

Indiana

Although Indiana has a few bright spots within its emergency care environment, they are overshadowed by numerous problems, including poor Medicaid reimbursement rates for office visits, a shortage of specialists, and inadequate funding for key injury prevention programs.

Strengths. Despite implementing a number of policies to help improve the *Quality and Patient Safety Environment*, Indiana receives an average grade in this category. The state has mandatory quality reporting and hospital-based infections reporting requirements. Indiana maintains a statewide trauma registry and has a uniform system for providing pre-arrival instructions. In addition, more than half of the state’s hospitals (52.9 percent) use electronic medical records.

In the *Disaster Preparedness* category, the state has made numerous efforts to increase its capacity to respond to a major public health tragedy or emergency. Indiana has the highest rate of physicians registered in the state-based Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program, which allows for the advanced screening, credentialing, and registration of volunteer physicians, nurses, and other health professionals. In addition, Indiana has real-time systems in place for surveillance of common emergency department presentations and the ability to notify health care providers of a disaster event.

Challenges. Indiana’s poor performance in *Public Health and Injury Prevention* reflects low rates of immunization for young children (79.6 percent) and older adults, among whom only 65.3 percent receive an annual influenza vaccine and just 63.8 percent have ever received a pneumococcal vaccine. Indiana also has among the lowest levels of funding for injury prevention programs (ranking 49th) and relatively high rates of fatal occupational injuries and unintentional fatalities. In addition,

Indiana’s infant mortality rate (8.0 deaths per 1,000 live births) is significantly higher than the national rate (6.9 per 1,000 live births).

Indiana also fared poorly in the area of *Access to Emergency Care*. Indiana ranks among the bottom 12 states for its low rates of neurosurgeons; orthopedists and hand surgeons; plastic surgeons; and ear, nose, and throat specialists per 100,000 people. The state also has a low rate of physicians accepting Medicare (2.5 physicians per 100 beneficiaries).

Indiana ranks 29th for its *Medical Liability Environment* due to the state’s failure to enact a number of liability reforms, such as additional liability protections for EMTALA-mandated emergency care and expert witness rules requiring witnesses to be of the same specialty as the defendant or licensed to practice medicine in the state. Perhaps reflective of this environment, the average malpractice award in the state is significantly higher than the average across the states (\$310,430 versus \$285,218, respectively).

Recommendations. Indiana’s poor grade for *Public Health and Injury Prevention* suggests a pressing need for further state investment in programs, activities, or campaigns aimed at promoting immunizations, obesity prevention, injury prevention, and smoking prevention and cessation. By applying tested health promotion strategies and tools more widely, the state could potentially lower rates of injury and illness, improving health outcomes and reducing demand for emergency and acute care services.

The state needs to focus efforts on improving access to specialty care.




The state should seek to encourage more physicians to accept Medicaid patients by increasing reimbursement rates, which for office visits are 69.5 percent of the national average. Additionally, increasing Medicaid payments across the board may be one incentive to help attract more needed specialists to the state.

	RANK	GRADE
ACCESS TO EMERGENCY CARE	29	D
QUALITY & PATIENT SAFETY ENVIRONMENT	26	C
MEDICAL LIABILITY ENVIRONMENT	29	D+
PUBLIC HEALTH & INJURY PREVENTION	41	D-
DISASTER PREPAREDNESS	31	C
OVERALL	40	D+






Emergency physicians in the state also report growing problems with emergency department and hospital crowding. The state’s relatively low hospital occupancy rate (60.4 per 100 staffed beds) may provide an opportunity for addressing this problem. Crowding, however, may also be exacerbated by the lack of specialists to provide timely on-call emergency care. The state needs to focus efforts on improving access to specialty care, as well as primary and preventive care, by decreasing the rate of the uninsured and increasing the rate of physicians who will accept public insurance.

In addition, if Indiana can apply its success in enrolling physicians in the ESAR-VHP system to include nurses and other health professionals and improve its bed surge capacity, this will go far in boosting the state’s level of preparedness for large-scale public health disasters or emergencies.


