

# North Dakota

North Dakota ranked among the top 10 states in the nation in the *Disaster Preparedness* and *Access to Emergency Care* categories, but a renewed focus on injury prevention efforts and a strong emphasis on quality and safety initiatives are still needed.

**Strengths.** North Dakota has taken significant strides to incorporate important *Disaster Preparedness* planning into state operations and to implement policies that enhance its ability to respond to a disaster. North Dakota has an all-hazards medical response or ESF-8 plan that is shared will all EMS and essential hospital personnel. Likewise, the state has written plans specifically for special needs patients and for supplying medications for chronic conditions in the event of a disaster. Additionally, the state has a plan for the coordination of the State Emergency Operations Center or local emergency management agencies to provide security to hospitals during an emergency event. North Dakota also has a real-time notification system in place to notify identified health care providers of an event, as well as statewide “just-in-time” training systems, and a medical communication system with one layer of redundancy. The state also ranks among the top six with regard to nurses and physicians registered in the state-based Emergency System for Advance Registration of Volunteer Health Professionals (636.2 and 73.5 per 1 million people, respectively) and ranks second for the number of ICU beds (434.5 per 1 million). These successes may be due in part to receipt of the fourth highest rate of federal funding for disaster preparedness (\$21.51 per capita).

Another high note for North Dakota is the *Medical Liability Environment*. Contributing to success in this area are factors such

as the exceptionally high rate of insurers writing medical liability policies within the state (26.6 per 1,000 physicians), the abolition of joint and several liability, and the provision for case certification by an expert witness. The state also has among the 10 lowest average medical liability premiums for specialists (\$35,922).

North Dakota’s above average grade for *Access to Emergency Care* is influenced by high per capita rates of Level I or II trauma centers, pediatric specialty centers, emergency departments, staffed inpatient beds, psychiatric care beds, and registered nurses. For each of these indicators, the state ranks among the top five. The state also has the sixth highest rate of physicians accepting Medicare with 4.1 physicians per 100 beneficiaries.

**Challenges.** The *Quality and Patient Safety Environment* grade for North Dakota suffers because the state does not have a funded EMS medical director or reporting requirements for adverse events or hospital-based infections. Furthermore, North Dakota does not have any emergency medicine residents and has the third lowest percentage of hospitals using computerized practitioner order entry or electronic medical records (4.9 and 18.0 percent, respectively).

## North Dakota faces many challenges regarding public health and injury prevention.

North Dakota faces many challenges regarding *Public Health and Injury Prevention* indicators. The lack of a helmet requirement for all motorcycle riders and the relatively high percentage of binge alcohol drinkers (21.2 percent versus 15.4 percent nationally) contribute to the state’s poor performance. The state also has a high proportion of traffic fatalities that are alcohol-related (45.0 percent) and ranks 45<sup>th</sup> for its high rates of uninten-




	RANK	GRADE
ACCESS TO EMERGENCY CARE	6	B-
QUALITY & PATIENT SAFETY ENVIRONMENT	31	C-
MEDICAL LIABILITY ENVIRONMENT	14	C+
PUBLIC HEALTH & INJURY PREVENTION	30	D+
DISASTER PREPAREDNESS	5	A
OVERALL	10	C+

tional fall-related fatal injuries (11.8 per 100,000 people) and fatal occupational injuries (75.8 per 1 million workers).

**Recommendations.** North Dakota should focus on improving the *Quality and Patient Safety Environment* through such mechanisms as requiring reporting of adverse events and hospital-based infections. The state should also work with hospitals and universities in the region to establish an emergency medicine residency program, which could result in attracting and maintaining needed emergency physicians.

Likewise, passing and enforcing a helmet law for all motorcycle riders and focusing health promotion efforts on binge alcohol drinking, driving under the influence of alcohol, and safety in the workplace would improve North Dakota’s *Public Health and Injury Prevention* outcomes.

