Oregon

Although Oregon ranked among the top 10 states in *Public Health and Injury Prevention*, that was more than offset by subpar grades in the remaining categories, including a failing grade for *Access to Emergency Care* and a ranking among the bottom 10 in *Disaster Preparedness*.

Strengths. Oregon's performance is strongest in *Public Health and Injury Prevention*. The state ranks first for the percentage of adults aged 65 and older who have ever had a pneumococcal vaccine (74.7 percent), and the rate of annual influenza vaccine among that population is only slightly lower (71.3 percent). The state also has below-average rates of smokers and binge drinkers (18.5 and 14.1 percent of adults, respectively). Seat belt use is third highest in the nation, with 95.3 percent of front occupants using seat belts. Oregon also has shown considerable commitment to improving the health and safety of the population through relatively high levels of funding for intentional injury prevention programs ($221.48 per 1,000 people).

Despite Oregon's poor grade with regard to *Disaster Preparedness*, the state has made some strides in this area. The state has numerous communications systems in place, including statewide "just-in-time" training systems, a statewide medical communication system with one layer of redundancy, and a real-time notification system to notify identified health care providers of an event.

Challenges. Access to all types of medical care in Oregon poses serious concerns. For instance, the state has higher-than-average rates of uninsured adults and children. More than 13 percent of children and 19 percent of adults in Oregon are uninsured, compared to national rates of 11.7 and 17.2 percent, respectively. The state also has the third lowest rate of staffed inpatient beds (210.8 per 100,000 people).

The *Medical Liability Environment* in Oregon is in need of reform. The state lacks many reforms aimed at retaining physicians and lowering medical liability premiums that other states have implemented. Oregon lacks expert witness rules such as requiring case certification by an expert witness and requiring witnesses to be of the same specialty as the defendant. The state also lacks a medical liability cap on non-economic damages and liability protections for EMTALA-mandated emergency care.

Oregon's poor grade for the *Quality and Patient Safety Environment* is partially due to the lack of funding for an EMS quality improvement program, as well as a lack of formal stroke and PCI/STEMI systems of care. Additionally, the state does not have a hospital-based infections reporting requirement and has a relatively low rate of emergency medicine residents (7.2 per 1 million people), a result of having only one residency program in the state.

Recommendations. Along with many problems identified in the *Access to Emergency Care* category, Oregon's emergency physicians also report significant problems with boarding of patients in the emergency department. Efforts should be made to address this problem, such as improving the excessively low rates of staffed inpatient and ICU beds. Further, despite the moderate number of psychiatric care beds compared with other states (28.8 per 100,000 people), emergency physicians report significant problems with patients being unable to access mental health care services; this problem must also be addressed. A first step in improving access to care for all residents would be to address the state's relatively high rates of uninsured adults and children.

Access to specialists and mental health care has posed problems for Oregon.

	RANK	GRADE
ACCESS TO EMERGENCY CARE	41	F
QUALITY & PATIENT SAFETY ENVIRONMENT	36	D+
MEDICAL LIABILITY ENVIRONMENT	37	D-
PUBLIC HEALTH & INJURY PREVENTION	9	B
DISASTER PREPAREDNESS	42	D
OVERALL	47	D

Oregon has the opportunity to substantially improve the *Medical Liability Environment* in the state. Policymakers should vigorously support a constitutional amendment permitting medical liability caps on non-economic damages. In addition, Oregon could benefit from stronger expert witness rules and implementation of pretrial screening panels. With emergency physicians in the state reporting problems in accessing specialists willing to provide on-call emergency services, particularly in rural areas, the state should consider enacting special liability protections for EMTALA-mandated care.

Finally, funding for an EMS quality improvement program and investing in the development of formal stroke and PCI/STEMI systems of care would substantially improve Oregon's *Quality and Patient Safety Environment.*

