninsured—whether children, pregnant women or other adults—received fewer services than their insured counterparts, or no care at all. Nationally, and in New Mexico, racial and ethnic minority groups are much more likely than non-Hispanic whites to be uninsured and are less likely to have job-based health insurance coverage.²⁰⁷

Three groups comprised the bulk of the uninsured in 2010, including foreign-born residents who are not U.S. citizens, young adults ages 19–25 and low-income families with an annual household income of less than \$25,000.²⁰⁸

The New Mexico Behavioral Risk Factor Surveillance System (BRFSS) demonstrates New Mexico challenges in 2009: The percentage of adult New Mexicans with health care coverage was lower, at 80.6 percent, than that of the United States at 85.6 percent. Among New Mexico adults under 65, fewer (77.0 percent) are covered by a plan than the rest of the United States (83.1 percent).

The U.S. Census Bureau reports the number of uninsured nationally increased to 46.3 million (15.4 percent) in 2008 from 45.7 million (15.3 percent) in 2007.²⁰⁹ New Mexico has the second highest uninsured rate in the nation with 21.6 percent of the population uninsured in 2010.²¹⁰

Of those who had coverage in 2009, the number insured through private health insurance slipped to 39 percent for employment based and 2 percent for direct purchase.²¹¹

Government health insurance comprised 35 percent of insurance coverage with 21 percent covered by Medicaid, 21 percent covered by Medicare and 2 percent by other public sources, including Military Health Care.²¹²

The first provisions of the Patient Protection and Affordable Care Act (PPACA), which took effect in 2010, have already increased the number of insured and their benefits and will continue to do so over the next several years. Nevertheless, the revamping of the healthcare system will take time, effort and organization to implement effectively. As the uninsured are gradually absorbed into coverage plans, there will still be gaps in coverage and access to services which will need to be addressed for both short term and long term solutions. Most notably, undocumented immigrants will not be eligible to participate in the PPACA and thus will remain uninsured. As a state with a large immigrant population, this issue requires attention in New Mexico.

My brother was ready to get clean and didn't qualify for help so he kept drinking. Now he has kidney failure and the state is paying for that. There's something wrong with the system.

– HOBBS FOCUS GROUP PARTICIPANT

Linguistic and Cultural Access

It is not just the zip code that affects the type of health care someone may receive; it is also their origins, culture, and language. Overall, non-white populations are more likely to experience poor provider-patient communication and receive care in understaffed clinics where providers face challenges of their own. These patients may not be able to get appointments in a timely manner, and might not feel listened to and respected.²¹³

²⁰⁴ U.S. Census Bureau, Current Population Survey, 2008–2011, Annual Sociological and Economic Supplement

²⁰⁵ U.S. Census Bureau, Small Area Health Insurance Estimates, October, 2011

²⁰⁶ Institute of Medicine (2004). *Insuring New Mexico's Health: Principals and Recommendations*, Washington, D.C.; The National Academies Press

²⁰⁷ Institute of Medicine (2002): *Care Without Coverage, Too Little Too Late*, Washington, D.C.; The National Academies Press.

²⁰⁸ Kaiser Family Foundation

²⁰⁹ Quick Facts 2010, New Mexico Health Policy commission, December 2009, p. 7.

²¹⁰ U.S. Census Bureau, Annual Social and Economic Supplement, Table HI05, Health Insurance Coverage Status by State for All People: 2010

²¹¹ Kaiser Family Foundation, State Health Facts.org, 2009–2010

²¹² Idem.

²¹³ National Quality Report, Agency for Health Care Research and Quality, U.S. Dept. of Health and Human Services, 2000

Language problems are one of the leading barriers to accessing and utilizing health care services among Hispanic/Latinos.^{214 215 216} Among households in New Mexico in 2009, 5.9 percent were characterized as linguistically isolated, meaning that all persons age 14 and over in the household had limited English proficiency.²¹⁷ Studies that examine the relationship between language and health care find that Spanish speakers are less likely than English speaking Hispanic/Latinos to have a usual source of healthcare. Effective communication between patient and provider remains a barrier for language minorities despite federal laws, such as Title VI Policy Guidance (Title VI Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency, 2000) which require government funded programs or services to ensure meaningful access to health and social services to persons with Limited English Proficiency (LEP).

There are other health professional competencies that when lacking may inhibit access and quality of care delivered such as: understanding the special health needs of ethnic groups across the life-span, cultural differences in lifestyle, knowledge of traditional medicine practices, variations in help seeking behaviors, awareness of behavioral health needs and regional differences.

Speaking Spanish doesn't guarantee a provider is culturally competent.

– LAS CRUCES FOCUS GROUP PARTICIPANT

Transportation

New Mexico's population is not one that is accustomed to public transit, nor does it necessarily prefer it. Because most health care providers practice in urban areas, transportation can be a barrier to health care access. In New Mexico, public bus systems primarily exist in larger cities, including Albuquerque, Las Cruces and Santa Fe. The Rail Runner train, which began running in December 2008 from Belen north to Santa Fe, is used primarily for worker commutes.

A transportation service commonly known as “the blue bus” run by the North Central Regional Transportation District, serves rural communities from Santa Fe north to Questa and three of the northern Pueblos, and has attracted a minimal number of riders for regular medical appointments. It is noteworthy to examine New Mexico residents' attitudes toward public transport. The census estimates for 2005–2009 showed that before the Rail Runner and blue bus, only 1 percent of the population commuted to work, and a significantly larger percentage preferred to carpool.²¹⁸ The mean travel time to work for workers 16 years and over who do not work at home is 21.5 minutes.²¹⁹ This time can vary widely: the mean travel time to work for Torrance County is 35.2 minutes, while in Curry County; the mean travel time to work is 14.5 minutes.²²⁰

Another impediment to accessing health care is the number of border crossing checkpoints in southern New Mexico, which was cited by the Las Cruces focus group.

I'm worried, especially if the weather is bad, how I will get to an (Albuquerque) hospital.

– ESTANCIA FOCUS GROUP PARTICIPANT

Health Care Workforce Shortage

Not only does New Mexico face a critical shortage of physicians, but they are aging, in short supply in specialty practices and in rural areas and many of them and other health care professionals are not fully culturally competent. Here is a health care provider summary for New Mexico:

- 32nd in the nation in the number of licensed, registered physicians per capita. The state needs 400–600 primary care physicians immediately²²¹ to provide adequate access, and the need is greatest in rural areas.²²² That is because more than 66 percent of primary care physicians live in the Rio Grande Corridor, defined as stretching from Belen to Santa Fe.

²¹⁴ Ku, L., & Matani, S. (2001). Left out: Immigrants' access to health care and insurance. *Health Affairs*, Volume 20 (1) pp. 1–10 and 247–256.

²¹⁵ Carrasquillo, E.J., Brennin, T.A., & Burstin, H.R. (1999). Impact of language barriers on patient satisfaction in an emergency department. *J. Gen Intern Med*, 14 (2), pp. 82–87.

²¹⁶ Ku, L., & Waidman, T. (2003). How race/ethnicity, immigration status and language affect health insurance coverage, access to health care and quality of care among the low-income population. Kaiser Commission on Medicaid and the Uninsured.

²¹⁷ Migration Policy Institute, 2010

²¹⁸ U.S. Census Bureau, American Community Survey, 2005–2009, five-year estimates

²¹⁹ Idem.

