

 **Iowa**

Iowa scores well for its relatively high rate of emergency departments and Level I and II trauma centers, as well as the substantial efforts it has put forth in planning for effective disaster response. However, a significant shortage of some critical specialists and a severe lack of medical liability reforms leave plenty of room for improvement.

**Strengths.** Iowa receives an above average grade for *Access to Emergency Care*, reflecting both strengths and weaknesses in this area. Among the strengths are high proportions of specialty facilities per capita. Iowa ranks 12<sup>th</sup> for the rate of Level I or II trauma centers (2.3 per 1 million people) and has the 6<sup>th</sup> highest rates of emergency departments and pediatric specialty centers (40.0 and 6.4 per 1 million people, respectively). In addition, while having a moderate number of staffed inpatient beds, Iowa has the fifth lowest hospital occupancy rate (59.9 per 100 staffed beds).

Iowa's grade in *Disaster Preparedness* was helped by the statewide infrastructure that has been developed in case of disaster events. Iowa supports statewide victim and patient tracking systems and has a statewide medical communication system with one layer of redundancy. The state has an all-hazards medical response plan, as well as a written plan specifically for special needs patients. Iowa requires training in disaster preparedness and response to bio- and chemical terrorism for all EMS and essential hospital personnel. In addition, medical assistance teams or strike teams are in place in case of an event.

**Challenges.** Iowa fell short with regard to the *Medical Liability Environment*, largely due to a failure to enact many of the liability reforms reviewed in this Report Card. The state lacks a medical liability cap on non-economic damages, expert witness rules providing for case certification or re-

quiring the witness to be of the same specialty as the defendant, and additional liability protection for EMTALA-mandated emergency care.

The state also has the potential to significantly improve its grade with regard to the *Quality and Patient Safety Environment*. Iowa has relatively low percentages of hospitals participating in electronic networking, ranking 41<sup>st</sup> in the country for electronic medical records (29.9 percent of hospitals) and 37<sup>th</sup> with regard to computerized practitioner order entry (14.6 percent of hospitals). Iowa also has a relatively low number of emergency medicine residents (6.4 per 1 million people), compared to the average across the states (12.9 per 1 million).

**Recommendations.** Iowa is facing a workforce shortage. Despite the relatively high rate of nurses reported as compared with other states, emergency physicians in Iowa have identified the nursing workforce shortage as a primary concern. In addition, the state lacks primary care and specialty physicians generally, as well as on-call specialists. This is highlighted by the state's low rates of neurosurgeons and emergency physicians (1.1 and 6.3 per 100,000 people, respectively), for which it ranks 50<sup>th</sup>. The state should take steps to draw additional specialists to the state through medical liability reforms and other efforts. To encourage specialists to provide on-call services to emergency patients, the state could start by enacting additional liability protections for EMTALA-mandated emergency care and instituting a \$250,000 medical liability cap on non-economic damages.

The state also might encourage workforce development through increases in Medicaid reimbursement rates across all medical and surgical specialties in Iowa. While the state's Medicaid fee level for office visits is




**Iowa is facing a workforce shortage.**

	RANK	GRADE
<b>ACCESS TO EMERGENCY CARE</b>	9	B-
<b>QUALITY &amp; PATIENT SAFETY ENVIRONMENT</b>	42	D
<b>MEDICAL LIABILITY ENVIRONMENT</b>	32	D
<b>PUBLIC HEALTH &amp; INJURY PREVENTION</b>	12	B
<b>DISASTER PREPAREDNESS</b>	23	C+
<b>OVERALL</b>	19	C






116.3 percent of the national average, this rate increased only 3.0 percent from 2004 to 2007, an increase that did not keep up with medical inflation. In order to draw and maintain a stronger workforce in the state, it is imperative that Medicaid reimbursement rates reflect the real costs of the medical care being provided.

While Iowa has a low hospital occupancy rate overall, this may be largely due to the low occupancy rate in many of its rural hospitals which are required to transfer patients with stays longer than three days to one of the larger urban hospitals. As such, emergency physicians have noted that hospital crowding and emergency department boarding of admitted patients is a burden on emergency departments in urban areas. Steps must be taken to ensure that boarding problems are addressed and that *Access to Emergency Care* in these hospitals is not compromised.


