Annual Report on the New Hampshire Health Care Workforce and Data Collection

Calendar Year 2023

Rural Health and Primary Care Section
Division of Public Health Services
Department of Health and Human Services

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NH DIVISION OF
Public Health Services
Department of Health and Human Services

Executive Summary

Introduction

RSA 126-A:5, XVIII-a authorizes the State Office of Rural Health (SORH) to receive and collect data from participating licensed health care professionals during the license renewal cycles. The data shall be reviewed, evaluated, and analyzed by SORH to provide policy decision makers and the commission on the interdisciplinary primary care workforce with critical information to develop and plan for New Hampshire's primary care workforce current and future needs. Beginning on December 1, 2019, and annually thereafter, the SORH shall make a written report to the legislature and the commission on interdisciplinary primary care workforce. The report shall include, but not be limited to, aggregate data and information on current and projected primary workforce needs.

Within the New Hampshire Rural Health and Primary Care (RHPC) Section, Division of Public Health Services (DPHS), Department of Health and Human Services (DHHS), the Health Professions Data Center (HPDC) exists alongside the Primary Care Office (PCO) and the SORH to serve in this role. The mission and function of HPDC is to collect, analyze, and report on key practice and capacity data from primary care-associated, licensed health care providers in NH to use for primary care workforce assessment and health care access planning. HPDC data supports and strengthens federal shortage designations; recruitment and retention initiatives; the development and expansion of existing educational and training programs; planning and policy of key state workforce organizations, including pipeline programs, higher education, and provider associations; and emergency preparedness.

Provider Response Rate

The HPDC experienced a significant upturn in survey compliance for Advanced Practice Registered Nurses (APRNs) and mental health practitioners (MHP) since the survey requirement was implemented as a condition of license renewal, which took effect in SFY2020. The APRN compliance rate increased by about 75% (55% to 93%) from State Fiscal Year (SFY) 2020 to SFY2021, while the compliance rate for MHPs increased by 3x the rate in SFY2020 (24% to 94%). The average survey response rate for all participating provider types is 90 percent, with rates ranging from a low of 81% (alcohol & drug counselors (ADCs)) to a high of 94% (MHPs).

Provider Supply

None of the participating provider workforces experienced a true loss of providers during this period; and in fact, several license types saw significant gains in SFY 2021. Most notable of these are the APRN and Physician Assistants (PA) workforces; where APRNs saw about a 25% increase in active providers in SFY 2021 (377 providers gained), and PAs saw a 20% increase in calendar year (CY) 2021 (110 providers gained). Consistent with SFY2020 figures, the MHP workforce experienced moderate workforce gains (10% with 234 providers gained), while physicians and ADCs saw minimal workforce gains (3.5%, 130 providers gained, and 6.3%, 32 providers gained, respectively).

Workforce Data Summaries

SFY2021 data summaries for medical (physicians, PAs, APRNs) and behavioral health (MHPs, psychologists, ADCs) workforces compare supply and capacity differences between provider types when considering practice status, demographics, distribution, practice capacity, retention, and access to care. Significant geographic disparities in provider and practice characteristics show statistical differences by rurality at the 95% confidence level.

Administration

DHHS is pursuing a Memorandum of Understanding (MOU), currently under review at the Office of Professional Licensure and Certification (OPLC), that details the compliance process and reinstatement of an automated, weekly data extract with non-public fields to support surveying and current supply figures, as well as reinstatement of program operations critical to survey response. In addition, legislation has been proposed (HB1609, 2024) to authorize OPLC to share workforce-related licensing fields fundamental to provider surveying, federal shortage designation, and workforce assessment.

Data Use

With consistent and reliable data on the supply and capacity of the New Hampshire (NH) health care workforces, data requests continue to increase each year. The HPDC provides workforce supply and demand figures year-round to inform grants, workforce initiatives, provider association materials, and internal reports. HPDC's provider data enables RHPC to successfully identify and maintain areas that qualify for federal shortage designation, ensuring the most vulnerable areas in New Hampshire are reinforced.

New to this year's report are two analyses targeting available workforce supply and need. The analysis of outpatient primary care rates by geography calculates workforce supply in a given area with respect to that area's population. This analysis reveals disparities between rural and non-rural areas and identifies areas in the state with a shortage of providers given the population size. The analysis on combined provider primary care supply, which includes physicians, APRNs, and PAs, allows for a more comprehensive look at primary care in the state.

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Definitions

ADCs – Bachelor's (LADC) and master's level (MLADC) Alcohol and Drug Counselors.

APRNs – Advanced Practice Registered Nurses (master's level).

FQHC - Federally Qualified Health Center (FQHC).

FTE – Full-time equivalent; ratio of the number of hours worked per week to full-time hours (i.e. 40). One FTE represents 40 hours of work per week.

HPDC – The New Hampshire Health Professions Data Center (HPDC) exists within the Rural Health and Primary Care Section (RHPC) in the Division of Public Health Services (DPHS) at the New Hampshire Department of Health and Human Services (DHHS). HPDC fulfills SORH's statutory duty to collect, analyze, and report on primary care workforce data and the PCO's grant requirement to validate provider capacity for federal shortage designation. The mission and function of the HPDC is to collect, analyze, and report on key practice and capacity data from primary care-associated, licensed health care providers in NH to use for primary care workforce assessment and health care access planning.

HPSA - Health Professional Shortage Area (HPSA).

MHPs – Mental health practitioners; includes independent clinical social workers (LICSWs), clinical mental health counselors (LCMHCs), marriage and family therapists (LMFTs), and pastoral psychotherapists (LPPs).

OPLC – The Office of Professional Licensure and Certification (OPLC) provides administrative support to over 50 professional Licensing Boards, Commissions and Councils responsible for licensing and regulating their professions within the State of New Hampshire.

PAs – Physician Assistants.

PCO – The Primary Care Office (PCO) exists within the Rural Health and Primary Care Section (RHPC) in the Division of Public Health Services (DPHS), at the New Hampshire Department of Health and Human Services (DHHS). The PCO works with other agencies and stakeholders to support and improve access to comprehensive, culturally competent, quality, primary health care services for underserved and vulnerable populations. The PCO is responsible for federal health care shortage designations.

PCPs – Outpatient, primary care providers as indicated by primary care specialty, outpatient/office-based practice setting, and corresponding outpatient primary care hours. Excludes telemedicine.

Physicians – Includes psychiatrists.

PHR – Public Health Region; communities with comparable public health issues and priorities. NH DPHS, DHHS established Regional Public Health Networks (RPHN) to integrate multiple public health initiatives and services into a common network of community stakeholders. There are 13 RPHNs statewide, each serving a defined PHR, covering every community in the state. For more information visit www.nhphn.org.

Rural Health and Primary Care – The Rural Health and Primary Care Section (RHPC) exists within the Division of Public Health Services (DPHS) at the New Hampshire Department of Health and Human Services (DHHS). The mission and function of RHPC is to support communities and stakeholders that provide innovative and effective access to quality health care services with a focus on the low income, uninsured, and Medicaid populations of New Hampshire.

Rural Status – The NH State Office of Rural Health defines PHRs with a population of 100,000 or more and with a population density of 150 people per square mile or more as non-rural. PHRs that don't meet these criteria are defined as rural.

Introduction

In 2008, the NH SORH was established in RSA 126-A:5, XVIII(a) to

1. Link rural health and human service providers with state and federal resources;
2. Seek long-term solutions to the challenges of rural health;
3. Increase access to health care in rural and underserved areas of the state;
4. Improve recruitment and retention of health professionals in rural areas;
5. Provide technical assistance and coordination to rural communities and health organizations;
6. Maintain a clearinghouse for collecting and disseminating information on rural health care issues and innovative approaches to the delivery of health care in rural areas;
7. Coordinate rural health interests and activities; and
8. Participate in strengthening state, local, and federal partnerships.

Following the establishment of SORH, HB1692 (Chapter 114, 2010) authorized the SORH to collect and organize data regarding the current and anticipated supply of health care professionals who make up the state's primary care workforce and the current and anticipated demand for primary care services in the future by planning and budgeting for a NH Health Professions Data Center (HPDC) to collect this data.

In 2019, HB127 amended RSA 126-A:5, XVIII-a to authorize the SORH to receive and collect data from participating licensed health care professionals during the license renewal cycles. The respective licensing boards shall adopt rules, requiring, as part of the license renewal process, completion by licensees of a survey or opt-out form provided by the SORH. The SORH will analyze and release aggregated data results to inform policy regarding the current and future needs of New Hampshire's primary care workforce.

Within RHPC, HPDC exists alongside the SORH and the PCO to fulfill SORH's statutory duty to collect, analyze, and report on primary care workforce data. The mission and function of the HPDC is to collect, analyze, and report on key practice and capacity data from primary care-associated, licensed health care providers in NH to use for primary care workforce assessment and health care access planning. HPDC data supports and strengthens:

- Federal shortage designations, which brings providers and grant funding to underserved areas of the state;
- Recruitment and retention initiatives including scholarships, loan repayment, and waiver programs;
- The development and expansion of existing educational and training programs;
- Planning/Policy of key state workforce organizations, including pipeline programs, higher education, and provider associations; and

- Emergency preparedness.

This work corresponds with RHPC's overarching work functions to 1) increase access to quality health care services for rural and underserved populations; and 2) quantify and increase the number of health care providers serving rural and underserved populations.

In 2023, the reporting requirement was amended in SB127 to separate SORH's two statutorily required reports, the health status of rural residents and workforce data collection. RSA 126-A:5, XVIII-a(e) now reads:

> (e) On or before December 1, 2019, and annually thereafter, the SORH shall make a written report to the speaker of the house of representatives, the senate president, the governor, the oversight committee on health and human services established under RSA 126-A:13, the chairs of the house and senate executive departments and administration committees, the chairs of the house and senate policy committee having jurisdiction over health and human services, and the commission on the interdisciplinary primary care workforce established by RSA 126-T:1. The report shall include, but not be limited to, aggregate data and information on current and projected primary workforce needs and the participation rate on surveys completed pursuant to this paragraph.