²²⁰ Idem.

²²¹ Derksen D: The Health Workforce & the Affordable Care Act. New Mexico Health Policy Commission. 10/14/10. <http://www.hsd.state.nm.us/pdf/hcr/101410percent20Derksenpercent20ACApersent20Healthpercent20Workforce.PDF>

²²² U.S. Department of Health and Human Services, HRSA: Shortage Areas: HPSA by State. <http://hpsafind.hrsa.gov/HPSASearch.aspx> 10/12/10.

- 32 of the state's 33 counties are defined as Health Professional Shortage areas.²²³
- 50th of 51 states (including the District of Columbia) in the number of nurses per 100,000 people.²²⁴ The nursing shortage will triple by 2015 to 2,800 nurses.²²⁵
- 49th of 51 states in the number of dentists per 100,000 people.²²⁶

This serious shortfall of trained, culturally competent health care professionals was high on the minds of rural focus group participants who report that physicians, particularly specialists, and dentists cannot be recruited and retained in their communities. Even when they are recruited, they leave within a few years, often because their families do not find enough activities.

Physicians: In 2009, there were 2,442 licensed primary care physicians in New Mexico. Primary care physicians include all physicians in family and general practice, general internal medicine, geriatric medicine, general pediatrics, obstetrics and gynecology, and sports medicine.²²⁷ The number of active, full-time family medical physicians declined by 50 percent from 1997–2007.²²⁸

The New Mexico Health Policy Commission conducted a Physician Supply survey in 2006 and found that while 82 percent of practicing physicians reported no significant practice changes in the next 12 months, 18 percent reported that they were planning to make significant changes by retiring, leaving the state to continue their practice, reducing patient care hours or relocating to another part of the state.²²⁹

The total number of New Mexico physicians per 1,000 population (2.28) lags behind the national benchmark (2.55).²³⁰ Only Los Alamos County, with a rate of 2.41 physicians per 1,000 population, came close to the national average of 2.42, and all other counties were far below. Furthermore, New Mexico relies on other states to provide physician supply with three quarters of physicians trained out of state. Of 1,117 fourth year medical students in the

state, only 2 percent reported they intend to stay in New Mexico after receiving their degrees.²³¹

The Robert Wood Johnson Center for Health Policy cautions that the raw numbers of physicians can be misleading. For example, while New Mexico has licensed 7,196 physicians, only 4,848 of them are in New Mexico, only 4,002 are actively practicing in New Mexico and the actual full time equivalent of these physicians' practice is 3,010.²³²

New Mexico's diversity is not reflected among the health care workforce. Of the active licensed practicing physicians in New Mexico, 77.2 percent are non-Hispanic white, 10.7 percent are Hispanic/Latino, 1.4 percent are African American, 6.3 percent are Asian or Pacific Islander, 0.7 percent are Native American or Alaskan native, 2.7 are multiple races/ethnicities, and 1.0 percent reported as other race/ethnicity.²³³ Minority health professionals are more likely to practice in shortage areas, yet the relatively small number of Hispanic/Latino and Native American students entering health programs makes recruitment and retaining Hispanic/Latino and Native American health professionals challenging.

Physician workforce diversity is increasing, albeit slightly. Among all active patient care physicians, from 2001–2006 American Indian physicians increased from 0.5 percent to 0.7 percent, Asian and Pacific Islander physicians increased from 3.7 percent to 6.3 percent, and Hispanic/Latino physicians increased from 6.5 percent to 10.7 percent.²³⁴

Nurses: The United States and New Mexico is in the midst of a nursing shortage that will worsen by the year 2020.²³⁵ The U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) predicts that this national nursing shortage will grow by 20 percent. In 2009, over 36 percent of New Mexico's RNs and about 38 percent of LPNs were over the age of 55, which is older than the national average of 46.8 years. This indicates that 38 percent of the workforce may need to be replaced over the next 15 years.

²²³ HRSA National Center for Workforce Analysis. Accessed 10/28/10 at: <http://bhpr.hrsa.gov/healthworkforce/reports/statesummaries/newmexico.htm>

²²⁴ Robinson-Avila K: New Mexico seeks educational remedy for nursing shortage. *New Mexico Business Weekly*. 4/8/10

²²⁵ Robinson-Avila K: New Mexico seeks educational remedy for nursing shortage. *New Mexico Business Weekly*. 4/8/10. Available at: <http://www.bizjournals.com/albuquerque/stories/2010/04/12/story5.html> Accessed 10/28/10.

²²⁶ HRSA National Center for Workforce Analysis. Accessed 10/28/10 at: <http://bhpr.hrsa.gov/healthworkforce/reports/statesummaries/newmexico.htm>

²²⁷ 2009 Geographic Access Data System Selected Healthcare Professionals in New Mexico; New Mexico Health Policy Commission (revised May 2010)

²²⁸ The Health Care Workforce and the Patient Affordability Care Act, a presentation by Daniel Dirksen, senior fellow Robert Wood Johnson Center for Health Policy, 2011.

²²⁹ New Mexico Health Policy, Physician Supply and Distribution in New Mexico, 2006.

²³⁰ New Mexico Health Policy, "Physician Supply and Distribution in New Mexico, 2006 with County and Specialty Profiles.

²³¹ The Health Care Workforce and the Patient Affordability Care Act, a presentation by Daniel Dirksen, senior fellow Robert Wood Johnson Center for Health Policy, 2011.

²³² The Health Care Workforce and the Patient Affordability Care Act, a presentation by Daniel Dirksen, senior fellow Robert Wood Johnson Center for Health Policy, 2011.

²³³ New Mexico Health Policy, "Physician Supply and Distribution in New Mexico, 2006 with County and Specialty Profiles

²³⁴ *Ibid*, p.7.

²³⁵ August 2009 Labor Force Employment & Unemployment; New Mexico Department of Workforce Solutions

GRANTMAKING IN ACTION

New Mexico State University, Grants campus Pathway to Nursing Careers received a Con Alma Health Foundation multi-year grant of \$40,000 to support nursing career recruitment and educational opportunities to address the critical shortage of bilingual and culturally competent nurses in Cibola County.

Promotoras: Community health workers, or *promotoras*, can deliver cultural care and increase access to care. These providers can play a crucial role in broadening access and coverage of health services in remote rural areas and for disadvantaged sub-population groups, and can undertake actions that lead to improved health outcomes in such areas as maternal and child health, continuity of care for chronic disease patients, and general health education to families and youth.²³⁶ The most recent estimates, for 2006, indicate 600 community health workers in New Mexico.²³⁷

*Social workers make
less money than waitresses.*

– LAS VEGAS FOCUS GROUP PARTICIPANT

Indian Health Services

Access to health care is perhaps the most complicated for the state's close to one in 10 people of Native American descent. There is no consistent health benefits package across Indian country. Some tribes operate their own health facilities, some rely on the Indian Health Service (IHS) and those tribes without facilities rely on Contract Health Services (CHS) with private clinics or hospitals. What is consistent, however, is that there is an overwhelming lack of funding to support even the basic health care demands in all three delivery models.²³⁸ In fact, the Indian Health Service, which is the federal government's obligation to American Indian and Alaska Natives in exchange for millions of acres of tribal lands ceded to the United States, is funded at 54 percent of its actual need.

