Access to Obstetric and Gynecological Services in Rural Areas in New Mexico

Historical Trends

As of the summer of 2016, there are 25 hospitals in New Mexico delivering obstetrical services. Since 2010, that number has dropped from 27. Specialty hospitals do not provide birthing services. (These include behavioral health, rehabilitation and long term acute care hospitals.) At a more detailed level, the statistics reveal a particularly challenging trend for rural New Mexico. **Four** rural hospitals have dropped OB services, while there was a gain of **two** urban hospitals with OB services:

8 Urban / High Volume Birthing Hospitals (greater than 1000 births per year)

- Presbyterian Hospital — Albuquerque
- Lovelace Women's Hospital — Albuquerque
- UNMH — Albuquerque
- San Juan Regional Medical Center — Farmington
- MountainView Reg. Medical Center — Las Cruces
- Plains Regional Medical Center — Clovis
- Presbyterian Rust Medical Center — Albuquerque (opened in 2012)
- Memorial Medical Center — Las Cruces

12 "Mid Volume" Birthing Hospitals

- Lovelace Regional Hospital — Roswell
- CHRISTUS St. Vincent RMC — Santa Fe
- Lea Regional Medical Center — Hobbs
- Gerald Champion RMC — Alamogordo
- Carlsbad Medical Center — Carlsbad
- Lovelace Westside Hospital — Albuquerque (reopened in 2011)
- Gila Regional Medical Center — Silver City
- Lincoln County Medical Center — Ruidoso
- Rehoboth McKinley Christian — Gallup
- Mimbres Memorial Hospital — Deming
- Eastern NM Medical Center — Roswell
- Presbyterian Espanola Hospital — Espanola

5 "Low Volume" rural hospitals (233 or fewer births per year)

- Holy Cross Hospital — Taos
- Cibola General Hospital — Grants
- Los Alamos Medical Center — Los Alamos
- Socorro General Hospital — Socorro
- Miners' Colfax Medical Center — Raton

- 4 Rural hospitals which have closed OB services since 2010
  - Alta Vista Regional Hospital — Las Vegas
  - Artesia General Hospital — Artesia
  - Trigg Memorial Hospital — Tucumcari
  - Union County General Hospital — Clayton
- 4 Rural hospitals which either never had OB service or closed prior to 2010:
  - Guadalupe County Hospital — Santa Rosa
  - Nor-Lea General Hospital — Lovington
  - Roosevelt General Hospital — Portales
  - Sierra Vista Hospital — Truth or Consequences
- 3 Urban hospitals which either never had OB service or closed prior to 2010
  - Presbyterian Kaseman Hospital — Albuquerque
  - Lovelace Medical Center — Albuquerque
  - UNM Sandoval Reg. Med. Ctr. — Rio Rancho

Factors and Challenges in Provision of OB Services

Cost & Capability

Obstetric services do not stand on their own but are highly intertwined with other services in the hospital. Birthing is a 24/7 service. Lower volume providers have a disproportionate amount on-call, down time. Specifically, the following support functions must be in place:

- The potential for medical emergency that requires immediate consultation or referral
- The potential for surgical intervention (like a Cesarean) requires anesthesia and surgical capability to be on standby or in house which can be costly
- Highly specialized (in more than 1 sub-specialty, (e.g. neonatal, high risk OB, peri-operative) nursing staff and other support staff is required – challenging in low volume setting
- Specialized monitoring equipment,
- Neonatal resuscitation and life-support equipment and medications
- Blood bank, and availability of certain tests
- Specialized lab testing
- A full-time Board certified physician with obstetric privileges, with back-up

Reimbursement Medicaid is by far the largest payer source for OB in New Mexico. In some communities, 90% of the births are to Medicaid recipients. Facility costs are generally reimbursed adequately, in the range of 82% to 95% of cost. The physician/provider costs are often incurred by hospital as well. Provider reimbursement is not adequate to cover the costs of an Obstetrical practice, especially in low-volume settings. To assure OB service is available in the community, hospitals end up assuming the cost of salary guarantees as well as the cost of malpractice coverage.

