



Ohio

Low numbers of uninsured residents and substantial hospital capacity to deal with disasters are among the highlights of Ohio's emergency care environment. However, opportunities for improvement abound in all five categories.

Strengths. Ohio has a number of characteristics that contribute to the state's above average grade in *Access to Emergency Care*. The state ranks fourth for its low rate of uninsured children (5.7 percent), which is less than half the national rate. Similarly, only 11.5 percent of adults in Ohio lack insurance, compared with 17.2 percent nationally. More than 96 percent of Ohio's population is within 60 minutes of a Level I or II trauma center.

Ohio has instituted some important medical liability reforms, including case certification by an expert witness and requiring witnesses to be of the same specialty as the defendant. In addition, Ohio is one of four states to require or provide for expert witnesses to be licensed to practice medicine in the state, which allows for state oversight of inappropriate expert witness testimony.

While Ohio did not fare well overall with regard to *Disaster Preparedness*, the state has substantial hospital capacity to deal with disaster events. Ohio is among the top 10 states with regard to verified burn centers (0.4 per 1 million people), burn unit beds (10.4 per 1 million), and ICU beds (375.5 per 1 million). Ohio has also established a medical reserve corps (a close analogue of the ESAR-VHP program) in 82 of its 88 counties. In addition, while the data reported indicate that Ohio's liability protections for health care workers during a disaster event are not clearly defined, the state has mandated that medical volunteers registered in the state database are guaranteed additional liability protections.

A number of health risk factors contribute to Ohio's below-average grade in public health and injury prevention.

Challenges. A number of health risk factors contribute to Ohio's below-average grade in *Public Health and Injury Prevention*. Ohio has a high percentage of adults who are obese (28.4 percent), as well as a significant number of current smokers (22.4 percent of adults). The state also has the ninth highest infant mortality rate (8.3 deaths per 1,000 live births), well above the national rate of 6.9 per 1,000 live births.

Despite Ohio's above-average grade for the *Quality and Patient Safety Environment*, the state is still lacking in some areas. For instance, the state does not have a uniform system for providing pre-arrival instructions and lacks a PCI network or STEMI system of care.

Disaster Preparedness poses some problems for the state, as well. While the state developed an all-hazards medical response plan, it lacks a written plan specifically for special needs patients. In addition, the state does not have a plan for the State Emergency Operations Center or local emergency management agencies to provide security to hospitals during a disaster event. Ohio also lacks patient and victim tracking systems, but to its credit has been investigating potential patient tracking systems through a patient tracking task force.

Recommendations. While Ohio fared well with respect to the number of specialists in the workforce, emergency physicians in the state have noted a shortage of on-call specialists. Increasing Medicaid reimbursements for emergency care-related services and providing limited immunity from liability for all EMTALA-mandated care would be significant steps in encouraging specialists to provide on-call emergency care.

The state also might consider strengthening the existing medical liability reforms to alleviate physicians' concerns with seeing patients considered to

	RANK	GRADE
ACCESS TO EMERGENCY CARE	14	C+
QUALITY & PATIENT SAFETY ENVIRONMENT	21	B-
MEDICAL LIABILITY ENVIRONMENT	18	C
PUBLIC HEALTH & INJURY PREVENTION	27	C-
DISASTER PREPAREDNESS	36	C-
OVERALL	18	C

be a high liability risk. Ohio could reduce the medical liability cap on non-economic damages to the recommended \$250,000 cap. In addition, the state could institute mandatory pretrial screening panels and admit their findings as evidence.

Emergency physicians in the state also report significant problems with psychiatric patients being boarded in emergency departments while waiting to see a psychiatrist or be admitted to a hospital psychiatric unit. Addressing the state's relatively low number of psychiatric care beds (23.0 per 100,000 people) and shortage of mental health providers (21.1 full-time equivalents needed for underserved populations), may be the first steps in alleviating these problems.