All reports produced by RHPC, including HPDC medical and behavioral health provider reports, can be found on the Department's Rural Health and Primary Care Reports page https://www.dhhs.nh.gov/rural-health-and-primary-care-reports. They include the State Office of Rural Health, State Loan Repayment Program, J-1 Visa Waiver Program, and the Primary Care Needs Assessments.

Overview of New Hampshire

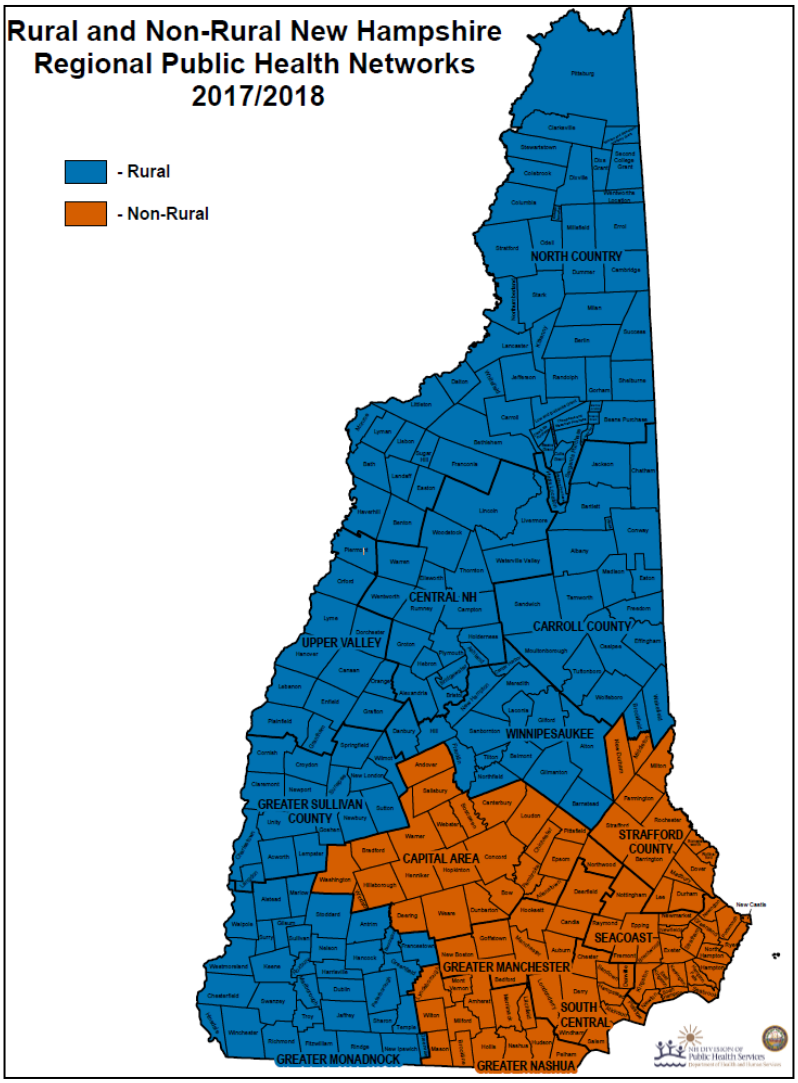
New Hampshire (NH) is one of the oldest states in the country; it was originally a land grant in 1623 and became a state in 1775. With its 1,300 lakes and ponds, 40,000 miles of river and 18 miles of seashore NH is the 7th smallest state with a land area of 8,951 square miles.[1] NH is bordered by Canada on the north and by Massachusetts on the south. On the east is the Atlantic Ocean and Maine and on the west is Vermont. New Hampshire's scenic rivers, mountain ranges, lakes and agricultural lands define the state's culture and geography but also create physical boundaries and barriers to the resources that improve health. The topography lends itself to difficult driving and long distances between places, particularly for rural residents. Access to primary and specialty medical, oral, and behavioral health care can be a significant challenge due to New Hampshire's geographical location and landscape.

Approximately 37% of the population and 84% of the landmass in New Hampshire is considered

[1] U.S. Census Bureau (2020). Profile of New Hampshire. Retrieved on 11/23/2023 from https://data.census.gov/profile/New_Hampshire?g=040XX00US33

rural, with most of the land area lying north and west of the capital city of Concord.[2] Most New Hampshire towns are considered rural, with non-rural areas located in the southeast and south-central regions and primarily rural areas in the western, central, and northern sections. The White Mountain National Forest separates the northernmost rural section of the state, which consists of Coos County. Coos County, known as the North Country, has the largest landmass of any county but the smallest population by county. Only two towns in NH, Manchester and Nashua, fall under the Census definition of a metropolitan urban area (50,000 or more inhabitants); and both are located in the southern tier, where the majority (53%) of the population lives. NH's population is disproportionately distributed across the state as density increases from north to south. Population density ranges from 25.5 people per square mile in Coos County to 492 people per square mile in Hillsborough County, which contains Nashua and Manchester.[3]

In July 2013, NH DHHS, through the Bureau of Drug and Alcohol Services (BDAS) and DPHS established a strategic partnership to align multiple regional and local public health partnerships into one integrated system. The Regional Public Health Networks, a network of 13 NH Public Health Regions (PHRs), integrates multiple public health initiatives and services into a common network of community stakeholders for communities with comparable public health issues and priorities to improve health outcomes specific to these regions. In place of counties or other geographically defined areas, DPHS, including RHPC, uses these PHRs when reporting on geographic areas of the state. This ensures both consistency and use of NH-appropriate definitions. RHPC defines rurality for PHR using population and population



[2] Economic Research Service, United States Department of Agriculture, 2022 New Hampshire State Data. Retrieved on 10/12/2023 from https://data.ers.usda.gov/reports.aspx?ID=17854

[3] New Hampshire Department of Business and Economic Affairs, Population Estimates for New Hampshire Cities and Towns. Retrieved on 12/01/2023 from https://www.nheconomy.com/office-of-planning-and-development/what-we-do/state-data-center-(census-data)/population-estimates.

density measures. PHRs with a population of 100,000 or more and with a population density of 150 people per square mile or more are considered non-rural. PHRs that do not meet these criteria are categorized as rural. The PHR with the smallest landmass, Greater Manchester PHR, has the highest population density in NH with 675 people per square mile, while North Country - which has the largest land mass of the PHRs - is the least densely populated region with 30 people per square mile.[4]

Health Professions Data Center (HPDC) Overview

Pursuant to RSA 126-A:5, XVIII-a, Chapter 254 Laws of 2019, HPDC collects provider data from participating New Hampshire licensed health care professionals as a requirement for license renewal under the respective licensing boards. Administrative rules for the survey requirement were established for all provider types under their respective boards by the end of 2020. Surveys have been implemented for all intended health care provider types since 2022. Licenses are renewed biennially, every two years, after the initial license is issued. As a result, annual surveys capture about 50% of the NH-licensed workforce, and full workforce data collection by provider type is achieved every two years. Dental provider types renew all together, dentists on even years and registered dental hygienists (RDHs) on odd years. APRN renewals occur two years after the initial registered nurse (RN) license, which is a prerequisite for APRN licensure and must be maintained together with the APRN license.

The individual medical and behavioral health workforce data reports are published at the end of each calendar year. Medical provider reports utilize one-year survey data. Behavioral health provider reports utilize 2-year survey data due to a maldistribution of mental health practitioners (MHPs) and psychologists by renewal year and a limited number of total alcohol and drug counselor (ADC) licenses. Dental provider reporting will begin in SFY25. Refer to Table 1 below for survey cycles of the datasets summarized in this year's report.

While survey legislation requires survey or opt-out completion as a condition of license renewal, the HPDC is still contending with non-response. However, high response rates and year-to-year comparisons suggest the HPDC datasets are largely representative of the workforces as a whole.

The HPDC now has 2.5 FTE, which includes the program administrator, the program analyst/programmer, and a program assistant. While funding had been available for the HPDC to hire an additional data analyst/programmer to expand program capacity since SFY21, the position was just filled in June of this year. With increased capacity, the HPDC anticipates an expedited turn-around time between data collection and dissemination, which includes fulfilling ad hoc data requests received throughout the year.

[4] New Hampshire Office of Health Statistics and Data Management, PHR Population Estimates, 2021.

Reports are developed in Tableau, a visual analytics platform, and accessed on the RHPC Reports webpage (https://www.dhhs.nh.gov/rural-health-and-primary-care-reports) as well as the HPDC webpage (https://www.dhhs.nh.gov/programs-services/health-care/rural-health-primary-care/health-professions-data-center). Workforce reports include the following sections:

- Response rate
- Practice status
- Demographics
- Recruitment - education/training
- Capacity – sites, hours, and specialties
- Distribution – setting and geographic practice location
- Access – payment and wait times
- Retention – years in practice, NH ties, and anticipated capacity
- Statistically significant workforce differences by geography (rural v. non-rural)

Table 1. Data Collection Years for Calendar Year 2023 Report

Provider Type	Data Collection Period
Advanced Practice Registered Nurse (APRN)	SFY 2021
Alcohol & Drug Counselor (MLADC/LADC)	2020 & 2021
*Mental Health Practitioner (LICSW/LCMHC/LMFT/LPP)	SFYs 2021-2022
Physician	2021
Physician Assistant (PA)	2021
Psychologist	2020 & 2021

** Due to the low response rate in SFY 2020, survey data from SFYs 2021-22 was analyzed.*

Provider Response Rate Data

Table 2 contains response rate statistics for the SFY2021 workforce reports scheduled to be published this calendar year (2023). This includes the data collection period, the number of licensees who met the survey requirement by completing the survey or the opt-out form, the number who completed the opt-out form of those who met the survey requirement, and total renewals from those due to renew. Of note is the upturn in survey compliance for APRNs and MHPs since the survey requirement was implemented as a condition of license renewal, which took effect in SFY20.