Recruitment challenges

It is challenging to recruit, orient and maintain competency of staff to a smaller institution without previous Ob/Neo experience. Many staff do not like having to float to other areas if their love is obstetrics/neo, so they look for other organizations that do not require cross-training to other specialties. "Growing your own" is an option, and can be challenging with a small volume. The high cost of medical malpractice coverage is a burden to hospitals and providers alike.

Geography – travel time to other services (pregnant women often make frequent trips to determine if they are in labor or not – this can be time-consuming, exhausting, costly, and can be a patient safety issue if travel time is extended when patients are sent home.

Unique Rural / Small hospital challenges

The challenges of maintaining "full range of services" –

- "specialist-generalist" nurses are required to cover multiple specialties
- staff competency, use & cost of "travelers" to replace staff out on leave/resignations who may not have adequate orientation or commitment to community,
- state of the art equipment, supplies, use of simulation labs

Urban Referral Hospital Role

The challenges of social issues (when to transfer, family left at home issues, availability of immediate family to stay in/near urban hospital with patient)

Potential Solutions

1. Enhanced Medicaid rates for OB services (for frontier hospitals?)
2. More state supported recruitment funding
3. Support for OB from county indigent funds
4. Support of a potential urban hospital Locums Program
5. Expansion of residency programs and clinical rotations to smaller hospitals
6. Encourage and incentivize sharing of OB providers at nearby facilities
7. Malpractice solutions to lure providers to New Mexico, i.e. *Neurologic Injury Compensation Act* in FL and VA, alternatives to malpractice suits when newborns suffer injury
8. Support of ongoing simulation education and mentor/preceptor programs to keep skills of staff current
9. Promote the fullest possible scope of practice for Advanced Practice Professionals

Legislative Health and Human Services Committee hospital attendees, July 7, 2016

Jeff Dye, President/CEO, New Mexico Hospital Association

Ellen Interlandi, RN, Nurse Consultant, New Mexico Hospital Association

Chris Wolf, CEO, Alta Vista Regional Hospital

Bill Patten, CEO, Holy Cross Hospital

Chris Kalinowski, CNO, Los Alamos Medical Center

NM HOSPITALS	BIRTHING HOSPITALS		
	2010	2016	2015 BIRTHS
General Acute Care			
Alta Vista Regional Hospital	Y	ceased in 2016	200
Artesia General Hospital	Y	ceased in 2010	0
Carlsbad Medical Center	Y	Y	457
CHRISTUS St. Vincent Regional Medical Center*	Y	Y	656
Cibola General Hospital*	Y	Y	205
Dr. Dan C. Trigg Memorial Hospital	Y	ceased in 2011	0
Eastern New Mexico Medical Center	Y	Y	312
Gerald Champion Regional Medical Center*	Y	Y	508
Gila Regional Medical Center*	Y	Y	356
Guadalupe County Hospital	ceased in 1988		0
Holy Cross Hospital*	Y	Y	233
Lea Regional Medical Center	Y	Y	575
Lincoln County Medical Center*	Y	Y	356
Los Alamos Medical Center*	Y	Y	191
Lovelace Medical Center	No birthing services		0
Lovelace Regional Hospital - Roswell*	Y	Y	994
Lovelace Westside Hospital*	ceased in 1998	reopened in 2011	358
Lovelace Women's Hospital*	Y	Y	3235
Memorial Medical Center*	Y	Y	1038
Mimbres Memorial Hospital	Y	Y	316
Miners' Colfax Medical Center*	Y	Y	117
MountainView Regional Medical Center	Y	Y	1219
Nor-Lea General Hospital	not since the 1970s		0
Plains Regional Medical Center*	Y	Y	1190
Presbyterian Espanola*	Y	Y	293
Presbyterian Hospital*	Y	Y	3591
Presbyterian Kaseman Hospital	No birthing services		0
Presbyterian Rust Medical Center*	opened in 2012	Y	1173
Rehoboth McKinley Christian Health Care Services*	Y	Y	330
Roosevelt General Hospital	No birthing services		0
San Juan Regional Medical Center*	Y	Y	1273
Sierra Vista Hospital	No birthing services		0
Socorro General Hospital*	Y	Y	134
Union County General Hospital	Y	ceased in 2014	0
University of New Mexico Hospital*	Y	Y	2970
UNM Sandoval Regional Medical Center	No birthing services		0
*May Include Newborn Readmitted Due to Complications; Baby May Have Been Transferred to NICU		Total	22280
Specialty Hospitals			
AMG Specialty Hospital			
Advanced Care Hospital of Southern NM			
Central Desert Behavioral Health Center			
Haven Behavioral Hospital of ABQ			
HealthSouth Rehabilitation Hospital	No birthing services		
Kindred Hospital			
Lovelace Rehabilitation Hospital			
Mesilla Valley Hospital			
Peak Behavioral Health Services			
Rehabilitation Hospital of Southern NM			
	27	**25**	