Shortfalls are even more dramatic in Bernalillo County where the annual Urban Indian Health Program funds a single clinic, and results in a per capita annual expenditure of about \$12.²³⁹

Close to 200,000 people in New Mexico rely on care from the Indian Health Service, Tribal 638 Programs and the Urban Indian Health Program. Of that population, the New Mexico Human Services Department estimates that 72.4 percent are living at or below 250 percent of the federal poverty level.

With the passage of P.L. 93-638 or "Indian Self-Determination and Education Assistance Act of 1975," American Indian tribes are authorized to contract and operate federal service programs within the Bureau of Indian Affairs and Indian Health Services. In New Mexico, a number of Pueblos, tribes and Nations have used Self-Determination contracts or Self-Governance compacts to assume control of all or part of the services previously provided by the Indian Health Service (IHS).

Further straining the IHS system, is that two of the 12 Area Offices of the IHS are located in Albuquerque and Gallup and are responsible for providing services to all the Pueblos, tribes and Nations located in New Mexico, as well as tribes in Arizona, Colorado, Utah and Texas.

Medicaid

Medicaid, which covers more than 550,000 residents, has been caught in a financial squeeze in New Mexico. Demand continues to increase while the federal match decreases until 2014 when Medicaid expansion could take effect, if the state chooses to expand. In fiscal year 2010, enrollment increased by 5.3 percent, and total program expenditures were projected to decrease in the same year by 2.3 percent.²⁴⁰ Yet the New Mexico Human Services Department was asked to reduce program expenditures by \$50 million for 2011.²⁴¹ Expenditures projected for fiscal year 2011 were \$3.72 billion with \$791 million of that contributed by the state.²⁴² The agency projects 2012 will cost the state \$1.148 billion because of the lower federal medical assistance percentage. The federal match drops to 69.36 percent for the last three quarters of 2012.²⁴³ The 2012 Legislative session passed increased

²³⁶ New Mexico Community Health Workers Association

²³⁷ March, 2007 Community Health Worker National Workforce Study; U.S. Department of Health and Human Services, Health Resources and Services Administration

²³⁸ Standing on Principles: A New Era in Tribal Government Relations, FY 2011 Tribal Budget Recommendation to the U.S. Department of Health and Human Services, http://www.nihb.org/docs/10192009/Standing%20on%20Principles%20for%20Stronger%20Tribal%20Communities_FINAL.pdf

²³⁹ BluePrint for Health New Mexico, Health Care Reform Implementation Work Plan for New Mexico, November, 2011

²⁴⁰ Julie B. Weinberg, Director, Medical Assistance Division, presentation to University of New Mexico School of Public Administration, March, 2011.

²⁴¹ Idem.

²⁴² Idem.

²⁴³ Idem.

funding for Medicaid to cover inflation, though no new funding was added to enroll children who are eligible and uninsured.²⁴⁴

Medicaid reimbursement is treated differently for Native Americans and allows Tribal 638 programs to bill Medicaid at a higher all-inclusive rate. Due to the federal trust obligation, Medicaid reimbursements are matched 100 percent by the federal government. In some instances, when tribes have assumed management of a health program, they have actually made a profit due to the higher reimbursement rate for Medicaid.²⁴⁵ (See Figure 8.)

Uncompensated Care

Because of the high number of uninsured residents, providers from physicians to hospitals to dentists to clinics provide a vast amount of care for which they are not paid. The cost falls on hospitals, counties and individuals with private insurance. If New Mexico moves forward with health care

reform, and most individuals and families are insured, the cost of uncompensated care will be greatly reduced. New Mexico hospitals provided a total of \$390.5 million in uncompensated care in 2010.²⁴⁶ Uncompensated care is a measure of hospital care provided for which no payment was received from the patient or an insurer.²⁴⁷

For example, the University of New Mexico Health Sciences Center reported uncompensated care gross billings of \$401.8 million in 2011 and \$198.3 million in total uncompensated care cost.²⁴⁸ This is care provided by University of New Mexico Hospital and the School of Medicine faculty, who are physicians there. Even after factoring in an \$89.3 million mill levy that helps support the state's largest hospital, the net deficit to the hospital was in excess of \$55 million.

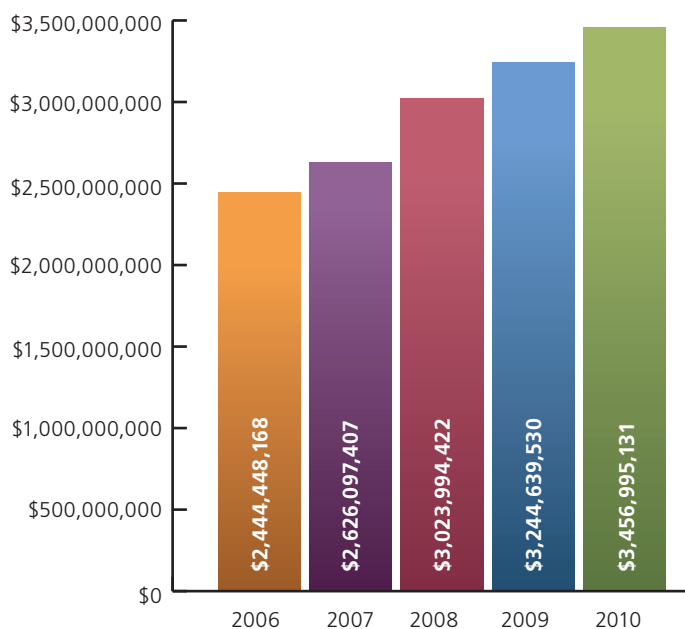
Additional public funds are needed to adequately address the Center's public mission and to build capacity for future needs. The UNM Health Sciences Center is not alone; all of New Mexico's hospitals reflect uncompensated care on their balance sheets.

New Mexico Human Services Department Medicaid Division is currently meeting with New Mexico hospital representatives to reach an agreement concerning the proposed Medicaid Waiver application and its impact on sole community provider funding.

Veterans' Health Care

The Department of Veteran Affairs reports total medical expenditures of \$398.8 million in New Mexico in 2010.²⁴⁹ Because of the rural nature of the state, available health care services may be at a great distance. There is one full Veterans Administration Health Care Hospital in Albuquerque (the Raymond G. Murphy VA Medical Center) and 14 community based outpatient clinics throughout the state.²⁵⁰ The VA hospital in Albuquerque reports 57,014 unique patients and 586,519 outpatient visits.²⁵¹ Outpatient clinics are beginning to see opportunities in tele-health and now offer one-on-one patient sessions, including tele-mental, tele-retinal screening, tele-dermatology, and tele-nutrition at some rural clinics.²⁵²

Figure 8. Total Medicaid Expenditures, New Mexico



²⁴⁴ New Mexico Voices for Children, Recap of the 2012 Legislative Session, February, 2012.

²⁴⁵ BluePrint for Health New Mexico, Health Care Reform Implementation Work Plan for New Mexico, November, 2011, Con Alma Health Foundation

²⁴⁶ New Mexico Hospital Association, Annual Report, 2011

²⁴⁷ Idem.

