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

Calendar Year 2024

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

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Executive Summary

This report assesses New Hampshire's (NH) current capacity and future needs across primary medical, behavioral health, and dental health care disciplines. The analysis identifies both significant workforce challenges and promising trends, providing evidence-based insights to guide policy development and strategic health care planning for the state.

Key Findings

- Primary care practice concentrations are significantly lower in rural NH for all disciplines, with Greater Sullivan County facing the most severe shortages.
- NH can anticipate a continued reduction in primary care physician supply, though the encouraging growth and anticipated supply of Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) may offset these shortages, particularly in rural regions.
- NH's behavioral health landscape faces critical challenges with limited psychologist supply and expected workforce decline, especially in rural outpatient services, though widespread telehealth adoption offers potential to partially offset these access challenges.

Medical Provider Workforce

The 2022 data points to an anticipated decline in the primary care physician workforce, especially in rural communities. While the overall physician workforce showed minimal growth, rural NH experienced a concerning 20% decrease in its population-based primary care physician rate. There are twice as many physicians aged 60+ as there are under 40, and 15% anticipate no clinical practice within the next five years. Concentration of physician practice is highest in non-rural Public Health Regions (PHRs), and the geographic distribution of physicians in rural regions remains highly uneven.

Despite these physician workforce challenges, the APRN and PA workforces demonstrate continued growth and primary care reinforcement. The PA workforce experienced significant growth with a 15% increase, with higher rates of newly trained providers in rural settings. The APRN workforce saw a sharp increase of over 40% and now shows comparable primary care practice rates to physicians in rural areas despite physicians outnumbering APRNs nearly 2:1 statewide. Among medical providers, APRNs have the highest PCP percentages (23%) in the state, and they are the only provider type with a higher population-based primary care rate in rural NH compared to non-rural areas. APRNs and PAs make up more than half of primary care provider (PCP) full-time equivalent (FTE) rates for all rural PHRs except for Upper Valley,

while physician rates make up more than half of all PCP FTE rates for all non-rural PHRs. Primary care APRNs and PAs present favorable demographic profiles with young age distribution, strong ties to the state, and limited anticipated reductions in practice, suggesting greater stability and retention potential.

Behavioral Health Provider Workforce

NH's behavioral health landscape reveals limited rural accessibility to outpatient services, despite significant workforce gains in supply for mental health practitioners (MHPs) (17.5%) and moderate growth for alcohol and drug counselors (ADCs) (11.0%) and psychologists (9.4%). While most licensed providers actively practice in the state, rural communities face significant shortages in outpatient services compared to non-rural areas, with only about 20% of total practice in rural areas. Psychologists present the most concerning demographic profile, with practitioners aged 60+ outnumbering those under 40 by nearly 3-to-1, and one-third anticipate practice reductions within the next five years - a rate significantly higher than that of other behavioral health professionals. Additionally, rural psychologists are less likely to practice in outpatient settings compared to their non-rural counterparts.

Among behavioral health providers, outpatient ADCs demonstrate the highest accessibility, with high patient acceptance rates and short wait times, especially in rural areas. This is despite having lower ratios of outpatient to total practice compared to other providers, suggesting greater access for substance use disorder services than general mental health services. Additionally, MHPs and ADCs in rural regions are more likely to offer financial assistance, improving access for low-income populations.

The anticipated reduction in the psychologist workforce, combined with concerningly low net patient acceptance rates, points to increased strain on behavioral health access across NH. However, the widespread adoption of telehealth may help offset these challenges, particularly in rural areas.

Dentist Workforce

The dental workforce presents concerning trends despite some positive indicators. A decline of 8% in dentist supply indicates more providers are leaving than being replaced. Although the demographic profile appears promising, with providers under 40 outnumbering those aged 60+ by 70% and a pipeline sufficient to replace dentists planning to leave practice (13%), the actual decline reveals underlying recruitment and retention challenges. Rural communities in particular face access issues. Dentist population rates are lower in rural areas compared to non-rural areas, and wait times are longer for both new and established patients, despite rural dentists working

more full-time hours and accepting Medicaid at higher rates, suggesting rural dentists face patient demand that exceeds their capacity.

Conclusions and Recommendations

NH can anticipate continued reductions in the rural physician and psychologist workforce, which may potentially exacerbate barriers to access primary care services within rural communities. Expanding opportunities for in-state training is crucial for physician retention, as clinicians are more likely to practice where they train.[1] NH has made significant progress in this area, developing several new residency programs in the last five years, including three new family medicine residencies, two of which exist in rural areas. Cheshire Family Medicine Residency in Keene welcomed its first class of residents in July 2024, while Coos County Family Health Services, a Teaching Health Center - the only residency program to be located north of Concord is still under development and anticipates the first inaugural class in July 2026. Another new training opportunity aiming to offset dentist shortages is the Harvard School of Dental Medicine's general dentistry rural track program, established in 2023 to train rural dentists at seven delivery sites across the state to grow NH's dental workforce, particularly in rural and other areas of the state lacking a sufficient supply of dentists.

NH has seen a substantial benefit from primary care workforce pipeline investments through NH ANEW (Advanced Nursing Education Workforce). The increased presence of rural primary care providers can partially be attributed to creating pathways for nurse practitioners to train and subsequently practice in rural settings, contributing to the strong rural primary care presence of APRNs evident in the workforce data. Supporting these efforts, the NH Recruitment Center provides recruitment for primary care providers with an emphasis on health care shortage areas, while the NH Area Health Education Center (AHEC) enhances the health workforce pipeline by offering rural learning experiences, and team-based, integrated care training. Expanding these pipeline programs, particularly for primary care and rural practice, will be essential for improving access across all regions of NH, along with continued investment in the State Loan Repayment Program (SLRP), as an effective recruitment tool to bring clinicians to areas with provider shortages, and policies that enhance access to health care services, such as telemedicine. These successful models should be replicated for other disciplines, developing similar pathways for behavioral health practitioners.

While newly trained primary care physicians in rural New Hampshire represent an important pathway for addressing critical healthcare shortages, realizing this potential will require ongoing resourcing and support. To date, this work has been made possible through state and federal

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[1] Russell DJ, et al. (2022). " Family Medicine Residencies: How Rural Training Exposure in GME Is Associated with Subsequent Rural Practice, 14(4): 441-450.

investments in rural training programs, loan repayment initiatives, and practice support systems. Moving forward, we may need to diversify funding sources to ensure long-term sustainability. To counteract anticipated losses in rural physician and psychologist workforce, funding for the SLRP remains an essential recruitment tool, as the program continues to demonstrate effectiveness in recruiting clinicians to areas with provider shortages across all primary care disciplines. Additional strategies like cross-state collaboration through interstate licensure compacts would expand NH's workforce capacity, particularly for behavioral health. Interprofessional, team-based care models represent another key strategy, integrating primary care providers with behavioral health specialists, dental professionals, and non-clinical support staff like Community Health Workers (CHWs).[2,3] This approach maximizes the impact of limited provider resources while providing more comprehensive care, particularly valuable in rural areas where single-discipline shortages are more pronounced. These programs are especially important for psychologists and primary care physicians where aging workforces threaten future access. By supporting interdisciplinary approaches, including non-clinical primary care support, through organizations like NH AHEC, NH can build a resilient health care system to ensure adequate care for all residents.

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[2] Goodrich DE, et al. (2013). "Mental Health Collaborative Care and its Role in Primary Care Settings." Psychiatry in Primary Care, 15(8):383.

[3] Knowles M, et al. (2023). "Community Health Worker Integration with and Effectiveness in Health Care and Public Health in the United States." Annual Review of Public Health, 44: 363-381.

Comparison of New Hampshire's Primary Care Workforce Strategies with Commonly Recommended National Strategies

Focus Area	State Approach	Commonly Recommended Strategies	Alignment
In-State Training & Rural Residencies	- New family medicine residencies (2 rural - 1 Teaching Health Center) - Harvard Dental School rural track program	- Develop rural residency programs - Use "grow-your-own" strategies - Teaching Health Centers as high-retention pathways	**Strong**
Pipeline Programs & Education Pathways	- NH ANEW supports rural APRN training - NH AHEC offers rural learning experiences and team-based care training	- Expand pipeline from rural schools to practice - Rural preceptorships and clinical rotations - HRSA-supported AHEC models	**Strong**
Recruitment & Loan Repayment	- State Loan Repayment Program (SLRP) & NH Recruitment Center supports provider placement in shortage areas	- Loan repayment (e.g. NHSC, SLRP) key for rural recruitment - Centralized recruitment hubs recommended	**Strong**
Behavioral Health Integration & Interdisciplinary Models	- Promotes team-based models with behavioral health, dental, and CHWs - Aims to develop similar pipelines for behavioral health providers	- Integrate behavioral health into primary care - Expand interprofessional teams with clinical & non-clinical staff (CHWs, social workers, etc.)	**Strong**
Licensure & Regulatory Flexibility	- Supports interstate licensure compacts to expand workforce (e.g. behavioral health via PSYPACT)	- Use of multi-state licensure compacts to enhance workforce mobility and telehealth services	**Moderate to Strong**
Sustainability & Diversified Funding	- Acknowledges reliance on federal/state funds - Notes need to diversify funding for long-term success	- Diversify funding (e.g. foundation support, Medicaid, public-private models)	**Forward-Looking / Emerging Strength**

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Definitions

ADC – Bachelor's (LADC) and master's level (MLADC) alcohol and drug counselor.

APRN – Advanced Practice Registered Nurse (master's level). Also includes the terms "Nurse Practitioner" and "Advanced Practice Nurse Practitioner."

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). The 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).

LCMHC – Licensed Clinical Mental Health Counselor.

LICSW – Licensed Independent Clinical Social Worker.

LMFT - Licensed Marriage and Family Therapist.

LPP – Licensed Pastoral Psychotherapist.

MHP – Mental health practitioner; 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.