ACCESS TO EMERGENCY CARE **C+**

Board-certified emergency physicians per 100,000 pop.	10.0
Emergency physicians per 100,000 pop.	13.9
Neurosurgeons per 100,000 pop.	2.2
Orthopedists and hand surgeon specialists per 100,000 pop.	9.2
Plastic surgeons per 100,000 pop.	2.0
ENT specialists per 100,000 pop.	3.6
Registered nurses per 100,000 pop.	1,002.5
Additional primary care FTEs needed	118.0
Additional mental health FTEs needed	21.1
Level I or II trauma centers per 1M pop.	1.9
% of population within 60 minutes of Level I or II trauma center	96.4
Accredited chest pain centers per 1M pop.	2.4
% of population with an unmet need for substance abuse treatment	7.7
Pediatric specialty centers per 1M pop.	2.7
Physicians accepting Medicare per 100 beneficiaries	2.6
Medicaid fee levels for office visits as a % of the national average	85.4
% change in Medicaid fees for office visits (2004-05 to 2007)	0.0
% of adults with no health insurance	11.5
% of children with no health insurance	5.7
% of adults with Medicaid	9.1
Emergency departments per 1M pop.	13.1
Hospital closures in 2006	0
Staffed inpatient beds per 100,000 pop.	329.0
Hospital occupancy rate per 100 staffed beds	65.3
Psychiatric care beds per 100,000 pop.	23.0
State collects data on diversion	No

MEDICAL LIABILITY ENVIRONMENT **C**

Lawyers per 10,000 pop.	13.6
Lawyers per physician	0.5
Lawyers per emergency physician	9.8
ATRA judicial hellholes (range 0 to -7)	0
Malpractice award payments/100,000 pop.	0.7
Average malpractice award payments	\$287,232
Databank reports per 1,000 physicians	20.6
Patient compensation fund	No
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	2.5
Average medical liability insurance premium for primary care physicians	\$23,027
Average medical liability insurance premiums for specialists	\$93,017
Pretrial screening panels	No
Are pretrial screening panels' findings admissible as evidence?	N/A
Periodic payments	At judge's or court's discretion
Medical liability cap on non-economic damages	\$350,001-500,000
Additional liability protection for EMTALA-mandated emergency care	No
Joint and several liability abolished	Partially
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	Yes

QUALITY & PATIENT SAFETY ENVIRONMENT **B-**

Funding for quality improvement within the EMS system	No
Funded state EMS medical director	Yes
Emergency medicine residents per 1M pop.	22.3
Adverse event reporting required	Yes
Hospital-based infections reporting required	Yes
Mandatory quality reporting requirement	Yes
% of counties with E-911 capability	95.5
Uniform system for providing pre-arrival instructions	No
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	No
Statewide trauma registry	Yes
% of hospitals with computerized practitioner order entry	23.6
% of hospitals with electronic medical records	40.8
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	59
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	12

PUBLIC HEALTH & INJURY PREVENTION **C-**

Traffic fatalities per 100,000 pop.	10.8
% of traffic fatalities alcohol related	39.0
Front occupant restraint use (%)	81.6
Helmet use required for all motorcycle riders	No
Child safety seat/seat belt legislation (10 points possible)	1
% of children immunized, aged 19-35 months	81.3
% of adults aged 65+ who received flu vaccine in the last 12 months	68.2
% of adults aged 65+ who ever received pneumococcal vaccine	68.5
Fatal occupational injuries per 1M workers	32.3
Homicides and suicides (non-motor vehicle) per 100,000 pop.	17.2
Unintentional fall-related fatal injuries per 100,000 pop.	7.3
Unintentional fire/burn-related fatal injuries per 100,000 pop.	1.1
Unintentional firearm-related fatal injuries per 100,000 pop.	0.2
Gun-purchasing legislation (8 points possible)	2.5
% of tobacco settlement funds spent on health-related services and programs	12.5
Total injury prevention funds per 1,000 pop.	\$263.76
Unintentional injury prevention funds per 1,000 pop.	\$73.87
Intentional injury prevention funds per 1,000 pop.	\$173.43
Fall injury prevention funds per 1,000 pop.	\$13.08
Infant mortality rate per 1,000 live births	8.3
% of adults with BMI > 30	28.4
Current smokers, % of adults	22.4
Binge alcohol drinkers, % of adults	16.3

DISASTER PREPAREDNESS **C-**

Per capita federal disaster preparedness funds	\$7.99
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, No
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	NR
Accredited by the Emergency Management Accreditation Program	No
Written plan specifically for special needs patients	No
Written plan to supply medications for chronic conditions	No
Written plan to supply dialysis for patients	No
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.	NR
Burn unit beds per 1M pop.	10.4
ICU beds per 1M pop.	375.5
Verified burn centers per 1M pop.	0.4
State able to verify credentials and assign volunteer health professionals to four ESAR-VHP levels	Yes
Nurses registered in ESAR-VHP per 1M pop.	116.1
Physicians registered in ESAR-VHP per 1M pop.	18.7
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	No
Additional liability protections for health care workers during a disaster	Civil, not clearly defined
% of RNs that received any emergency training	41.6
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	