²⁴⁸ http://www.hospitals.unm.edu/about/finances/summir_fy11/1-report.pdf

²⁴⁹ <http://www.va.gov/vetdata/Expenditures.asp>

²⁵⁰ <http://www.albuquerque.va.gov/index.aspx>

²⁵¹ The Veterans Administration Hospital Report Card, 2010

²⁵² U.S. Veterans Administration

State Health Policy

Patient Protection and Affordable Care Act

From a public policy viewpoint, New Mexico has opportunities to lead in health care policy. Governor Susana Martinez announced in November, 2011 the award of a \$34.3 million grant from the U.S. Department of Health and Human Services to establish a health exchange that will become operational by 2013. Popularly known as NMHIX (New Mexico Health Insurance Exchange), it is designed to be a one-stop-shop for individuals, families and small businesses. The administration's goal is to make the program self-sustaining by 2015 and bring state laws into compliance. New Mexico's exchange will include a call center, tribal assistance center, and customer assistance through navigators to help individuals and small businesses choose health insurance benefits tailored to their needs.²⁵³

Public sentiment is high in New Mexico for expanding health care options. Bills were introduced in both the Senate and the House of the 2012 Legislative session to amend the Constitution to declare that health care is a fundamental right. The legislation, which did not pass, has been described as “aspirational.”²⁵⁴

Health care is a fundamental right that is an essential safeguard of human life and dignity. The state shall ensure that every resident has the opportunity to realize this right by establishing a comprehensive system of quality health care that is accessible to each resident on an equitable basis regardless of ability to pay.

– LEGISLATIVELY PROPOSED AMENDMENT TO THE NEW MEXICO CONSTITUTION

NMHIX, which arose from the National Health Care Reform (Patient Protection and Affordable Health Care Act or PPACA), offers more realistic changes from the national level that could cover up to 425,000 New Mexicans and 32 million uninsured people nationwide by 2019.²⁵⁵ In fact, BluePrint for Health New Mexico estimates that a Health Insurance Exchange could cover up to 90 percent of New Mexico's population eligible for coverage, or 382,500 individuals, by

2020. The national average is much lower for the non-elderly uninsured: 45.8 percent.²⁵⁶

The backdrop to policy change is that New Mexico, like all states, is in a slow recovery mode from the recession, which led to lay-offs, pay cuts, clinic cutbacks and overall less access to health care for our communities. The state gained about \$500,000 in revenues for the 2012–13 fiscal year budget; Governor Martinez asked the Legislature to earmark more than \$40 million of that for Medicaid in an effort to meet enrollment growth, a decreased federal match and nursing home assistance.²⁵⁷ Legislation sent to the Governor's desk in February, 2012, however, allocated a \$38 million increase, \$8 million to raise reimbursement rates for nursing homes dealing with federal cutbacks.

Private foundations, which suffered declines in assets during the recession, have funded flat for 2010 and 2011,²⁵⁸ and it is unlikely there will be a significant increase in national health care funding in the near future.

Analysts of Medicaid reform believe that states will see an increased cost shift onto providers and patients in the form of lower payments, higher co-payments and possible premiums. The Federal Budget Office estimates that by the year 2020, some of the federal dollars flowing to the state for Medicaid will decrease to 90 percent. This applies to people who were not eligible for Medicaid as of December 1, 2009.²⁵⁹

The PPACA law provides an opportunity for addressing racial and ethnic disparities through a number of key provisions including additional funding to New Mexico to improve and expand on community based prevention, public health, community health centers and to expand access to health coverage with expansion of Medicaid to include more families and individuals.²⁶⁰

New Mexico's quest to implement the PPACA and a resulting NMHIX was marked by starts and stops. Briefly, the New Mexico Legislature failed to establish a New Mexico Health Insurance Exchange in 2011 when the bill was vetoed by Governor Martinez, who stated the federal rule had not yet been promulgated, and again in 2012 when the State Legislature did not pass legislation to create the Exchange. The Governor joined 28 other states' chief executives nationwide calling for

²⁵³ Governor's Office: <http://www.hsd.state.nm.us/pdf/newsroom/nr/Governor%20Susana%20Martinez%20Announces%20Award%20of%20Health%20Insurance%20Exchange%20Grant.pdf>

²⁵⁴ Winthrop Quigley, Albuquerque Journal, February, 22, 2012

²⁵⁵ BluePrint for Health New Mexico, Health Care Reform Implementation Work Plan for New Mexico, November, 2011, Con Alma Health Foundation

²⁵⁶ Health Care Reform Across States, Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid, March, 2011.

²⁵⁷ Tom Clifford, Secretary of the Department of Finance and Administration, presentation University of New Mexico School of Public Administration, January, 2012.

²⁵⁸ Foundation Center, Growth and Giving Estimate, 2011

²⁵⁹ Kaiser Family Foundation, Financing Medicaid Coverage Under Health Reform: The Role of the Federal Government and States, May, 2010.

²⁶⁰ <http://www.healthreform.gov/reports/statehealthreform/newmexico.html>

a repeal of the Affordable Care Act. Nevertheless, following the 2011 Legislative session, Governor Martinez appointed a director of the Office of Health Care Reform to lead planning efforts, and the federal government has since released proposed rules on Health Insurance Exchanges and Qualified Health Plans. The Director of the Office of Health Care Reform left in March 2012 and as of August 2012 has not been replaced. New Mexico Human Services Department has contracted with Leavitt and Associates of Utah to work on the planning of the Exchange. The Governor indicated she will establish the Exchange by executive action. In addition to the grant announced by the Governor in November, 2011, other financial support has been made available:²⁶¹

- Close to \$1 million to implement an evidence-based home visiting program focused on maternal and child health outcomes in Bernalillo County's South Valley and McKinley County
- \$1.5 million in Community Transformation Grant funding to the state from the Centers for Disease Control and Prevention, which created eligibility solely for Bernalillo County
- Selection by the Robert Wood Johnson Foundation as one of 10 states to receive technical assistance for Exchange planning

Focus group participants question whether funding and planning to date has taken into account community-based opinions and models. Though the federal law makes available additional funding opportunities for increasing coverage and access and improving the quality of health care, the complicated eligibility and benefits policy changes (such as immediate coverage for children with pre-existing conditions, small business health insurance tax credits, Medicare benefits for seniors and enhanced reimbursements to primary care providers) may not easily trickle down to local communities. They also may not be understandable to practitioners and the general public. Therefore, local community, community based organizations, state governments and foundations will play a vital role in bridging the gap between new policies and complicated implementation challenges. (See Appendix: Patient Protection and Affordable Health Care Act.)

We need more providers and clinics and fewer think tanks.

– SANTA FE FOCUS GROUP PARTICIPANT

Insurance Reform

With the Supreme Court decision to mostly uphold PPACA, New Mexico needs to prepare for the enforcement of health insurance provisions. Important provisions are: an agreement on a set of “essential health benefits” applicable to plans in New Mexico; coverage requirements such as the ban on preexisting conditions (already in effect for children and adults will be eligible in 2014); adherence to medical loss ratio minimums; a transparent process for review of health insurance rates; and the creation of a Health Insurance Exchange.

The legislature has already passed a law which is stricter than the federal law on medical loss ratio. The legislature has over the years passed over 45 insurance coverage mandates that will need to be part of the essential health benefits package.