PA – Physician Assistant.

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 particularly in areas where access may be limited. 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.

RHPC – 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.

SFY – State Fiscal Year; July 1 – June 30.

SORH – State Office of Rural Health.

Introduction

In 2008, the NH State Office of Rural Health (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 the State Office of Rural Health (SORH), HB1692 (Chapter 114, 2010) authorized the SORH to plan and budget for a New Hampshire Health Professions Data Center (HPDC). The HPDC was created to collect and organize data on the current and projected supply of primary care health professionals, as well as the current and future demand for primary care services in the state.

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 the Rural Health and Primary Care Section (RHPC), the HPDC exists alongside the SORH and the Primary Care Office (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. The HPDC data supports and strengthens:

- Federal shortage designations, which brings providers and grant funding to areas where access may be limited;

- 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.

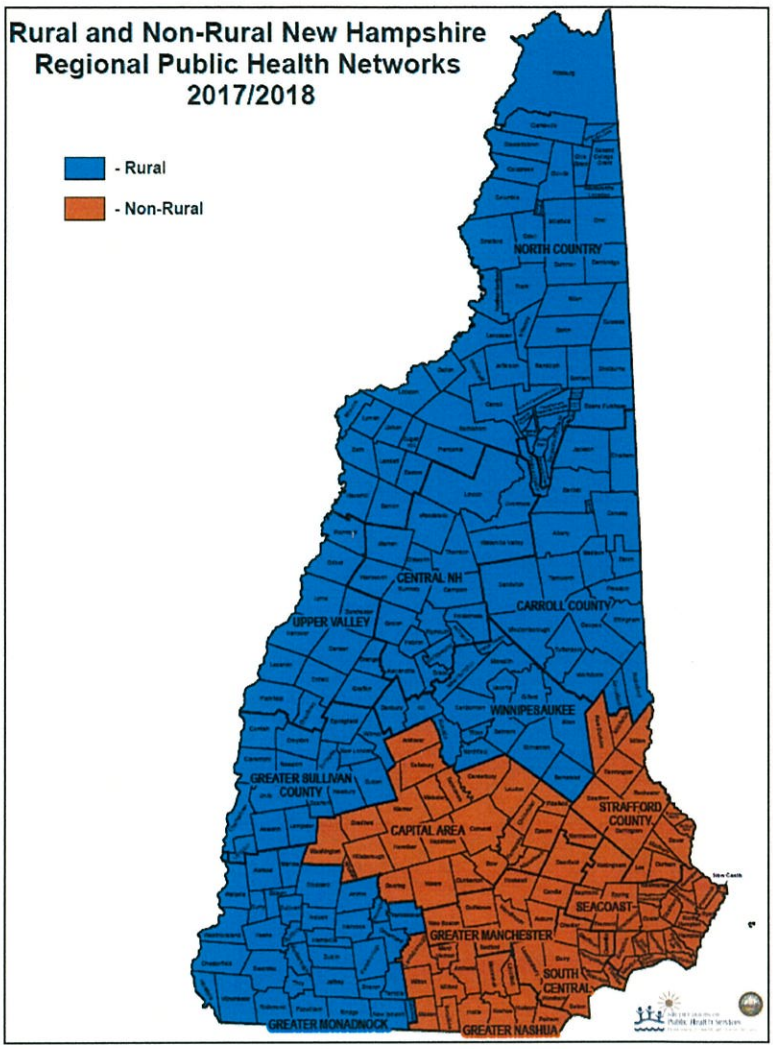
This work corresponds with RHPC's overarching work functions to 1) increase access to quality health care services for areas where access is limited; and 2) quantify and increase the number of health care providers serving areas where access is limited.

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 the 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 8,953 square miles.[4] 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 NH's geographical location and landscape.

Approximately 37% of the population and 84% of the landmass in NH is considered rural, with most of the land area lying north and west of the capital city of Concord.[5] 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 New Hampshire's northernmost rural region—Coos

[4] U.S. Census Bureau (2020). Profile of New Hampshire. Retrieved on 11/12/2024 from https://data.census.gov/profile/New_Hampshire?g=040XX00US33

[5] 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=4035&StateFIPS=33&StateName=New%20Hampshire

County—from the rest of the state. Known as the North Country, Coos County has the largest geographic area of any county in New Hampshire but also the smallest population. 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 of the population lives. NH's population is disproportionately distributed across the state, with density increasing from north to south. Population density ranges from 29.9 people per square mile in North Country PHR to 675.1 people per square mile in Greater Manchester PHR.[6] 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 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. Rather than using counties or other geographic divisions, DPHS - including RHPC - frequently relies on Public Health Regions (PHRs) for reporting. This approach promotes consistency and reflects geographic definitions tailored to New Hampshire. RHPC defines rurality for PHR using population and population 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.

Health Professions Data Center (HPDC) Overview

Pursuant to RSA 126-A:5, XVIII-a, Chapter 254 Laws of 2019, the HPDC collects provider data from participating NH 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. License renewal patterns vary by provider type. 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. For all other participating provider types (Table 1), the biennial renewal schedule is based on issue year of the current license. See Appendix A for 2022 license renewal periods of each provider type included in this report.

[6] New Hampshire Office of Health Statistics and Data Management, 2022 PHR Population Estimates.

Since June 30, 2022, the 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.

The HPDC reports aggregated workforce data two years after the close of the data collection period for each participating provider type. Physicians and APRNs have adequate counts and are evenly distributed across renewal years to produce reliable annual statistics using approximately half of all licensed providers. However, for all other provider types, including all behavioral health providers and PAs, the analysis must combine two consecutive years of data to generate accurate workforce estimates. 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 consistently achieves high but not complete response rates. Nevertheless, high response rates and year-to-year comparisons suggest the provider datasets are largely representative of the workforces as a whole.

The HPDC currently includes 2.0 filled FTE positions: a Program Administrator and a Program Analyst/Programmer. A 0.5 FTE Program Assistant position, previously supported through American Rescue Plan Act funding, remains vacant following the expiration of those funds. This position played a valuable role in supporting HPDC operations, and the Department is exploring opportunities to sustain this work moving forward.

Since 2020, the HPDC has published annual visualization dashboard reports summarizing provider and practice characteristics for each provider workforce. Following the release of the 2021 data dashboards, the HPDC transitioned from producing individual reports to developing a comprehensive dashboard that will aggregate provider data across multiple years. This dashboard, initiated at the beginning of SFY2025, is scheduled for release in July 2025 (see Workforce Reports).

The previous data dashboards – and the upcoming comprehensive dashboard – will 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

Table 1. Data Collection *Years for Calendar Year 2024 Report

Provider Type	Data Collection Period
Advanced Practice Registered Nurse (APRN)	SFY2022
Alcohol & Drug Counselor (MLADC/LADC)	2021 & 2022
Dentist	2022
Mental Health Practitioner (LICSW/LCMHC/LMFT/LPP)	SFY2021 & 2022
Physician	2022
Physician Assistant (PA)	2021 & 2022
Psychologist	2021 & 2022

**Two-year data is combined for provider types with uneven distribution across renewal years or small counts in individual years.*

Provider Response Rate Data

Table 2 contains response rate statistics for SFY2022 data collection. 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 percentage of active license renewals from those due to renew. Provider response rates improved from SFY2021 overall, with the exception of APRNs, whose rate declined by six percentage points. Current response rates range from 87% (APRNs) to 99.6% (PAs), with most provider types approaching complete participation. Provider retention is relatively strong in the state according to license renewal statistics, where between 85% (dentists) and 94% (MHPs) renew an active status license due for renewal.

Table 2. Provider Response Rate Data, SFY2022

Provider Type	Data Collection Period	Survey Compliance		Opt Outs	*% Renewals
		2022	*2021*		
Advanced Practice Registered Nurse (APRN)	July 1 - June 30	86.8%	92.6%	1.6%	86.3%
Alcohol & Drug Counselor (MLADC/LADC)	May 1 - June 30	98.8%	81.2%	0.8%	90.4%
Dentist	March 1 – April 30	92.4%		2.7%	85.4%
Mental Health Practitioner (MHP)	July 1 – June 30	97.4%	93.7%	1.0%	93.8%
Physician	May 1 - June 30	97.8%	90.5%	2.4%	85.5%
Physician Assistant (PA)	November 1 - December 31	99.6%	92.9%	2.0%	90.2%
Psychologist	May 1 - June 30	98.5%	88.3%	1.0%	90.9%

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

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 SFY2022 data collection period using licensing list figures from the Office of Professional Licensure and Certification (OPLC). Two-year data is combined for provider types with uneven distribution across renewal years or small counts in individual years.

Most provider workforces experienced significant gains in SFY2022. The APRN workforce saw the most substantial growth with approximately 42% increase in active providers (N=709). This growth followed the NH COVID-19 State of Emergency (which ended June 11, 2021) when several executive orders (EOs 8, 15, 29)[7] removed barriers to NH licensure and clinical practice. Several key policy changes to reduce barriers to licensure have remained in effect since, resulting in a continued influx of advanced-practice providers, particularly APRNs, who practice largely independently across various settings with a scope comparable to physicians. MHPs and PAs also experienced high net gains (17.5% and 16.6% respectively), while ADCs (11.0%) and psychologists (9.4%) saw moderate increases. The physician workforce showed minimal growth (5.5%), while the dentist workforce experienced a moderate decline (-7.7%).

Note that while the workforce supply for most provider types increased, this analysis does not inform net change of primary care providers, which may be similar or largely different from all active license providers.

[7] https://www.governor.sununu.nh.gov/news-and-media/emergency-orders-2020.

