

New Mexico

With a wide array of problem areas and below average scores in every category, New Mexico ranks third to last in the nation for its overall emergency care environment.

Strengths. Policies and systems have been implemented to help improve the *Quality and Patient Safety Environment* in New Mexico. The state provides funding for quality improvement within the EMS system, as well as a state EMS medical director position. There is a uniform system for providing pre-arrival instructions and a statewide trauma registry. In addition, high proportions of hospitals use electronic medical records (57.9 percent) and computerized practitioner order entry (39.5 percent) to promote greater accuracy, tracking, and safety.

While New Mexico did not excel in the area of *Disaster Preparedness*, the state has made some strides with regard to planning and statewide communications. The state has developed an all-hazards medical response plan, as well as a written plan for special needs patients. New Mexico also has a statewide victim tracking system, medical assistance teams, and a real-time or near real-time syndromic surveillance system.

Challenges. New Mexico faces important struggles regarding *Access to Emergency Care* due to factors such as lack of health insurance and workforce shortages. The state has some of the highest rates of uninsured adults and children in the country, ranks 43rd for the number of staffed inpatient beds, and 51st for its lack of pediatric specialty centers. The state is facing severe workforce shortages, with low per capita rates of neurosurgeons (ranks 49th); ear, nose, and throat specialists (45th); plastic surgeons (38th); orthopedists and hand surgeons (35th); and registered nurses (50th). The state also

has a substantial need for primary care providers: an additional 149.0 full-time equivalent providers are needed to serve its population.

Similarly, New Mexico faces serious challenges regarding *Public Health and Injury Prevention*. The state is among the worst five states for high rates of fatal injuries, including those due to falls, homicides and suicides, and traffic fatalities. The state also has a relatively low rate of immunization among children aged 19-35 months (76.2 percent).

The *Medical Liability Environment* in New Mexico needs further reform. The average medical liability premiums for primary care physicians and specialists are somewhat higher than the average across the states. New Mexico has failed to enact expert witness rules that require the witness to be of the same specialty as the defendant or be licensed in the state. The state also lacks any special liability protections for providers of EMTALA-mandated emergency care.

Recommendations. New Mexico must act immediately to address hospital crowding and emergency department patient boarding. Emergency physicians in the state report that these issues have reached critical proportions throughout New Mexico. Possible contributors to these problems include a low number of staffed inpatient beds and a severe workforce shortage. As

noted above, the dearth of specialists and registered nurses is among the worst in the nation, a topic that needs to be addressed at the state level to ensure access to quality care at all times.

Emergency physicians also report a serious lack of specialists willing to provide on-call services for emergency patients, as well as a decreasing number of primary

	RANK	GRADE
ACCESS TO EMERGENCY CARE	49	F
QUALITY & PATIENT SAFETY ENVIRONMENT	32	C-
MEDICAL LIABILITY ENVIRONMENT	30	D
PUBLIC HEALTH & INJURY PREVENTION	32	D+
DISASTER PREPAREDNESS	39	D+
OVERALL	49	D

care providers. Policymakers should enact medical liability reforms to encourage on-call specialists to provide EMTALA-mandated emergency care and institute broad recruitment efforts to address the severe workforce shortage in New Mexico. Increasing Medicaid reimbursement rates might also help retain the current, overwhelmed workforce as well as draw more physicians to the state.

While hospitals' use of electronic medical records and computerized practitioner order entry helped boost the state's grade with regard to the *Quality and Patient Safety Environment*, emergency physicians in the state report a need for such systems to be more thoroughly evaluated prior to implementation in order to ensure that they are efficient and effective from the clinical perspective.

New Mexico faces important struggles regarding access to emergency care.

ACCESS TO EMERGENCY CARE F

Board-certified emergency physicians per 100,000 pop.	9.1
Emergency physicians per 100,000 pop.	13.4
Neurosurgeons per 100,000 pop.	1.2
Orthopedists and hand surgeon specialists per 100,000 pop.	8.7
Plastic surgeons per 100,000 pop.	1.7
ENT specialists per 100,000 pop.	2.6
Registered nurses per 100,000 pop.	586.9
Additional primary care FTEs needed	149.0
Additional mental health FTEs needed	18.2
Level I or II trauma centers per 1M pop.	0.5
% of population within 60 minutes of Level I or II trauma center	59.9
Accredited chest pain centers per 1M pop.	2.0
% of population with an unmet need for substance abuse treatment	8.8
Pediatric specialty centers per 1M pop.	1.5
Physicians accepting Medicare per 100 beneficiaries	2.7
Medicaid fee levels for office visits as a % of the national average	126.2
% change in Medicaid fees for office visits (2004-05 to 2007)	13.2
% of adults with no health insurance	24.8
% of children with no health insurance	17.9
% of adults with Medicaid	8.4
Emergency departments per 1M pop.	15.4
Hospital closures in 2006	1
Staffed inpatient beds per 100,000 pop.	254.7
Hospital occupancy rate per 100 staffed beds	63.5
Psychiatric care beds per 100,000 pop.	21.1
State collects data on diversion	No