New Mexico was one of only seven grantees nationwide to learn in February, 2012 that the Centers for Medicare and Medicaid Services will award up to \$70.4 million in loans to implement a nonprofit, consumer-governed health insurance plan. The funds will go to New Mexico Health Connections.²⁶² It is the seed money for the state's first nonprofit insurance company and came immediately following a 6.9 percent rate increase granted by the State Public Regulation Commission to Blue Cross Blue Shield, one of the state's primary providers. Blue Cross Blue Shield had requested a 9.9 percent increase after taking a 21 percent increase in 2010.²⁶³

The plan will be implemented over several years and will first target rural areas to provide affordable health insurance options. New Mexico Health Connections is a collaborative that filed for nonprofit 501 (c) (29) status in 2011 to promote access to health care and opposed cuts in Medicaid funding. It reports the insurance co-op plan will be governed by experts in health care, consumer protection and medicine. Profits from the co-op will be returned to consumers through expansion of benefits and lower premiums.

²⁶¹ Blueprint for Health New Mexico, Health Care Reform Implementation Work Plan for New Mexico, November, 2011, Con Alma Health Foundation

²⁶² http://www.healthactionnm.org/about_us/news.php?ID=685

²⁶³ Michael Hartranft, Albuquerque Journal, “Individual Health Plans Facing 6.9% Increase,” *Albuquerque Journal*, February 23, 2012

Medicaid Reform

New Mexico Human Services Department (HSD) submitted a 1115 waiver application entitled Centennial Care in April 2012. The purpose of this waiver plan is to slow spending and maintain most of the recipients' benefits.

The plan would impose co-payments for Medicaid recipients: \$3 for brand name drugs if generics are available and co-pays ranging from \$6–\$50 for using the emergency room for non-emergency treatment. In what has been described as a “carrot rather than stick” approach,²⁶⁴ Medicaid patients would get a gift card for eating a healthy diet or losing weight. Hospitals would have more accountability. If a hospital readmits a patient for the same condition within 30 days of discharge, the hospital could lose payments. This is expected to affect urban hospitals more than rural ones. The plan would also require Native Americans to join the managed care system.

In June 2012, the plan was not accepted by Center for Medicare and Medicaid Services and HSD was asked to resubmit a plan with more public input and tribal consultation. HSD did resubmit the plan in late August 2012. However, that was before the Supreme Court ruling which changed the requirement that states must accept the Medicaid expansion plan as determined in PPACA. Because of the ruling all states now have the option to expand Medicaid with 100 percent funding for three years or remain in the current Medicaid program.

Medicaid spending is high in New Mexico: 16 percent of the state general fund for fiscal year 2011–12, up from 12 percent the year before.²⁶⁵ The plan, if approved, would slow the growth in state Medicaid spending over five years by \$140 million to as much as \$205 million.²⁶⁶ The state will spend \$870 million in state funds and close to \$3 billion in federal funds this fiscal year (2011–2012).²⁶⁷

In 2010 Medicaid provided health care for more than half of New Mexico's children (54.6 percent of those under 18 years old).²⁶⁸

If New Mexico chooses expansion, and enrolls adults in Medicaid through 2016, there will be a gradual reduction

of the federal share to 90 percent by 2020. Meanwhile, a “maintenance of effort” provision requires states to continue paying at the regular match rate (roughly 70 percent federal/30 percent state) for coverage of those who would otherwise qualify under existing income guidelines.

The Human Services Department estimates an additional 175,000 New Mexicans, including American Indians, will be eligible for Medicaid once the expansion goes into effect in 2014. This figure includes 62,000 children who are already eligible for Medicaid or the Children's Health Insurance Program (CHIP), but who are not currently enrolled.²⁶⁹ The Kaiser Family Foundation cites New Mexico as one of five states where in certain places in the state up to 40 percent of the population could benefit from new Medicaid eligibility rules.²⁷⁰ Medicaid expansion will expand access to health care for many New Mexicans. Most of these enrollees will be “working poor” adults. If New Mexico chooses not to expand Medicaid, New Mexicans will be paying for other states that do expand Medicaid with our federal tax dollars. For New Mexico hospitals and other health care providers that provide uncompensated care, this will reduce the uncompensated care as more New Mexicans will be insured through Medicaid.

*It's not enough
to increase access to Medicaid,
it must focus on outcomes.*

– ALBUQUERQUE FOCUS GROUP PARTICIPANT

Long-term Care Reform

Reform of the long-term care system is a focus of the Patient Protection and Affordable Care Act and is intended to meet the needs and preferences of a growing senior and disabled population. Even with PPACA, it is estimated that up to 220,000 individuals may remain uninsured.²⁷¹ This includes people not eligible for Medicaid or coverage through the Exchange—or who find the Exchange unaffordable. BluePrint for Health New Mexico identified strategies to engage stakeholders such as hospitals, counties, physicians

²⁶⁴ Trip Jennings, “State Unveils Plan for Medicaid Revamp,” *Santa Fe New Mexican*, February 22, 2012

²⁶⁵ Winthrop Quigley, “NM to Restrain Medicaid Growth,” *Albuquerque Journal*, February 22, 2012

²⁶⁶ Idem.

²⁶⁷ Idem.

²⁶⁸ U.S. Center Small Area Health Insurance, Estimates 2010

²⁶⁹ New Mexico Office of Health Reform–Transition Document, December 27, 2010.

²⁷⁰ Kaiser Family Foundation, Health Reform Summary, 2011

²⁷¹ Urban Institute, “Who Will Be Uninsured After Health Care Reform?” Matthew Buettgens. March, 2011.

and advocates, to redefine the role of counties, Public Health Offices and publicly supported programs to create a health care safety net system for those who fall between these cracks. Focus group participants pointed to success stories in their communities such as Casa de Salud, a safety net clinic in Albuquerque's South Valley that treats 10,000 patients a year.

Over the past 10 years, New Mexico has been active in transforming its long-term care system to address the rapidly changing demographics, demand in services, limited resources and the growing preference for home- and community-based services (HCBS). The long-term care opportunities presented in the PPACA position the state to further enhance its long-term care system by creating funding opportunities that enable seniors, people with disabilities and an increasingly diverse population to determine how and where they wish to live.²⁷²

Workforce Development

Trained, committed professionals are the key to insure broad and culturally competent health care coverage. The PPACA includes competitive state health care workforce development grants; workforce diversity grants and demonstrations to address health professions' workforce needs. The PPACA also includes additional loan repayment options for certain types of medical professionals working in medically underserved areas and for certain medical professionals who are faculty at medical institutions.

An increased "pipeline" to address production, recruitment and retention strategies for health care professionals is underway, but state officials wonder if it will move far enough fast enough.²⁷³ Examples of successful efforts in our state to address shortages include: expansion of University of New Mexico affiliated, community-based family medicine and dental residencies in Albuquerque, Santa Fe, Roswell, and

GRANTMAKING IN ACTION

Community Coalition for Healthcare Access received a Con Alma Health Foundation grant for \$20,000 to continue expansion of Community Health Worker Training for health planners, improving access to fair and affordable health services for all Bernalillo County residents.

