

South Dakota

Substantial challenges face South Dakota’s emergency care environment, as the state ranked last in the nation for its *Quality and Patient Safety Environment* and 48th in *Public Health and Injury Prevention*. The state’s strongest performance was in *Access to Emergency Care*.

Strengths. South Dakota’s average medical liability insurance premiums are among the lowest in the nation. The state also has the sixth lowest average malpractice award payment (\$182,638), which is more than \$100,000 less than the average state. South Dakota also has instituted a medical liability cap on non-economic damages and allows for periodic payments of malpractice awards.

South Dakota has significant infrastructure for providing emergency care. The state has relatively high rates of emergency departments and Level I or II trauma centers per capita. With regard to *Disaster Preparedness* indicators, the state has the third highest bed surge capacity in the nation and a relatively high number of ICU beds (375.4 per 1 million people) compared with the average across the states (299.0 per 1 million people).

Challenges. The *Quality and Patient Safety Environment* poses numerous challenges to the state. South Dakota lacks funding for quality improvement within the EMS system, as well as a funded state EMS medical director position. In addition, there is no uniform system in place for providing pre-arrival instructions. South Dakota also lacks a statewide trauma registry. Finally, the state ranks among the bottom five with regard to hospitals’ use of computerized practitioner order entry and electronic medical records.

The state’s failing grade in *Public Health and Injury Prevention* points to significant problems. South Dakota ranked among the six worst states with regard to traffic fa-

talities, fatal occupational injuries, and fatal fall-related unintentional injuries. The state also has a low rate of seat belt use and a higher than average percentage of adults reporting binge drinking.

In *Disaster Preparedness*, South Dakota fared poorly for numerous volunteer preparedness indicators. While the state has the ability to verify credentials of volunteer health professionals in a state-based Emergency System for Advance Registration of Volunteer Health Professionals program, South Dakota reported having no nurses or physicians registered in the system. In addition, the state does not require EMS or essential hospital personnel to be trained in disaster management and response to bio- and chemical terrorism.

South Dakota faces a number of challenges regarding *Access to Emergency Care*. Despite having the highest number of emergency departments per capita, the state has the lowest rate of emergency physicians. Similarly, despite a relatively high rate of Level I or II trauma centers, only 33.3 percent of the population lives within 60 minutes of a Level I or II trauma center. The state also has a below average rate of psychiatric care beds (25.7 per 100,000 people).

Recommendations. South Dakota must implement programs to improve traffic safety and the overall health of its population. Implementing a primary seat belt law would be a step toward improving the state’s high traffic fatality rate and low rate of seat belt use.

Targeted investment in injury prevention programs might also be used to address the state’s high rates of fatal injuries.

The state should also develop programs and devote resources to pursue improvements within the EMS system and other quality and patient safety priorities. Such improvements could include a uniform system for providing pre-arrival instruc-




	RANK	GRADE
ACCESS TO EMERGENCY CARE	12	C+
QUALITY & PATIENT SAFETY ENVIRONMENT	51	F
MEDICAL LIABILITY ENVIRONMENT	21	C
PUBLIC HEALTH & INJURY PREVENTION	48	F
DISASTER PREPAREDNESS	43	D
OVERALL	41	D+

tions and the development of a statewide trauma registry. The state would also benefit from implementing a hospital-based infections reporting requirement. Requiring training for EMS and hospital personnel in disaster management is another initiative that should be considered.

Emergency physicians in South Dakota have reported transferring patients to facilities more than four hours away for needed emergency care. The state must work to address problems related to crowding and ambulance diversion by collecting and reviewing hospital diversion data as a first step in determining how best to address this issue.

Emergency physicians in South Dakota have also reported a lack of critical on-call coverage. As such, the state should investigate ways to encourage on-call coverage. Additional liability protections for EMTALA-mandated emergency care and expert witness rules may encourage more specialists to provide on-call services.