MEDICAL LIABILITY ENVIRONMENT D

Lawyers per 10,000 pop.	10.6
Lawyers per physician	0.4
Lawyers per emergency physician	7.8
ATRA judicial hellholes (range 0 to -7)	-2
Malpractice award payments/100,000 pop.	2.7
Average malpractice award payments	\$255,195
Databank reports per 1,000 physicians	28.2
Patient compensation fund	● Yes
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	10.5
Average medical liability insurance premium for primary care physicians	\$17,546
Average medical liability insurance premiums for specialists	\$79,526
Pretrial screening panels	● Mandatory
Are pretrial screening panels' findings admissible as evidence?	No
Periodic payments	At judge's or court's discretion
Medical liability cap on non-economic damages	● >\$500,000
Additional liability protection for EMTALA-mandated emergency care	● No
Joint and several liability abolished	● Yes
State provides for case certification	No
Expert witness required to be of the same specialty as the defendant	No
Expert witness must be licensed to practice medicine in the state	No

QUALITY & PATIENT SAFETY ENVIRONMENT C-

Funding for quality improvement within the EMS system	Yes
Funded state EMS medical director	Yes
Emergency medicine residents per 1M pop.	13.7
Adverse event reporting required	No
Hospital-based infections reporting required	No
Mandatory quality reporting requirement	No
% of counties with E-911 capability	97.0
Uniform system for providing pre-arrival instructions	Yes
State has or is working on a stroke system of care	Yes
State has or is working on a PCI network or a STEMI system of care	NR
Statewide trauma registry	Yes
% of hospitals with computerized practitioner order entry	39.5
% of hospitals with electronic medical records	57.9
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	50
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	19

PUBLIC HEALTH & INJURY PREVENTION D+

Traffic fatalities per 100,000 pop.	24.8
% of traffic fatalities alcohol related	38.0
Front occupant restraint use (%)	91.5
Helmet use required for all motorcycle riders	● No
Child safety seat/seat belt legislation (10 points possible)	8
% of children immunized, aged 19-35 months	76.2
% of adults aged 65+ who received flu vaccine in the last 12 months	67.6
% of adults aged 65+ who ever received pneumococcal vaccine	64.5
Fatal occupational injuries per 1M workers	56.0
Homicides and suicides (non-motor vehicle) per 100,000 pop.	25.7
Unintentional fall-related fatal injuries per 100,000 pop.	14.1
Unintentional fire/burn-related fatal injuries per 100,000 pop.	1.2
Unintentional firearm-related fatal injuries per 100,000 pop.	0.5
Gun-purchasing legislation (8 points possible)	0
% of tobacco settlement funds spent on health-related services and programs	0.0
Total injury prevention funds per 1,000 pop.	\$1,206.52
Unintentional injury prevention funds per 1,000 pop.	NR
Intentional injury prevention funds per 1,000 pop.	NR
Fall injury prevention funds per 1,000 pop.	\$16.94
Infant mortality rate per 1,000 live births	6.1
% of adults with BMI > 30	22.9
Current smokers, % of adults	20.1
Binge alcohol drinkers, % of adults	13.2

DISASTER PREPAREDNESS D+

Per capita federal disaster preparedness funds	\$9.47
Disaster preparedness funds used specifically for health care-related preparedness are tracked	Yes
All-hazards medical response plan or ESF-8 plan?	Yes
Plan shared with all EMS and essential hospital personnel?	Yes
Public health and emergency physician input into the state planning process	Yes, Yes
Public health and emergency physician input into the daily operations of the SEOC	NR
Written plan for the coordination of the SEOC or local EMAs to provide security to hospitals in case of emergency events	Yes
Number of drills and exercises conducted involving hospital personnel, equipment, or facilities	34
Accredited by the Emergency Management Accreditation Program	No
Written plan specifically for special needs patients	Yes
Written plan to supply medications for chronic conditions	No
Written plan to supply dialysis for patients	No
Real-time notification system in place to notify identified health care providers of an event	Yes
"Just-in-time" training systems in place	Statewide
Statewide medical communication system with one layer of redundancy	Yes
Statewide patient tracking system	No
Statewide victim tracking system	Yes
Statewide real-time or near real-time syndromic surveillance system	Yes
Real-time surveillance system in place for common ED presentations	Yes
Bed surge capacity per 1M pop.	215.2
Burn unit beds per 1M pop.	5.1
ICU beds per 1M pop.	216.8
Verified burn centers per 1M pop.	0.0
State able to verify credentials and assign volunteer health professionals to four ESAR-VHP levels	Yes
Nurses registered in ESAR-VHP per 1M pop.	NR
Physicians registered in ESAR-VHP per 1M pop.	NR
Training required in disaster management and response to bio- and chem terrorism for essential hospital personnel, EMS personnel	No, No
State or regional strike teams or medical assistance teams	Yes
Additional liability protections for health care workers during a disaster	Civil, not clearly defined
% of RNs that received any emergency training	39.4
State requires EMS and essential ED personnel to be NIMS compliant	Yes

	Improved since 2006
	Worsened since 2006
●	No change since 2006
NR	Not reported
N/A	Not applicable
See Summary Statistics for State Comparisons	