Las Cruces; New Mexico Health Resources recruitment and placement efforts; UNM's Locum Tenens Program; UNM School of Medicine Combined BA/MD Program; UNM Health Science Center's Health Careers Pathways Programs and Office of Diversity; New Mexico State University – Grants Campus Pathway to Nursing Careers; New Mexico Health Resources; New Mexico Area Health Education Centers; New Mexico Health Professional Loan Repayment Program; New Mexico Loan-for-Service Programs; New Mexico Health Service Corps Medical and Dental Stipends and Community Retention Support by the New Mexico Department of Health; Center for Rural and Community Behavioral Health; New Mexico Center for Nursing Excellence; the New Mexico Rural Health Care Practitioner Tax Credit; and the Health Extension Rural Offices – Primary Care Extension Services.

Con Alma Health Foundation has also invested in increasing and diversifying the health workforce in New Mexico through grantmaking and program initiatives supporting mid-level oral health providers, community health workers/promotoras, and pipeline programs to encourage students to consider health careers, including nursing.

Registered nurses (RNs) comprise the largest health care group of providers in the United States. As a minority-majority state, we need to provide culturally competent care; a more diverse nursing workforce improves health care to make sure all of the state's residents receive quality health care, and providers must be able to communicate with patients and understand their needs in a culturally competent manner.

Minorities make up 59 percent of the state's population, but only 11 percent of the nursing workforce. This discrepancy has contributed to decreased patient satisfaction in these minority groups. In addition, Hispanics, Native Americans and other populations of color have disproportionately increased rates of diabetes, obesity and teen pregnancy, thus creating a great need for more Hispanic and Native American nurses to provide culturally competent care.

*Today we provide sick care
and not health care.*

– SILVER CITY FOCUS GROUP PARTICIPANT

²⁷² New Mexico Office of Health Reform–Transition Document, December 27, 2010.

²⁷³ New Mexico Health Policy Committee, Recommendations of Addressing New Mexico Health Care Workforce Solutions, January, 2011.

Solutions

Based on our rapidly changing environment, Con Alma Health Foundation determined to update its landmark research project of 2006, “Closing the Health Disparity Gap in New Mexico: A Roadmap for Grantmaking.” This 2012 report focuses on health equity, added community voices through focus groups, updated secondary data; and includes current challenges and issues such as federal health care reform.

Key Findings Summary

1. Improved conditions and policies that address Social Determinants of Health and advance health equity, especially among racially and ethnically diverse and underserved populations, can significantly improve health in New Mexico.
2. Access to quality and affordable health care services continues to be a barrier to good health, especially in rural New Mexico, communities of color, and underserved populations (e.g. elderly, immigrants, border communities, and veterans).
3. Prevention, nutrition, health promotion and holistic health are critical to improving health in New Mexico.
4. Our rapidly changing environment, including demographic shifts, will have major implications in health for the people and communities of New Mexico.

Key Findings

1. **Improved conditions and policies that address Social Determinants of Health and advance health equity, especially among racially and ethnically diverse and underserved populations, can significantly improve health in New Mexico.**
 - The correlation between poverty, educational attainment, and good health is evident when comparing health outcomes. New Mexico ranks 48 and 49 respectively in teen death and teen birth rates.
 - Health care in the United States has improved overall, though racial and ethnic minorities suffer higher rates of mortality and illness from asthma, diabetes and a range of other diseases, compared to other Americans.

This population also tends to receive a lower quality of health care than non-minorities, even when access-related factors such as insurance status and income are controlled.

- New Mexico has the second highest poverty rate in the nation. A family of four with less than \$22,341 annually is counted at the poverty level. One out of three of our children live in poverty and more than half live in low-income households.
 - The number of households receiving food stamps has almost doubled during the recession, from 6 percent to 11 percent.
 - Children ages 0–5 are more likely to die: New Mexico experienced a 20 percent increase in youth death rates since 2000.
2. **Access to quality and affordable health care services continues to be a barrier to good health, especially in rural New Mexico, communities of color, and underserved populations (e.g. elderly, immigrants, border communities, and veterans).**
 - More than one in five of New Mexico’s population has no health insurance coverage. The state has the second highest rate of uninsured in the nation (21.6 percent).
 - Hispanic and American Indian adults were over twice as likely to be without health insurance coverage as whites (26.4 percent and 40.9 percent compared to 10.9 percent).
 - Access to health care is perhaps the most complicated for the state’s close to one in 10 people of Native American descent. There is no consistent health benefits package across Indian country, and there is an overwhelming lack of funding to support even the basic health care needs and demands.
 - The lack of a diverse health workforce and culturally competent providers impacts health care. For example, minorities make up 59 percent of the population, but only 11 percent of the nursing workforce.
 - New Mexico faces a critical shortage of health care professionals: 32 of the state’s 33 counties are defined

as Health Professional Shortage areas. Physicians are aging and in short supply in specialty practices and rural areas. The state is also in the midst of a nursing shortage that will worsen by the year 2020. In 2009, over 36 percent of the state's RNs and 38 percent of LPNs were over the age of 55, which is older than the national average of 46.8 years. This could mean that 38 percent of the workforce may need to be replaced over the next 15 years.

- Substance abuse/dependence and/or mental disorders affect more than half a million individuals in New Mexico or about one in four—24.3 percent—of the state's total population. Between 25 and 35 percent of people with substance use and/or mental health disorders will need services from the publicly funded system of care (Medicaid, Medicare, IHS, other sources of state and federal payment).
- Returning veterans from Iraq and Afghanistan are expected to sharply increase the number of veterans in New Mexico. Not only do veterans, especially in rural areas, lack access to essential health care, they are more likely to suffer from behavioral issues such as post-traumatic stress disorder and more likely to be unemployed.

3. Prevention, nutrition, health promotion and holistic health are critical to improving health in New Mexico.

- Nationally, there has been a shift in the conversation about health care in the last decade to focus on prevention, access and alleviating equity boundaries.
- The percentage of obesity among the total population of New Mexico doubled from 1990 to 2009 (it was 25.6 percent in 2009). Obesity is associated with an increased risk for a number of chronic diseases, including heart disease, stroke, diabetes, and some cancers. Rates for racial/ethnic groups are significantly higher than the rates for white/non-Hispanics.
- More New Mexico adolescents are obese: 12 percent, compared to the national 13 percent, putting them at high risk for diabetes, high blood pressure, and other preventable diseases.

- Preventative oral health is limited in New Mexico for some people including those that live in rural areas. Poor oral health can result in impaired general health, particularly impacting the mortality rate due to heart disease at younger ages.
- Health care reform provides opportunities for communities to develop and implement health promotion, prevention, and wellness programs to improve the health of children and families in underserved communities in New Mexico.
- In 2010 U.S. Census projections, people of color comprised 58.7 percent of the population of the state. While New Mexico values its diversity of residents, people of color fare far worse than their white counterparts across a range of health indicators.
- New Mexico had a 25 percent increase (2010 census) in the Hispanic population from the 2000 census compared to a 13 percent increase in total population.
- The number of residents 18 and under is growing to almost one in five of the population (18 percent in 2010); and the state's Hispanic population under 18 years of age was 58 percent (2010 census), the largest in the United States.
- The largest percent increase from 2000 to 2010 was among those 60 years to 64 years, at 5.8 percent of the state's population, while those at 65 years and older are expected to grow at a faster rate. By the year 2030, the state will rank fourth in the nation in percentage of population age 65 and older; currently New Mexico is thirty-ninth.
- Almost half of New Mexico's grandparents provide a home for their grandchildren.
- In no other area is New Mexico showing a more dramatic shift than in the number of children from minority populations: almost three in four children under five is African American (2 percent), Hispanic (59 percent) or Native American (12 percent).