Table 2. Provider Response Rate Data, SFY2021

Provider Type	Data Collection Period	Survey Compliance		Opt Outs	*Total Renewals
		2021	*2020*		
Advanced Practice Nurse Practitioner (APRN)	July 1 - June 30	1,294 **(92.6%)**	610 **(55.4%)**	22 **(1.7%)**	1,397 of 1,618
Alcohol & Drug Counselor (MLADC/LADC)	May 1 - June 30	168 **(81.2%)**	248 **(98.0%)**	3 **(1.8%)**	207 of 228
**Mental Health Practitioners (MHP)	July 1 – June 30	1,165 **(93.7%)**	208 **(23.8%)**	15 **(1.3%)**	1,244 of 1,388
Physician	May 1 - June 30	2,827 **(90.5%)**	2,991 **(95.1%)**	62 **(2.2%)**	3,124 of 3,698
Physician Assistant (PA)	November 1 - December 31	485 **(92.9%)**	851 **(96.4%)**	4 **(0.8%)**	522 of 553
Psychologist	May 1 - June 30	316 **(88.3%)**	174 **(95.1%)**	6 **(1.9%)**	358 of 396

**Active status license renewals of active status licenses due for renewal*

***Due to the low response rate in the 2019-20 survey cycle, workforce data from the two-year survey period, 2020-22, was analyzed for MHPs. The response rate for the SFY22 survey cycle was 97.4%*

Provider Supply – Licensing List Figures

Table 3 identifies changes in provider supply in the state by calculating the net change from providers lost and providers gained during the data collection period ending in State Fiscal Year (SFY) 2021 using licensing list figures from the Office of Professional Licensure and Certification (OPLC). Due to the significant differences in provider distribution by even/odd renewal year for mental health practitioners and psychologists, and the limited number of ADC licenses in the state, two-year data is combined for these provider types.

None of the participating provider workforces experienced a true loss of providers during this period; and in fact, several license types saw significant gains in SFY2021. Most notable of these are the APRN and PA workforces; where APRNs saw about a 25% increase in active providers from in SFY 2021, and PAs saw a 20% increase in calendar year (CY) 2021. During this time, the NH COVID-19 State of Emergency was in effect (declared on March 13, 2020) and ended June 11, 2021. Several executive orders (EOs) impacting health professions licensing were issued during this time, which removed barriers to NH licensure and clinical practice, and resulted in an influx of advanced-practice providers with scope of practice comparable to physicians that can work in a variety of settings and practice largely independently. The MHP workforce continues to see moderate workforce gains (10%) in part because of ease to licensure and reduced practice barriers, including expanded reimbursable telehealth services during the COVID-19 state of emergency. Physicians and ADCs saw minimal workforce gains (3.5% and 6.3% respectively) comparable to SFY2020 figures.

Note that while the workforce supply for all provider types seem to have remained stable, and for many strengthened, during the COVID-19 pandemic, it's unclear whether providers maintaining an active license are clinically practicing in New Hampshire or practicing at the top of their license versus just aiding in pandemic efforts. Moreover, this analysis does not inform net change of primary care providers, which may be similar or largely different from all active license providers.

Table 3. Net Change of Provider Supply, SFY2021

Provider Type	*Year(s)	Eligible to Renew	**Providers Lost	***Providers Gained	Provider Change	Net Change
Advanced Practice Nurse Practitioner (APRN)	SFY2021	1,618	218	595	377	**23.3%**
Alcohol & Drug Counselor (MLADC/LADC)	2020-2021	507	47	79	32	**6.3%**
Mental Health Practitioner (LICSW/LCMHC/LMFT/LPP)	SFY2021	2,344	227	461	234	**10.0%**
Physician	2021	3,698	574	704	130	**3.5%**
Physician Assistant (PA)	2021	553	31	141	110	**19.9%**
Psychologist	SFY2021	616	75	68	-7	**-1.1%**

** MHPs and APRNs were the only provider types with rolling license renewals throughout the listed SFY; all other provider types had set renewal periods (open for 2-3 month) under the respective board.*
*** Non-renewals/Non-active status license renewals*
**** Initial licenses issued*

SFY21 Health Professions Survey Data Statistics

Medical Providers

Supply and capacity indicators of the surveyed medical provider workforces – physicians, advanced practice registered nurses (APRNs), and physician assistants (PAs) - actively practicing in NH.

Practice Status/PCP Practice - The percentage of physicians clinically practicing in NH is considerably less than both PAs and APRNs. Over one-third of physicians who maintain an active medical license in New Hampshire are not clinically practicing within the state. Nearly all PAs with an active, New Hampshire license are providing clinical services in the state. Among those clinically practicing in New Hampshire, approximately 20% of physicians and APRNs are PCPs, while among the PA workforce, approximately 16% are PCPs.

Table 4.1. Practice Status

% of clinically active providers

	Physicians	APRNs	PAs
Active, Clinical Practice	63.6	76.3	91.3

Includes full-time/part-time practice (including telemedicine-only providers) and practice as a locum tenens at a NH location for one year or longer.

Table 4.2. PCP Practice

% of PCPs

	Physicians	APRNs	PAs
Primary Care Providers	20.2	20.8	16.0

PCP status is determined by principal specialty and corresponding outpatient primary care hours at any listed site (excludes urgent care services)

Demographics - While the vast majority of APRNs and over two-thirds of PAs are female, the physician workforce continues to be male dominated, with approximately one-third of the workforce identifying as female. When isolating to PCPs, the proportion of females is larger for all provider types, with just under 50% of physicians identifying as female. The medical PCP workforces are primarily non-Hispanic White, to a greater extent with PAs (90%) and APRNs

(94%) than physicians (81%). While the median age for the APRN (45) and PA (43) PCPs is comparable, the physician median age is 10 years older (54).

Table 4.3. Demographics
% of clinically active providers in each demographic group

	Physicians		APRNs		PAs	
	All	PCPs	All	PCPs	All	PCPs
Female	36.8	48.8	87.7	95.1	69.3	81.7
Non-Hispanic White	78.8	81.0	91.1	94.2	89.9	90.1
Median Age	51	54	47	45	38	43

Distribution – Compared to non-rural areas of the state, overall medical practice, as well as PCP practice, is limited in rural NH; about one-third of all physician and APRN practice, and only one-quarter of all PA practice exists in rural regions. Outpatient primary care practice ratios generally follow that of all practice except for PAs, who have 4x as much FTE in non-rural areas as they do in rural areas. By contrast, physicians and APRNs have over twice as much FTE in rural primary care practice than PAs as a percentage of their total FTE.

While overall medical practice is not evenly distributed among individual PHRs, where Central NH has the lowest total FTE (1% of physician, 1.5% of APRN FTE) and Upper Valley the highest (19% of physician, 13% of APRN FTE), outpatient primary care is more evenly distributed, between about 0.5% and 2% of total FTE across all PHRs, as demonstrated in Figure 1 below. Interestingly, while Upper Valley has the highest FTE of all rural PHRs, it has the lowest percentage of outpatient primary care as a proportion of total FTE; and Central NH, with the lowest FTE, has the highest proportion. With the exception of Upper Valley, about 25-40% of the total FTE within each rural PHRs is in outpatient primary care.

As evidenced in Figure 2 below, most of non-rural medical practice exists in Greater Manchester (19-22%). Unlike the distribution of outpatient primary care practice across rural PHRs, which ranges from 5% to 47%, the proportion of outpatient primary care practice is relatively consistent across non-rural PHRs. Non-rural Strafford County has the lowest supply of combined provider, outpatient primary care practice; with just 4% of the total medical practice by FTE. While APRN PCP practice is lowest in South Central, PA PCP practice is highest in this PHR, demonstrating that PCP supply is best evaluated with consideration to all primary care provider types to best understand practice distribution patterns.

Table 4.4. Distribution

% of total FTE by geography and clinical practice

	Physicians		APRNs		PAs	
	All	PCPs	All	PCPs	All	PCPs
Rural Regions	35.4	6.7	34.2	7.6	28.6	*3.2
Non-Rural Regions	64.6	14.9	65.8	14.1	71.4	12.6

Telemedicine and non-direct patient office setting FTE is excluded from geographic analysis