ACCESS TO EMERGENCY CARE **D**

Board-certified emergency physicians per 100,000 pop.	 7.3
Emergency physicians per 100,000 pop.	9.7
Neurosurgeons per 100,000 pop.	1.4
Orthopedists and hand surgeon specialists per 100,000 pop.	8.0
Plastic surgeons per 100,000 pop.	1.6
ENT specialists per 100,000 pop.	2.9
Registered nurses per 100,000 pop.	 869.0
Additional primary care FTEs needed	86.7
Additional mental health FTEs needed	32.4
Level I or II trauma centers per 1M pop.	1.0
% of population within 60 minutes of Level I or II trauma center	90.9
Accredited chest pain centers per 1M pop.	2.8
% of population with an unmet need for substance abuse treatment	8.3
Pediatric specialty centers per 1M pop.	3.3
Physicians accepting Medicare per 100 beneficiaries	2.5
Medicaid fee levels for office visits as a % of the national average	69.5
% change in Medicaid fees for office visits (2004-05 to 2007)	NR
% of adults with no health insurance	13.1
% of children with no health insurance	7.8
% of adults with Medicaid	6.0
Emergency departments per 1M pop.	 14.4
Hospital closures in 2006	1
Staffed inpatient beds per 100,000 pop.	332.6
Hospital occupancy rate per 100 staffed beds	60.4
Psychiatric care beds per 100,000 pop.	19.0
State collects data on diversion	No





MEDICAL LIABILITY ENVIRONMENT **D+**

Lawyers per 10,000 pop.	11.5
Lawyers per physician	0.5
Lawyers per emergency physician	11.7
ATRA judicial hellholes (range 0 to -7)	0
Malpractice award payments/100,000 pop.	1.2
Average malpractice award payments	\$310,430
Databank reports per 1,000 physicians	21.3
Patient compensation fund	 Yes
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	5.3
Average medical liability insurance premium for primary care physicians	\$11,161
Average medical liability insurance premiums for specialists	\$59,076
Pretrial screening panels	 Mandatory
Are pretrial screening panels' findings admissible as evidence?	Yes
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	 No
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	No
Funded state EMS medical director	No
Emergency medicine residents per 1M pop.	 8.2
Adverse event reporting required	Yes
Hospital-based infections reporting required	Yes
Mandatory quality reporting requirement	Yes
% of counties with E-911 capability	98.9
Uniform system for providing pre-arrival instructions	Yes
State has or is working on a stroke system of care	No
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	24.2
% of hospitals with electronic medical records	52.9
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	57
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	13

PUBLIC HEALTH & INJURY PREVENTION **D-**

Traffic fatalities per 100,000 pop.	14.2
% of traffic fatalities alcohol related	 36.0
Front occupant restraint use (%)	87.9
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	 79.6
% of adults aged 65+ who received flu vaccine in the last 12 months	 65.3
% of adults aged 65+ who ever received pneumococcal vaccine	 63.8
Fatal occupational injuries per 1M workers	50.4
Homicides and suicides (non-motor vehicle) per 100,000 pop.	17.8
Unintentional fall-related fatal injuries per 100,000 pop.	4.8
Unintentional fire/burn-related fatal injuries per 100,000 pop.	1.5
Unintentional firearm-related fatal injuries per 100,000 pop.	0.3
Gun-purchasing legislation (8 points possible)	0.5
% of tobacco settlement funds spent on health-related services and programs	78.2
Total injury prevention funds per 1,000 pop.	\$5.67
Unintentional injury prevention funds per 1,000 pop.	\$3.31
Intentional injury prevention funds per 1,000 pop.	\$2.36
Fall injury prevention funds per 1,000 pop.	\$0.00
Infant mortality rate per 1,000 live births	8.0
% of adults with BMI > 30	27.8
Current smokers, % of adults	24.1
Binge alcohol drinkers, % of adults	16.0

DISASTER PREPAREDNESS **C**

Per capita federal disaster preparedness funds	\$7.69
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	Yes, Yes
Written plan for the coordination of the SEOC or local EMAs to provide security to hospitals in case of emergency events	No
Number of drills and exercises conducted involving hospital personnel, equipment, or facilities	776
Accredited by the Emergency Management Accreditation Program	No
Written plan specifically for special needs patients	NR
Written plan to supply medications for chronic conditions	NR
Written plan to supply dialysis for patients	NR
Real-time notification system in place to notify identified health care providers of an event	Yes
"Just-in-time" training systems in place	NR
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.	0.0
Burn unit beds per 1M pop.	3.8
ICU beds per 1M pop.	314.5
Verified burn centers per 1M pop.	0.5
State able to verify credentials and assign volunteer health professionals to four ESAR-VHP levels	Yes
Nurses registered in ESAR-VHP per 1M pop.	0.0
Physicians registered in ESAR-VHP per 1M pop.	467.6
Training required in disaster management and response to bio- and chem terrorism for essential hospital personnel, EMS personnel	Yes, Yes
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	34.9
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	