Idaho

D

	RANK	GRADE
ACCESS TO EMERGENCY CARE	42	F
QUALITY & PATIENT SAFETY ENVIRONMENT	48	D-
MEDICAL LIABILITY ENVIRONMENT	6	B+
PUBLIC HEALTH & INJURY PREVENTION	29	D+
DISASTER PREPAREDNESS	50	F
OVERALL	46	D

With significant shortages of providers, few programs to improve quality and patient safety and a lack of critical disaster preparedness systems, Idaho's overall emergency care environment is among the worst in the country.

Strengths. Idaho has a rather favorable *Medical Liability Environment*. The state ranks among the best states with regard to average medical liability insurance premiums for primary care physicians and specialists ($6,884 and $35,547, respectively). These rates are roughly half the average premiums across the states. Idaho also has a relatively high number of insurers writing medical liability policies (21.4 per 1,000 physicians). The state has a medical liability cap on non-economic damages, as well as mandatory pretrial screening panels. Although the state doesn't require expert witnesses to practice in the same specialty as the defendant, Idaho has a "local standard of care" mandate that requires witnesses to have an understanding of the standard of care in the community where the defendant practices.

Challenges. Idaho is experiencing a scarcity of medical professionals, which significantly affects *Access to Emergency Care* throughout the state. Idaho ranks among the worst 6 states for its lack of plastic surgeons; ear, nose, and throat specialists; and registered nurses per capita. While the state has a relatively high rate of emergency departments (20.5 per 1 million people), access to trauma centers remains a serious concern: less than 29 percent of Idaho's population is within 60 minutes of a Level I or II trauma center. The state also has a below-average rate of psychiatric care beds (29.0 per 100,000 people). Emergency physicians in the state are reporting increasing problems with psychiatric patients being boarded in emergency departments, largely because of a lack of psychiatric beds.

Idaho is experiencing a scarcity of medical professionals.

Idaho's *Disaster Preparedness* also needs significant improvement. The state lacks patient and victim tracking systems, as well as a real-time syndromic surveillance system. In addition, Idaho lacks the ability to verify the credentials of volunteer health professionals and assign them to one of four levels in a state-based Emergency System for Advance Registration of Volunteer Health Professionals program. The state also has no verified burn centers or burn unit beds.

Idaho faces numerous challenges with regard to *Public Health and Injury Prevention*. The state has relatively low levels of immunization among older adults. Fewer than 63 percent of adults aged 65 and older have ever received the pneumococcal vaccine, while 65.2 percent receive an annual influenza vaccine. The state also has a higher than average rate of traffic fatalities (18.2 per 100,000 people) and relatively low seat belt usage (78.5 percent of front occupants).

Recommendations. Emergency physicians in the state report that access to specialists of all types and especially on-call specialists is a serious problem in Idaho. To help attract providers to the state and encourage specialists to provide emergency on-call services, the state should ensure that reimbursement practices and payment rates are adequate and consider enacting additional liability protections for providers of EMTALA-mandated emergency care.

Idaho can significantly improve its *Quality and Patient Safety Environment* by pursuing statewide system changes. The state could provide funding for an EMS medical director and institute a uniform system for providing pre-arrival instructions. In addition, the state should seek to create a regionalized trauma system to address the low percentage of the population with access to Level I or II trauma centers.

State officials should also review Idaho's disaster preparedness plans and programs and develop a prioritized action plan to address key deficiencies noted above.

Finally, *Public Health and Injury Prevention* could be significantly improved through implementation and enforcement of a universal motorcycle helmet law and a primary seat belt law, which may help to decrease the traffic fatality rate and increase front occupant restraint use. The state would also benefit from outreach efforts to increase immunization rates among both children and adults.