**PHR-level geography data is suppressed for outpatient primary care practice due to small numbers*

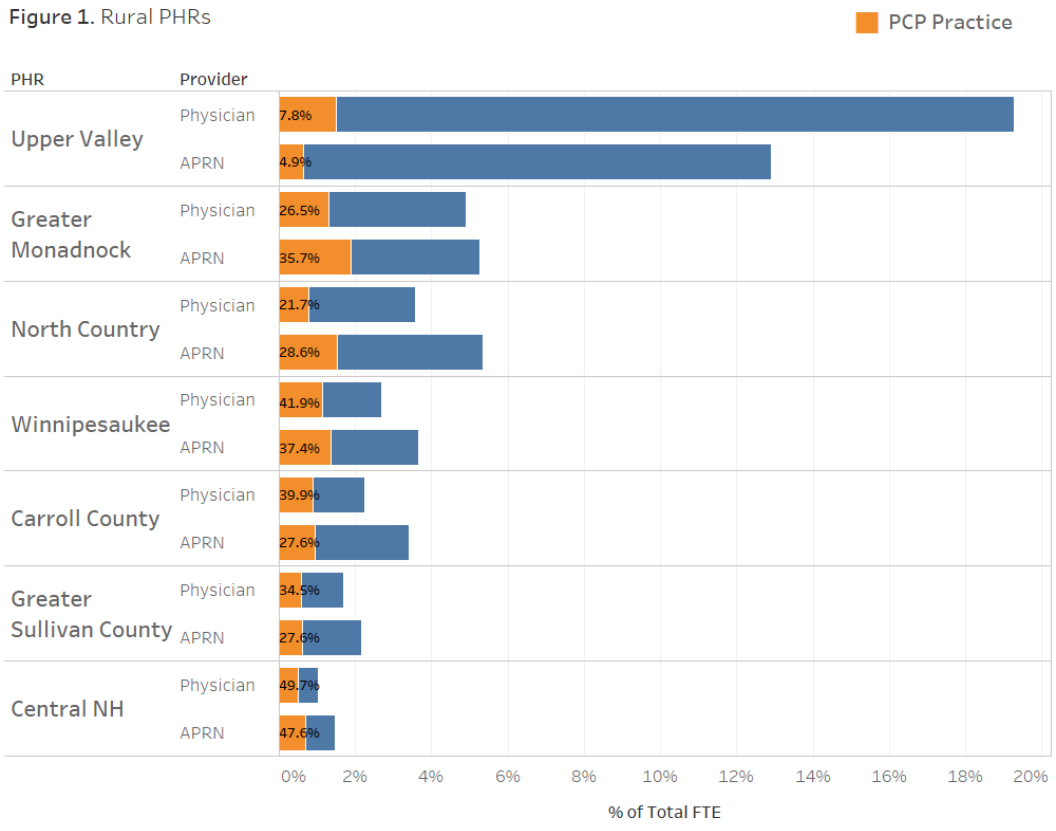
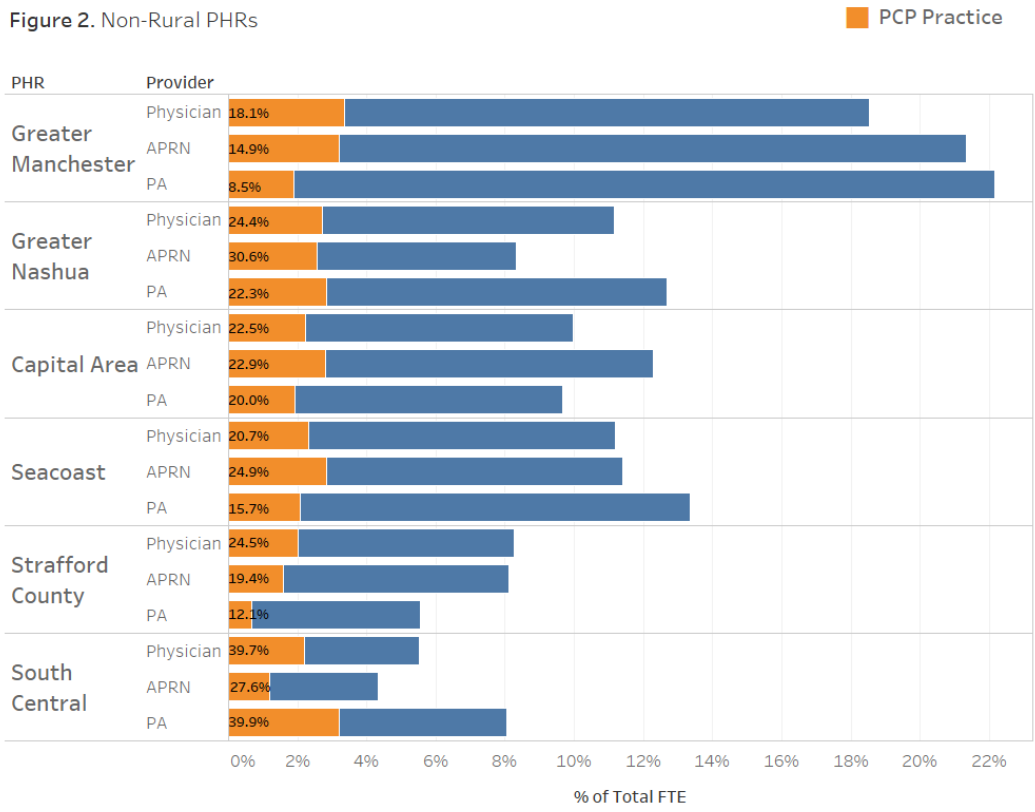


Figure 2. Non-Rural PHRs



Anticipated Supply **–** We can inform anticipated supply of the primary care workforce using indicators such as age, state ties, time practicing within a geographic location, and future plans. Across all provider types, the proportion of PCPs with less than five years of practice in NH is about 10% less than all practice providers, which bodes well for primary care retention. APRN and PA PCPs are considerably more likely (>2.5x) than physicians to have New Hampshire ties, which is associated with a greater likelihood of staying in the state; but almost 3x as likely to have only practiced in NH for less than five years, a measure that can inform retention, or likelihood of staying.

Provider age informs anticipated supply where younger providers can offset workforce shortages that result from retiring providers. A large proportion of both the APRN (32%) and PA (55%) workforces are under 40 years old, while only 15% of the physician workforce is in this age bracket. Consequently, there are twice as many physician PCPs nearing retirement (60+) than physicians under 40; whereas the opposite is true for APRNs and even more so with PAs, where there are 3.5x as many PCPs under 40 as there are 60 years and older. Older age is a strong indicator of nearing retirement, and, when informed by other retention indicators, anticipated provider shortages. Almost one-third of the outpatient primary care physician workforce is 60 years and older; about twice as high as APRN and PA PCP percentages.

One-third of physician PCPs plan to reduce their capacity in the next five years; of these, 17% plan to move to another state or not practice at all. This is a stark contrast to the limited anticipated cessation of practice in NH for PCP APRNs (8%) and PAs (3%). These retention statistics are consistent with expected trends, given the inherent correlation between age and both years of clinical practice in NH and anticipated reduction in practice. Workforce retention indicators, taken with supply figures, suggest NH can anticipate a steady reduction in physician PCP supply when compared to other medical provider types. However, a key measure that could offset this reduction is the increased opportunities for in-state training for physicians and APRNs, as research suggests clinicians are more likely to practice where they train. In the last five years, NH has developed several new advanced-training programs, including three new family medicine residencies – two of which exist in rural areas – and an advanced nursing education workforce (ANEW), which supports training in rural NH for APRN students.

Table 4.5. Anticipated Supply
% of clinically active providers in each indicator group

	Physicians		APRNs		PAs	
	All	PCPs	All	PCPs	All	PCPs
<40 Years Old	15.3	12.1	32.2	34.2	55.1	43.7
60+ Years Old	26.3	30.8	18.4	16.1	7.5	12.7
NH Ties	21.8	25.0	58.3	64.9	61.8	69.0
Less than 5 Years Practicing in NH	23.6	12.6	43.9	34.6	39.9	35.2
*Anticipated Reduction in Practice in 5 Years	29.3	33.2	22.3	19.5	20.8	16.9
- Practice in another state or no intention to practice	14.1	17.3	10.6	8.3	7.8	2.8

*** Indicated by an anticipation of reduced hours, practice in another state, or no clinical practice***

Access – Access indicators within provider groups varies by rurality. Providers across all types indicated a high percentage of new patient acceptance at outpatient, primary care practice sites, with rural PCPs indicating higher rates of open panels than non-rural providers. APRNs have the highest rate of new patient acceptance, where the rural rate is about 15% higher for APRN PCPs than physicians. Average wait time for established patients is relatively low, about 1 week, and consistent between provider types and geography. The average wait times are between 2 and 2.5 weeks for new patients, with the exception of rural practicing physicians who reported a wait time for new patients of over 3 weeks.

Table 4.6. Access

% new patient acceptance and average wait times for outpatient primary care for total sites

	Physicians		APRNs		PAs
	Non-Rural	Rural	Non-Rural	Rural	*All
Accepting New Patients (%)	68.2	77.7	87.2	90.1	82.5
Average Wait for Routine Appointments, Established Patients (days)	8.4	8.5	8.7	6.7	7.3
Average Wait for Routine Appointments, New Patients (days)	18.3	23.4	16.3	15.0	14.9

** Geography data is suppressed for outpatient PA primary care practice due to the limited size of the provider population.*

Significant Workforce Differences by Rurality, Medical Providers

Tables 5.1-5.3. Chi-Square tests of independence were used for select measures to assess whether significant differences in medical provider and practice characteristics exist by geography (rural v. non-rural). The following tables contain indicators that were found to be significantly different by geography at the 95% confidence level. For test statistics, please refer to the individual provider workforce reports, available on the New Hampshire Health Professions Data Center website.

Provider and practice characteristic differences by geography changed considerably from the 2020 analysis. In 2020, rural practicing medical providers were more likely to anticipate a reduction in NH practice in five years compared to their non-rural counterparts, which suggested NH could anticipate a reduction in rural medical providers. 2021 data reflects no significant difference between rural and non-rural practicing providers with respect to an anticipated reduction in practice due to a spike in non-rural rates, likely resulting, in part, from pandemic-induced provider burnout. No significant difference by geography in the rates of International Medical Graduate (IMGs) physicians were found this year, also a result of a spike in the non-rural rate. Within the PA workforce, this year's analysis revealed rural practicing providers are more likely to practice full time than non-rural PAs. A new trend to all three medical provider types is a higher rate of newly trained providers in rural compared to non-rural settings. Rural practicing providers are more likely to have graduated college within the last 10 years and have less than five years of practice in NH (APRNs and PAs only). Following recent graduation metrics, there are no longer differences in age between rural and non-rural NH for APRNs and PAs, likely a result of newly trained (younger) providers balancing out the proportion of older providers.

Several trends did not change since last year's analysis. APRNs practicing in rural are more likely to practice at outpatient locations that offer financial assistance (Medicaid and/or sliding fee scale) compared to their non-rural counterparts. Rural physicians are less likely than their non-rural counterparts to practice both a primary care specialty and in outpatient primary care. Overall, APRNs and PAs are more similar when comparing provider and practice characteristics than physicians are to either provider type. Non-rural practicing APRNs and PAs are more likely to have graduated from a New England school and have NH ties prior to receiving their NH license, whereas the opposite is true for physicians; rates for NH ties and graduation from a NH medical school are statistically higher for rural practicing physicians compared to non-rural physicians. In addition to these encouraging physician indicators for rural retention is a higher rate of NH residency for rural practicing physicians. These indicators provide evidence for the "grow your own" model as an effective strategy to increase the rural workforce.

