

# Kentucky

With inadequate investment in quality improvement programs, virtually none of the medical liability reforms measured in this Report Card, and inordinately high rates of accident-related fatalities, the emergency care environment in Kentucky needs considerable attention.

**Strengths.** Contributing to the state’s grade in *Access to Emergency Care*, Kentucky ranks among the top 15 states in the nation for its low daily hospital occupancy rate (63.2 per 100 staffed beds) and its high rates of staffed inpatient beds (401.2 per 100,000 people) and pediatric specialty centers (4.0 per 1 million people). Kentucky also has relatively high per capita rates of accredited chest pain centers and registered nurses.

Kentucky has implemented a number of measures to advance the state’s readiness in the event of a wide-scale disaster or emergency. The state has made significant progress in registering physicians and nurses with the state-based Emergency System for Advance Registration of Volunteer Health Professionals, for which it ranks 19<sup>th</sup> and 6<sup>th</sup> in the nation, respectively. The state has an all-hazards medial response plan and a statewide system for “just-in-time” training during a disaster, as well as statewide patient and victim tracking systems.

## Access to specialists is of particular concern in Kentucky.

**Challenges.** *Access to Emergency Care* in Kentucky is challenged by factors such as lower than average Medicaid fee levels for office visits (72.4 percent of the national average) that have not increased since 2004. Kentucky also has lower than average rates of physicians accepting Medicare (2.5 per 100 beneficiaries versus an average of 3.2 across the states). Access to specialists is of particular concern in Kentucky, where per capita rates of specialists consistently fall well below average.

The *Quality and Patient Safety Environment* in Kentucky receives a poor grade,

due in part to a lack of funding for quality improvement within the EMS system, no uniform system for providing pre-arrival instructions, no PCI network or STEMI system of care, and no requirements for reporting hospital-based infections and adverse events. The state also receives a low ranking (46<sup>th</sup>) for the percentage of patients with acute myocardial infarction who receive PCI within 90 minutes of arrival.

Several efforts to enact medical liability reforms in Kentucky by passing legislation or amending the state constitution have failed. As a result, the state continues to lack a medical liability cap on non-economic damages, liability protections for EMTALA-mandated emergency care, requirements for case certification by an expert witness, or expert witness rules requiring the witness to be of the same specialty as the defendant.

Kentucky’s low rank for *Public Health and Injury Prevention* masks wide variations. Kentucky ranks among the worst states for the low rate of seat belt use (48<sup>th</sup>) and high traffic fatality rate (41<sup>st</sup>). The state has high rates of unintentional fatal injuries, and ranks 43<sup>rd</sup> for its high percentage of obese adults. The state also has the highest percentage of adult smokers in the nation (28.5 percent). In contrast to these poor rates, however, the state has the second lowest percentages of binge drinkers (8.6 percent of adults) and alcohol-related traffic fatalities (30.0 percent).

**Recommendations.** Kentucky must find a way to improve its poor *Medical Liability Environment* as a first step in addressing the shortage of specialists in the state. Emergency physicians in the state report problems with on-call specialist coverage for emergency patients. The state could attempt to alleviate this problem by enacting special liability protections for EMTALA-mandated emergency care. At the same




	RANK	GRADE
<b>ACCESS TO EMERGENCY CARE</b>	19	C
<b>QUALITY &amp; PATIENT SAFETY ENVIRONMENT</b>	49	F
<b>MEDICAL LIABILITY ENVIRONMENT</b>	47	F
<b>PUBLIC HEALTH &amp; INJURY PREVENTION</b>	35	D
<b>DISASTER PREPAREDNESS</b>	28	C+
<b>OVERALL</b>	44	D+

time, Medicaid reimbursement rates should be increased to encourage more primary care physicians to see Medicaid patients, thereby improving access to care for the state’s Medicaid population.

Kentucky’s emergency physicians also report problems with hospital crowding and boarding of emergency patients, particularly at university trauma centers. With its lower than average hospital occupancy rate, Kentucky may be better positioned than some states to facilitate the movement of admitted patients out of the emergency department.

The state should work to address its failing grade in the *Quality and Patient Safety Environment* by providing funding for quality improvement within the EMS system and developing a uniform system for pre-arrival instructions as first steps in the process.