233 or fewer births per year

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ADVANCED PRACTICE PROFESSIONALS MATRIX

AT A GLANCE:

ADVANCED PRACTICE REGISTERED NURSE, CERTIFIED NURSE MIDWIFE, CERTIFIED REGISTERED NURSE ANESTHETIST AND PHYSICIAN ASSISTANT PRACTICE IN THE HOSPITAL SETTING IN NEW MEXICO

HEALTHCARE PRACTITIONER	Clinical Nurse Specialist	Certified Nurse Practitioner	Certified Nurse Midwife	Certified Registered Nurse Anesthetist
Practice Act	√	√	√	√
Continuing Education Requirement	√	√	√	√
Collaborative Agreement Requirement				
Written Agreement Requirement				
Permitted to Write Orders	Not addressed in statute/regulation	Not addressed in statute/regulation	Not addressed in statute/regulation	√
Permitted to Issue Verbal Orders	Not addressed in statute/regulation	Not addressed in statute/regulation	Not addressed in statute/regulation	√
Requirement for Countersignature of Documentation				
Prescriptive Authority	√	√	√	√
Pronouncement of Death	Unclear	√	Unclear	Unclear
Completion of Death Certificate	Not addressed in statute/regulation	√	Not addressed in statute/regulation	Not addressed in statute/regulation
NO Medicare Requirement of medical necessity by physician for inpatient stays < 20 days	**§424.13 Requirements for inpatient services of hospitals other than inpatient psychiatric facilities** (http://www.ecfr.gov/cgi-bin/text-idx?SID=dc885b5cb868d33231f327e89efeee60&mc=true&node=se42.3.424_113&rgn=div8) The Medicare rules requiring physicians to sign admission orders for all hospital inpatient admissions have been revised so that certification by a physician is required only in the case of inpatient stays of 20 days or more. As a result, various types of Licensed Independent Practitioners (LIPs), including CNMs can (provided that hospital bylaws allow, order admissions. For LIPs with admitting privileges per hospital bylaws and in compliance with applicable state law, there is no longer a legal basis for requiring the medical necessity of these admissions to be certified by a physician. http://www.midwife.org/acnm/files/ccLibraryFiles/Filename/000000004822/CY2015HOPPSIssueBrief.pdf		

DEFINITIONS

Advanced Practice Registered Nurse (APRN) (https://www.ncsbn.org/APRN_Brochure_June2012.pdf)
APRNs have advanced education, knowledge and skills to care for a specific population of patients, including adults, families, children and infants in one of four APRN roles: certified registered nurse anesthetist (CRNA); certified nurse-midwife (CNM); clinical nurse specialist (CNS); or certified nurse practitioner (CNP). Boards of nursing (BONs) in each state license and regulate the practice of APRNs (in NM, CNMs are regulated by the NM Dept of Health).

Clinical Nurse Specialist (CNS)
A clinical nurse specialist is an advanced practice nurse with a graduate-level degree in nursing and competence in a specialized area of nursing, such as gerontology, pediatrics, or psychiatric nursing. Functions of the clinical nurse specialist include providing direct patient care, teaching patients and their families, guiding and planning care with other personnel, and conducting research. These skills are made

directly available through the provision of nursing care to clients and indirectly available through guidance and planning of care with other nursing personnel. Clinical nurse specialists hold a master's degree in nursing, preferably with an emphasis in a specific clinical area of nursing.