Table 5.1. Significant Geographic Disparities, Rural Physicians

More likely to…	*Less likely to…*
Have NH ties prior to receiving initial NH license	Practice a primary care specialty
Have graduated medical school within the last 10 years	Provide outpatient, primary care services
Have graduated from a NH medical school	
Have trained at a residency within NH	

Table 5.2. Significant Geographic Disparities, Rural APRNs

More likely to…	*Less likely to…*
Have graduated nursing school within the last 10 years	Have graduated from a New England nursing school
Have less than 5 years of practice in NH	Have NH ties prior to receiving initial NH licensure
Practice at locations that offer payment assistance	

Table 5.3. Significant Geographic Disparities, Rural PAs

More likely to…	*Less likely to…*
Have graduated PA school within the last 10 years	Be female
Have less than 5 years of practice in NH	Have graduated from a New England PA school
Practice full time (>30 clinical hours/week in NH)	Have NH ties prior to receiving initial NH license

Primary Care Supply - Rates by Geography

The workforce supply figures in tables 6.1. and 6.2. below are an estimate of primary care FTE per 100,000 resident population in NH. Our analysis reveals significant gaps in supply between provider types, with the physician rate (54.1) about 75% higher than the APRN rate (30.5) and almost 6x as high as the PA rate (9.2). Across provider types, NH has 93.8 outpatient primary care FTE providers per 100,000 resident population, which translates to one primary care provider for every 1,066 people. Rates are slightly higher in rural NH than in the non-rural aggregate, with the exception of PAs.

Through focused policy changes and increased state and federal policy efforts, we've seen a marked increase in provider FTE in rural regions of NH. The top three highest outpatient primary care FTE provider rates are in rural PHRs. It comes as no surprise that Upper Valley, where Dartmouth-Hitchcock Medical Center sits, has the highest rate in the state, given that Dartmouth Health is the largest health care system in NH and is affiliated with the state's only medical school. The high PCP FTE rates in North Country and Carroll County are likely the result of successful health care workforce efforts supported by their federal shortage designation status. Designation as a HPSA brings providers and funding to underserved areas of the state. In order to qualify for shortage designation, an area must meet rigid criteria that proves population vulnerability and lack of adequate PCP supply. Facility HPSAs (e.g. Rural Health Clinics (RHCs), FQHCs, and FQHC Look-alikes) receive a number of financial and operational benefits to incentivize health care providers to practice in underserved areas of the state (Appendix B). Federal designation status also provides the opportunity to seek additional grant funding to support workforce and health care access initiatives. North Country contains all of Coos County and part of Grafton County, both federally designated HPSAs, where several FQHCs and several Rural Health Clinic (RHCs) designations and expansion have come in the last 10 years. Much of Carroll County, which has the 3rd highest provider-to-population ratio in the state, is also designated as a HPSA with an FQHC and RHC. These rates, reflective of primary care availability, demonstrate the pivotal role of shortage designation and ensuing workforce initiatives that bolster primary care in underserved, vulnerable communities.

The PCP FTE rate is an important measure to understand availability of primary care in NH's communities. To illustrate this, consider Greater Monadnock and Greater Nashua; both have a relatively large proportion of PCP practice by FTE in the state compared to other PHRs, however, they also have large populations to serve. The PCP FTE rate allows for a more comprehensive understanding of supply as it relates to need in NH. The difference between the highest and lowest rates by PHR is staggering; the rate of primary care FTE to population in Upper Valley is twice that of Greater Sullivan County. While part of Greater Sullivan County has a HPSA designation, and North Star Health, an FQHC, exists within its borders, outpatient primary care is limited within this PHR.[5]

Table 6.1. Provider-to-Population Ratio, Medical Providers, 2021
Total Outpatient Primary Care FTE Providers per 100,000 Resident Population

Provider Type	Year	Statewide Rate	Rural Rate	Non-Rural Rate
Physicians	2021	54.1	56.9	52.9
APRNs	2021	30.5	36.3	28.1
PAs	2021	9.2	6.3	10.4
Combined	2021	93.8	99.5	91.4

[5] In 2022, Concord Hospital opened a primary care practice in New London, increasing the primary care FTE rate within Great Sullivan County PHR.

Table 6.2. Provider-to-Population Ratio by Public Health Region, Combined Medical Providers, 2021

Total Outpatient Primary Care FTE Providers per 100,000 Resident Population

Rurality	PHR	Rate per 100,000 population	*Resident Population
Rural	Upper Valley	144.4	46,772
Rural	North Country	127.2	51,539
Rural	Carroll County	111.7	51,500
Non-Rural	Capital Area	108.2	137,172
Rural	Central NH	107.3	31,106
Non-Rural	Seacoast	102.1	149,780
Non-Rural	Greater Manchester	100.1	193,752
Non-Rural	South Central	85.2	147,466
Rural	Winnipesaukee	84.1	80,547
Non-Rural	Strafford County	80.4	132,416
Rural	Greater Monadnock	80.3	101,996
Non-Rural	Greater Nashua	76.5	218,551
Rural	Greater Sullivan County	73.9	46,395

Sorted from highest to lowest PCP FTE

** Population estimates were provided by the Office of Health Statistics and Data Management, Bureau of Public Health Statistics and Informatics, NH DHHS. Estimates are based on the 2020 Census PL94-171 Redistricting File, 2020 Demographic Analysis Estimates, and Vintage 2020 Postcensal Population Estimates; together these form the Population Estimates Program (PEP) vintage 2021. For population estimates methodology statements, see http://www.census.gov/programs-surveys/popest/technical-documentation/methodology.html. All population estimates for the Public Health Regions (PHR) in NH are completed based on these estimates rolled up to the PHR.*

Due to the methodology HPDC employed for health workforce supply analysis, the resulting statistics are inconsistent with published workforce supply figures, which use the American Medical Association (AMA) Physician Masterfile, for state-to-state comparison. The primary difference between the HPDC data and the Masterfile is the granularity of data collected, which allows our program to assess primary care distribution more accurately in the state. Outpatient primary care provider FTE estimates are calculated using workforce data statistics collected during the 2021 survey year under HPDC. For medical providers with active status licenses who did not complete the survey during 2021, unique calculations are applied to this cohort, which includes both providers who are not due for renewal (including initial licenses) and non-respondents. Calculations applied to estimate workforce figures include percentage of active clinical practice in NH, percentage of outpatient primary care practice, and percentage of outpatient primary care FTE.

Analysis Limitations

With the expansion of telemedicine services, particularly under the COVID-19 emergency orders, available capacity (by FTE) may be underestimated in this analysis due to the exclusion of telemedicine/telehealth-only practice. While this mode of clinical service delivery is becoming a critical component of access to care, especially for more remote, underserved areas in the state, health care access by geography was indeterminable in this analysis without corresponding location data for telemedicine FTE. In this same vein, the analysis was conducted only for medical providers and not behavioral health providers due to the widespread use of telemedicine to deliver behavioral health services. For this reason, calculating the rate of behavioral health practice by geographic location is unfeasible using data collected with the 2021 survey tool. However, with recent survey modifications to account for telehealth practice (see Data Use), HPDC anticipates statewide behavioral health capacity analysis in future reports. Another practice consideration during this period the analysis could not account for is the added health provider supply through licensing policy changes under the Office of Professional Licensure and Certification (OPLC) during the New Hampshire State of Emergency, which began in April 2020 and ended June 10, 2021. During the Public Health Emergency, NH's governor issued several executive orders (EOs) targeting OPLC licensing policy to increase access to medical care in NH. Through emergency licensure, among other licensing policy changes, the EOs allowed for out-of-state health professionals whose profession is licensed in NH to practice in the state and the use of all modes of telehealth. Because the survey only captures data from health professionals with active status NH licenses, the full breadth of health care supply and access services may be underestimated, though it's unclear what scope of practice and capacity additional health care providers would have within primary care, and apart from the pandemic emergency response (e.g. testing centers, emergency departments, intensive care/acute care units, in-hospital care etc.). Additionally, to collect provider capacity independent from pandemic practice disruptions to accurately inform shortage designation, surveys asked respondents to answer questions "as you would have responded before any COVID-19 related changes to your work occurred." Because of the ways the pandemic disrupted provider availability and practice patterns between 2020 and 2021, caution should be exercised when interpreting this analysis for workforce capacity during this time.

SFY21 Health Professions Survey Data Statistics

Behavioral Health Providers

Supply and capacity indicators of the surveyed behavioral health workforces – mental health practitioners (MHPs), psychologists, and alcohol and drug counselors (ADCs) - actively practicing in NH.

Note: Due to the low response rate in 2019-20, mental health practitioner (LICSW, LCMHC, LMFT, LPP) workforce figures come from survey data collected between 2020 and 2022.

Practice Status – The percentage of behavioral health providers with an active status New Hampshire license (i.e. unrestricted license for clinical practice) who are clinically practicing in NH is comparable across provider types. Over three-quarters of active status behavioral health licensees are providing clinical services in NH.

Table 7.1. Practice Status
% of clinically active providers

	MHPs	Psychologists	ADCs
Active, Clinical Practice	82.8	76.3	82.7

Includes full-time/part-time practice (including telemedicine only).

Demographics – There is limited diversity in New Hampshire's behavioral health workforce. The majority of behavioral health service providers are female, with MHPS showing the highest proportion (over 80%) identifying as female. Additionally, there is little racial/ethnic diversity within the mental health workforce as evidenced by approximately 95% of providers across license types identifying as non-Hispanic White. The median age for behavioral health providers is relatively consistent across provider types ranging between 50 and 56 years old.

Table 7.2. Demographics
% of clinically active providers in each demographic group

	MHPs	Psychologists	ADCs
Female	82.5	66.6	71.7
Non-Hispanic White	94.6	93.2	93.2
Median Age	50	56	53

Distribution – Behavioral health practice in rural NH is limited, particularly for outpatient services, which represents about 20% of total FTE for all provider types. Compared to MHPs and psychologists, ADC outpatient practice is limited across the state for both rural and non-rural aggregates; less than 30% of ADC rural practice and 50% of non-rural practice is in outpatient settings. MHP outpatient practice to all practice is relatively high and comparable between rural and non-rural NH (~75%). Psychologist practice is less consistent across geography, with 60% of all rural psychologist practice in outpatient settings and 85% of all non-rural practice in outpatient.