Table 3. Net Change of Provider Supply, SFY2022

Provider Type	*Year(s)	Eligible to Renew	**Providers Lost	***Providers Gained	Provider Change	Net Change
Advanced Practice Registered Nurse (APRN)	SFY2022	1,697	232	941	709	**41.8%**
Alcohol & Drug Counselor (MLADC/LADC)	2021 & 2022	509	50	106	56	**11.0%**
Dentist	2022	1,249	181	85	-96	**-7.7%**
Mental Health Practitioner (LICSW/LCMHC/LMFT/LPP)	SFY2021 & 2022	2,513	214	655	441	**17.5%**
Physician	2022	3,856	555	767	212	**5.5%**
Physician Assistant (PA)	2022	499	49	132	83	**16.6%**
Psychologist	2021 & 2022	615	58	116	58	**9.4%**

** 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 months) under their respective boards.*

*** Non-renewals/Non-active status license renewals*

**** Initial licenses issued*

SFY2022 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. Thirty percent of physicians who maintain an active medical license in NH are not clinically practicing within the state. Nearly all PAs with an active NH license are providing clinical services in the state, and just under 80% of APRNs are clinically practicing in NH. While the physician rate remains comparatively low, this represents the first significant increase in clinically active physicians since tracking began in 2018. This positive shift likely reflects a demographic transition, with younger physicians entering the workforce to replace those who have retired. Among those clinically practicing in NH, primary care rates are highest among APRNs, followed closely by physicians, while only 15% of the PA workforce are PCPs.

Table 4.1. Practice Status
% of clinically active providers

	Physicians	APRNs	PAs
Active, Clinical Practice	70.0	78.2	87.8

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	19.5	22.8	14.7

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 remains predominantly male, with women comprising less than 40% of the physician workforce, though this percentage continues to increase annually. Among PCPs, female representation is notably higher, accounting for more than half of PCPs across all provider types. Regarding racial and ethnic demographics, both the overall and primary care

provider (PCP) workforces are predominantly non-Hispanic White, with the PCP workforce ranging from 83% to 95%. The median age for APRNs is similar between PCPs and the full workforce (43 vs. 44 years). In contrast, PA and physician PCPs tend to be older than the overall median for their professions, with median ages of 44 vs. 39 years for PAs and 52 vs. 49 years for physicians. Particularly noteworthy is that the median age for PCP physicians is nearly a decade older than that of their APRN and PA counterparts.

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

	Physicians		APRNs		PAs	
	All	PCPs	All	PCPs	All	PCPs
Female	38.0	54.0	85.7	92.4	67.3	78.5
Non-Hispanic White	76.9	82.7	93.2	94.6	91.7	90.5
Median Age	49	52	44	43	39	44

Distribution – Medical and primary care practice is more limited in rural New Hampshire compared to non-rural areas. Approximately one-third of all physicians and APRNs, and just over one-quarter of all PAs, practice in rural regions of the state. Outpatient primary care practice patterns by rural status generally follow proportions of all practice, with practice percentages approximately twice as high in non-rural NH compared to rural areas. However, the rate of primary care physicians is significantly lower in rural areas, with non-rural regions having a rate 3.5x higher (15.4% compared to 4.4%). Although physicians represent the largest percentage of health care providers in rural NH (33.8%), they have the smallest proportion practicing primary care, whereas APRNs have the highest proportion of PCP practice as a proportion of provider total practice in both rural and non-rural NH.

Table 4.4. Distribution
% of total FTE by geography and clinical practice

	Physicians		APRNs		PAs	
	All	PCPs	All	PCPs	All	PCPs
Rural Regions	33.8	4.4	32.9	7.6	28.1	4.5
Non-Rural Regions	66.2	15.4	67.1	18.3	72.0	12.7

Telemedicine and non-direct patient settings are excluded from geographic analysis

Figures 1 and 2 illustrate the distribution of overall and PCP practice across provider types and PHRs. In each figure, the full bar represents the percentage of total practice within rural (Figure 1) or non-rural (Figure 2) NH. The inner bars show total primary care practice, with percentages indicating the proportion of primary care practice by PHR for each provider type. Important note on interpretation: Bars reflect proportion of total FTE by provider type, without indicating the total FTE. Therefore, longer bars indicating a greater percentage of practice for one provider type can represent less FTE than shorter bars representing another provider type with higher FTE. For example, while the full bars for physician and PA practice within non-rural Greater Nashua PHR appear similar in size, the actual physician FTE in this region is 1.5x higher than PA FTE.

Regarding the total percentage of FTE available in rural NH (Figure 1), overall medical practice is not evenly distributed among individual PHRs. Central NH has the lowest percentage of total provider FTE and Upper Valley the highest among rural PHRs, and second only to Greater Manchester among non-rural PHRs. While Upper Valley has the highest overall FTE of all rural PHRs, it has one of the lowest percentages of outpatient primary care as a proportion of total rural practice across all provider types. The percentage of PCP practice remains low across rural PHRs (0.1-1.8%); however, outpatient primary care varies by PHR and provider type, as demonstrated in Figure 1 below. Physician PCP practice is highest in Upper Valley but extremely limited in Central NH, Greater Sullivan County, and Winnipesaukee; PA practice is most prevalent in North Country while minimal in Greater Monadnock; and APRN practice is highest in Greater Monadnock. Importantly, APRN PCP practice is highest in regions where physician and PA PCP practice is lowest. Evaluating all PCP practice across rural PHRs demonstrates that APRNs and PAs are critical contributors to the provision of primary care services.

As evidenced in Figure 2 below, Greater Manchester has the highest percentage of overall medical practice among PHRs, accounting for 61.4% of the total non-rural FTE, and South Central has the lowest overall FTE (19.3%). While Greater Manchester also has the highest percentage of combined outpatient PCP practice in the state (3.5%), Strafford County has the lowest combined FTE among non-rural PHRs (1.7%). Consistent with the pattern observed in Figure 1 (rural PHRs), many non-rural PHRs with limited practice under one provider type compensate with higher practice rates from another provider type. For example, Strafford County has a limited supply of PCP physicians and PAs but a higher proportion of PCP APRNs. South Central has limited PCP physicians and APRNs but the greatest proportion of PCP PA practice among non-rural PHRs. These examples illustrate that across both rural (Figure 1) and non-rural (Figure 2) regions, PCP supply is best evaluated with consideration to all primary care provider types to best understand practice distribution patterns.

Figure 1. Rural PHRs

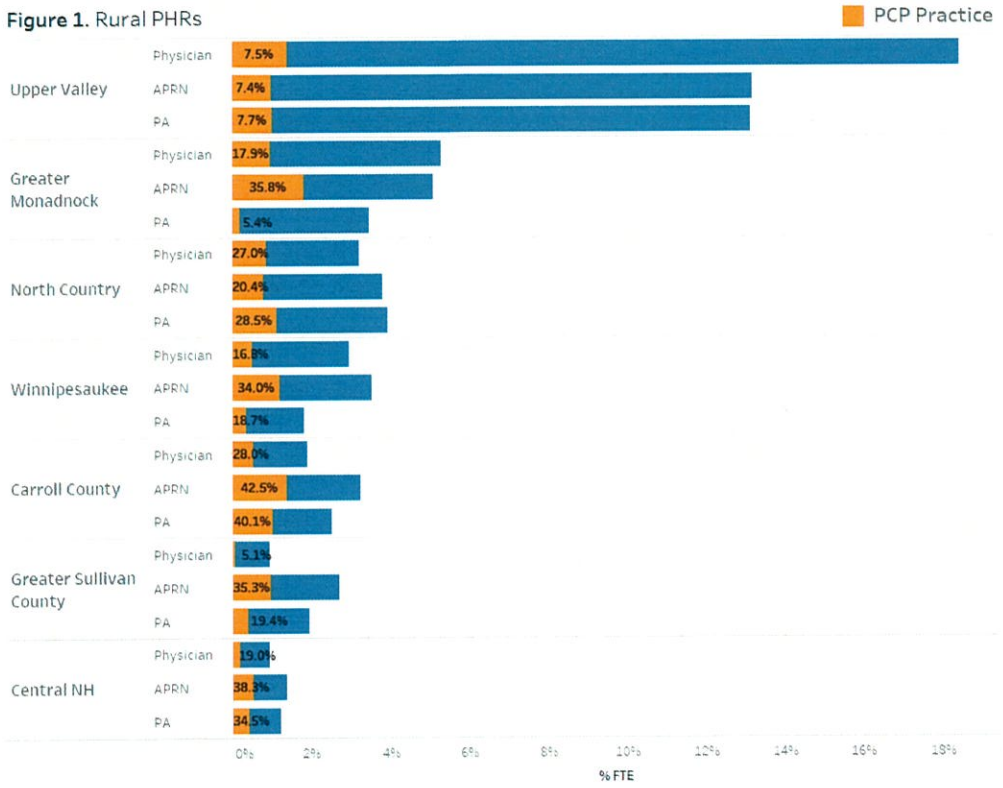
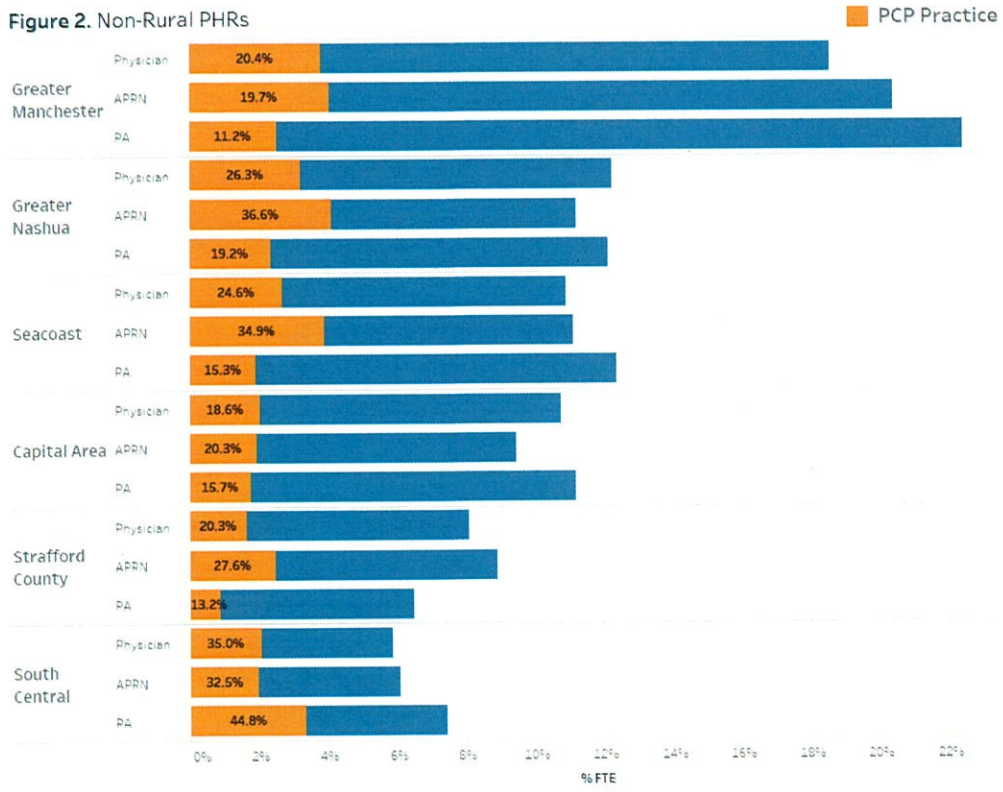