Certified Nurse Practitioner (CNP)
Nurse practitioners are licensed, independent practitioners, with or without prescriptive authority, who provide primary and/or specialty nursing and medical care in ambulatory, acute and long-term care settings. They are registered nurses with specialized, advanced education and clinical competency to provide health and medical care for diverse populations in a variety of primary care, acute and long-term care settings. Master's, post-master's or doctoral preparation is required for entry-level practice.

Certified Nurse Midwife (CNM)
CNMs are licensed, independent health care providers with prescriptive authority. CNMs are nurses first, and complete additional training to become midwives. This Matrix references Certified Nurse Midwives only.
There are also Certified Midwives (CM) and Certified Professional Midwives (CPM) who have different education/degree requirements. See:
http://www.midwife.org/ACNM/files/ccLibraryFiles/Filename/000000001385/CNM%20CM%20CPM%20ComparisonChart%20082511.pdf

Certified Registered Nurse Anesthetist (CRNA)
CRNAs are anesthesia professionals who administer anesthesia in collaboration with surgeons, anesthesiologists, dentists, podiatrists, and other qualified healthcare professionals. When anesthesia is administered by a nurse anesthetist, it is recognized as the practice of nursing; when administered by an anesthesiologist, it is recognized as the practice of medicine.

Physician Assistant (PA)
PAs are medical professionals who work as part of a team with a physician. Most PA programs are 3 academic years and require the same pre-requisite courses as medical schools. Most programs also require students to have healthcare training or experience prior to entering an accredited PA program. Before they can practice, PAs who graduate from an accredited program must pass the Physician Assistant Certifying Exam (PANCE) and become licensed by the state in they intend to practice. The "PA-C" after a PA's names means they are currently certified to practice medicine.

Licensed Independent Practitioner (LIP)
The term LIP is increasingly used to refer to practitioners who are permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the practitioner's license and consistent with individually assigned clinical responsibilities.
(Joint Commission Perspectives).

	CLINICAL NURSE SPECIALISTS	CERTIFIED NURSE PRACTITIONERS	CERTIFIED NURSE MIDWIVES	CERTIFIED REGISTERED NURSE ANESTHETISTS
REGULATION STATUS	NMAC 16.12.2 NMSA 1978, 61-3-1 to 61-3-30. N.M. Stat. Ann. § 61-3-23.4 http://www.nmcpr.state.nm.us/nmac/parts/title16/16.012.0002.htm Boardofnursing@state.nm.us New Mexico Board of Nursing 505-841-9083 http://www.bon.state.nm.us/	NMAC 16.12.2 NMSA 1978, 61-3-1 to 61-3-30. N.M. Stat. Ann. § 61-3-23.2 http://www.nmcpr.state.nm.us/nmac/parts/title16/16.012.0002.htm Boardofnursing@state.nm.us New Mexico Board of Nursing 505-841-9083 http://www.bon.state.nm.us/	NMAC 16.11.2, 10/15/09 NMSA 1978, 61-3-1 to 61-3-30. State Statute: N.M. Stat. Ann. § 61-3-24.11.4.1 http://www.health.state.nm.us/ Public Health Division of the Department of Health 505-476-8908 www.health.state.nm.us NOTE: CNMs are not licensed as Advanced Practice Nurses in NM, but are licensed/regulated under Public Health Act	NMAC 16.12.2 NMSA 1978, 61-3-1 to 61-3-30. N.M. Stat. Ann. § 61-3-23.2 http://www.nmcpr.state.nm.us/nmac/parts/title16/16.012.0002.htm Boardofnursing@state.nm.us New Mexico Board of Nursing 505-841-9083 http://www.bon.state.nm.us/

