Nevada

	RANK	GRADE
ACCESS TO EMERGENCY CARE	46	F
QUALITY & PATIENT SAFETY ENVIRONMENT	35	D+
MEDICAL LIABILITY ENVIRONMENT	11	C+
PUBLIC HEALTH & INJURY PREVENTION	33	D
DISASTER PREPAREDNESS	47	F
OVERALL	48	D

Nevada's poor showing not only includes failing grades in *Access to Emergency Care* and *Disaster Preparedness*, but also last place rankings for indicators in other categories as well.

Strengths. Nevada ranks 11th in the nation with regard to its *Medical Liability Environment*. This is reflective of the state's success in passing numerous liability reforms. These include a $350,000 medical liability cap on non-economic damages and expert witness rules providing for case certification.

While Nevada's *Public Health and Injury Prevention* grade leaves much room for improvement, the state demonstrates a few successes with regard to traffic safety indicators. The state has a universal helmet law requiring all riders to wear a helmet regardless of their position on all motorized cycles. The state also has a high rate of seat belt use, with 92.2 percent of front seat occupants using seat belts.

Challenges. The *Quality and Patient Safety Environment* in Nevada faces numerous challenges. Nevada ranks last in the nation for the percentage of patients with acute myocardial infarction receiving PCI within 90 minutes of arrival. There is no funding for a state EMS medical director position or quality improvement within the EMS system. The state's lack of funding may be reflected in the low percentage of counties with Enhanced 911 capability (52.9 percent), for which the state ranks 50th.

Overall, Nevada fares poorly with regard to *Public Health and Injury Prevention*. The state has the nation's lowest percentages of both childhood immunizations and annual influenza vaccinations among older adults. The state also has the second highest rate of homicides and suicides, at 27.8 per 100,000 people. The rate of traffic fatalities is higher than in most states (17.3 per 100,000), as is the percentage of traffic fatalities that are alcohol-related (43.0 percent).

Regarding *Access to Emergency Care*, Nevada faces severe shortages of medical specialists; the state ranks last or near last with regard to the rate of neurosurgeons; orthopedists and hand surgeons; ear, nose, and throat specialists; and registered nurses. The state fares only slightly better regarding the supply of emergency physicians and plastic surgeons. The state is ranked 48th for the proportion of uninsured children (18.8 versus 11.7 percent nationally) and 42nd for the percentage of uninsured adults (19.8 versus 17.2 percent nationally). The state also ranks among the bottom 10 for its low rates of emergency departments, staffed inpatient beds, and psychiatric care beds per capita, as well as for its high daily hospital occupancy rate.

Nevada receives a poor grade in *Disaster Preparedness*, as well. It lacks a statewide medical communication system with one layer of redundancy, patient and victim tracking systems, and medical assistance teams. The state also lacks the ability to verify credentials of volunteer health professionals and assign them to one of four levels within a state-based Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program.

Access to emergency care in Nevada is in crisis.

Recommendations. *Access to Emergency Care* in Nevada is in crisis. The state must employ strategies to increase the recruitment and retention of providers, including specialists, registered nurses, and emergency medicine residents. There is also an urgent need to address the high rates of uninsured children and adults, increase immunization rates, and expand patient bed capacity. Nevada needs to build on or expand systems to ensure high standards, coordination, and quality for both emergency and disaster situations (e.g., by developing a state-based ESAR-VHP system or implementing a PCI network or STEMI system of care).

While Nevada fares well in comparison to other states with regard to the *Medical Liability Environment*, average medical liability insurance premiums and malpractice awards are higher than the averages across the states. The state could further alleviate the medical liability burden on physicians by providing additional liability protections for EMTALA-mandated emergency care, requiring pretrial screening panels, and requiring or providing for expert witnesses to be licensed to practice in the state.

