

New Hampshire

New Hampshire scored well in the *Quality and Patient Safety Environment* and in *Access to Emergency Care*, but a lack of medical liability reforms, growing concerns related to the availability of on-call specialists, and the loss of mental health facilities pose substantial challenges for the state.

Strengths. New Hampshire’s strong performance in the *Quality and Patient Safety Environment* is largely due to multiple quality control and improvement systems, including funding for quality improvement within the EMS system, required reporting of hospital-based infections, a uniform system for providing pre-arrival instructions, and a statewide trauma registry.

New Hampshire’s score for *Access to Emergency Care* benefits from having a high proportion of physicians accepting Medicare (4.4 per 100 beneficiaries) and a relatively low level of need for additional primary care physicians (12.4 full-time equivalents). The state also has relatively high rates of orthopedists and hand surgeons, neurosurgeons, and registered nurses, though not plastic surgeons or ear, nose, and throat specialists. New Hampshire ranks sixth for the number of Level I or II trauma centers per 1 million people. While New Hampshire has the nation’s lowest percentage of adults on Medicaid, it has lower than average rates of uninsured adults and children, as well.

The *Public Health and Injury Prevention* grade in New Hampshire shows mixed, though generally positive, results. The state ranks among the top 10 with regard to its relatively low rates of traffic fatalities (9.7 per 100,000 people), homicides and suicides (13.9 per 100,000), and fatal occupational injuries (21.8 per 1 million workers). The state’s infant mortality rate is lower than the national rate (5.3 versus 6.9 deaths per 1,000 live births, respective-

ly), as is the rate of obesity among adults. Immunization rates for children and older adults are all higher than the national rates as well.

Regarding *Disaster Preparedness*, New Hampshire has developed an all-hazards medical response plan, which has been shared with all EMS and essential hospital personnel. There is a written plan for coordination of the State Emergency Operations Center or local emergency management agencies to provide security to hospitals during a disaster event, and the state tracks disaster preparedness funds used for health care-related preparations. The state has a real-time or near real-time syndromic surveillance system and a system for surveillance of common emergency department presentations.

Challenges. New Hampshire’s *Medical Liability Environment* is ranked 36th primarily due to the paucity of medical liability reforms currently in place. The state lacks a medical liability cap on non-economic damages and expert witness rules requiring case certification and that witnesses be of the same specialty as the defendant. While the state allows for periodic payments, these are permitted only at the court’s discretion. New Hampshire also suffers from an average malpractice award that is significantly higher than the average across the states (\$321,011 versus \$285,218, respectively).

While the state received an average grade with regard to *Disaster Preparedness*, New Hampshire’s infrastructure lacks patient and victim tracking systems, as well as plans to supply medications for chronic conditions and dialysis to patients during a disaster.

Recommendations. Despite having high rates of some physician specialties in relation to other states, emergency physicians in New Hampshire have reported a lack of




Policymakers should act immediately to develop a more favorable medical liability environment.

	RANK	GRADE
ACCESS TO EMERGENCY CARE	11	B-
QUALITY & PATIENT SAFETY ENVIRONMENT	14	B+
MEDICAL LIABILITY ENVIRONMENT	36	D-
PUBLIC HEALTH & INJURY PREVENTION	20	C+
DISASTER PREPAREDNESS	32	C
OVERALL	15	C+

on-call specialists of all types that has resulted in delayed care and/or patient transfers to hospitals often hours away. Policymakers should act immediately to develop a more favorable *Medical Liability Environment* to help recruit and retain health care providers. Specifically, instituting additional liability protections for EMTALA-mandated emergency care may encourage specialists to provide on-call services and treat higher-risk patients presenting to the emergency department.