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	CLINICAL NURSE SPECIALISTS	CERTIFIED NURSE PRACTITIONERS	CERTIFIED NURSE MIDWIVES	CERTIFIED REGISTERED NURSE ANESTHETISTS
SCOPE OF PRACTICE	Clinical nurse specialists practice: The CNS is a nurse who through graduate level preparation has become an expert in a defined area of knowledge and practice in a selected clinical area of nursing. The CNS makes independent decisions in a specialized area of nursing practice, using knowledge about the health care needs of the individual, family and community. The CNS collaborates as necessary with other members of the health care team, when the needs are beyond the scope of practice of the CNS. The CNS may assume specific functions or perform specific procedures which are beyond the advanced educational preparation and certification for the CNS provided the knowledge and skills required to perform the function or procedure emanates from a recognized body of knowledge or advanced practice of nursing and the function or procedure is not prohibited by any law or statute. When assuming specific functions or performing specific procedures, which are beyond the CNS's advanced educational preparation and certification, the CNS is responsible for obtaining the appropriate knowledge, skills and supervision to assure he/she can perform the function/procedure safely and competently and recognize and respond to any complications that may arise. Carries out therapeutic regimens in the area of the specialty. [16.12.2.15 L] http://164.64.110.239/nmac/parts/title16/16.012.0002.htm	Certified nurse practitioners may: (1) perform an advanced practice that is beyond the scope of practice of professional registered nursing; (2) practice independently and make decisions regarding health care needs of the individual, family or community and carry out health regimens, including the prescription and distribution of dangerous drugs and controlled substances included in Schedules II through V of the Controlled Substances Act [30-31-1 NMSA 1978]; and (3) serve as a primary acute, chronic long-term and end of life health care provider and as necessary collaborate with licensed medical doctors, osteopathic physicians or podiatrists. **"Valid practitioner-patient relationship"** means a professional relationship between the practitioner and the patient for the purpose of maintaining the patient's well-being. At minimum, this relationship is an interactive encounter between the practitioner and patient involving an appropriate history and physical or mental examination, ordering labs or diagnostic tests sufficient to make a diagnosis and providing, prescribing or recommending treatment, or referring to other health care providers. A patient record must be generated by the encounter. [16.12.2.7 NMAC]	Midwifery practice as conducted by a CNM is the independent management of women's health care, focusing particularly on common primary care issues, family planning and the gynecologic needs of women, pregnancy, childbirth, the postpartum period, the care of the newborn, and treatment of male partners of female clients for sexually transmitted diseases. A CNM independently prescribes, distributes and administers dangerous drugs and devices appropriate to a client's condition. A CNM practices within a health care system that provides for consultation, collaborative management or referral as indicated by the health status of the client. A CNM practices in accordance with the ACNM "standards for the practice of midwifery". Practice guidelines for home births should be informed by the "ACNM home birth practice handbook" [16.11.2.3 NMAC] ADDITIONAL FOR CNM Certified nurse-midwife (CNM) means an individual educated in the two disciplines of nursing and midwifery, who is certified by the ACNM or its designee.	The CRNA provides pre-operative, intra-operative and post-operative anesthesia care and related services, including ordering of diagnostic tests, in accordance with current *American Association of Nurse Anesthetists'* guidelines for nurse anesthesia practice. The CRNA provides pre-operative, intra-operative and post-operative anesthesia care and related services, including ordering of diagnostic tests, in accordance with the current *American association of nurse* anesthetists' guidelines for nurse anesthesia practice. The CRNA makes independent decisions regarding the health care needs of the client and also makes independent decision in carrying out health care regimes. The CRNA may assume specific functions or perform specific procedures which are beyond the advanced educational preparation and certification for the CRNA provided the knowledge and skills required to perform the function or procedure emanates from a recognized body of knowledge or advanced practice of nursing and the function or procedure is not prohibited by any law or statute. When assuming specific functions or performing specific procedures, which are beyond the CRNA's advanced educational preparation and certification, the CRNA is responsible for obtaining the appropriate knowledge, skills and supervision to ensure he/she can perform the function/procedure safely and competently and recognize and respond to any complications that may arise. The CRNA collaborates as necessary with the licensed physician, osteopathic physician, dentist or podiatrist concerning the anesthesia care of the patient. Collaboration means the process in which each health care provider contributes his/her respective expertise. Collaboration includes systematic formal planning and evaluation between the health care professionals involved in the collaborative practice arrangement [16.12.2.14 M] CRNAs who do not plan to prescribe controlled substances but do plan to prescribe dangerous drugs must meet the requirements relative to prescriptive authority except those specifically required for controlled substances. [16.12.2.14 NMAC]
	NEW: Senate Bill 299 was passed in 2015 NM legislative session, amending several sections of law to include the words "advanced practice registered nurse, certified nurse-midwife or physician assistant working with that person's scope of practice" to existing sections that currently just have the word "physician"; and expand certain provisions of the Uniform Health-care Decisions Act to include non-physician primary care practitioners; and require state agencies and political subdivisions to update their rules to include these health care practitioners where appropriate (e.g. for certificates stating a person is free from a communicable disease, for pre-employment physicals, attesting to permanent significant mobility limitation). *http://www.nmlegis.gov/lcs/legislation.aspx?Chamber=S&LegType=B&LegNo=299&year=15.* *H.R.2, the Medicare Access and CHIP Reauthorization Act of 2015 was passed in April 2015. It expands who can document the face-to-face encounter required for Medicare durable medical equipment prescriptions to include advanced practice registered nurses (APRNs) and physician assistants, as allowed by state law https://www.congress.gov/114/bills/hr2/BILLS-114hr2ih.pdf*			