Recommendations for Grantmaking

- Invest in communities
- Invest in health basics
- Leverage resources
- Invest in systems change

1) INVEST IN COMMUNITIES

The data and focus group responses point to the Con Alma's core mission to understand and respond to the health rights and needs of the culturally and demographically diverse peoples and communities of New Mexico. They also underscore Con Alma's core values to involve, collaborate and partner with New Mexico communities.

Recommendations:

- Support improved access to quality and affordable health care. This includes supporting programs that increase the scope of medical services in rural clinics, increase transportation to health facilities and enhance educational efforts that make Medicaid more understandable to the community user.
- Expand grantmaking to rural communities, including efforts that seek to link rural communities to health care resources from other areas such as tele-health and sharing means to implement best practices with limited resources.
- Strengthen outreach to Tribes, Pueblos, Apache Nation, and Navajo Nation.
- Fund programs that increase cultural and linguistic competency with providers trained to be culturally competent, that increase access to bilingual health and that support traditional uses such as promotoras and traditional healers.
- Support preservation and enhancement of cultural and spiritual assets.
- Give grants that increase and diversify the health workforce and support leadership development for people of color in health care professions.

2) INVEST IN HEALTH BASICS

Communities need the most basic of health care: sufficient access to primary care physicians and other health professionals, dental checkups and oral health, mental health services and preventative measures that alleviate undesired health care outcomes.

Recommendations:

- Continue to support organizations that promote wellness strategies such as prevention, nutrition, health promotion, holistic health, and spiritual health and well-being.
- Provide support for replications of basic health programs that have worked elsewhere.
- Give grants to nonprofit organizations that offer technical and capacity building skills.
- Continue general operating support to nonprofit, health-related organizations to support infrastructure and administrative overhead costs.
- Continue to fund organizations that serve preadolescent children (below age 10) to encourage healthy lifestyles (reducing youth risk behaviors such as obesity, diabetes, substance abuse, teen pregnancy and accidental deaths.)
- Support programs that provide mental health care in wrap-around approaches in rural communities.

3) LEVERAGE RESOURCES

Leverage Con Alma Health Foundation's human and financial resources to attract other resources for New Mexico; and support/encourage multi-sector collaboration.

Recommendations:

- Leverage Con Alma Health Foundation's resources to attract local, state and national funding and other resources to improve health in New Mexico.
- Continue to participate in advocacy networks that pool resources and ideas to lead to improved health policy making at the state and local levels.
- Support collaborations such as partnerships between public health departments and community-based health programs and organizations offering mentoring programs to tap underutilized community resources and strengthen social networks.
- Support organizational efforts to enhance coordination and multi-sector collaboration.

4) INVEST IN SYSTEMS CHANGE

Innovation, leadership, acting as an effective advocate and promoting change are all underpinnings of Con Alma's mission. While experience has shown there are no easy answers to the mission of health equity, Con Alma can continue to serve as a catalyst for positive, systemic change in New Mexico.

Recommendations:

- Support policies that advance health equity, especially among racially and ethnically diverse populations, and underserved populations/communities
- Support policy development through research, evaluation and advocacy
- Support programs that provide analysis of health data, policy issues and programs
- Support workforce development that provides a pathway to health care professions. Inherent in this goal is encouraging organizations to use innovative models that blend traditional and nontraditional health and support cultural and linguistic competency.
- Support and strengthen nonprofits that seek to improve the health of underserved populations through community organizing and advocacy
- Provide support and foster collaborations for organizations to educate legislators and policy makers on the work of nonprofits in New Mexico on strengthening health equity and on the impact of Medicaid and the Patient Protection and Affordable Care Act to the state's underserved populations

Beyond Grantmaking

Achieving health equity depends on a broad policy focus; recognizing the role of government and social policy; collaboration to address social determinants; a multi-stakeholder and sector approach; community understanding and participation; and support for civic capacity of the community, which is essential to understanding and changing policies and systems.

The Foundation's grantmaking has evolved and so has the Foundation's role in engaging stakeholders in public policy issues, leveraging resources to increase philanthropic engagement and dollars for New Mexico, and promoting statewide initiatives to improve health in New Mexico.

Con Alma Health Foundation's assets go beyond the dollars with which it makes grants; Con Alma also serves as a convener and as a catalyst for positive, systemic change. Con Alma Health Care Foundation is committed to:

Convening: When state funding for health councils was eliminated, CAHF and its partners convened health/tribal councils/alliances throughout the state to provide an opportunity for them to explore ways to support and sustain their important work. One outcome was the creation of a New Mexico Alliance of Health Councils, designed to establish a unified voice to define and promote the value and services of county/tribal health councils; establish a unified voice to advocate for policies and funding that support community health; build the capacity of all health councils and strengthen communities.

Leveraging: CAHF partnered with Grantmakers in Health (GIH) on the State Grant Writing Assistance Fund by providing a pool of grantwriters to state, county and tribal government to secure federal funding for health care reform. As a result, close to \$36 million has already been brought into the state. Con Alma also serves as the anchor foundation for Hispanics in Philanthropy, Funders' Collaborative for a Strong Latino Community to increase the capacity of Hispanic led and/or Hispanic serving nonprofits. The funders' collaborative has leveraged over \$1.8 million for New Mexico nonprofits since inception.

Collaborating: Con Alma and the University of New Mexico are collaborating with the Robert Wood Johnson Foundation and the Northwest Health Foundation to increase diversity of the nursing workforce in New Mexico. Con Alma was chosen as one of 11 organizations nationwide to receive funding from Partners Investing in Nursing's Future (PIN). [The New Mexico Nursing Diversity Partnership](#) program will increase the diversity and pool of the nursing workforce to meet the state's unique and pressing needs.

Supporting policy changes: CAHF partnered with the W. K. Kellogg Foundation to develop a health care reform implementation work plan for New Mexico. BluePrint for Health New Mexico is a multi-stakeholder, collaborative planning and design effort to develop a statewide plan to successfully implement the Patient Protection and Affordable Care Act in our state. (Visit www.conalma.org to view the full report and other resource information).

Methodology

This report, “Health Equity in New Mexico: A Roadmap for Grantmaking and Beyond,” (2012) supersedes the 2006 report “Closing the Health Disparity Gap in New Mexico: A Roadmap for Future Grantmaking” with a deeper look at issues and solutions facing New Mexicans. Primary data was derived from 15 focus groups conducted throughout the state and a current environmental update based upon information from the Foundation’s grantees and others. The focus groups were geographic: Grants, Las Cruces, Hobbs, Silver City, Roswell, Santa Fe, Las Vegas, Estancia, Socorro, Albuquerque, Clovis and Raton. Three were racial/ethnic groups: African American, Hispanic/Latino and Native American. There was cross-cultural participation in the site-based focus groups as well. The focus groups, which were two hours in length, were composed of public health consumers, health providers, policy makers, nonprofit executives, and other community leaders, and convened in their own communities.

Focus group participants were provided with state and local data profiles (snapshots), worked with a detailed facilitation tool and a facilitator and were guided by four questions:

1. Does this snapshot accurately describe your community?
2. What are the priorities for health in your community?
3. What do you want for the future of health in your community?
4. What are the resources, strengths and opportunities that promote health equity in your community?