As illustrated in Figure 3, outpatient provider supply (by FTE) in rural PHRs is comparable between MHP and ADC workforces, and less so for psychologist practice. Upper Valley has the highest overall and outpatient FTE for behavioral health practice among rural PHRs. Over 15% of all psychologist practice in the state is in Upper Valley, with over 10% in outpatient practice. This is almost twice the amount of FTE than the next highest rural PHR, Greater Monadnock, for outpatient psychologist services. Greater Sullivan County has the lowest overall and outpatient FTE for behavioral health practice. While Greater Manchester and Capital Area have the highest overall and outpatient FTE in the state for behavioral health practice, the proportion of outpatient services in these two counties is lower than in other non-rural and rural PHRs, save for ADCs who indicate less outpatient practice relatively consistently across PHRs (Figure 4). South Central has the lowest combined provider, outpatient FTE among the non-rural PHRs; about 15% of the total behavioral health practice in the state.

Table 7.3. Distribution
% of total FTE by geography and clinical practice

	MHPs		Psychologists		ADCs	
	All	Outpatient	All	Outpatient	All	Outpatient
Rural Regions	24.0	18.8	32.3	22.3	31.1	18.1
Non-Rural Regions	76.0	60.2	67.7	58.3	68.9	44.5

Telehealth-only practice is excluded from geographic analysis.

Figure 3. Rural PHRs

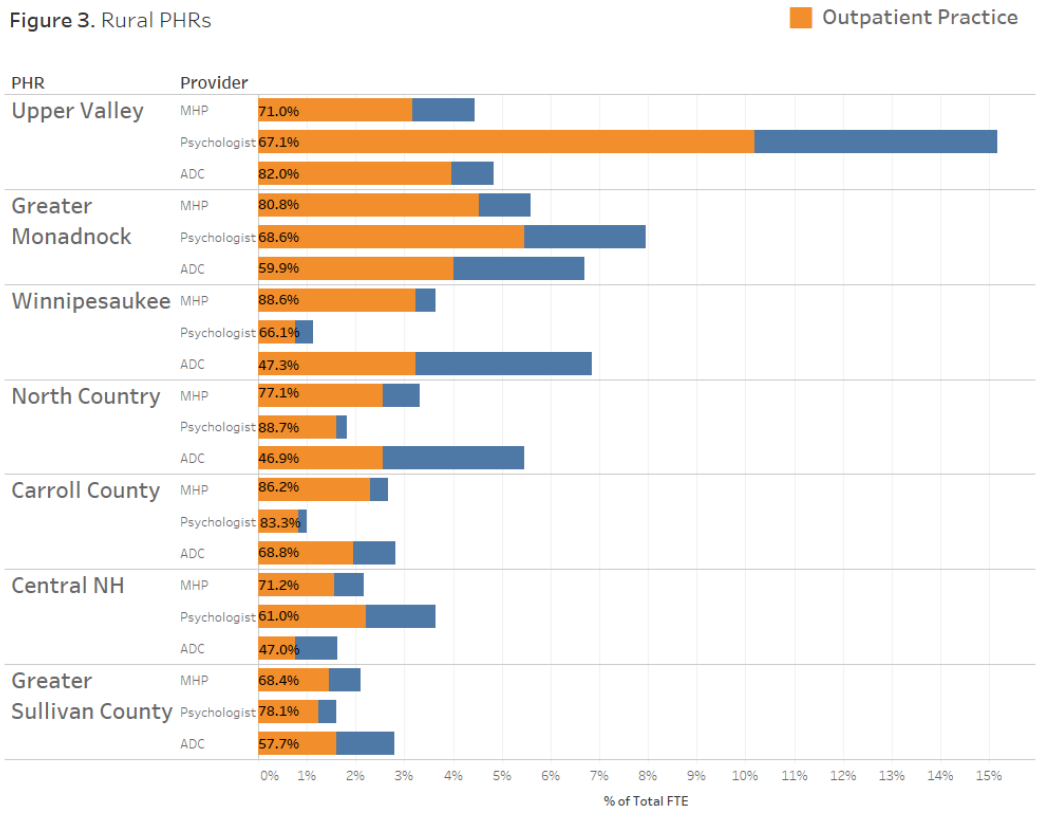
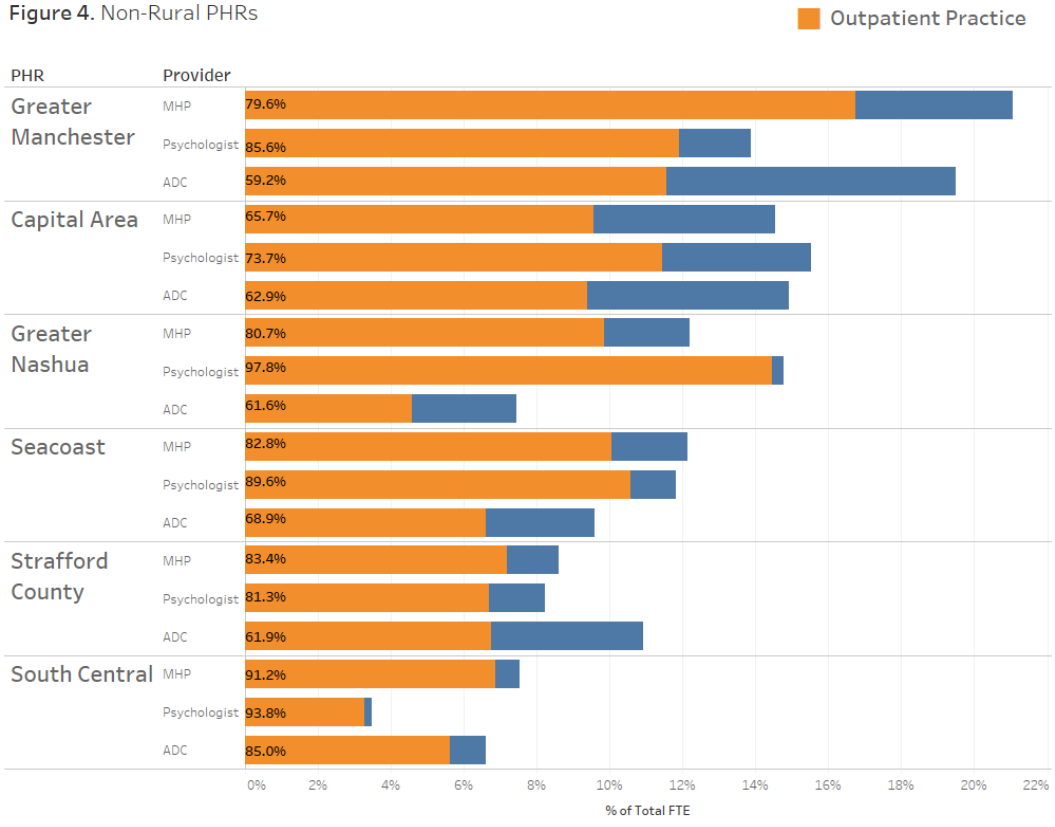


Figure 4. Non-Rural PHRs



Anticipated Supply – Among behavioral health provider license types there's considerable spread across retention indicators. Age statistics reveal a maldistribution of outpatient behavioral health providers, particularly psychologists, entering the workforce and those nearing retirement. Within outpatient practice, there are substantially more outpatient behavioral health providers over the age of 60 than there are under 40; the proportion of providers 60 years and older to those under 40 is 30% higher for MHPs, and twice as high for ADCs and psychologists. About one-third of psychologists plan to reduce their practice in 5 years, which is moderately higher than MHPs (<25%), and considerably higher when compared to ADCs (<15%). Between 90-95% of ADCs and MHPs have lived or worked in NH prior to licensure, indicating those with state ties are staying to practice. A relatively large proportion of ADCs (>40%) have practiced in NH for less than 5 years, which may in part reflect the increase in MLADC licenses granted since 2018 changes to reimbursement for Medicaid billing. Taken with anticipated reductions in practice, it appears NH can anticipate a forthcoming reduction in psychologist supply. However, the ubiquity of telehealth may temper losses in behavioral health services and could explain, in part, the low percentage of no clinical practice indicated for anticipated practice in five years.

Table 7.4. Anticipated Supply
% of clinically active providers in each indicator group

	MHPs		Psychologists		ADCs	
	All	Outpatient	All	Outpatient	All	Outpatient
<40 Years Old	23.0	21.0	14.2	22.5	21.2	13.9
60+ Years Old	29.8	31.4	42.5	43.1	29.6	29.2
NH Ties	89.5	89.9	67.2	67.2	94.1	94.2
Less than 5 Years Practicing in NH	23.4	22.2	20.5	21.0	43.4	42.0
*Anticipated Reduction in Practice in 5 Years	23.1	23.0	32.5	31.4	13.9	14.2
- Practice in another state or no intention to practice	7.4	6.9	9.3	8.1	3.5	3.4

*** Indicated by an anticipation of reduced hours, practice in another state, or no clinical practice*

Access – ADCs are more widely available when compared to their counterparts according to access indicators. Over 85% of ADCs are accepting new patients, whereas about 60% of psychologists and 65-70% MHPs indicate new patient acceptance. ADCs also report an average wait of one week or less for established patients and 1-1.5 weeks for new patients. While the rural MHP wait time is slightly shorter for established patients than non-rural providers (1.5 weeks v. 2 weeks), the wait time for new patients, about 3 weeks, is the same across geography. Psychologists have reduced access compared to their behavioral health counterparts, with rural figures revealing longer wait times than for non-rural practitioners. Average wait time for non-rural practicing psychologists is 1.5 weeks for established and 2.5 weeks for new patients, while rural figures show a 3-week wait for both established patients - twice the wait for non-rural practice - and new patients.