ACCESS TO EMERGENCY CARE — F

Indicator	Trend	Value
Board-certified emergency physicians per 100,000 pop.	Improved	9.2
Emergency physicians per 100,000 pop.		10.9
Neurosurgeons per 100,000 pop.		1.1
Orthopedists and hand surgeon specialists per 100,000 pop.		6.1
Plastic surgeons per 100,000 pop.		1.7
ENT specialists per 100,000 pop.		1.9
Registered nurses per 100,000 pop.	Improved	588.6
Additional primary care FTEs needed		85.7
Additional mental health FTEs needed		3.3
Level I or II trauma centers per 1M pop.		1.2
% of population within 60 minutes of Level I or II trauma center		93.9
Accredited chest pain centers per 1M pop.		0.8
% of population with an unmet need for substance abuse treatment		8.5
Pediatric specialty centers per 1M pop.		2.4
Physicians accepting Medicare per 100 beneficiaries		2.3
Medicaid fee levels for office visits as a % of the national average		117.1
% change in Medicaid fees for office visits (2004-05 to 2007)		0.0
% of adults with no health insurance		19.8
% of children with no health insurance		18.8
% of adults with Medicaid		4.1
Emergency departments per 1M pop.	Improved	8.4
Hospital closures in 2006		0
Staffed inpatient beds per 100,000 pop.		254.3
Hospital occupancy rate per 100 staffed beds		73.7
Psychiatric care beds per 100,000 pop.		19.3
State collects data on diversion		Yes

MEDICAL LIABILITY ENVIRONMENT — C+

Indicator	Trend	Value
Lawyers per 10,000 pop.		17.6
Lawyers per physician		0.9
Lawyers per emergency physician		15.7
ATRA judicial hellholes (range 0 to -7)		-3
Malpractice award payments/100,000 pop.		2.5
Average malpractice award payments		$296,383
Databank reports per 1,000 physicians		24.5
Patient compensation fund	●	No
Health court pilot project grant		No
Number of insurers writing medical liability policies per 1,000 physicians		12.2
Average medical liability insurance premium for primary care physicians		$19,427
Average medical liability insurance premiums for specialists		$84,511
Pretrial screening panels	●	No
Are pretrial screening panels' findings admissible as evidence?		N/A
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		Yes
Expert witness required to be of the same specialty as the defendant		Yes
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		No
Funded state EMS medical director		No
Emergency medicine residents per 1M pop.	Improved	3.5
Adverse event reporting required		Yes
Hospital-based infections reporting required		Yes
Mandatory quality reporting requirement		Yes
% of counties with E-911 capability		52.9
Uniform system for providing pre-arrival instructions		Yes
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		NR
Statewide trauma registry		Yes
% of hospitals with computerized practitioner order entry		23.5
% of hospitals with electronic medical records		39.4
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival		31
Number of Joint Commission reviewed sentinel events per 1M pop. (1995–2006)		13

PUBLIC HEALTH & INJURY PREVENTION — D

Indicator	Trend	Value
Traffic fatalities per 100,000 pop.		17.3
% of traffic fatalities alcohol related	Improved	43.0
Front occupant restraint use (%)		92.2
Helmet use required for all motorcycle riders	●	Yes
Child safety seat/seat belt legislation (10 points possible)		3
% of children immunized, aged 19–35 months	Worsened	64.7
% of adults aged 65+ who received flu vaccine in the last 12 months	Worsened	57.7
% of adults aged 65+ who ever received pneumococcal vaccine	Improved	69.1
Fatal occupational injuries per 1M workers		44.4
Homicides and suicides (non-motor vehicle) per 100,000 pop.		27.8
Unintentional fall-related fatal injuries per 100,000 pop.		6.0
Unintentional fire/burn-related fatal injuries per 100,000 pop.		0.7
Unintentional firearm-related fatal injuries per 100,000 pop.		0.2
Gun-purchasing legislation (8 points possible)		1
% of tobacco settlement funds spent on health-related services and programs		47.3
Total injury prevention funds per 1,000 pop.		$158.26
Unintentional injury prevention funds per 1,000 pop.		$31.18
Intentional injury prevention funds per 1,000 pop.		$14.03
Fall injury prevention funds per 1,000 pop.		$0.00
Infant mortality rate per 1,000 live births		5.8
% of adults with BMI > 30		25.0
Current smokers, % of adults		22.2
Binge alcohol drinkers, % of adults		15.7

DISASTER PREPAREDNESS — F

Indicator	Value
Per capita federal disaster preparedness funds	$13.08
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	Yes
Number of drills and exercises conducted involving hospital personnel, equipment, or facilities	8
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	Statewide
Statewide medical communication system with one layer of redundancy	No
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.	158.7
Burn unit beds per 1M pop.	4.7
ICU beds per 1M pop.	303.7
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, Yes
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	44.9
State requires EMS and essential ED personnel to be NIMS compliant	Yes