ACCESS TO EMERGENCY CARE C+

Board-certified emergency physicians per 100,000 pop.	 4.9
Emergency physicians per 100,000 pop.	5.3
Neurosurgeons per 100,000 pop.	2.3
Orthopedists and hand surgeon specialists per 100,000 pop.	9.0
Plastic surgeons per 100,000 pop.	1.6
ENT specialists per 100,000 pop.	3.6
Registered nurses per 100,000 pop.	 1,226.4
Additional primary care FTEs needed	103.4
Additional mental health FTEs needed	17.0
Level I or II trauma centers per 1M pop.	2.5
% of population within 60 minutes of Level I or II trauma center	33.3
Accredited chest pain centers per 1M pop.	1.3
% of population with an unmet need for substance abuse treatment	8.8
Pediatric specialty centers per 1M pop.	5.1
Physicians accepting Medicare per 100 beneficiaries	3.2
Medicaid fee levels for office visits as a % of the national average	103.4
% change in Medicaid fees for office visits (2004-05 to 2007)	38.6
% of adults with no health insurance	12.7
% of children with no health insurance	9.2
% of adults with Medicaid	4.8
Emergency departments per 1M pop.	 66.0
Hospital closures in 2006	0
Staffed inpatient beds per 100,000 pop.	643.0
Hospital occupancy rate per 100 staffed beds	62.0
Psychiatric care beds per 100,000 pop.	25.7
State collects data on diversion	No





MEDICAL LIABILITY ENVIRONMENT C

Lawyers per 10,000 pop.	7.5
Lawyers per physician	0.3
Lawyers per emergency physician	14.0
ATRA judicial hellholes (range 0 to -7)	0
Malpractice award payments/100,000 pop.	5.5
Average malpractice award payments	\$182,638
Databank reports per 1,000 physicians	18.1
Patient compensation fund	No
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	22.6
Average medical liability insurance premium for primary care physicians	\$8,512
Average medical liability insurance premiums for specialists	\$24,661
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	\$350,001-500,000
Additional liability protection for EMTALA-mandated emergency care	No
Joint and several liability abolished	No
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 F


Funding for quality improvement within the EMS system	No
Funded state EMS medical director	No
Emergency medicine residents per 1M pop.	0.0
Adverse event reporting required	Yes
Hospital-based infections reporting required	No
Mandatory quality reporting requirement	No
% of counties with E-911 capability	87.9
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	No
% of hospitals with computerized practitioner order entry	6.1
% of hospitals with electronic medical records	14.3
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	74
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	6


PUBLIC HEALTH & INJURY PREVENTION F


Traffic fatalities per 100,000 pop.	24.4
% of traffic fatalities alcohol related	 42.0
Front occupant restraint use (%)	73.0
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	 82.1
% of adults aged 65+ who received flu vaccine in the last 12 months	 74.1
% of adults aged 65+ who ever received pneumococcal vaccine	 65.0
Fatal occupational injuries per 1M workers	83.1
Homicides and suicides (non-motor vehicle) per 100,000 pop.	18.5
Unintentional fall-related fatal injuries per 100,000 pop.	14.8
Unintentional fire/burn-related fatal injuries per 100,000 pop.	1.5
Unintentional firearm-related fatal injuries per 100,000 pop.	0.6
Gun-purchasing legislation (8 points possible)	0
% of tobacco settlement funds spent on health-related services and programs	2.0
Total injury prevention funds per 1,000 pop.	NR
Unintentional injury prevention funds per 1,000 pop.	NR
Intentional injury prevention funds per 1,000 pop.	NR
Fall injury prevention funds per 1,000 pop.	NR
Infant mortality rate per 1,000 live births	7.2
% of adults with BMI > 30	25.4
Current smokers, % of adults	20.3
Binge alcohol drinkers, % of adults	18.2

DISASTER PREPAREDNESS D

Per capita federal disaster preparedness funds	\$17.55
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?	No
Public health and emergency physician input into the state planning process	NR
Public health and emergency physician input into the daily operations of the SEOC	No, 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	615
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	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	No
Real-time surveillance system in place for common ED presentations	NR
Bed surge capacity per 1M pop.	1,433.0
Burn unit beds per 1M pop.	7.5
ICU beds per 1M pop.	375.4
Verified burn centers per 1M pop.	0.0
State able to verify credentials and assign volunteer health professionals to four ESAR-VHP levels	Yes
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	No
Additional liability protections for health care workers during a disaster	Yes, civil
% of RNs that received any emergency training	44.1
State requires EMS and essential ED personnel to be NIMS compliant	No

 Improved since 2006

 Worsened since 2006

 No change since 2006

NR Not reported

N/A Not applicable

See *Summary Statistics for State Comparisons*