Table 7.5. Access

% of clinically active outpatient providers in each access indicator group

	MHPs		Psychologists		ADCs	
	Non-Rural	Rural	Non-Rural	Rural	Non-Rural	Rural
Accepting New Patients	65.8	71.8	62.6	61.9	86.8	86.6
Average Wait for Routine Appointments, Established Clients (days)	13.3	10.0	10.5	20.6	7.0	5.4
Average Wait for Routine Appointments, New Clients (days)	20.7	20.3	18.3	21.1	10.7	6.2

**Analyzed by site count*

Significant Workforce Differences by Rurality, Behavioral Health Providers

Tables 8.1. – 8.3. Chi-Square tests of independence were run for select measures to assess whether significant differences in behavioral health provider and practice characteristics exist by geography (rural v. non-rural). The following tables contain indicators that were found to be significantly different by geography at the 95% confidence level. For test statistics, please refer to the individual provider workforce reports, available on the New Hampshire Health Professions Data Center website. New to this year's analysis is 2020-22 mental health provider (MHP) data.

Rural practicing providers in all three behavioral provider types were less likely than non-rural providers to practice full time in NH (i.e. more than 30 of clinical practice a week), which can impact availability of services. Other workforce characteristics where rural rates were found to be significantly different from, and less favorable to, non-rural rates include a lower rate of outpatient/office-based practice for rural psychologists, a lower rate of completing higher education within both the region and state for ADCs, and higher median age for rural practicing MHPs and ADCs. With respect to practice capacity and scope of practice, rural NH has a higher rate of LADCs (bachelor's-level clinician), whereas non-rural NH has a higher rate of MLADCs (master's-level clinicians). Interestingly, rural MHPs were found to have shorter wait times (7 days or less) for established patients than non-rural MHPs.

Table 8.1. Significant Geographic Disparities, Rural MHPs

More likely to…	*Less likely to…*
Be older than 51 (median age)	Have NH ties prior to receiving initial NH license
Practice at locations that offer payment assistance	Practice full time (>30 clinical hours/week in NH)
Have wait times 7 days or less for established patients	

Table 8.2. Significant Geographic Disparities, Rural Psychologists

More likely to…	*Less likely to…*
	Be female
	Work in outpatient/office-based settings
	Practice full time (>30 clinical hours/week in NH)

Table 8.3. Significant Geographic Disparities, Rural ADCs

More likely to…	*Less likely to…*
Hold a LADC (not MLADC) license	Practice full time (>30 clinical hours/week in NH)
Be older than 54 (median age)	Have completed their highest level of education prior to licensure in New England or NH

Administrative Rules Update

DHHS administrative rules, He-C 801 (http://gencourt.state.nh.us/rules/state_agencies/he-c800.html), established the purpose of data collection and requirements for the collection of health care provider data by HPDC – which sits under RHPC with the SORH. Provider surveys are amended annually through the DHHS administrative rules process to reflect current Health Professions Survey iterations.

By the end of 2020, each participating licensing board (6) had promulgated rules requiring licensees to fulfill the survey requirement – completion of the Health Professions Survey or opt-out form - as a condition of license renewal.

Program Updates

Administration

A number of administrative changes occurred in August 2023, following an internal review of capacity and legal review of the data sharing agreement by the Office of Professional Licensure and Certification (OPLC). OPLC determined that it does not have the legal authority to comply with the 2020 data sharing agreement, which allowed for sharing of public and non-public data. Because data sharing is a central element of survey implementation and workforce evaluation, DHHS developed a Memorandum of Understanding (MOU), currently under review at OPLC, that details the compliance process and reinstatement of an automated, weekly data extract to support surveying and current supply figures. In the absence of a pre-existing MOU that formally outlines agreed-upon operations, such as the notification process for complaint mailings designed to prevent administrative errors, there has been a notable disruption to program operations. This disruption has led to an increased burden on both agencies and providers, who have received complaints issued in error and experienced trouble locating survey links. Legislation has been proposed (HB1609, 2024) to authorize OPLC to share workforce-related licensing fields fundamental to HPDC's role in provider surveying, federal shortage designation, and workforce assessment.

Survey implementation and response rate management has been possible with access to the OPLC public data file, published on a bi-weekly basis. This file contains the minimum fields necessary to conduct provider surveying but does not include public data fields utilized for primary care workforce analysis to inform health care access planning and workforce assessment. Until more complete data sharing resumes, HPDC will be limited in its ability to provide comprehensive workforce analysis reports and ad hoc data requests to inform workforce policy.

Prior to August 2023, workforce data challenges were addressed in standing monthly meetings between the HPDC administrator, the Legislative Commission on the Interdisciplinary Primary Care Workforce chair, and OPLC executive director. These meetings precipitated improvements to survey implementation, workforce data, and compliance. Although standing meetings ended in August, the program anticipates that ongoing collaboration with key contacts within OPLC will

support program efforts around best practices for workforce data analysis on current and anticipated primary care supply figures.

As a condition of license renewal for providers, completion of the survey requirement was intended to be verified prior to issuing license renewals for participating health care professionals. OPLC confirms compliance by provider attestation on the electronic license renewal application form, following procedure for all license renewal requirements. OPLC is in the process of updating the initial and renewal electronic license application forms for, among other reasons, question uniformity across license types. This includes an amendment to the renewal application's question form to include the survey requirement, where all other licensure requirement attestations exist. Relocating the attestation from the survey page to the questions page will allow for more visibility and increased compliance.

In 2022, the OPLC Enforcement Division ("enforcement") was created to manage non-compliance of regulatory requirements, which includes the Health Professions Survey. By the end of 2022, enforcement had developed a protocol to issue formal complaints to licensees on the final non-compliance list shared by the HPDC. As with all other unmet license requirements, the complaint outlines the violation, encourages compliance, and asks for response within 30 days. This process proved effective for compliance and resulting response rates, reducing the non-compliance rates from 15-25% to less than one percent. An evaluation of OPLC internal practices in July 2023 lead to the request that HPDC file individual complaints using the public electronic form. Due to limited staff resources, HPDC is unable to implement the requested change. The MOU currently under review at OPLC includes language to support sending final non-compliance to enforcement in order to reinstate this compliance activity. However, until HPDC resumes sending final non-compliance lists to OPLC, HPDC expects the discontinued enforcement action will lead to reduced survey response rates.

Relocating the Health Professions Survey links from OPLC's electronic renewal application to the DHHS website this past year proved beneficial for provider accessibility and corresponding survey response. Hosting the survey page has allowed for timely survey postings and improved guidance, reducing provider confusion and survey posting errors.

Data Use

With consistent and reliable data on the supply and capacity of the NH health care workforces, data requests continue to increase each year. HPDC is the only entity in the state that can provide the level of granularity necessary for accurate medical, behavioral health, and dental workforce estimates. As such, HPDC provides workforce supply and demand figures year-round. In addition to producing analytics for public consumption, this past year HPDC has informed the work of the following stakeholder organizations:

- Higher education - University of New Hampshire (UNH) and Geisel School of Medicine at Dartmouth College grants and residency trends;
- Provider associations - NH Dental Society, the NH Nurse Practitioner Association, and the NH Alcohol & Drug Abuse Counselors Association;
- Health policy and practice organizations - The NH Recruitment Center, UNH's Institute for Health Policy and Practice, NH Children's Health Foundation; and

- DHHS programs, including the State Loan Repayment Program, the Oral Health Program, Maternal and Child Health, and the Immunization Section.

New to this year's report are two analyses targeting available workforce supply and need. The analysis of outpatient primary care rates by geography calculates workforce supply in a given area with respect to that area's population. This analysis reveals disparities between rural and non-rural areas and identifies areas in the state with a shortage of providers given the population size. The analysis on combined provider primary care supply, which includes physicians, APRNs, and PAs, allows for a more comprehensive look at primary care in the state. Isolating supply figures to only physicians diminishes the impact of all relevant provider types and underrepresents the availability of primary care in the state. These additions to the report allow for evaluation of need, which is crucial for policy around emergency preparedness, workforce planning, and the identification of disparities in health care access.

The impetus for creating HPDC was to support federal shortage designation work through the collection of current and accurate provider data. Shortage designations bring providers and funding to underserved areas of the state. A variety of grants and other federal and state programs with funding opportunities, including the State Loan Repayment Program, use these designations to target resources to areas of need. Provider survey data enables RHPC to identify physician supply and practice in existing or potential designated areas within New Hampshire within the Health Resources and Services Administration's (HRSA) Shortage Designation Management System (SDMS). Because HRSA utilizes the National Provider Identifier (NPI) database – a source for provider practice frequently cited for its data challenges - to indicate current provider capacity within SDMS, RHPC relies heavily on HPDC's provider data to perform provider validation. Provider validation is essentially the most important component of shortage designation work, as population-to-provider ratios have the greatest point potential for HPSA scores, designed to identify areas of need and prioritize funding. These scores affect whether facilities will be eligible locations for National Health Service Corps and Nurse Corps providers; Centers for Medicaid and Medicare Services (CMS) HPSA Bonus Payments for delivering Medicare-covered services to patients; and status as a designated Rural Health Clinic, which have enhanced reimbursement and other financial incentives. In 2022, HRSA developed a new shortage designation, called Maternal Care Target Areas (MCTAs), to identify areas within an existing HPSA experiencing a shortage of maternity health care professionals. Because surveying is already implemented for Certified Nurse Midwives (CNM) and obstetrician gynecologists (OB/GYN), recognized maternal care providers under the new shortage designation, HPDC was able to incorporate maternal care provider validation into our existing work without utilizing additional resources. With HPDC's provider data, our office will continue to successfully conduct shortage designation work to ensure the most vulnerable areas in New Hampshire are reinforced.

Staffing

HPDC recruited a data scientist at the end of SFY23 to support program activities and expedite reporting timelines. While creation of and funding for this new position was supported by 2019 legislation (HB 4, Laws of 2019), the position remained vacant for two years. RHPC moved to targeted recruitment at the end of 2022 by updating the position classification and requirements,

which resulted in more applications and eventual success in filling the position. Prior to the new hire, the HPDC manager was the only staff member under HPDC, executing all aspects of the program, including provider tracking and follow up; survey development, building, and administration; implementation coordination with OPLC and the Department of Information Technology (DoIT); HPDC website management; and data cleaning, analysis, and reporting. An additional FTE was critical to the success of HPDC as the primary resource for current health workforce data in the state.