**ACCESS TO EMERGENCY CARE** **B-**

Board-certified emergency physicians per 100,000 pop.	 <b>4.0</b>
Emergency physicians per 100,000 pop.	<b>6.3</b>
Neurosurgeons per 100,000 pop.	<b>1.1</b>
Orthopedists and hand surgeon specialists per 100,000 pop.	<b>7.8</b>
Plastic surgeons per 100,000 pop.	<b>1.2</b>
ENT specialists per 100,000 pop.	<b>3.5</b>
Registered nurses per 100,000 pop.	 <b>994.1</b>
Additional primary care FTEs needed	<b>40.2</b>
Additional mental health FTEs needed	<b>22.2</b>
Level I or II trauma centers per 1M pop.	<b>2.3</b>
% of population within 60 minutes of Level I or II trauma center	<b>71.0</b>
Accredited chest pain centers per 1M pop.	<b>0.7</b>
% of population with an unmet need for substance abuse treatment	<b>8.8</b>
Pediatric specialty centers per 1M pop.	<b>6.4</b>
Physicians accepting Medicare per 100 beneficiaries	<b>2.8</b>
Medicaid fee levels for office visits as a % of the national average	<b>116.3</b>
% change in Medicaid fees for office visits (2004-05 to 2007)	<b>3.0</b>
% of adults with no health insurance	<b>11.9</b>
% of children with no health insurance	<b>6.3</b>
% of adults with Medicaid	<b>9.7</b>
Emergency departments per 1M pop.	 <b>40.0</b>
Hospital closures in 2006	<b>0</b>
Staffed inpatient beds per 100,000 pop.	<b>377.3</b>
Hospital occupancy rate per 100 staffed beds	<b>59.9</b>
Psychiatric care beds per 100,000 pop.	<b>33.5</b>
State collects data on diversion	<b>No</b>






**MEDICAL LIABILITY ENVIRONMENT** **D**

Lawyers per 10,000 pop.	<b>9.2</b>
Lawyers per physician	<b>0.4</b>
Lawyers per emergency physician	<b>14.7</b>
ATRA judicial hellholes (range 0 to -7)	<b>0</b>
Malpractice award payments/100,000 pop.	<b>2.1</b>
Average malpractice award payments	<b>\$208,060</b>
Databank reports per 1,000 physicians	<b>22.7</b>
Patient compensation fund	 <b>No</b>
Health court pilot project grant	<b>No</b>
Number of insurers writing medical liability policies per 1,000 physicians	<b>9.4</b>
Average medical liability insurance premium for primary care physicians	<b>\$7,719</b>
Average medical liability insurance premiums for specialists	<b>\$34,907</b>
Pretrial screening panels	 <b>No</b>
Are pretrial screening panels' findings admissible as evidence?	<b>N/A</b>
Periodic payments	<b>At judge's or court's discretion</b>
Medical liability cap on non-economic damages	 <b>No</b>
Additional liability protection for EMTALA-mandated emergency care	 <b>No</b>
Joint and several liability abolished	 <b>Yes</b>
State provides for case certification	<b>No</b>
Expert witness required to be of the same specialty as the defendant	<b>No</b>
Expert witness must be licensed to practice medicine in the state	<b>No</b>

**QUALITY & PATIENT SAFETY ENVIRONMENT** **D**




Funding for quality improvement within the EMS system	<b>Yes</b>
Funded state EMS medical director	<b>No</b>
Emergency medicine residents per 1M pop.	 <b>6.4</b>
Adverse event reporting required	<b>No</b>
Hospital-based infections reporting required	<b>No</b>
Mandatory quality reporting requirement	<b>No</b>
% of counties with E-911 capability	<b>100.0</b>
Uniform system for providing pre-arrival instructions	<b>No</b>
State has or is working on a stroke system of care	<b>Yes</b>
State has or is working on a PCI network or a STEMI system of care	<b>No</b>
Statewide trauma registry	<b>Yes</b>
% of hospitals with computerized practitioner order entry	<b>14.6</b>
% of hospitals with electronic medical records	<b>29.9</b>
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	<b>72</b>
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	<b>14</b>