Figure 2. Non-Rural PHRs



Anticipated Supply – We can inform anticipated supply of the primary care workforce using indicators such as age, state ties, time practicing within the state, and future practice plans. Provider age informs anticipated supply where younger providers can offset workforce shortages that result from retiring providers. Older age is a strong indicator of nearing retirement, and, when informed by other retention indicators, can reliably predict anticipated provider shortages. According to indicators presented in Table 4.5 below, the PCP physician primary care workforce appears particularly vulnerable, with fewer new entrants, higher anticipated reductions, and a significant proportion of providers nearing retirement compared to other provider types.

Compared to all practice providers, PCPs are less likely to have been practicing in NH for less than five years, indicating a lower influx of new professionals into the primary care pipeline. However, physician rates are substantially lower than those of other PCPs (16.2% vs. 36.8% vs. 28.5%). While anticipated reduction rates for PCP APRNs and PAs are comparable to those for their respective total practice groups, the anticipated reduction rate for PCP physicians is 20% higher than that for all physicians. Most concerning is that 15% of the PCP physician workforce anticipates no clinical practice in the next five years.

Compared to the PCP APRN (40%) and PA (41%) primary care workforces, the percentage of physician PCPs under 40 years old is limited (16%), and there are twice as many PCP physicians nearing retirement (60+) than physicians under 40. The opposite is true for APRNs and even more so with PAs, where there are 2.5x and 3.6x respectively as many PCPs under 40 as there are 60 years and older.

While rates of state ties are similar between all practice providers and PCPs, notably, APRN and PAs are more likely (>1.5x) than physicians to have NH ties, which is associated with a greater likelihood of coming and staying to practice in the state. The limited percentage of physicians with NH ties may contribute to the workforce's recruitment and retention challenges.

Anticipated supply statistics are consistent with expected trends related to age, given the inherent correlation between age and both years of clinical practice in NH and anticipated reduction in practice. Workforce supply indicators, taken with supply figures, suggest NH can anticipate a steady reduction in physician PCP supply when compared to other PCPs. However, given the encouraging anticipated supply of APRNs and PAs, we can expect physician shortages to be partially offset by other PCPs. Additionally, the increased opportunity for in-state training through the recent development of several new residency programs could help offset the anticipated physician reduction, as research suggests clinicians are more likely to practice where they train.

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	19.0	15.7	35.7	39.5	52.3	40.5
60+ Years Old	23.0	27.4	16.2	16.1	7.5	11.2
NH Ties	23.3	23.7	63.9	69.5	61.5	66.4
Less than 5 Years Practicing in NH	24.1	16.2	42.6	36.8	35.5	28.5
*Anticipated Reduction in Practice in 5 Years	30.7	37.0	21.1	21.1	19.3	19.0
- Practice in another state or no intention to practice	13.7	14.9	9.3	9.9	7.2	4.3

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

Access – Access indicators highlight varying trends in health care availability across provider types and geographic regions. Among rural PCPs, physicians report the lowest percentage of new patient acceptance (71%) while PAs report the highest (86%). While PCP physicians and PAs show higher rates of new patient acceptance among rural providers compared to all practice providers, APRN rates are comparable regardless of rurality. Rural and non-rural PCP APRNs, along with rural physicians, experienced a marked decrease in new patient acceptance from last year's analysis, with rural PCP APRNs and physicians down 10 and 7 percentage points, respectively, and non-rural PCP APRNs showing a 6-percentage point decrease. This decline in patient acceptance signals growing access challenges to primary care services across all geographic areas.

Median wait times for established patients generally reflect shorter waits for non-rural PCPs, with the exception of APRNs, who maintain consistent median wait times (5 days) across geography. Among rural PCPs, APRNs report the shortest wait times for established patient appointments, with wait times for new patient appointments comparable to those of PAs. PCP PAs exhibit the largest spread between rural and non-rural provider wait times for established patients with rural wait times 7x longer (14 vs. 2 days). New patient wait times for PCP APRNs and physicians are significantly longer than those for established patients. PCP physicians demonstrate the longest new patient appointment wait times, especially for rural providers (21 days) which, combined with their lower new patient acceptance rates, underscores important access constraints that disproportionately affect individuals seeking to establish new primary care relationships.

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	Non-Rural	Rural
Accepting New Patients (%)	66.2	71.1	81.2	80.3	78.5	85.7
Median Wait for Routine Appointments, Established Patients (days)	7	10	5	5	2	14
Median Wait for Routine Appointments, New Patients (days)	14	20.5	10	14	7	14

** Wait times reported as medians rather than averages to better represent typical patient experience*

Significant Workforce Differences by Rurality, Medical Providers

Tables 5.1-5.3. Chi-Square tests of independence were run 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.

The 2022 analysis reveals key differences in provider and practice characteristics between rural and non-rural providers, capturing the landscape one year after the conclusion of the public health emergency. The findings indicate that some pandemic-induced shifts are reverting to pre-pandemic levels while other changes remain.

PAs are now the sole medical provider type maintaining a higher rate of newly trained providers in rural settings. Rural PAs are more likely to have graduated college within the last 10 years and have less than five years of practice in NH. In contrast, the rural APRN workforce has returned to its pre-pandemic profile, no longer reflecting geographic differences for newly trained providers as seen with PAs. Rural APRNs are older and more likely to anticipate a reduction in practice compared to the non-rural workforce. Similarly, the proportion of International Medical Graduates (IMGs) among physicians has also returned to pre-pandemic levels, with higher IMG representation in non-rural areas of NH.

In 2022, new trends emerge for the physician workforce. Rural physicians are more likely to identify as White compared to their non-rural counterparts, with differences in International Medical Graduate (IMG) representation also contributing to workforce composition. Non-rural physicians are more often graduates of New England medical schools outside of NH. Additionally, rural physicians are no longer more likely to have NH ties - having lived or worked in NH prior to licensure - compared to their non-rural counterparts. This shift results from increased non-rural rates, perhaps, in part, due to exposure through New England education tracks.

Key trends have remained consistent across years. Both APRNs and physicians in rural areas are more likely to practice in outpatient settings that offer financial assistance (Medicaid and/or sliding fee scale), compared to their non-rural counterparts. Rural physicians remain less likely to practice outpatient primary care, suggesting reduced primary care availability in rural areas compared to non-rural areas.

Provider characteristics of the APRN and PA workforces continue to align more closely with each other than with physicians. Non-rural APRNs and PAs are more likely to have graduated from a NH school and have NH ties prior to receiving their NH license. For physicians, the opposite holds: rural physicians exhibit higher rates of graduation from a NH medical school and training at a NH residency compared to non-rural physicians. These indicators provide evidence for the "grow your own" model as an effective strategy to increase the rural physician workforce.

Table 5.1. Significant Geographic Differences in Workforce Composition, Rural Physicians

More likely to…	*Less likely to…*
Identify as White	Have graduated from a New England medical school
Have graduated from a NH medical school	Have graduated from a medical school outside the U.S. (IMG)
Have trained at a residency within NH	Provide outpatient, primary care services
Practice at locations that offer payment assistance	

Table 5.2. Significant Geographic Differences in Workforce Composition, Rural APRNs

More likely to…	*Less likely to…*
Be older (based on median age)	Have graduated from a NH or New England nursing school
Anticipate a reduction in practice in the next 5 years	Have NH ties prior to receiving initial NH license
Practice at locations that offer payment assistance	

Table 5.3. Significant Geographic Differences in Workforce Composition, Rural PAs

More likely to…	*Less likely to…*
Have graduated PA school within the last 10 years	Identify as female
Have less than 5 years of practice in NH	Have graduated from a NH or New England PA school
	Have NH ties prior to receiving initial NH license

Primary Medical Care Supply - Provider Rates by Geography

The workforce supply figures in tables 6.1. and 6.2. below are estimates of primary care provider rates per 100,000 residents in NH. Our analysis reveals significant gaps in supply between provider types, with the statewide physician rate (52.0) about 1.4x higher than the APRN rate (37.6) and 6.5x higher than the PA rate (8.0). Across provider types, NH has 97.5 outpatient primary care FTE providers per 100,000 resident population, which translates to one primary care provider for every 1,025 people. This year's analysis utilized two-year data to provide more reliable PHR statistics, as small numbers can significantly impact rates in these more granular geographic areas. Rural status classification is generally more stable as they cover large areas of the state, yet there are striking shifts in provider rates by rurality. Compared to last year's analysis, physician rates in rural regions have dropped by nearly 20% (from 56.9 to 46.9) and increased in non-rural NH (from 52.9 to 53.7). APRN rates have risen in both rural and non-rural NH, though more dramatically in non-rural NH (from 28.1 to 36.2). PA rates increased in rural areas (from 6.3 to 7.1) but decreased in non-rural NH (from 10.4 vs. 8.3). APRNs are the only provider type with higher primary care practice rates in rural NH compared to non-rural areas. Physician and PA primary care practice rates are about 15% greater in non-rural compared to rural regions. Notably, the rural practice rates between APRNs and physicians are comparable, despite physicians outnumbering APRNs by nearly two-to-one statewide. According to the 2022 licensing list, there were almost twice as many licensed physicians (7,807) as there were APRNs (4,046), yet rural physician primary care practice rates (46.9) are only slightly higher than APRN rates (41.0). The gap between non-rural rates is significantly greater, with physician rates (53.7) about 50% higher than APRN rates (36.2).

