New Mexico Commission on the Status of Women

Meeting Date: Wed July 24th , 2024
Meeting Time: 4:00 PM Mountain Time
Meeting Place: Virtually via Zoom Video-conferencing
Topic: NMCSW Monthly Meeting

https://us06web.zoom.us/j/88942998579?pwd=QjZCaEFNVUM0MmFRdTZnVmRMQmVwUT09

Meeting ID: 889 4299 8579
Passcode: 670212
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Commissioner	**Present**	**Public in attendance**
Lisa Curtis, Chair	X	
Erin Armstrong – Vice Chair	X	
Mary Ann Ustick– Treasurer		Jenifer Raphael Getz (executive director NMCSW)
Christina Herrera Furst – Secretary	X	
Denise Torres – Commissioner		
Brenda Saiz – Commissioner	X	
Gabriella Begay – Commissioner		
Mary Lane Leslie – Commissioner	X	
Leigh Ana Shaw – Commissioner		
Songtree Pioche – Commissioner	X	
Celina Bryant – Commissioner	X	
Melissa Lopez Sullivan –Commissioner	X	

AGENDA

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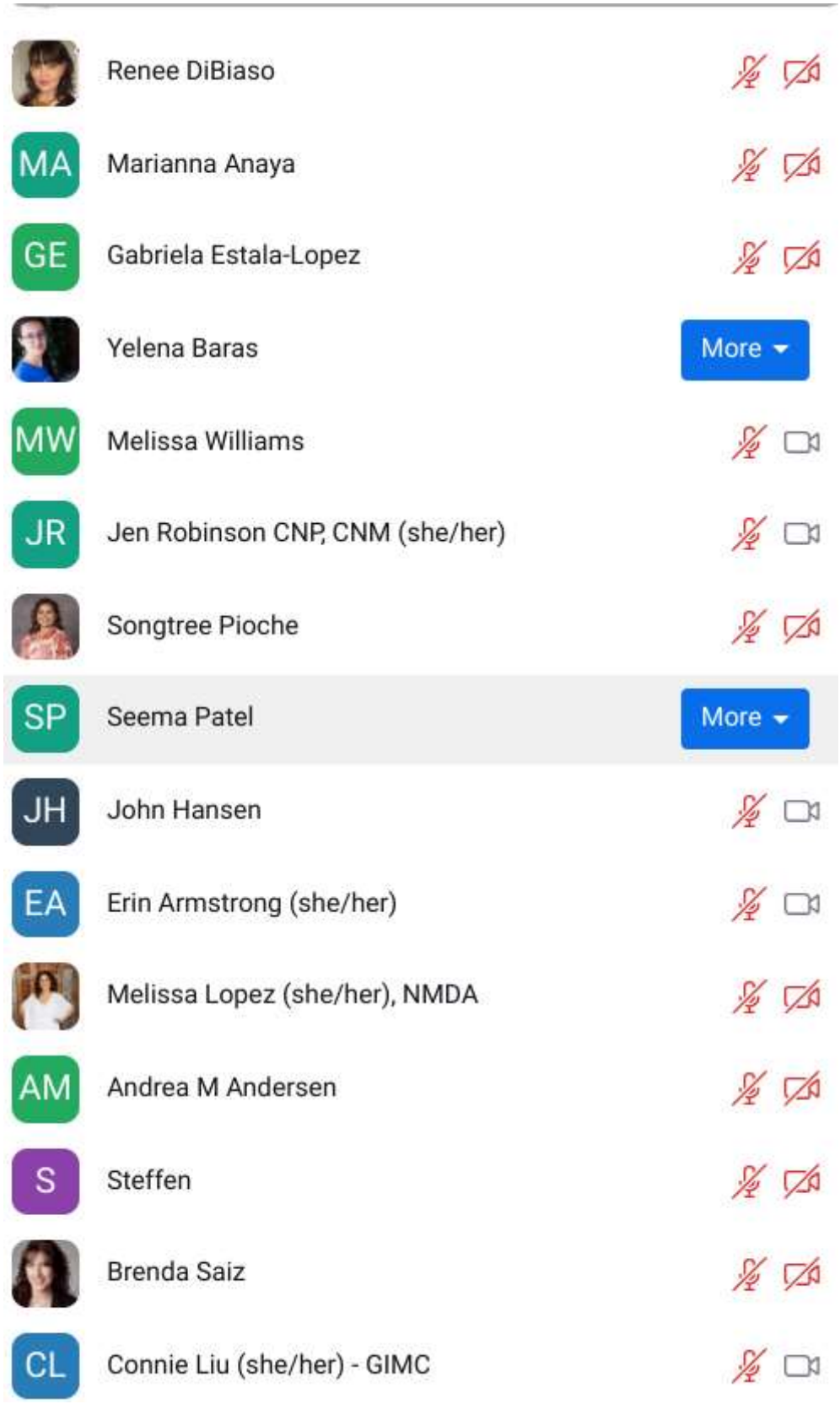
4:00 PM Call to Order
4:05 PM Lisa Curtis, Commission Chair-Open meeting, and announcements.
Searching for Data on Women's Healthcare

This will be a conversation with medical professionals on women's health focused on the following issues.
Expanding access to quality women's health care throughout New Mexico.
The challenges of being a practitioner in women's health.
What do medical providers need to attract and stay in New Mexico, Training / Retention / Recruitment.