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	CLINICAL NURSE SPECIALISTS	CERTIFIED NURSE PRACTITIONERS	CERTIFIED NURSE MIDWIVES	CERTIFIED REGISTERED NURSE ANESTHETISTS
COLLABORATIVE AGREEMENT	No requirement for advanced practice nurses to enter collaborative agreements with physicians ("as necessary collaborate with licensed medical doctors, osteopathic physicians or podiatrists.")	No requirement for advanced practice nurses to enter collaborative agreements with physicians ("the CNP collaborates as necessary with other healthcare providers.")	No requirement. "The CNM practices within a health care system that provides for consultation, collaborative management or referral as indicated by the health status of the client." [NMAC 16.11.2.7]	No requirement. The CRNA collaborates as necessary with the licensed physician, osteopathic physician, dentist or podiatrist concerning the anesthesia care of the patient. Collaboration means the process in which each health care provider contributes his/her respective expertise. Collaboration includes systematic formal planning and evaluation between the health care professionals involved in the collaborative practice arrangement.
WRITTEN ORDERS	Not addressed in statute/regulation; should be consistent with hospital privileges and medical staff bylaws if applicable.	Not addressed in statute/regulation; should be consistent with hospital privileges and medical staff bylaws if applicable.	Not addressed in statute/regulation; should be consistent with hospital privileges and medical staff bylaws if applicable.	Not addressed in statute/regulation; should be consistent with hospital privileges and medical staff bylaws if applicable.
HISTORY AND PHYSICAL	The CoPs expand the permissible professional categories of individuals who may perform an H&P. The new rule allows physicians, oral maxillofacial surgeons, or "other qualified individuals in accordance with state law and hospital policy" to perform H&Ps. The Guidelines interpret such "other qualified practitioners" as including nurse practitioners or physician assistants. History and Physical Examinations (H&Ps) (Final Rule: January 26, 2007) --§482.24(c)(2)	The CoPs expand the permissible professional categories of individuals who may perform an H&P. The new rule allows physicians, oral maxillofacial surgeons, or "other qualified individuals in accordance with state law and hospital policy" to perform H&Ps. The Guidelines interpret such "other qualified practitioners" as including nurse practitioners or physician assistants. History and Physical Examinations (H&Ps) (Final Rule: January 26, 2007) -- §482.24(c)(2)	The CoPs expand the permissible professional categories of individuals who may perform an H&P. The new rule allows physicians, oral maxillofacial surgeons, or "other qualified individuals in accordance with state law and hospital policy" to perform H&Ps. The Guidelines interpret such "other qualified practitioners" as including nurse practitioners or physician assistants. History and Physical Examinations (H&Ps) (Final Rule: January 26, 2007) -- §482.24(c)(2)	The CoPs expand the permissible professional categories of individuals who may perform an H&P. The new rule allows physicians, oral maxillofacial surgeons, or "other qualified individuals in accordance with state law and hospital policy" to perform H&Ps. The Guidelines interpret such "other qualified practitioners" as including nurse practitioners or physician assistants. History and Physical Examinations (H&Ps) (Final Rule: January 26, 2007) --§482.24(c)(2)
ORAL/ VERBAL ORDERS	Not addressed in statute/regulation; should be consistent with hospital privileges CMS has eliminated the requirement for authentication of verbal orders within 48-hrs and has deferred to applicable State law to establish authentication time frames. (NM Statute states 72 hr) Authentication of Orders: CMS made permanent the previous temporary requirement that all orders, including verbal orders, must be dated, timed, and authenticated by either the ordering practitioner or another practitioner who is responsible for the care of the patient and who is authorized to write orders by hospital policy in accordance with State law. (CMS CoPs Final Rule 42 CFR Parts 482 and 485 [FR Doc. 2012-11548 Filed 05/10/2012 at 9:15 am; Publication Date: 05/16/2012].			
IDENTIFICATION OF COLLABORATING/ SUPERVISING PHYSICIAN	**GCNS only -** GCNs practice under the direct supervision of another CNS CNP or physician in the specialty.	**GNP only - G**NPs practice under the direct supervision of a physician, NM CNP or CNS in the specialty.	No requirement. CNM practices within a health care system that provides for consultation, collaborative management or referral as indicated by the health status of the client.	GRNAs only GRNAs must function in an interdependent role as a member of a health care team and practice at the direction of and in collaboration with a physician, osteopathic physician, dentist or podiatrist. GRNAs may prescribe and administer medications only in collaboration with a physician, osteopathic physician, dentist or podiatrist in compliance with these rules.