Table 6.2. reveals substantial variation in primary care rates across NH's rural regions. Notably, both the highest and lowest rates are found in rural PHRs. Two of the three PHRs with the highest outpatient primary care FTE provider rates are in rural PHRs, while the three lowest ranking PHRs are also rural. The variation between the highest and lowest rates among PHRs is staggering: the rate of primary care FTE in Upper Valley is 2.5x that of Greater Sullivan County. 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 Health Professional Shortage Area (HPSA) brings providers and funding to areas of the state with less access. 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), Federally Qualified Health Centers (FQHCs), FQHC Look-alikes, etc.) receive a number of financial and operational benefits to incentivize health care providers to practice in areas of the state with less access (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 FQHC and Rural Health Clinic (RHC) designations and expansion have come in the last 10 years. These rates, reflective of primary care availability, demonstrate the pivotal role of shortage designation and ensuing workforce initiatives that bolster primary care in medically vulnerable communities.

The PCP FTE rate effectively measures availability of primary care in NH's communities. To illustrate this, consider Greater Nashua, which has the second highest PCP FTE in the state, but a large population to serve, resulting in its PCP FTE rate being 5th lowest in the state. The PCP FTE rate allows for a more comprehensive understanding of supply as it relates to need in NH.

Table 6.2 also highlights the impact of non-physician primary care provider practice. North Country and Carroll County rank 2nd and 5th for overall primary care provider rates among PHRs in the state but would rank 4th and 8th if only considering physician rates. Most significantly, APRNs and PAs make up more than half of PCP FTE rates in all rural PHRs except for Upper Valley, while physicians make up more than half of the PCP FTE rates in all non-rural PHRs.

Table 6.1. Primary Care Rates, Medical Providers, 2022

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

Provider Type	Year	Statewide Rate	Rural Rate	Non-Rural Rate
Physicians	2022	52.0	46.9	53.7
APRNs	2022	37.6	41.0	36.2
PAs	2022	8.0	7.1	8.3
Combined	2022	97.5	94.9	98.2

Analysis combines data from SFY2021 & 2022.

Table 6.2. Primary Care Rates by Public Health Region, All Providers, 2022

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

Rurality	PHR	Rate per 100,000 population (% physician)	*Resident Population **(↑/↓)
Rural	Upper Valley	160.1 (67.5)	46,472 ↓
Rural	North Country	119.2 (46.4)	51,711 ↑
Non-Rural	Seacoast	115.0 (50.4)	150,759 ↑
Non-Rural	Greater Manchester	114.0 (56.8)	194,113 ↑
Rural	Carroll County	108.5 (43.6)	51,970 ↑
Non-Rural	Capital Area	99.4 (54.0)	137,369 ↑
Rural	Central NH	91.5 (41.6)	30,693 ↓
Non-Rural	South Central	87.4 (56.8)	148,780 ↑
Non-Rural	Greater Nashua	86.7 (54.1)	221,108 ↑
Non-Rural	Strafford County	86.4 (56.6)	132,275 ↓
Rural	Greater Monadnock	79.4 (48.1)	102,031 ↑
Rural	Winnipesaukee	72.1 (47.6)	81,001 ↑
Rural	Greater Sullivan County	64.0 (35.5)	46,949 ↑

Sorted from highest to lowest PCP FTE rate.

** 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 2022. For population estimates methodology statements, see http://www.census.gov/programs-surveys/popest/technical-documentation/methodology.html. All population estimates for the PHRs in NH are completed based on these estimates rolled up to the PHR.*

*** Increase ↑ / Decrease ↓ since 2021.*

Analysis Considerations

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.

Due to the methodology the HPDC employs 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 PCP FTE estimates are calculated using workforce data statistics collected during 2021 and 2022 survey years under the HPDC. Estimates are calculated for medical providers with active status licenses who did not complete the survey during this period, 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.

With the expansion of telemedicine services during the NH State of Emergency (April 2020-June 11, 2021), available capacity (by FTE) may be underestimated in this analysis due to the exclusion of telemedicine/telehealth-only practice. 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, including the expansion of telehealth services. While this mode of clinical service delivery is becoming a critical component of access to care, especially for more remote, rural areas in the state, health care access by geography was indeterminable in this analysis without corresponding location data for telemedicine FTE. The analysis only captures data from health professionals with at least partial in-person services. Therefore, the full breadth of primary care supply and access to services during this time may be underestimated, though it's unclear what the scope of practice and capacity was for telehealth-only clinicians within primary care, apart from the pandemic emergency response (e.g. testing centers, emergency departments, intensive care/acute care units, in-hospital care etc.).

SFY2022 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.

Practice Status – The percentage of behavioral health providers with an active status NH license (i.e. unrestricted license for clinical practice) who are clinically practicing in the state is comparable across provider types. Over 80% of active status behavioral health licensees are providing clinical services in NH. Psychologists saw an increase in clinical practice since last year (~6 percentage points), which, like physicians, may reflect a demographic transition as older clinicians retire.

Table 7.1. Practice Status
% of clinically active providers

	MHPs	Psychologists	ADCs
Active, Clinical Practice	82.8	81.6	84.2

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

Demographics – The behavioral health workforce is predominantly female (72-82%); approximately 95% of providers across all provider types identify as non-Hispanic White. The median age of behavioral health providers falls in the middle-aged range, from 50 years old (MHPs) to 56 (psychologists).

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

	MHPs	Psychologists	ADCs
Female	82.4	67.2	72.4
Non-Hispanic White	94.6	93.2	95.1
Median Age	50	56	52

**Excluding median age, reported in years.*

Distribution – Behavioral health practice in rural NH is limited, particularly for outpatient services, which represents 19-23% of total FTE across provider types. While MHPs have the lowest percentage of practice in rural NH – though with a comparable outpatient practice percentage – compared to ADCs and psychologists, they have the highest percentage in non-rural NH. Despite this, the proportion of outpatient practice to all practice is relatively high and comparable between rural and non-rural NH. Both overall and outpatient practice is comparable between psychologists and ADCs in rural NH.

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

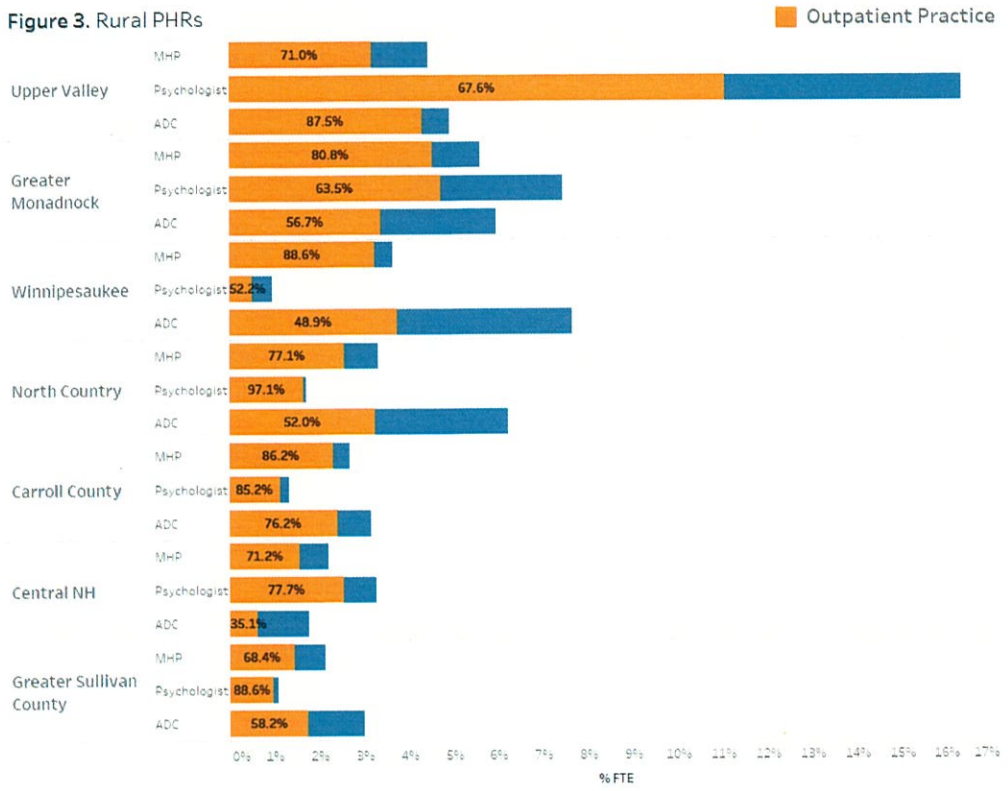
	MHPs		Psychologists		ADCs	
	All	Outpatient	All	Outpatient	All	Outpatient
Rural Regions	24.0	18.8	32.1	22.5	32.7	19.4
Non-Rural Regions	76.0	60.2	67.9	56.6	67.3	44.6

Telehealth-only practice is excluded from geographic analysis.