5:30 PM Closing

CH	Christina Herrera Furst (she/her) (Me)	
	Lisa K. Curtis, JD (Host)	
	Curtis & Co.	
	Jenifer Raphael Getz (She / Her)	
HI	Hal's iPhone 14 Pro	
	Celina Bryant	
CL	Carla Law, she/her/ella	
C	CHBROWN	
EH	Emma Hines- NMDC	
BOLD FUTURES	Kat - she/her -Bold Futures	
LT	Liz Thomson	
	Thanh-Tam Ho (she/her)	
	Renee DiBiaso	
MA	Marianna Anaya	
GE	Gabriela Estala-Lopez	



Dr. Carrie Swartz: has been looking for another provider in private practice for a few years. She has one medical assistant serving 5 providers. Hiring from top to bottom has been a problem for them.

Dr. Liu: works for a stable health system, but people she knows who work in women's health leave because there is a significant misalignment of what they want to do to serve women and the policies of the corporate

leadership. Causes burnout and feeling lack of support. Gallup Community Health has taken and kept a lot of the providers who left; they work to align themselves with what the community needs.

Dr. Roberts: she has one provider who works opposite (family provider); next provider is in Taos which takes about an hour and a half. Little resources for high-risk pregnancy. Alignment with Dr. Brown to read scans. Great OR and great staff, but some women drive 2.5-3 hours. No paramedics in their community. They are doing telehealth with Clayton due to a grant. Live scans with Pinon. Patient is local, doctor is remote. Seconds that leadership does not understand and burnout is a big thing. NPs, midwives, additional providers would be helpful. Hospital not interested in sending anyone new. She is doing a mentorship-relationship to provide more training and experience for another person.

Dr. Christy Brown- in Alabama. Changed from a more corporate environment to a community environment. She feels supported now. Corporatization is a huge problem. Like with Dr. Roberst, the hospital doesn't want to support her because the orthopedics etc. bring in more money. They have the same issue hiring medical assistants because remote/at home positions can pay the same and people don't want to come in. Depersonalization of healthcare is a problem.

Yelena @ Dar a Luz- 501cp3 non profit. 8 widwives, 7 nurses. Work closely with doctors like Dr. Brown. Clients coming from all over state and surrounding states because of dedication to birth center model or lack of access. Huge lack of insurance reimbursement for birthing center. They lose $4-9K per patient as compared to hospitals. Really challenging as a nonprofit, as well as 24 shifts being burdensome.

Jen Robinson, CNP: pay parity was to start Jan. 1st. Is it all only Medicare plans or do commercial plans also have pay parity. Lots of extra admin work to hold all the payers accountable. Still having implementation problems with _____. Extra support to office of Superintendent of Insurance would be helpful.

Dr. Swartz: for those in smaller private practices with limited resources. If my biller has a choice between calling insurance companies and trying to get paid for smaller easier things, that wins out over trying to convince them that they need to pay for insertion of IUD. Admin support, contract negotiation. Today seeing paying, interviewing med assistant, help single med assistant doing vitals…Not enough time to call up Pres and ask them to pay her more.

Dr. Espey has brought a number of OB/gYNs back to UNMH because of her personally. At UNM, they do a good job trying to recruit the home team. 50-60% chance provider will stay in NM if doctor does med school and residency in NM, 30% each for proviers who do one or the other. They do well with diverse medical students. Not doing well with diverse faculty. Some issues with compensation for health care staff in general, not just doctors. The more we can recruit the faculty and retain them, the better a job we can do with getting our students and residence to stay. Paid family leave is abig issue for us. Schools, crime…the other things people look at when they are looking for a job.

Dr. Steffan Brown goes all over the state. What can we do to support super specialists? How do we take care of patients in the interim with high-risk patients? We have to have resources in local communities. Gallup and other places: need to have places in their community where they can safely deliver a baby. Have state support places for people to deliver their baby across the state.

Rep. Thomson: considering a bill around facility fees. Letter to the ed in SF talking about facility fee is bigger than his bill.

How to pay for administrative costs? How to keep a place open so they can provide care because they aren't going to be reimbursed enough for that.