ACCESS TO EMERGENCY CARE — F

Indicator	Trend	Value
Board-certified emergency physicians per 100,000 pop.	Improved	13.4
Emergency physicians per 100,000 pop.		15.6
Neurosurgeons per 100,000 pop.		2.5
Orthopedists and hand surgeon specialists per 100,000 pop.		9.4
Plastic surgeons per 100,000 pop.		1.8
ENT specialists per 100,000 pop.		3.9
Registered nurses per 100,000 pop.	Worsened	804.6
Additional primary care FTEs needed		37.0
Additional mental health FTEs needed		9.0
Level I or II trauma centers per 1M pop.		1.3
% of population within 60 minutes of Level I or II trauma center		76.4
Accredited chest pain centers per 1M pop.		0.3
% of population with an unmet need for substance abuse treatment		8.5
Pediatric specialty centers per 1M pop.		2.7
Physicians accepting Medicare per 100 beneficiaries		2.9
Medicaid fee levels for office visits as a % of the national average		96.3
% change in Medicaid fees for office visits (2004-05 to 2007)		0.4
% of adults with no health insurance		19.3
% of children with no health insurance		13.1
% of adults with Medicaid		7.1
Emergency departments per 1M pop.	Worsened	15.7
Hospital closures in 2006		0
Staffed inpatient beds per 100,000 pop.		210.8
Hospital occupancy rate per 100 staffed beds		65.9
Psychiatric care beds per 100,000 pop.		28.8
State collects data on diversion		NR

MEDICAL LIABILITY ENVIRONMENT — D-

Indicator	Trend	Value
Lawyers per 10,000 pop.		13.4
Lawyers per physician		0.5
Lawyers per emergency physician		8.4
ATRA judicial hellholes (range 0 to -7)		0
Malpractice award payments/100,000 pop.		1.5
Average malpractice award payments		$251,695
Databank reports per 1,000 physicians		16.3
Patient compensation fund	●	No
Health court pilot project grant		No
Number of insurers writing medical liability policies per 1,000 physicians		6.3
Average medical liability insurance premium for primary care physicians		$9,685
Average medical liability insurance premiums for specialists		$48,510
Pretrial screening panels	●	No
Are pretrial screening panels' findings admissible as evidence?		N/A
Periodic payments		No
Medical liability cap on non-economic damages	●	No
Additional liability protection for EMTALA-mandated emergency care	●	No
Joint and several liability abolished	●	Yes
State provides for case certification		No
Expert witness required to be of the same specialty as the defendant		No
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		Yes
Emergency medicine residents per 1M pop.	●	7.2
Adverse event reporting required		No
Hospital-based infections reporting required		No
Mandatory quality reporting requirement		Yes
% of counties with E-911 capability		100.0
Uniform system for providing pre-arrival instructions		No
State has or is working on a stroke system of care		No
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		24.1
% of hospitals with electronic medical records		56.9
% 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)		10

PUBLIC HEALTH & INJURY PREVENTION — B

Indicator	Trend	Value
Traffic fatalities per 100,000 pop.		12.9
% of traffic fatalities alcohol related	Worsened	41.0
Front occupant restraint use (%)		95.3
Helmet use required for all motorcycle riders	●	Yes
Child safety seat/seat belt legislation (10 points possible)		7
% of children immunized, aged 19–35 months	Improved	78.8
% of adults aged 65+ who received flu vaccine in the last 12 months	Improved	71.3
% of adults aged 65+ who ever received pneumococcal vaccine	Improved	74.7
Fatal occupational injuries per 1M workers		39.5
Homicides and suicides (non-motor vehicle) per 100,000 pop.		18.2
Unintentional fall-related fatal injuries per 100,000 pop.		10.4
Unintentional fire/burn-related fatal injuries per 100,000 pop.		0.9
Unintentional firearm-related fatal injuries per 100,000 pop.		0.3
Gun-purchasing legislation (8 points possible)		1
% of tobacco settlement funds spent on health-related services and programs		28.8
Total injury prevention funds per 1,000 pop.		$182.79
Unintentional injury prevention funds per 1,000 pop.		$41.36
Intentional injury prevention funds per 1,000 pop.		$221.48
Fall injury prevention funds per 1,000 pop.		$2.67
Infant mortality rate per 1,000 live births		5.9
% of adults with BMI > 30		24.8
Current smokers, % of adults		18.5
Binge alcohol drinkers, % of adults		14.1

DISASTER PREPAREDNESS — D

Indicator	Value
Per capita federal disaster preparedness funds	$8.70
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	Yes
Number of drills and exercises conducted involving hospital personnel, equipment, or facilities	40
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	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.	309.5
Burn unit beds per 1M pop.	4.3
ICU beds per 1M pop.	251.1
Verified burn centers per 1M pop.	0.3
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, No
State or regional strike teams or medical assistance teams	Yes
Additional liability protections for health care workers during a disaster	Yes, civil
% of RNs that received any emergency training	48.0
State requires EMS and essential ED personnel to be NIMS compliant	No

- Improved since 2006 (thumbs-up icon)
- Worsened since 2006 (thumbs-down icon)
- ● No change since 2006
- NR Not reported
- N/A Not applicable

See *Summary Statistics for State Comparisons*