ACCESS TO EMERGENCY CARE — F

Indicator	Trend	Value
Board-certified emergency physicians per 100,000 pop.	Improved	8.7
Emergency physicians per 100,000 pop.		9.7
Neurosurgeons per 100,000 pop.		1.6
Orthopedists and hand surgeon specialists per 100,000 pop.		9.2
Plastic surgeons per 100,000 pop.		1.2
ENT specialists per 100,000 pop.		2.5
Registered nurses per 100,000 pop.	Worsened	655.8
Additional primary care FTEs needed		58.2
Additional mental health FTEs needed		8.1
Level I or II trauma centers per 1M pop.		0.7
% of population within 60 minutes of Level I or II trauma center		28.8
Accredited chest pain centers per 1M pop.		1.3
% of population with an unmet need for substance abuse treatment		8.1
Pediatric specialty centers per 1M pop.		3.4
Physicians accepting Medicare per 100 beneficiaries		2.8
Medicaid fee levels for office visits as a % of the national average		129.8
% change in Medicaid fees for office visits (2004-05 to 2007)		3.7
% of adults with no health insurance		16.3
% of children with no health insurance		13.0
% of adults with Medicaid		5.6
Emergency departments per 1M pop.	Improved	20.5
Hospital closures in 2006		0
Staffed inpatient beds per 100,000 pop.		268.6
Hospital occupancy rate per 100 staffed beds		59.9
Psychiatric care beds per 100,000 pop.		29.0
State collects data on diversion		No

MEDICAL LIABILITY ENVIRONMENT — B+

Indicator	Trend	Value
Lawyers per 10,000 pop.		13.5
Lawyers per physician		0.8
Lawyers per emergency physician		13.6
ATRA judicial hellholes (range 0 to -7)		0
Malpractice award payments/100,000 pop.		3.8
Average malpractice award payments		$211,893
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		21.4
Average medical liability insurance premium for primary care physicians		$6,884
Average medical liability insurance premiums for specialists		$35,547
Pretrial screening panels	●	Mandatory
Are pretrial screening panels' findings admissible as evidence?		No
Periodic payments		Upon request or agreement of party(ies)
Medical liability cap on non-economic damages	●	$250,001-350,000
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 — D-

Indicator	Trend	Value
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		No
Mandatory quality reporting requirement		No
% of counties with E-911 capability		68.9
Uniform system for providing pre-arrival instructions		No
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		No
Statewide trauma registry		Yes
% of hospitals with computerized practitioner order entry		25.0
% of hospitals with electronic medical records		42.1
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival		74
Number of Joint Commission reviewed sentinel events per 1M pop. (1995–2006)		26

PUBLIC HEALTH & INJURY PREVENTION — D+

Indicator	Trend	Value
Traffic fatalities per 100,000 pop.		18.2
% of traffic fatalities alcohol related	Worsened	40.0
Front occupant restraint use (%)		78.5
Helmet use required for all motorcycle riders	●	No
Child safety seat/seat belt legislation (10 points possible)		4
% of children immunized, aged 19–35 months	Worsened	78.1
% of adults aged 65+ who received flu vaccine in the last 12 months	Improved	65.2
% of adults aged 65+ who ever received pneumococcal vaccine	Improved	62.8
Fatal occupational injuries per 1M workers		50.8
Homicides and suicides (non-motor vehicle) per 100,000 pop.		19.1
Unintentional fall-related fatal injuries per 100,000 pop.		7.1
Unintentional fire/burn-related fatal injuries per 100,000 pop.		0.9
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		92.3
Total injury prevention funds per 1,000 pop.		$518.21
Unintentional injury prevention funds per 1,000 pop.		$0.00
Intentional injury prevention funds per 1,000 pop.		$140.06
Fall injury prevention funds per 1,000 pop.		$378.15
Infant mortality rate per 1,000 live births		6.1
% of adults with BMI > 30		24.1
Current smokers, % of adults		16.8
Binge alcohol drinkers, % of adults		14.8

DISASTER PREPAREDNESS — F

Indicator	Value
Per capita federal disaster preparedness funds	$10.45
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	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	19
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	No
Real-time surveillance system in place for common ED presentations	NR
Bed surge capacity per 1M pop.	801.7
Burn unit beds per 1M pop.	0.0
ICU beds per 1M pop.	262.3
Verified burn centers per 1M pop.	0.0
State able to verify credentials and assign volunteer health professionals to four ESAR-VHP levels	No
Nurses registered in ESAR-VHP per 1M pop.	0.0
Physicians registered in ESAR-VHP per 1M pop.	0.0
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	No
Additional liability protections for health care workers during a disaster	Civil, not clearly defined
% of RNs that received any emergency training	39.5
State requires EMS and essential ED personnel to be NIMS compliant	No

Legend

- Improved since 2006
- Worsened since 2006
- ● No change since 2006
- NR Not reported
- N/A Not applicable

See *Summary Statistics for State Comparisons*