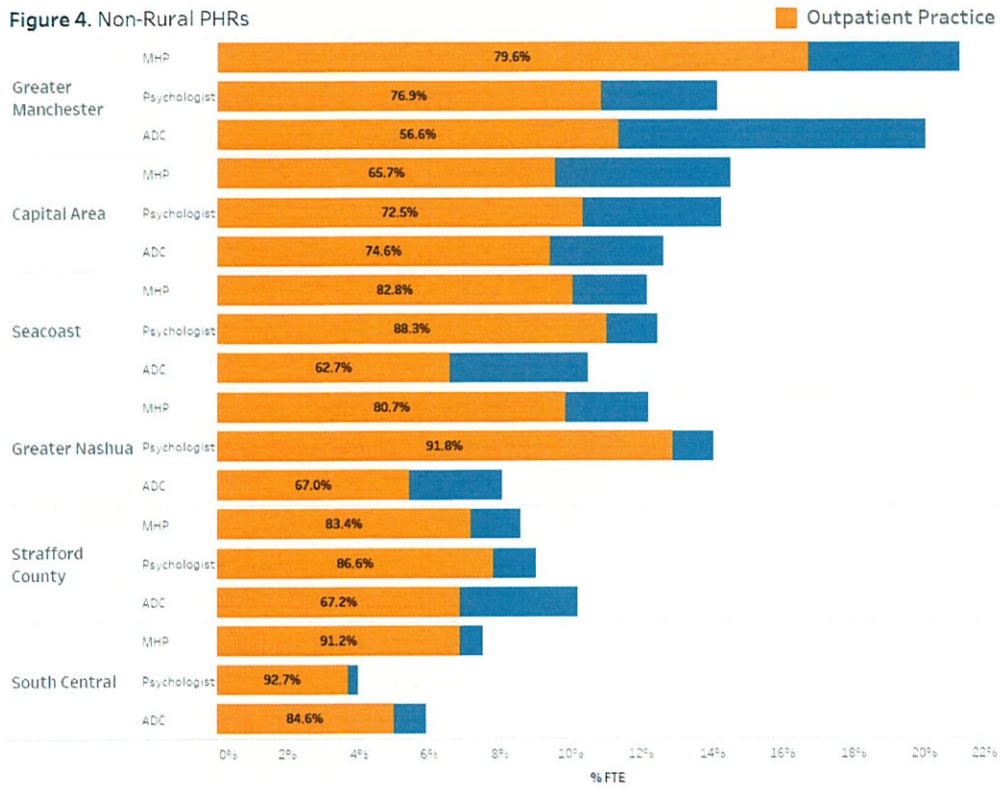
Figures 3 and 4 illustrate the distribution of overall and outpatient supply across provider types and PHRs. In each figure, the full bar represents the percentage of total practice within rural (Figure 3) or non-rural (Figure 4) NH. The inner bars show total outpatient practice, with percentages indicating the proportion of outpatient practice by PHR for each provider type. Important note on interpretation: Bars reflect proportion of total FTE by provider type, without indicating the total FTE. Therefore, longer bars indicating a greater percentage of practice for one provider type can represent less FTE than shorter bars representing another provider type with higher FTE. For example, while the outpatient bars for MHP and ADC practice within rural Carroll County PHR appear similar in size, the actual MHP FTE in this region is 3x higher than the ADC FTE, as the bars represent percentages of each provider type's statewide practice rather than absolute values.

As illustrated in Figure 3, outpatient practice in rural PHRs is comparable between MHP and ADC workforces, and less so for psychologist practice. Psychologists have the most variation in practice, with outpatient practice ranging from about 0.5% in Winnipesaukee to 11% in Upper Valley. Upper Valley has the highest overall and outpatient practice among rural PHRs due to psychologists, whose total practice percentage is about 3.7x and outpatient practice is 2.8x the percentages of MHPs and ADCs. Over 15% of all psychologist practice in the state is in Upper Valley, with over 10% in outpatient practice. Greater Sullivan County has the lowest overall and outpatient practice percentages for behavioral health practice. Figures 3 (rural PHRs) and 4 (non-rural PHRs) below show that ADC rates trend lower in outpatient practice to total practice, compared to psychologists and MHPs, in several PHRs.

Figure 3. Rural PHRs



In Figure 4, while non-rural Greater Manchester and Capital Area have the highest overall and outpatient behavioral health practice percentages in the state, the proportion of outpatient services to total services in these two PHRs is lower than in many non-rural and rural PHRs. While South Central has the lowest combined provider outpatient and total practice percentages among the non-rural PHRs, it has the highest percentage of outpatient to total practice. This indicates that the full picture of provider distribution, including the proportion of outpatient services, is crucial for evaluating behavioral health supply in NH.



Anticipated Supply – As with practice distribution (table 7.3.), among behavioral health provider types, MHPs and ADCs demonstrate comparable statistics across anticipated supply indicators, while psychologists demonstrate significant differences. The workforce imbalance according to anticipated supply indicators, suggests the pipeline of new psychologists may not sufficiently replace reduced practice to maintain current services compared to the ADC and MHP workforces.

Within outpatient practice, there are substantially more outpatient clinicians aged 60+ than there are under 40, particularly for the psychologist workforce where the percentage of clinicians 60 years and older is almost 3x higher than the percentage under 40 years old. Additionally, about one-third of the outpatient psychologist workforce plans to reduce their practice in five years, which is considerably higher than MHPs (23.4%) and ADCs (19.5%). However, the anticipated practice lost to another state or from ending practice altogether, is comparable to the MHP percentage (7.2% vs. 6.9%), indicating most of the anticipated reduction to practice is from reduced hours, not complete cessation of practice in the state.

A considerably high percentage (90-92%) of ADCs and MHPs have lived or worked in NH prior to licensure, suggesting those with state ties are coming or staying to practice. In contrast, psychologists, while still high, have a lower rate (~67%). The percentages of psychologists under 40 and with less than five years of practice in the state are notably lower compared to other

provider types, and the limited pipeline of new entrants may be related to the lower percentage of psychologists with pre-existing ties to the state.

Taken together, these indicators suggest 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	22.2	11.7	10.6	20.5	19.5
60+ Years Old	29.8	31.5	41.0	41.7	28.7	32.7
NH Ties	89.5	89.7	67.7	67.2	92.0	92.0
Less than 5 Years Practicing in NH	23.4	22.0	16.2	15.8	36.5	35.0
*Anticipated Reduction in Practice in 5 Years	23.1	23.4	34.5	33.6	18.7	19.5
- Practice in another state or no intention to practice	7.4	6.9	9.2	7.2	4.6	3.1

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

Access – Access indicators reveal that ADCs demonstrate greater availability than other behavioral health providers. ADCs consistently maintain higher rates of new patient acceptance (i.e. open patient panels), with rural ADC providers showing higher new patient acceptance compared to their non-rural counterparts. This geographic difference may reflect the specialized nature of substance use disorder treatment offered by ADCs compared to the broader behavioral health services provided by psychologists and MHPs, which cover a range of mental health conditions. Particularly concerning are the substantially lower rates of open patient panels (61.0%) compared to other rural providers, suggesting potential rural access challenges specific to outpatient psychological services.

Rural ADCs have the shortest median wait time (5 days) for both established and new patients among all rural and non-rural workforces. Non-rural ADCs, and all other provider types in both geographic settings, report a median wait of 7 days for established patients. For new patients, median wait times are 14 days for MHPs and psychologists in both rural and non-rural settings, while non-rural ADCs report a shorter median wait time for new patients (10 days).

These findings suggest that substance use disorder services through ADCs may be more immediately accessible than general behavioral health services, particularly in rural areas where ADCs demonstrate both higher acceptance rates of new patients and shorter wait times. However, this variation in access to in-person behavioral health services may be offset by telehealth practice.

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	67.8	61.0	83.8	87.1
Median Wait for Routine Appointments, Established Clients (days)	7	7	7	7	7	5
Median Wait for Routine Appointments, New Clients (days)	14	14	14	14	10	5

**Excluding median wait, reported in days.*

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.

The analysis of behavioral health providers highlights both shared trends and notable differences between rural and non-rural areas in NH regarding in-person behavioral health services. Because this geographic analysis relies on physical locations where services are rendered, clinicians providing telehealth-only services are excluded.

There are key differences in licensure between rural and non-rural behavioral health providers. Non-rural areas have higher rates of LICSWs among MHPs and MLADCs who require master's-level education, while rural areas have more LCMHCs and bachelor's-level LADCs.

Regarding health care access, MHPs and ADCs are more likely to work in settings that offer financial assistance than their non-rural counterparts, while these patterns do not hold for psychologists. Rural psychologists remain less likely to practice in outpatient settings compared to their non-rural counterparts. Rural MHPs continue to report shorter wait times (7 days or less) for established patients and higher new patient acceptance rates compared to their non-rural counterparts.

This year's analysis shows positive changes since 2021. Rural ADCs and psychologists now work clinical hours comparable to their non-rural peers, addressing the previous difference in part-time work patterns. Additionally, rural providers show demographic shifts, with age distributions between rural and non-rural MHPs now aligned. The previous gender imbalance - where rural psychologists were more likely to be male - has also evened out. However, rural ADCs continue to be significantly older than their non-rural counterparts.

These findings highlight the complexity of the behavioral health landscape in rural New Hampshire. While challenges remain—such as gaps in outpatient care and variation in licensure levels—rural providers also show strengths, particularly in client accessibility and financial support. Continued efforts to expand opportunities in education, licensure, and practice settings will help strengthen behavioral health access across the state. Additionally, the ubiquity of telehealth as a primary mode of service delivery for behavioral health cannot be overlooked. Future analyses will incorporate telehealth services where methodologically feasible.