Future Plans

Workforce Reports

As previously mentioned, HPDC aims to publish workforce reports with aggregated provider data two years after the close of the data collection/renewal cycle for each participating provider type. Because renewals are determined by initial license year (save for dental professionals), data collection on the full license list is achieved every two years to capture providers who renew on both even and odd years. Until this year, annual workforce reports represented one year of data collection, or approximately half of all licensed providers. Dental professionals were the exception, as dentist renewals occurred on even and registered dental hygienist (RDH) renewals on odd years, with all providers under the respective license type (i.e. dentist/RDH) renewing all together in one year.

This year, OPLC modified their administrative rules to effectuate consistent license renewal periods across all license types. All licenses issued after February 14, 2023, will expire two years from the date of issuance, on the last day of the month. To avoid effects of provider maldistribution by renewal year, HPDC will move from dental reports summarizing data collected in even (dentists) or odd (RDHs) year renewals to combined two-year data reports. Without doing so, only new licensees (often recently trained and young) will renew on both even and odd years while providers who have maintained an active NH license will continue to renew only on even (dentists) or odd (RDHs) years. Dental provider workforce reports containing survey data from 2021 and 2022, respective to RDH and dentist survey cycles, will reflect the full dental workforces, save for initial licenses not yet subject to renewal.

Last year, HPDC discovered licensee maldistribution by expiration year for psychologists and mental health practitioners, which lead the program to modify reporting in the same way we will for dental providers: summarizing two-year data instead of one-year. Because mental health practitioner data collection runs on the State Fiscal Year (SFY), and SFY2020 was unusable due to the exceedingly low response rate, the workforce report released this year reflects data collected between SFYs 2021 and 2022.

Two thousand and twenty (2020) legislation and subsequent amendment to OPLC administrative rules moved physician assistant (PA) renewals from an annual to biennial basis to be consistent with all other licensed health professions under OPLC. Prior to this change, PAs were the only health professions license type to renew annually and, as such, workforce reports prior to this legislative amendment (i.e. 2018-2020) reflected data collected from the full NH-licensed PA

workforce, excluding initial licenses. This is the first year the 2021 PA report reflects data from half of the NH-licensed workforce. Future reports will combine two-year data to avoid bias that results from inaccurate and unreliable statistics when analyzing small datasets.

See Appendix A for the license renewal cycles of each provider type included in this year's published data reports, reflecting license renewal periods prior to February 15, 2023. Since June 30, 2022, HPDC has maintained full workforce data reflecting both even and odd renewal years for all participating provider types: physicians, APRNs, PAs, mental health practitioners (LICSWs/LCMHCs/LMFTs/LPPs), psychologists, alcohol and drug counselors (LADCs/MLADCs), dentists, and RDHs. Annual provider data collection will continue during license renewal to ensure data on the full NH-licensed workforces is maintained and available for state use.

Compliance

All license renewal requirements are confirmed by provider attestation on the electronic license renewal application form. Without verification of compliance prior to issuing license renewals, HPDC continues to contend with non-compliance. Formation of the Enforcement Division ("enforcement") within OPLC in 2021, allowed for collaboration to increase survey compliance and response rates. Following changes to this process implemented by OPLC in August 2023, HPDC expects survey non-compliance to rise, which will impact the availability of reliable, representative workforce data, only achievable with high response rates. Establishment of an updated MOU, detailing survey compliance processes and intended enforcement action for non-compliance, will effectively prevent any increase to non-response rates.

Data Use

Together with state and national stakeholders, HPDC designed the Health Professions Surveys to collect rich, comprehensive workforce data that would lend itself to improved health care access planning and workforce assessment, supporting and strengthening:

- Federal shortage designations, which brings providers and grant funding to underserved areas of the state;
- Recruitment and retention initiatives including scholarships, loan repayment, and visa waiver programs;
- The expansion of existing educational programs and employment training programs; and
- Emergency preparedness.

To ensure the Health Professions Survey questions reflect current data needs (i.e. are actionable), subject matter experts review and request modifications to provider surveys annually. Policy changes to reimbursement for telemedicine services, brought about by the COVID-19 pandemic, warranted survey modification to include several telemedicine considerations to delineate between in-person and remote services provided. All SFY2023 provider surveys incorporated these changes.

Additional changes to licensing policy this year under OPLC include reciprocity licensing and conversion of temporary licenses issued in response to the COVID-19 pandemic to permanent licenses. Reciprocity licensing went into effect on August 27, 2023, to increase NH's clinical workforce. Reciprocity licensing allows for NH licensure of professionals who are licensed in another state with comparable licensure requirements to NH. The new OPLC licensing policies streamline the licensing process, removing unnecessary licensing barriers to clinical practice in NH. Workforce supply estimates utilizing only the licensing list poses workforce supply uncertainty when analyzing current supply trends, given that practice intent within NH is unclear. However, workforce evaluation to account for licensing list supply figures and HPDC survey statistics will ensure reliable estimates for health workforce policy. HPDC's methodological approach applies HPDC provider and practice statistics to OPLC supply figures in order to enumerate the current capacity. This approach accounts for any fluctuations in the number of active NH licenses, ensuring an accurate assessment of the health care workforce, particularly in the context of primary care.

Equipped with the most accurate and current provider workforce data in the state, RHPC will continue to educate stakeholders and inform workforce policy. The SORH's statutory survey requirement enables HPDC to maintain ongoing provider surveying integral to shortage designation work, provider-to-population analysis to determine need, and supply and distribution statistics to inform emergency preparedness on a sub-county level. In addition, HPDC will continue to identify geographic disparities in provider and practice characteristics by rurality, enabling targeted allocation of limited resources for health care access planning. Working alongside health care workforce leaders in NH, and nationally, will continue to strengthen best practices and ensure a collaborative approach to identifying and addressing health professions workforce challenges.

The administrative rules on the licensure of regulated professions under OPLC are currently under review and include a new section on the collection of workforce data for analysis for all license types. The questions, to be included in both the initial and renewal application, were recommended by Healthcare Regulatory Research Institute (HRRI) and are designed to collect data on demographics, education and training, current employment, practice capacity, and anticipated practice. If implemented, this additional dataset on provider and practice characteristics will supplement survey data and enable HPDC to assess current health care workforce figures more comprehensively by providing data on non-respondents, which includes non-compliant providers, providers due to renew on alternate years, and newly licensed providers.

Appendix A

Board	List of Provider Surveys as of December 2023	License Renewal Cycles
Board of Licensing for Alcohol and Other Drug Use Professionals	Alcohol and Drug Counselor Licensure Survey ▪ Licensed Alcohol and Drug Counselors (LADCs) ▪ Master Licensed Alcohol and Drug Counselors (MLADCs)	Biennially, 5/1-6/30, by initial license year
Board of Nursing	Advanced Practice Registered Nurse (APRN) Licensure Survey	Biennially, rolling, by birthday
Board of Mental Health Practice	Mental Health Practitioner Licensure Survey ▪ Licensed Independent Clinical Social Workers (LICSWs) ▪ Licensed Clinical Mental Health Counselors (LCMHCs) ▪ Marriage and Family Therapists (MFTs) ▪ Pastoral Psychotherapists (PPs)	Biennially, rolling, *by initial license year
Board of Medicine	Physician Licensure Survey	Biennially, 5/1-6/30, by initial license year
Board of Medicine	Physician Assistant Licensure Survey	Biennially, 11/1-12/31, by initial license year
Board of Psychologists	Psychologist Licensure Survey	Biennially, 5/1-6/30, **by initial license year

* Initial license issued before year 2000, are renewed in June of odd years

** Initial license issued before year 2000, are renewed in odd years

Appendix B

Health Professional Shortage Areas (HPSAs)

A HPSA is a federal designation status that indicates a shortage of health care providers in primary care (physicians), dental health (dentists), or mental health (psychiatrists). These shortages may be geographic-based (a shortage of providers for the entire population within a defined geographic area), population-based (a shortage of providers for a high-needs population group within a defined geographic area – e.g. low income, etc.), or facility-based (correctional facilities, state mental hospitals, Auto-HPSA facilities – see below, and other facilities serving a geographic or population with a shortage of providers).[6]

Shortage Designation Status (Primary Care)	National Health Service Corps (NHSC)	Nurse Corps	Health Center	CMS HPSA Bonus Payment	CMS Rural Health Clinic (RHC)	State Loan Repayment Program (SLRP)	J-1 Visa Waiver Program (Conrad 30)
Geographic HPSA	Yes	Yes	No	Yes	Yes	Yes	Yes
Population HPSA	Yes	Yes	No	No	Yes	Yes	Yes
Facility HPSA	Yes	Yes	No	No	No	Yes	Yes
Medically Underserved Area (MUA)	No	No	Yes	No	Yes	Yes	Yes
Medically Underserved Population (MUP)	No	No	Yes	No	No	Yes	Yes
Exceptional MUP (E-MUP)	No	No	Yes	No	No	Yes	Yes

[6] Community Health Association of Mountain/Plains States, 2023, http://champsonline.org/tools-products/rrresources/understanding-hpsas-and-muas

Federally-Qualified Health Centers (FQHCs) & Look-Alikes

Benefits	Health Centers	Look-alikes
Receiving funding from HRSA	Yes	No
Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) reimbursement through the Centers for Medicare and Medicaid Services (CMS)	Yes	Yes
HRSA's 340B Drug Pricing Program for discounted drugs	Yes	Yes
Free vaccines for uninsured and underinsured children through the Vaccines for Children program	Yes	Yes
Assistance in the recruitment and retention of primary care providers through HRSA's National Health Service Corps	Yes	Yes
HRSA-supported training and technical assistance	Yes	Yes

Automatic Facility HPSAs (Auto-HPSAs) are facilities that are automatically designated as a HPSA by statute or through regulation without having to apply for a designation. These include Health Center Program grantees and Look-Alikes (community-based health care providers that meet the requirements of the Health Center Program but do not receive funding). A facility with an Auto-HPSA may also have separate geographic and/or population HPSAs. All Community Health Centers (CHCs) are automatically located in HPSAs by the nature of being FQHCs.