New Mexico Hospital Association

	CLINICAL NURSE SPECIALISTS	CERTIFIED NURSE PRACTITIONERS	CERTIFIED NURSE MIDWIVES	CERTIFIED REGISTERED NURSE ANESTHETISTS
INFORMED CONSENT	Not addressed in NMAC regulations CMS CoP: Surgical consent: Hospitals must assure that the practitioner(s) responsible for the surgery obtain informed consent from patients in a manner consistent with the hospital's policies governing the informed consent process. See guidelines for §482.13(b)(2) under Patients' Rights and the guidelines for §482.24(c)(2)(v) under Medical Records to understand all requirements related to informed consent CMS Interpretive Guidelines §482.51(b)(2) April 13, 2007	Not addressed in NMAC regulations CMS CoP: Surgical consent: Hospitals must assure that the practitioner(s) responsible for the surgery obtain informed consent from patients in a manner consistent with the hospital's policies governing the informed consent process. See guidelines for §482.13(b)(2) under Patients' Rights and the guidelines for §482.24(c)(2)(v) under Medical Records to understand all requirements related to informed consent. CMS Interpretive Guidelines §482.51(b)(2) April 13, 2007	Not addressed in NMAC regulation CMS CoP: Surgical consent: Hospitals must assure that the practitioner(s) responsible for the surgery obtain informed consent from patients in a manner consistent with the hospital's policies governing the informed consent process. See guidelines for §482.13(b)(2) under Patients' Rights and the guidelines for §482.24(c)(2)(v) under Medical Records to understand all requirements related to informed consent. CMS Interpretive Guidelines §482.51(b)(2) April 13, 2007	Not addressed in NMAC regulation CMS CoP: Surgical consent: Hospitals must assure that the practitioner(s) responsible for the surgery obtain informed consent from patients in a manner consistent with the hospital's policies governing the informed consent process. There is no specific requirement for informed consent within the regulation at §482.52 governing anesthesia services. However, given that surgical procedures generally entail use of anesthesia, hospitals may wish to consider specifically extending their informed consent policies to include obtaining informed consent for the anesthesia component of the surgical procedure. See guidelines for §482.13(b)(2) under Patients' Rights and the guidelines for §482.24(c)(2)(v) under Medical Records to understand all requirements related to informed consent. CMS Interpretive Guidelines §482.51(b)(2) April 13, 2007
PRONOUNCEMENT OF DEATH	UNCLEAR. New Mexico law limits pronouncement of death to a physician, certified nurse practitioner, or the Office of the Medical Investigator. [7.2.2.1 NMAC] Vital Statistics Unless there is reasonable cause to believe that the death is not due to natural causes, a registered nurse employed by a nursing home may pronounce the death of a resident of the nursing home and a registered nurse employed by a hospital may pronounce the death of a patient of the hospital. The nurse shall have access to the medical history of the case and view the deceased at or after death, and the individual who completes the medical certification shall not be required to view the deceased at or after death. The death shall be pronounced pursuant to procedures or facility protocols prescribed by the hospital for patients or by the physician who is the medical director of the nursing home for residents. The procedures or facility protocols shall ensure that the medical certification of death is completed in accordance with the provisions of Subsection C of this section.	YES. New Mexico law limits pronouncement of death to a physician, certified nurse practitioner, or the Office of the Medical Investigator. [7.2.2.1 NMAC] Vital Statistics	UNCLEAR. New Mexico law limits pronouncement of death to a physician, certified nurse practitioner, or the Office of the Medical Investigator. If a fetal death occurs with a midwife in attendance, the office of the medical investigator must be notified or a physician or CNP must pronounce death since New Mexico law limits pronouncement of death to a physician, certified nurse practitioner, or the office of the medical investigator. [7.2.2.1 NMAC] Vital Statistics CNMs are not CNPs legally in NM, but could qualify as RN with training (see CNS).	UNCLEAR. New Mexico law limits pronouncement of death to a physician, certified nurse practitioner, or the Office of the Medical Investigator. [7.2.2.1 NMAC] Vital Statistics Unless there is reasonable cause to believe that the death is not due to natural causes, a registered nurse employed by a nursing home may pronounce the death of a resident of the nursing home and a registered nurse employed by a hospital may pronounce the death of a patient of the hospital. The nurse shall have access to the medical history of the case and view the deceased at or after death, and the individual who completes the medical certification shall not be required to view the deceased at or after death. The death shall be pronounced pursuant to procedures or facility protocols prescribed by the hospital for patients or by the physician who is the medical director of the nursing home for residents. The procedures or facility protocols shall ensure that the medical certification of death is completed in accordance with the provisions of Subsection C of this section.
COMPLETION OF DEATH CERTIFICATE	Not addressed in statute/regulation	The medical certification shall be completed and signed within forty-eight hours after death by the physician or nurse practitioner in charge of the patient's care for the illness or condition that resulted in death, except when inquiry is required by law http://statutes.laws.com/new-mexico/chapter-24/article-14/section-24-14-20	Not addressed in statute/regulation	Not addressed in statute/regulation