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

Board-certified emergency physicians per 100,000 pop.	 <b>6.1</b>
Emergency physicians per 100,000 pop.	<b>6.9</b>
Neurosurgeons per 100,000 pop.	<b>1.9</b>
Orthopedists and hand surgeon specialists per 100,000 pop.	<b>8.3</b>
Plastic surgeons per 100,000 pop.	<b>1.9</b>
ENT specialists per 100,000 pop.	<b>3.0</b>
Registered nurses per 100,000 pop.	 <b>1,098.1</b>
Additional primary care FTEs needed	<b>32.9</b>
Additional mental health FTEs needed	<b>8.4</b>
Level I or II trauma centers per 1M pop.	<b>9.4</b>
% of population within 60 minutes of Level I or II trauma center	<b>56.1</b>
Accredited chest pain centers per 1M pop.	<b>0.0</b>
% of population with an unmet need for substance abuse treatment	<b>9.7</b>
Pediatric specialty centers per 1M pop.	<b>11.0</b>
Physicians accepting Medicare per 100 beneficiaries	<b>4.1</b>
Medicaid fee levels for office visits as a % of the national average	<b>120.1</b>
% change in Medicaid fees for office visits (2004-05 to 2007)	<b>3.2</b>
% of adults with no health insurance	<b>12.8</b>
% of children with no health insurance	<b>10.3</b>
% of adults with Medicaid	<b>4.8</b>
Emergency departments per 1M pop.	 <b>56.5</b>
Hospital closures in 2006	<b>0</b>
Staffed inpatient beds per 100,000 pop.	<b>618.5</b>
Hospital occupancy rate per 100 staffed beds	<b>61.3</b>
Psychiatric care beds per 100,000 pop.	<b>48.5</b>
State collects data on diversion	<b>No</b>





**MEDICAL LIABILITY ENVIRONMENT** **C+**

Lawyers per 10,000 pop.	<b>9.3</b>
Lawyers per physician	<b>0.4</b>
Lawyers per emergency physician	<b>13.4</b>
ATRA judicial hellholes (range 0 to -7)	<b>0</b>
Malpractice award payments/100,000 pop.	<b>6.3</b>
Average malpractice award payments	<b>\$293,145</b>
Databank reports per 1,000 physicians	<b>18.8</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>26.6</b>
Average medical liability insurance premium for primary care physicians	<b>\$10,621</b>
Average medical liability insurance premiums for specialists	<b>\$35,922</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>\$350,001-500,000</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>Yes</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** **C-**


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>0.0</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>98.1</b>
Uniform system for providing pre-arrival instructions	<b>Yes</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>Yes</b>
Statewide trauma registry	<b>Yes</b>
% of hospitals with computerized practitioner order entry	<b>4.9</b>
% of hospitals with electronic medical records	<b>18.0</b>
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	<b>80</b>
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	<b>11</b>


**PUBLIC HEALTH & INJURY PREVENTION** **D+**


Traffic fatalities per 100,000 pop.	<b>17.5</b>
% of traffic fatalities alcohol related	 <b>45.0</b>
Front occupant restraint use (%)	<b>82.2</b>
Helmet use required for all motorcycle riders	<b>No</b>
Child safety seat/seat belt legislation (10 points possible)	<b>3</b>
% of children immunized, aged 19-35 months	 <b>82.8</b>
% of adults aged 65+ who received flu vaccine in the last 12 months	 <b>71.4</b>
% of adults aged 65+ who ever received pneumococcal vaccine	 <b>69.4</b>
Fatal occupational injuries per 1M workers	<b>75.8</b>
Homicides and suicides (non-motor vehicle) per 100,000 pop.	<b>16.2</b>
Unintentional fall-related fatal injuries per 100,000 pop.	<b>11.8</b>
Unintentional fire/burn-related fatal injuries per 100,000 pop.	<b>1.3</b>
Unintentional firearm-related fatal injuries per 100,000 pop.	<b>0.2</b>
Gun-purchasing legislation (8 points possible)	<b>0</b>
% of tobacco settlement funds spent on health-related services and programs	<b>13.1</b>
Total injury prevention funds per 1,000 pop.	<b>\$4,505.60</b>
Unintentional injury prevention funds per 1,000 pop.	<b>NR</b>
Intentional injury prevention funds per 1,000 pop.	<b>NR</b>
Fall injury prevention funds per 1,000 pop.	<b>\$0.00</b>
Infant mortality rate per 1,000 live births	<b>6.0</b>
% of adults with BMI > 30	<b>25.4</b>
Current smokers, % of adults	<b>19.5</b>
Binge alcohol drinkers, % of adults	<b>21.2</b>

**DISASTER PREPAREDNESS** **A**

Per capita federal disaster preparedness funds	<b>\$21.51</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, No</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>96</b>
Accredited by the Emergency Management Accreditation Program	<b>Yes</b>
Written plan specifically for special needs patients	<b>Yes</b>
Written plan to supply medications for chronic conditions	<b>Yes</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>No</b>
Statewide victim tracking system	<b>No</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>Yes</b>
Bed surge capacity per 1M pop.	<b>789.4</b>
Burn unit beds per 1M pop.	<b>0.0</b>
ICU beds per 1M pop.	<b>434.5</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>No</b>
Nurses registered in ESAR-VHP per 1M pop.	<b>636.2</b>
Physicians registered in ESAR-VHP per 1M pop.	<b>73.5</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>Civil, not clearly defined</b>
% of RNs that received any emergency training	<b>44.8</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