What Do New Mexicans Want for Health Equity?

Focus group feedback resulted in the following broad themes:

- Improve local socioeconomic conditions;
- Support policies that advance health equity, especially for racially and ethnically diverse populations;
- Support/increase health workforce, and diverse and culturally competent health providers;
- Support preservation and enhancement of cultural and spiritual assets;
- Invest in prevention, health promotion and holistic health; and
- Increase access to quality and affordable healthcare.

Focus group feedback was included, along with secondary data from government and nonprofit sources, and information on current challenges and opportunities were used to complete the Foundation’s 2012 Report, “Health Equity in New Mexico: A Roadmap for Grantmaking and Beyond.”

Resources

- Con Alma Health Foundation: various policy and planning reports by the Con Alma Health Foundation can be found at: www.conalma.org.
 - [Key Findings on New Mexico's Oral Health Gap \(2009–2010\)](#)
 - [Closing the Health Disparity Gap: A Roadmap for Grantmaking, 2006](#)
 - [Project DIVERSITY](#), final report about a nursing pipeline program to increase ethnically diverse nurses in New Mexico
 - [Building a 21st Century Health Care Workforce in a Diverse Rural State: A Funder's Perspective and Framework for Innovation & Impact of Health Career Pipeline Programs](#)
 - NNMHGG Report [Data for Grantmaking: A Comparative Study of Community Health in Los Alamos, Rio Arriba and Northern Santa Fe Counties](#)
 - [Women's Health Inequalities in New Mexico: Challenges & Policy Options](#)
- Other reports and initiatives Con Alma Health Foundation was involved with:**
- Elder Economic Security Standard Index for New Mexico www.wowonline.org/ourprograms/eesi/state-resources/newmexico.asp
 - National Center for Responsive Philanthropy, [Sept. 2009 Bulletin](#)
 - [PIN Point Newsletter, 2011](#), featuring Project DIVERSITY
- Other Resources:**
- Atlantic Philanthropies: www.atlanticphilanthropies.org
 - Bernalillo County Place Matters: www.bcplacematters.com
 - Community Catalyst: www.communitycatalyst.org
 - Families USA: www.familiesusa.org
 - Grantmakers In Health: www.gih.org
 - Health Action New Mexico: www.healthactionnm.org
 - HealthCare.gov: www.healthcare.gov
 - Herndon Alliance: <http://herndonalliance.org>
 - Healthy People 2020: www.healthypeople.gov/2020
 - Joint Center for Political and Economic Studies: “Patient Protection and Affordable Care Act of 2010: Advancing Racially and Ethnically Diverse Populations,” July 2010. www.jointcenter.org
 - Kaiser Family Foundation: www.kff.org
 - National Academy for State Health Policy: “State Policymakers’ Priorities for Successful Implementation of Health Reform” can be found at: www.nashp.org
 - National Congress of American Indians, Policy Research Center: “Investing in Tribal Governments: An Analysis of Impact and Remaining Need Under the American Recovery and Reinvestment Act,” March 2010. www.ncaiprc.org
 - National Rural Health Resource Center: www.ruralcenter.org
 - New Mexico Health Equity Working Group: www.bcplacematters.com/new-mexico-health-equity-working-group
 - New Mexico Office of Health Care Reform: www.hsd.state.nm.us
 - New Mexico Voices for Children: www.nmvoices.org
 - Prevention Institute: www.preventioninstitute.org
 - Robert Wood Johnson Foundation: www.rwjf.org
 - RWJF Center for Health Policy at UNM: <http://healthpolicy.unm.edu>
 - Rural Assistance Center: www.raconline.org
 - Small Business Majority: www.smallbusinessmajority.org
 - Unnatural Causes: www.unnaturalcauses.org
 - US–Mexico Border Philanthropy Partnership: <http://borderpartnership.org>
 - W.K. Kellogg Foundation: www.wkcf.org

Appendix

Patient Protection and Affordable Health Care Act

Since passage of the PPACA, these changes have gone into effect:

- Small business tax credits: 25,700 small businesses in New Mexico can be helped by a new small business tax credit that makes it easier for businesses to provide coverage to their workers and makes premiums more affordable.²⁷⁴ Small businesses pay, on average, 18 percent more than large businesses for the same coverage, and health insurance premiums have gone up three times faster than wages in the past 10 years.
- Closing the Medicare Part D donut hole: Roughly 25,000 Medicare beneficiaries in New Mexico have hit the donut hole, or gap in Medicare Part D drug coverage, and received no help to defray the cost of their prescription drugs.²⁷⁵ Medicare beneficiaries in New Mexico who hit the gap starting in 2010 received a one-time \$250 rebate check. The new law continues to provide additional discounts for seniors on Medicare and completely closes the donut hole by 2020.
- Support for health coverage for early retirees: An estimated 24,400 people from New Mexico retired before they were eligible for Medicare and have health coverage through their former employers. The number of firms that provide health coverage to their retirees has decreased over time.²⁷⁶ Beginning June 1, 2010, a \$5 billion temporary early retiree reinsurance program helped stabilize early retiree coverage and ensured that firms continue to provide health coverage to early retirees. Companies, unions, and state and local governments are eligible for these benefits.
- Insurance companies no longer can place lifetime limits on the coverage they provide, ensuring that the 853,000 New Mexico residents with private insurance coverage never have to worry about their coverage ending and facing catastrophic out-of-pocket costs.
- Insurance companies are banned from dropping people from coverage when they get sick, protecting the 98,000 individuals who purchase insurance in the individual market.
- Insurance companies cannot exclude children from coverage because of a pre-existing condition.
- Insurance plans' use of annual limits are tightly regulated to ensure access, protecting the 755,000 of the population with employer health insurance, along with anyone who signs up with a new insurance plan in New Mexico.
- Health insurers offering new plans must develop an appeals process to make it easy for enrollees to dispute the denial of a medical claim.
- Plans are required to offer coverage to children on their parents' policy and must allow children to remain on their parents' policy until they turn 26, unless the adult child has another offer of job-based coverage. This provision will bring relief to about 13,000 individuals.²⁷⁷
- Affordable insurance for uninsured with pre-existing conditions: \$37.5 million federal dollars were made available to New Mexico starting July 1, 2010 over three years to provide coverage for uninsured residents with pre-existing medical conditions through a new transitional high-risk pool program, funded entirely by the Federal government. The program is a bridge to 2014 when Americans will have access to coverage options in the new health insurance exchanges and insurance companies will be prohibited from denying coverage to Americans with pre-existing conditions.

For more information on the Patient Protection and Affordable Health Care Act, what is changing and the implementation timeline, visit:

- Families USA: www.familiesusa.org
- HealthCare.gov: www.healthcare.gov
- Health Action New Mexico: www.healthactionnm.org
- New Mexico Office of Health Care Reform: www.hsd.state.nm.us

²⁷⁴ http://www.irs.gov/pub/newsroom/count_per_state_for_special_post_card_notice.pdf

²⁷⁵ Office of the Actuary, Centers for Medicare and Medicaid Services. Number represents only non LIS seniors.

²⁷⁶ Kaiser Family Foundation. 2009 Employer Health Benefits Survey.

²⁷⁷ U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements, March 2009; and 45 CFR Parts 144, 146, and 147. http://www.hhs.gov/ocio/regulations/pra_omnibus_final.pdf



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