Dr. Robinson: continue capacity to call in to UNM to consult. She used to try to provide full pre-and-post natal care but doesn't do it anymore because she was doing too much that an office person could do in unpaid hours.

Dr. Zimmer (WA):

Renee DiBiaso: It's important for business owners to look at how to support women. Still a lot of hurdles for women in the workforce–flexible work policies, comprehensive affordable healthcare. Change can be made with the businesses. Women business owners to support healthcare initiatives, be more active, because we can make a difference.

Erin Armstrong: Our legislature and superintendent of insurance are looking at hospital mergers and other significant issues (SF private companies coming in to take over administration duties that might affect ____). Are others seeing or feeling impacts from mergers and other shifts in the way our community hospitals are being run.

Mary Lane Leslie: Should a medical practice be owned by CPAs, not doctors?

Rep. Anaya: I see so many amazing local providers who are trying to resist corporatization of medicine every day. I hear often that the priority of these private equity companies and private corporations are pushing people out. These seems like a big root or driver of burnout, moral injury…

Kat (Bold Futures): Rwo parts: hospital consolidations as a whole and what we see when that happens–reduction in labor and delivery, increased pressures on those left. Hard to get seen at smaller facilities because of not enough providers, especially for kids, specific to Christus network/ Otero county. Titles of medical assistants went to something like "faith __", which can affect what past health history and current needs the patient shares. No clear view of how workers feel about that title change. Bold Futures and allies are going to the OSI meetings to track impact of these mergers on communities and providers.

ERDs= dictate care that can be provided in Catholic hospitals.

Lisa: any perceived hurdles for going into private practice?

Dr. Forbis: in depart of OB/gyo at UNM and complex family planning specialist to provide abortion, contraception care. Sandoval Med Center for surgeries, some on-call work.

Lisa: How to keep providers here, how to attract people to come here?

Dr. Forbis: she has some role in education at UNM. She's from Kentucky, thought she knew rural until she came here. The isolation has blown her away. Learning that it takes a year to get into UNM for a PCP. To echo remote providers, at UNM we are taking care of very sick patients, and that can cause a lot of burnout. That's been one of the biggest challenges she's faced here. Getting local providers who are familiar with the challenges. Providers want to take care of population that looks like them, stats show increased quality of care, increasing diversity. Student loan relief would be very helpful.

Dr. Swartz: idea of loan repayment is super important. She can't compete with Pres or UNM because she can't pay off their loans (still paying off her loans). In rural communities, more access to loan repayment help, but urban doctors are still seeing the same challenges to provide care. We need providers everywhere.

Chair Thomson: Job Training Incentive Program (manufacturing company getting $ to train employees). Is it possibility to get JTIP $ to help train medical assistants.

Emma Hines (NMDC)-- because they are a nonprofit, employees can get loans paid off after 10 years of employment with them. Could this be applied to other practices?

Lisa: Issue with the legislature funding this education and tying strings to it (stay here).

Dr. Robinson: National Health Service Corps. It would be awesome to see somethings similar to BA-MD program. If we had something like that for folks in NM. Similar conversation with NP at ____ about pipeline programs to expose young people to health careers.

Dr. Liu: —- how another rural Native community pulls in providers through rotations.

Lisa: Expansion of telehealth services for your area? Is telehealth a real solution to taking some of the pressure off? Or is this not realistic because we're already so short on providers.

Dr. Espey– need depth to the bench so it's not one-person carrying it. When we do telehealth, there is not a facility fee. For institutions that depend on a facility, telemedicine is tough because there's not reimbursement for phone calls. NM Perinatal Collaborative–very challenged organization–some movement on the part of the collaborative to create synergies with other organizations. In terms of morbidity data, lots of effort into putting in the data to help NM birthing facilities move forward. Lots of folks are writing grants. I can't stress how great that would be to understand what the drivers are and what efforts prove effective in reducing infant and maternal morbidity..

Lisa: Perhaps the commission could be a partner: gathering data is a big piece of what we're doing. What is the actual reimbursement for providers for women's care? The provider fee for prenatal care and pregnancy is shockingly low–money from giving birth, but discrepancy between the two rates is terrible.

Dr. Swartz: I agree. Huge amounts of money that it takes to put together and run a facility. I don't have facility fees to offset that. I believe there's a NM statute that creates parity in reimbursement for telehealth and in-person visit. We found telehealth helps a lot to go over tests, follow-ups, etc.

Chair Thomson: Project ECHO has project to use AI to help insurance companies with prior authorization. We did a prior auth bill this year on certain drugs, but it was encouraging that Project Echo is working on this.

Dr. Liu: I can take full spectrum care of patients because there is an operating room, support staff, midwives… Our responsibility is to the Native population, so non-Native pop doesn't have access to that. There's a new clinic that popped up and got running quickly. Tax breaks, whatever supports organizations like that would be helpful.