Table 8.1. Significant Geographic Differences in Workforce Composition, Rural MHPs

More likely to…	*Less likely to…*
⅄ Hold a Clinical Mental Health Counselor (LCMHC) license	⅄ Hold a Clinical Social Worker (LICSW) license
⅄ Practice at locations that offer payment assistance	⅄ Have NH ties prior to receiving initial NH license
⅄ Have shorter appointment wait times for established clients	⅄ Have graduated school within the last 10 years
⅄ Be accepting new clients	

Table 8.2. Significant Geographic Differences in Workforce Composition, Rural Psychologists

More likely to…	*Less likely to…*
	⅄ Practice in an outpatient, office-based setting

Table 8.3. Significant Geographic Differences in Workforce Composition, Rural ADCs

More likely to…	*Less likely to…*
⅄ Hold a LADC (bachelor's) license	⅄ Hold an MLADC (master's) license
⅄ Be older (based on median age)	⅄ Have graduated from a NH school
⅄ Practice at locations that offer payment assistance	

SFY2022 Health Professions Survey Data Statistics

Oral Health Providers

Supply and capacity indicators of surveyed dentists actively practicing in NH.

Practice Status/PCP Practice – The vast majority (87%) of dentists with an active, NH license are providing clinical services in the state. Among dentists clinically practicing in NH, 70% practice pediatric or general dentistry.

Table 9.1. Practice Status
% of clinically active providers

	Dentists
Active, Clinical Practice	86.7

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

Table 9.2. PCP Practice
% of PCPs

	Dentists
Primary Care Providers	70.1

PCP status is determined by practice in general or pediatric dentistry specialty and corresponding outpatient general practice hours at any listed site.

Demographics – The overall and primary care (PCP) dentist workforce is predominantly male, with women representing less than 40% of dentists. The majority identify as non-Hispanic White (73–75%). Demographic patterns differ somewhat from those seen in the medical and behavioral health workforces. The median age is consistent across all dentists (46) and PCP dentists (45), suggesting a balanced age distribution.

Table 9.3. Demographics
% of clinically active providers in each demographic group

	Dentists	
	All	PCPs
Female	37.4	38.9
Non-Hispanic White	74.9	72.7
Median Age	46	45

Distribution – Compared to dentistry in non-rural NH, overall and PCP dentist practice is limited in rural NH, with just a quarter of all dentists, and 20% of PCPs practicing in rural regions.

Table 9.4. Distribution
% of total FTE by geography and clinical practice

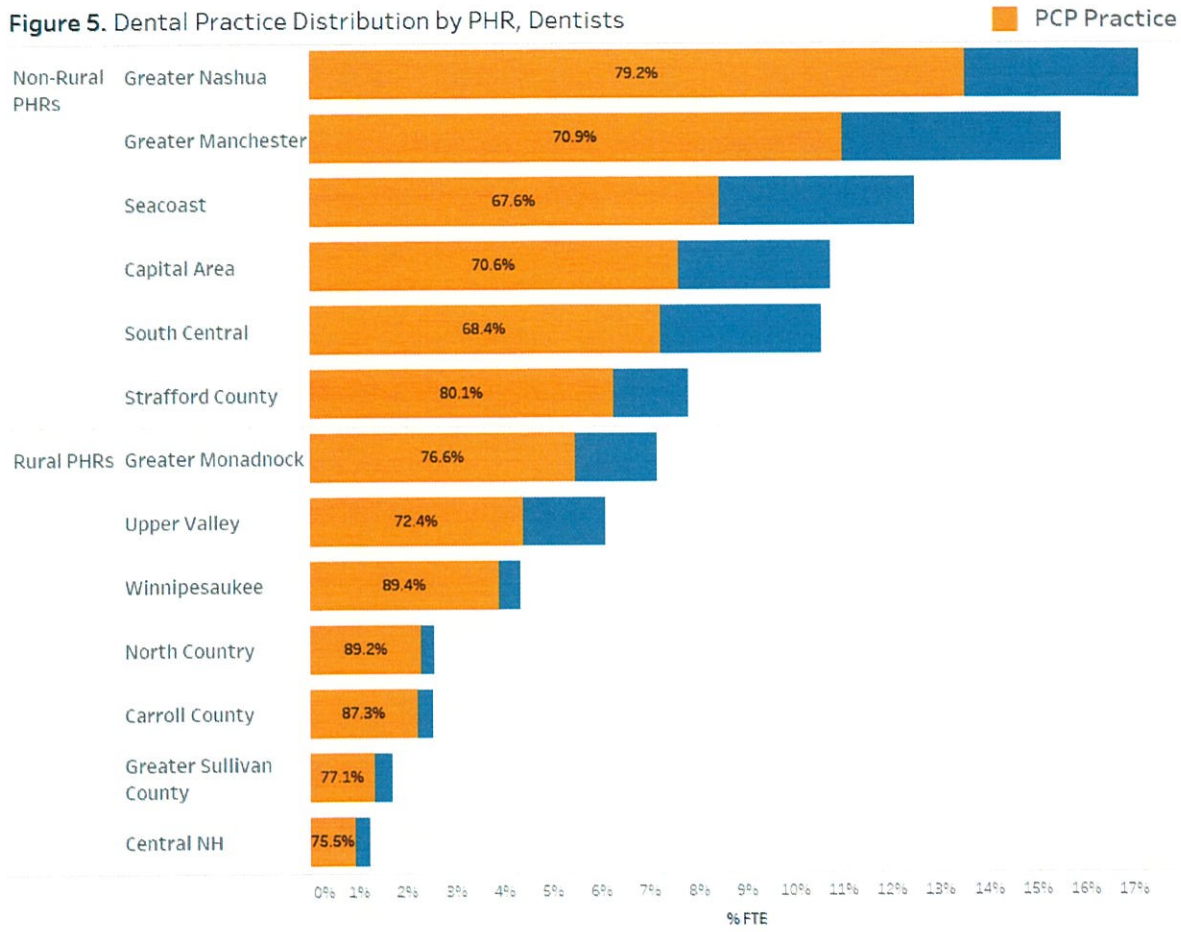
	Dentists	
	All	PCPs
Rural Regions	25.7	20.5
Non-Rural Regions	74.3	54.2

Teledentistry and non-direct patient settings are excluded from geographic analysis

Figure 5 illustrates the distribution of overall dental supply and primary care practice across rural and non-rural PHRs. The full bars represent the percentage of total dental practice in each region, while the inner bars show the percentage of primary care practice within those totals by PHR.

Dental practice distribution varies significantly across PHRs, with considerable variation observed in both rural and non-rural regions. Non-Rural Greater Nashua shows the highest concentration of dental practice (~17%), while rural Central NH shows the lowest concentration of both total dental practice and primary care practice (~1%). While the proportion of PCP practice to total practice is higher in rural PHRs than in non-rural regions, the absolute percentages of PCP practice are consistently higher in non-rural regions of the state compared to rural PHRs.

Figure 5. Dental Practice Distribution by PHR, Dentists



Anticipated Supply – According to indicators presented below, the dentist workforce shows relative stability but with vulnerabilities of concern. Over one-quarter of PCP dentists plan to reduce their capacity in the next five years, with 13% intending to leave the state or cease practice entirely. However, provider age informs anticipated supply where younger providers can offset workforce shortages that result from retirement. The percentage of primary care dentists under 40 is about 70% higher than those 60 and older, suggesting an adequate supply of new dentists to replace those retiring.

Despite having no in-state dental school, one-third of PCP dentists have ties to NH, either through prior work experience or residence before obtaining licensure. About one-quarter of dentists have practiced clinically in the state for less than five years; a metric that helps assess new entrants to the workforce as well as retention potential.

When considered alongside licensing data and population ratios that reveal limited supply, these anticipated supply indicators point to a dental workforce that faces significant vulnerability in coming years. However, the increased opportunity for in-state training through the recent

development of a new general dentistry residency rural track program in 2023 could offset the dentist shortages, as research suggests clinicians are more likely to practice where they train.

Table 9.5. Anticipated Supply

% of clinically active providers in each indicator group

	Dentists	
	All	PCPs
<40 Years Old	31.5	34.4
60+ Years Old	21.1	20.3
NH Ties	29.9	33.3
Less than 5 Years Practicing in NH	25.5	26.2
*Anticipated Reduction in Practice in 5 Years	26.2	27.2
- Practice in another state or no intention to practice	12.0	13.0

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

Access – Outpatient primary care dentists show high new patient acceptance rates, with nearly all rural (93%) and non-rural (96%) dentists indicating open panels. However, when isolating to Medicaid providers, non-rural acceptance rates are slightly lower than rural rates (90.4% vs. 92.6%). The median wait time for both new and established patients is one week longer at rural dental practices compared to non-rural locations when looking at all dentists, but comparable when isolating to Medicaid dentists. For Medicaid providers in non-rural areas, the median wait is extended by five days for established patients and one week for new patients. Despite high new patient acceptance rates, rural communities face greater challenges accessing dental care regardless of dentists' Medicaid participation, as evidenced by consistently longer wait times. Similarly, Medicaid populations in both rural and non-rural communities face significant access barriers, as evidenced by extended wait times for all patients.

Table 9.6. Access

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

	Dentists	
	Non-Rural	Rural
Accepting New Patients (% of Medicaid providers)	95.7 (90.4)	92.5 (92.6)
Median Wait in Days for Routine Appointments, Established Patients (Medicaid providers)	7 (12)	14 (14)
Median Wait in Days for Routine Appointments, New Patients (Medicaid providers)	7 (14)	14 (14)

** Wait times reported as medians rather than averages to better represent typical patient experience.*

Significant Workforce Differences by Rurality, Dentists

Table 10.1. Chi-Square tests of independence were run for select measures to assess whether significant differences in dentist 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.