New Mexico Hospital Association

Substantive Changes to Advanced Practice Professionals Matrix from 2013 to 2015 edition

1. No Medicare requirements for medical necessity by physician for inpatient stay < 20 days

The Medicare rules requiring physicians to sign admission orders for all hospital inpatient admissions have been revised so that certification by a physician is required only in the case of inpatient stays of 20 days or more. As a result, various types of Licensed Independent Practitioners (LIPs), including CNMs can (provided that hospital bylaws allow, order admissions. For LIPs with admitting privileges per hospital bylaws and in compliance with applicable state law, there is no longer a legal basis for requiring the medical necessity of these admissions to be certified by a physician. http://www.midwife.org/acnm/files/ccLibraryFiles/Filename/000000004822/CY2015HOPPSIssueBrief.pdf §424.13 Requirements for inpatient services of hospitals other than inpatient psychiatric facilities http://www.ecfr.gov/cgi-bin/text-idx?SID=dc885b5cb868d33231f327e89efeee60&mc=true&node=se42.3.424_113&rgn=div8.

2. Scope of Practice

Senate Bill 299 was passed in 2015 NM legislative session; amending several sections of law to include the words *"advanced practice registered nurse, certified nurse-midwife or physician assistant working within that person's scope of practice"* to existing sections that currently just have the word "physician"; and expand certain provisions of the Uniform Health-care Decisions Act to include non-physician primary care practitioners; and require state agencies and political subdivisions to update their rules to include these health care practitioners where appropriate (e.g. for certificates stating a person is free from a communicable disease, for pre-employment physicals, attesting to permanent significant mobility limitation). http://www.nmlegis.gov/lcs/legislation.aspx?chamber=S&legtype=B&legno=299&year=15