Lack of access to mental health care also is a critical issue for New Hampshire patients. While the data reported were from the most current sources of state-by-state information, they do not reflect recent events, such as the closing of one of New Hampshire’s mental health hospitals or the closing of three mental health community centers in 2008. These occurrences, combined with a greater than average percentage of the population with an unmet need for substance abuse treatment (8.5 percent), indicate a need for further investment in services and programs for mental health care and substance abuse

ACCESS TO EMERGENCY CARE **B-**

Board-certified emergency physicians per 100,000 pop.	 9.8
Emergency physicians per 100,000 pop.	11.9
Neurosurgeons per 100,000 pop.	2.1
Orthopedists and hand surgeon specialists per 100,000 pop.	10.9
Plastic surgeons per 100,000 pop.	1.8
ENT specialists per 100,000 pop.	3.1
Registered nurses per 100,000 pop.	 970.4
Additional primary care FTEs needed	12.4
Additional mental health FTEs needed	1.2
Level I or II trauma centers per 1M pop.	3.8
% of population within 60 minutes of Level I or II trauma center	81.7
Accredited chest pain centers per 1M pop.	0.0
% of population with an unmet need for substance abuse treatment	8.5
Pediatric specialty centers per 1M pop.	3.8
Physicians accepting Medicare per 100 beneficiaries	4.4
Medicaid fee levels for office visits as a % of the national average	99.6
% change in Medicaid fees for office visits (2004-05 to 2007)	12.0
% of adults with no health insurance	12.7
% of children with no health insurance	7.5
% of adults with Medicaid	3.3
Emergency departments per 1M pop.	 20.6
Hospital closures in 2006	0
Staffed inpatient beds per 100,000 pop.	257.4
Hospital occupancy rate per 100 staffed beds	66.2
Psychiatric care beds per 100,000 pop.	34.5
State collects data on diversion	Yes




MEDICAL LIABILITY ENVIRONMENT **D-**

Lawyers per 10,000 pop.	13.6
Lawyers per physician	0.5
Lawyers per emergency physician	11.3
ATRA judicial hellholes (range 0 to -7)	0
Malpractice award payments/100,000 pop.	3.5
Average malpractice award payments	\$321,011
Databank reports per 1,000 physicians	16.0
Patient compensation fund	No
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	12.9
Average medical liability insurance premium for primary care physicians	\$13,119
Average medical liability insurance premiums for specialists	\$56,054
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	No
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 **B+**


Funding for quality improvement within the EMS system	Yes
Funded state EMS medical director	No
Emergency medicine residents per 1M pop.	0.0
Adverse event reporting required	No
Hospital-based infections reporting required	Yes
Mandatory quality reporting requirement	Yes
% of counties with E-911 capability	100.0
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	Yes
Statewide trauma registry	Yes
% of hospitals with computerized practitioner order entry	15.4
% of hospitals with electronic medical records	46.2
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	63
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	11


PUBLIC HEALTH & INJURY PREVENTION **C+**


Traffic fatalities per 100,000 pop.	9.7
% of traffic fatalities alcohol related	41.0
Front occupant restraint use (%)	63.8
Helmet use required for all motorcycle riders	No
Child safety seat/seat belt legislation (10 points possible)	1
% of children immunized, aged 19-35 months	 81.5
% of adults aged 65+ who received flu vaccine in the last 12 months	 71.9
% of adults aged 65+ who ever received pneumococcal vaccine	 68.4
Fatal occupational injuries per 1M workers	21.8
Homicides and suicides (non-motor vehicle) per 100,000 pop.	13.9
Unintentional fall-related fatal injuries per 100,000 pop.	8.2
Unintentional fire/burn-related fatal injuries per 100,000 pop.	1.0
Unintentional firearm-related fatal injuries per 100,000 pop.	0.2
Gun-purchasing legislation (8 points possible)	1.5
% of tobacco settlement funds spent on health-related services and programs	0.0
Total injury prevention funds per 1,000 pop.	\$317.67
Unintentional injury prevention funds per 1,000 pop.	\$159.60
Intentional injury prevention funds per 1,000 pop.	\$158.08
Fall injury prevention funds per 1,000 pop.	\$0.00
Infant mortality rate per 1,000 live births	5.3
% of adults with BMI > 30	22.4
Current smokers, % of adults	18.7
Binge alcohol drinkers, % of adults	15.2

DISASTER PREPAREDNESS **C**

Per capita federal disaster preparedness funds	\$11.71
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	NR
Public health and emergency physician input into the daily operations of the SEOC	No, No
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	51
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	No
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.	657.4
Burn unit beds per 1M pop.	0.0
ICU beds per 1M pop.	314.1
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.	91.2
Physicians registered in ESAR-VHP per 1M pop.	0.8
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	Yes, civil
% of RNs that received any emergency training	38.1
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