The 2022 analysis reveals notable differences in provider and practice characteristics between rural and non-rural dentists in NH. Rural dentists are more likely to be male and identify as non-Hispanic White compared to their non-rural counterparts, indicating less demographic diversity. Interestingly, rural dentists are more likely to work full time compared to non-rural dentists but, despite working more hours, rural dentists do not report shorter wait times for patients. In fact, non-rural dentists have shorter wait times for both established and new patients. This difference suggests rural dentists face patient demand that exceeds their capacity. Non-rural dentists are also more likely to have attended a dental school in New England and to have ties to NH prior to practicing in the state. These findings underscore the need for targeted strategies to address workforce and access challenges, particularly in rural areas.

Table 10.1. Significant Geographic Differences in Workforce Composition, Rural Dentists

More likely to…	*Less likely to…*
⅄ Identify as White	⅄ Identify as female
⅄ Work full time (>30 hours)	⅄ Have graduated from a New England dental school
⅄ Have longer appointment wait times for new and established patients	⅄ Have NH ties prior to receiving initial NH license

Primary Dental Care Supply - Provider Rates by Geography

The workforce supply figures in tables 11.1. and 11.2. below are estimates of primary dental care provider rates per 100,000 resident population in NH. Primary care FTE dentist rates are slightly higher in non-rural than rural NH (38.2 vs. 34.2), while Medicaid acceptance rates, a valuable access indicator, are slightly higher in rural NH. Overall, NH has 37.1 outpatient primary care FTE dentists per 100,000 resident population, which translates to one primary care dentist for every 2,695 people.

Table 11.2. reveals substantial variation in primary care dentist rates across NH's rural regions. Both the highest and lowest rates are found in rural PHRs, though non-rural rates tend to be higher and rural rates trend lower overall. The disparity between the highest and lowest rates among PHRs is staggering: the primary care FTE rate in Upper Valley is 3.4x that of Greater Sullivan County, mirroring the patterns seen in primary medical care. Medicaid acceptance rates are generally higher in rural regions compared to non-rural, with two notable exceptions: rural Upper Valley, which has the lowest Medicaid acceptance rate in NH, and non-rural Capital Area, which has the highest.

Table 11.1. Primary Care Rates, Dentists, 2022

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

Provider Type	Year	Statewide Rate	Rural Rate (% Medicaid)	Non-Rural Rate (% Medicaid)
Dentists	2022	37.1	34.2 (41.8)	38.2 (37.4)

Restricted to pediatric and general dentistry only.

Table 11.2. Primary Care Rates by Public Health Region, Dentists, 2022

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

Rurality	PHR	Rate per 100,000 population (% Medicaid)	*Resident Population **(↑/↓)
Rural	Upper Valley	65.0 (29.5)	46,472 ↓
Non-Rural	Greater Nashua	43.1 (33.1)	221,108 ↑
Non-Rural	Greater Manchester	39.5 (31.9)	194,113 ↑
Non-Rural	Seacoast	39.1 (35.9)	150,759 ↑
Non-Rural	Capital Area	37.9 (53.8)	137,369 ↑
Rural	Greater Monadnock	36.8 (51.0)	102,031 ↑
Non-Rural	South Central	33.4 (38.7)	148,780 ↑
Rural	Winnipesaukee	33.0 (38.2)	81,001 ↑
Non-Rural	Strafford County	32.4 (37.1)	132,275 ↓
Rural	North Country	30.3 (38.7)	51,711 ↑
Rural	Carroll County	29.2 (54.2)	51,970 ↑
Rural	Central NH	20.7 (47.8)	30,693 ↓
Rural	Greater Sullivan County	19.1 (36.3)	46,949 ↑

Sorted from highest to lowest PCP FTE rate.

** 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 2022. For population estimates methodology statements, see http://www.census.gov/programs-surveys/popest/technical-documentation/methodology.html. All population estimates for the PHRs in NH are completed based on these estimates rolled up to the PHR.*

*** Increase ↑ / Decrease ↓ since 2021.*

Analysis Considerations

Outpatient primary care dentist FTE estimates are calculated using workforce data statistics collected during the 2022 survey year under HPDC. Estimates are calculated for dentists with active status licenses who did not complete the survey during this period, which includes both providers who are not due for renewal (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.

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 the HPDC – which sits under RHPC with the SORH. Provider surveys are amended 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

After an internal review of capacity and legal review of the data sharing agreement in August 2023, OPLC determined that it did not have the legal authority to comply with the 2020 data sharing agreement, which allowed for sharing of public and non-public data. In July 2024, legislation passed (HB1609, 2024) authorizing OPLC to share workforce-related licensing fields fundamental to the HPDC's role in provider surveying, federal shortage designation, and workforce assessment. A Memorandum of Understanding (MOU) is 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.

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 data sharing resumes, the HPDC will be limited in its ability to provide comprehensive workforce analysis reports and ad hoc data requests to inform workforce policy.

The HPDC administrator maintains direct communication with executive staff at OPLC to address workforce data and compliance issues as they arise. Continued collaboration 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. In 2024,

OPLC updated 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 enhanced 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. In July 2023, an internal evaluation of OPLC practices resulted in a request for the HPDC to submit individual complaints through the public electronic form. While the HPDC is committed to supporting compliance efforts, current staffing constraints limit our ability to fully implement this process as requested. The Memorandum of Understanding (MOU) currently under review at OPLC includes provisions to facilitate the transfer of final non-compliance cases for enforcement, helping to restore this important compliance activity. In the interim, HPDC will continue to explore workable solutions to align with enforcement processes and support strong survey participation.

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. The 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, the HPDC provides workforce supply and demand figures year-round. In addition to producing analytics for legislative requests and public consumption, the HPDC consistently informs the work of the following stakeholder organizations:

- Higher education - University of New Hampshire (UNH) and Geisel School of Medicine at Dartmouth College;
- Provider associations – NH Medical Society, 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 Health care Workforce Coalition, NH Children's Health Foundation; and
- DHHS programs and other state agencies, including the State Loan Repayment Program, the Oral Health Program, Maternal and Child Health, the Immunization Section, and Department of Insurance.

New to this year's report are dentist supply and workforce data trends. Sections include statistics on dentist demographics, geographic distribution, anticipated supply, access, workforce differences by rurality, and primary care FTE dentist rates by geography.

The impetus for creating the HPDC was to support federal shortage designation work through the collection of current and accurate provider data. Shortage designations bring providers and funding to areas of the state where people may have limited access. A variety of grants and other federal and state programs with funding opportunities, including the State Loan Repayment Program and the National Health Service Corps, 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 the 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. In 2024, states were required to upload maternal care provider data - specifically Certified Nurse Midwives (CNMs) and obstetrician-gynecologists (OB/GYNs) - to SDMS. RHPC was able to seamlessly complete this requirement using existing provider survey data without utilizing additional resources. With the HPDC's provider data, our office will continue to successfully conduct shortage designation work to ensure the most vulnerable areas in NH are reinforced.

Workforce supply estimates utilizing only the licensing list presents reliability challenges 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. The HPDC's methodological approach applies survey provider and practice statistics to OPLC supply figures in order to enumerate 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.

Staffing

HPDC operations are currently supported by a full-time administrator (1.0 FTE) and a data programmer/analyst (1.0 FTE). The program assistant position (0.5 FTE), originally established through 2019 legislation (HB 4, Laws of 2019), has remained vacant since the start of SFY2025. Following the expiration of ARPA funds, which previously supported this role, RHPC is exploring opportunities to leverage existing resources and partnerships to sustain this important function. While core HPDC activities continue, the vacancy has required staff to shift priorities, resulting in extended timelines for deliverables and the scaling back of foundational program support tasks. The program assistant position remains essential to the HPDC's operational capacity and long-term effectiveness.

Future Plans

Workforce Reports

The HPDC is currently developing a comprehensive health care workforce data dashboard for all primary medical care, behavioral health, and oral health disciplines surveyed. This integrated platform will incorporate health care workforce survey data collected by the HPDC to date, providing a collective view of the state's health care workforce landscape. The dashboard is a strategic shift from individual provider dashboards to a single, comprehensive tool that offers a complete picture of the health care workforce across disciplines and survey years. Time trend analysis will enable identifying changes in provider supply and practice characteristics over time, which can support evidence-based workforce planning decisions for NH. Beyond serving as an analytical tool, this dashboard will serve as a critical resource for primary care workforce planning and assessment. It will enhance federal shortage designation analyses and advance several grant objectives, including statewide primary care needs assessments, and the development of a long-term strategic plan to address health care provider shortages and shortage designations. The dashboard is scheduled for public release at the beginning of SFY2026.

The expansion of telehealth/telemedicine services, which accelerated during the COVID-19 State of Emergency, has significantly impacted behavioral health practice. Capturing this mode of service delivery is critical for accurate supply and capacity estimates. While telehealth has become an essential component of health care access, especially for rural areas in the state, geographic analysis of supply remains indeterminable without corresponding location data for telemedicine FTE. The 2021 and 2022 survey tool did not allow for calculating the rate of behavioral health practice by geographic location. However, with recent survey modifications to account for telehealth practice, implemented for all 2023 surveys, the HPDC anticipates statewide behavioral health capacity analysis in future reports.

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, the HPDC regularly performs compliance checks and sends out reminders for completion. Formation of the Enforcement Division within OPLC in 2022 allowed for collaboration to increase survey compliance and response rates. Following changes to this process implemented by OPLC in August 2023, survey non-compliance has increased, though not to a degree that impacts the reliability or representativeness of provider datasets, as response rates remain high. Establishment of an updated MOU, detailing survey compliance processes and intended enforcement action for non-compliance, will effectively increase response rates.

Data Use

Together with state and national stakeholders, the 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 bring providers and grant funding to areas of the state with access issues;
- 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.

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 Health care 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 the 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.

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 the 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, the HPDC will continue to analyze geographic variations in provider and practice characteristics by rurality, supporting the strategic 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.

Appendix A

Board	List of Provider Surveys as of December 2024	2022 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 and initial license year
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).[8]

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

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

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 Health Professional Shortage Areas (HPSAs) by the nature of being FQHCs.

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

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