**PUBLIC HEALTH & INJURY PREVENTION** **B**

Traffic fatalities per 100,000 pop.	<b>14.7</b>
% of traffic fatalities alcohol related	 <b>34.0</b>
Front occupant restraint use (%)	<b>91.3</b>
Helmet use required for all motorcycle riders	 <b>No</b>
Child safety seat/seat belt legislation (10 points possible)	<b>5</b>
% of children immunized, aged 19-35 months	 <b>85.0</b>
% of adults aged 65+ who received flu vaccine in the last 12 months	 <b>73.6</b>
% of adults aged 65+ who ever received pneumococcal vaccine	 <b>71.1</b>
Fatal occupational injuries per 1M workers	<b>50.5</b>
Homicides and suicides (non-motor vehicle) per 100,000 pop.	<b>12.7</b>
Unintentional fall-related fatal injuries per 100,000 pop.	<b>11.3</b>
Unintentional fire/burn-related fatal injuries per 100,000 pop.	<b>1.1</b>
Unintentional firearm-related fatal injuries per 100,000 pop.	<b>0.2</b>
Gun-purchasing legislation (8 points possible)	<b>1.5</b>
% of tobacco settlement funds spent on health-related services and programs	<b>93.1</b>
Total injury prevention funds per 1,000 pop.	<b>\$262.18</b>
Unintentional injury prevention funds per 1,000 pop.	<b>\$81.46</b>
Intentional injury prevention funds per 1,000 pop.	<b>\$180.72</b>
Fall injury prevention funds per 1,000 pop.	<b>\$0.00</b>
Infant mortality rate per 1,000 live births	<b>5.3</b>
% of adults with BMI > 30	<b>25.7</b>
Current smokers, % of adults	<b>21.4</b>
Binge alcohol drinkers, % of adults	<b>20.6</b>

**DISASTER PREPAREDNESS** **C+**

Per capita federal disaster preparedness funds	<b>\$7.62</b>
Disaster preparedness funds used specifically for health care-related preparedness are tracked	<b>Yes</b>
All-hazards medical response plan or ESF-8 plan?	<b>Yes</b>
Plan shared with all EMS and essential hospital personnel?	<b>Yes</b>
Public health and emergency physician input into the state planning process	<b>Yes, Yes</b>
Public health and emergency physician input into the daily operations of the SEOC	<b>Yes, No</b>
Written plan for the coordination of the SEOC or local EMAs to provide security to hospitals in case of emergency events	<b>Yes</b>
Number of drills and exercises conducted involving hospital personnel, equipment, or facilities	<b>486</b>
Accredited by the Emergency Management Accreditation Program	<b>No</b>
Written plan specifically for special needs patients	<b>Yes</b>
Written plan to supply medications for chronic conditions	<b>No</b>
Written plan to supply dialysis for patients	<b>No</b>
Real-time notification system in place to notify identified health care providers of an event	<b>Yes</b>
"Just-in-time" training systems in place	<b>Statewide</b>
Statewide medical communication system with one layer of redundancy	<b>Yes</b>
Statewide patient tracking system	<b>Yes</b>
Statewide victim tracking system	<b>Yes</b>
Statewide real-time or near real-time syndromic surveillance system	<b>Yes</b>
Real-time surveillance system in place for common ED presentations	<b>No</b>
Bed surge capacity per 1M pop.	<b>649.9</b>
Burn unit beds per 1M pop.	<b>5.4</b>
ICU beds per 1M pop.	<b>291.3</b>
Verified burn centers per 1M pop.	<b>0.3</b>
State able to verify credentials and assign volunteer health professionals to four ESAR-VHP levels	<b>No</b>
Nurses registered in ESAR-VHP per 1M pop.	<b>0.0</b>
Physicians registered in ESAR-VHP per 1M pop.	<b>0.0</b>
Training required in disaster management and response to bio- and chem terrorism for essential hospital personnel, EMS personnel	<b>Yes, Yes</b>
State or regional strike teams or medical assistance teams	<b>Yes</b>
Additional liability protections for health care workers during a disaster	<b>Yes, civil</b>
% of RNs that received any emergency training	<b>40.3</b>
State requires EMS and essential ED personnel to be NIMS compliant	<b>Yes</b>

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