**ACCESS TO EMERGENCY CARE C**

Board-certified emergency physicians per 100,000 pop.	 <b>6.1</b>
Emergency physicians per 100,000 pop.	<b>10.1</b>
Neurosurgeons per 100,000 pop.	<b>1.7</b>
Orthopedists and hand surgeon specialists per 100,000 pop.	<b>8.4</b>
Plastic surgeons per 100,000 pop.	<b>2.1</b>
ENT specialists per 100,000 pop.	<b>2.9</b>
Registered nurses per 100,000 pop.	 <b>930.4</b>
Additional primary care FTEs needed	<b>76.9</b>
Additional mental health FTEs needed	<b>27.8</b>
Level I or II trauma centers per 1M pop.	<b>0.5</b>
% of population within 60 minutes of Level I or II trauma center	<b>75.3</b>
Accredited chest pain centers per 1M pop.	<b>3.5</b>
% of population with an unmet need for substance abuse treatment	<b>7.8</b>
Pediatric specialty centers per 1M pop.	<b>4.0</b>
Physicians accepting Medicare per 100 beneficiaries	<b>2.5</b>
Medicaid fee levels for office visits as a % of the national average	<b>72.4</b>
% change in Medicaid fees for office visits (2004-05 to 2007)	<b>0.0</b>
% of adults with no health insurance	<b>17.5</b>
% of children with no health insurance	<b>9.7</b>
% of adults with Medicaid	<b>9.6</b>
Emergency departments per 1M pop.	 <b>20.5</b>
Hospital closures in 2006	<b>0</b>
Staffed inpatient beds per 100,000 pop.	<b>401.2</b>
Hospital occupancy rate per 100 staffed beds	<b>63.2</b>
Psychiatric care beds per 100,000 pop.	<b>24.6</b>
State collects data on diversion	<b>Yes</b>




**MEDICAL LIABILITY ENVIRONMENT F**

Lawyers per 10,000 pop.	<b>10.9</b>
Lawyers per physician	<b>0.5</b>
Lawyers per emergency physician	<b>10.7</b>
ATRA judicial hellholes (range 0 to -7)	<b>0</b>
Malpractice award payments/100,000 pop.	<b>1.7</b>
Average malpractice award payments	<b>\$259,179</b>
Databank reports per 1,000 physicians	<b>26.2</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>6.8</b>
Average medical liability insurance premium for primary care physicians	<b>\$12,465</b>
Average medical liability insurance premiums for specialists	<b>\$61,405</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>Partially</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 F**


Funding for quality improvement within the EMS system	<b>No</b>
Funded state EMS medical director	<b>Yes</b>
Emergency medicine residents per 1M pop.	 <b>12.0</b>
Adverse event reporting required	<b>No</b>
Hospital-based infections reporting required	<b>No</b>
Mandatory quality reporting requirement	<b>Yes</b>
% of counties with E-911 capability	<b>85.1</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>12.1</b>
% of hospitals with electronic medical records	<b>30.0</b>
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	<b>48</b>
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	<b>20</b>


**PUBLIC HEALTH & INJURY PREVENTION D**


Traffic fatalities per 100,000 pop.	<b>21.7</b>
% of traffic fatalities alcohol related	<b>30.0</b>
Front occupant restraint use (%)	<b>71.8</b>
Helmet use required for all motorcycle riders	<b>No</b>
Child safety seat/seat belt legislation (10 points possible)	<b>7</b>
% of children immunized, aged 19-35 months	 <b>84.0</b>
% of adults aged 65+ who received flu vaccine in the last 12 months	 <b>66.0</b>
% of adults aged 65+ who ever received pneumococcal vaccine	 <b>64.6</b>
Fatal occupational injuries per 1M workers	<b>72.1</b>
Homicides and suicides (non-motor vehicle) per 100,000 pop.	<b>18.9</b>
Unintentional fall-related fatal injuries per 100,000 pop.	<b>5.0</b>
Unintentional fire/burn-related fatal injuries per 100,000 pop.	<b>2.0</b>
Unintentional firearm-related fatal injuries per 100,000 pop.	<b>0.8</b>
Gun-purchasing legislation (8 points possible)	<b>0</b>
% of tobacco settlement funds spent on health-related services and programs	<b>38.7</b>
Total injury prevention funds per 1,000 pop.	<b>\$527.23</b>
Unintentional injury prevention funds per 1,000 pop.	<b>\$457.10</b>
Intentional injury prevention funds per 1,000 pop.	<b>\$70.13</b>
Fall injury prevention funds per 1,000 pop.	<b>\$0.00</b>
Infant mortality rate per 1,000 live births	<b>6.6</b>
% of adults with BMI > 30	<b>28.0</b>
Current smokers, % of adults	<b>28.5</b>
Binge alcohol drinkers, % of adults	<b>8.6</b>

**DISASTER PREPAREDNESS C+**

Per capita federal disaster preparedness funds	<b>\$7.49</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>No</b>
Number of drills and exercises conducted involving hospital personnel, equipment, or facilities	<b>749</b>
Accredited by the Emergency Management Accreditation Program	<b>No</b>
Written plan specifically for special needs patients	<b>No</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>No</b>
Real-time surveillance system in place for common ED presentations	<b>NR</b>
Bed surge capacity per 1M pop.	<b>731.8</b>
Burn unit beds per 1M pop.	<b>4.5</b>
ICU beds per 1M pop.	<b>314.0</b>
Verified burn centers per 1M pop.	<b>0.0</b>
State able to verify credentials and assign volunteer health professionals to four ESAR-VHP levels	<b>Yes</b>
Nurses registered in ESAR-VHP per 1M pop.	<b>340.9</b>
Physicians registered in ESAR-VHP per 1M pop.	<b>21.2</b>
Training required in disaster management and response to bio- and chem terrorism for essential hospital personnel, EMS personnel	<b>No, 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>42.3</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

**NR** Not reported

**N/A** Not applicable

See *Summary Statistics for State Comparisons*