Arizona

While Arizona has demonstrated an impressive commitment to disaster preparedness, the state suffers from critical deficiencies in a number of key areas ranging from a shortage of specialists and hospital beds to a paucity of medical liability reforms.

Strengths. Arizona has made significant efforts to improve *Disaster Preparedness.* Despite receiving a below average amount of federal funding for disaster preparedness – only $9.51 per person – there is a patient tracking system, as well as a statewide medical communication system with one layer of redundancy. Arizona also ranks 12th and 16th, respectively, with regard to the per capita rates of nurses and physicians registered in the state-based Emergency System for Advance Registration of Volunteer Health Professionals program.

Despite the state's poor grade in *Access to Emergency Care*, the state has demonstrated accomplishments in this area. Arizona's Medicaid fee levels for office visits are the fourth highest in the nation – 140 percent of the national average. In addition, reimbursement rates for office visits have increased 16.2 percent since 2004–2005. This is particularly important in Arizona where 10.4 percent of the adult population is enrolled in Medicaid.

Challenges. One of the state's greatest shortcomings in *Public Health and Injury Prevention* is especially low immunization rates. Fewer than three-quarters of Arizona's children (aged 19–35 months) are immunized, compared to 80.6 percent nationally. Meanwhile, only 65.4 percent of adults aged 65 years and older receive their annual influenza vaccine. In addition to immunization shortcomings, Arizona has among the nation's highest rates of homicides and suicides and unintentional fall-related fatal injuries (24.8 and 11.8 per 100,000 people, respectively). A lack of funding for injury prevention may hamper efforts to reduce these rates. Arizona ranks 47th in the nation with regard to total injury prevention funds ($18.42 per 1,000 people).

Arizona's most stifling medical liability issues include the state's relatively high average medical liability insurance premiums for primary care physicians and specialists ($22,798 and $87,175, respectively). The state also lacks additional liability protections for EMTALA-mandated emergency care, a medical liability cap on non-economic damages, and pretrial screening panels to discourage frivolous lawsuits.

Arizona's *Access to Emergency Care* crisis is threefold. First, the state faces a critical workforce shortage in many areas, falling among the bottom five with regard to ear, nose, and throat specialists (2.2 per 100,000 people); orthopedists and hand surgeon specialists (7.1 per 100,000); and registered nurses (560.8 per 100,000). Second, Arizona falls among the lowest ranking states with regard to uninsured adults and children (22.3 and 17.0 percent, respectively). Lastly, the state also scores poorly with regard to the rate of emergency departments, staffed inpatient beds, and psychiatric care beds.

Recommendations. Emergency physicians in the state report that Arizona is facing serious crowding and boarding issues in emergency departments and hospitals, as well as a lack of on-call specialists. As part of an effort to attract and maintain a broader workforce, Arizona should take immediate action to improve the *Medical Liability Environment.* While caps on non-economic damages have been declared unconstitutional, the state should enact policy requiring expert witnesses to be of the same specialty as the defendant and requiring pretrial screening panels to discourage frivolous law suits.

Arizona must take immediate action to improve the medical liability environment.

	RANK	GRADE
ACCESS TO EMERGENCY CARE	48	F
QUALITY & PATIENT SAFETY ENVIRONMENT	29	C
MEDICAL LIABILITY ENVIRONMENT	48	F
PUBLIC HEALTH & INJURY PREVENTION	40	D-
DISASTER PREPAREDNESS	9	A-
OVERALL	45	D+

In addition, instituting additional liability protections for EMTALA-mandated emergency care may encourage more specialists to be on call in the emergency department, where more high-risk patients present themselves.

As noted above, the state lacks significant resources with regard to emergency departments, staffed inpatient beds, and psychiatric care beds, which may also contribute to issues of boarding and crowding. Arizona must work closely with hospitals and other facilities to identify ways to increase capacity and serve a larger population.

Finally, Arizona would benefit significantly from ensuring that more children and adults have adequate health insurance. The high rates of uninsured residents, combined with a depleted workforce, hamper access to adequate preventive and emergency care.

ACCESS TO EMERGENCY CARE — F

Indicator	Trend	Value
Board-certified emergency physicians per 100,000 pop.	👍	8.6
Emergency physicians per 100,000 pop.		11.0
Neurosurgeons per 100,000 pop.		1.6
Orthopedists and hand surgeon specialists per 100,000 pop.		7.1
Plastic surgeons per 100,000 pop.		2.2
ENT specialists per 100,000 pop.		2.2
Registered nurses per 100,000 pop.	👎	560.8
Additional primary care FTEs needed		268.8
Additional mental health FTEs needed		30.3
Level I or II trauma centers per 1M pop.		1.1
% of population within 60 minutes of Level I or II trauma center		87.6
Accredited chest pain centers per 1M pop.		1.4
% of population with an unmet need for substance abuse treatment		8.9
Pediatric specialty centers per 1M pop.		1.8
Physicians accepting Medicare per 100 beneficiaries		2.6
Medicaid fee levels for office visits as a % of the national average		140.4
% change in Medicaid fees for office visits (2004-05 to 2007)		16.2
% of adults with no health insurance		22.3
% of children with no health insurance		17.0
% of adults with Medicaid		10.4
Emergency departments per 1M pop.	👎	7.1
Hospital closures in 2006		0
Staffed inpatient beds per 100,000 pop.		225.2
Hospital occupancy rate per 100 staffed beds		69.2
Psychiatric care beds per 100,000 pop.		14.8
State collects data on diversion		Yes

MEDICAL LIABILITY ENVIRONMENT — F

Indicator	Trend	Value
Lawyers per 10,000 pop.		12.7
Lawyers per physician		0.5
Lawyers per emergency physician		11.2
ATRA judicial hellholes (range 0 to -7)		-2
Malpractice award payments/100,000 pop.		1.2
Average malpractice award payments		$275,770
Databank reports per 1,000 physicians		27.1
Patient compensation fund	●	No
Health court pilot project grant		No
Number of insurers writing medical liability policies per 1,000 physicians		5.2
Average medical liability insurance premium for primary care physicians		$22,798
Average medical liability insurance premiums for specialists		$87,175
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		Yes
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 — C

Indicator	Trend	Value
Funding for quality improvement within the EMS system		Yes
Funded state EMS medical director		Yes
Emergency medicine residents per 1M pop.	👎	10.6
Adverse event reporting required		No
Hospital-based infections reporting required		No
Mandatory quality reporting requirement		Yes
% of counties with E-911 capability		93.3
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		Yes
Statewide trauma registry		Yes
% of hospitals with computerized practitioner order entry		28.4
% of hospitals with electronic medical records		40.3
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival		44
Number of Joint Commission reviewed sentinel events per 1M pop. (1995–2006)		16

PUBLIC HEALTH & INJURY PREVENTION — D-

Indicator	Trend	Value
Traffic fatalities per 100,000 pop.		20.9
% of traffic fatalities alcohol related	👎	45.0
Front occupant restraint use (%)		80.9
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	👎	74.8
% of adults aged 65+ who received flu vaccine in the last 12 months	👎	65.4
% of adults aged 65+ who ever received pneumococcal vaccine	👎	66.5
Fatal occupational injuries per 1M workers		38.3
Homicides and suicides (non-motor vehicle) per 100,000 pop.		24.8
Unintentional fall-related fatal injuries per 100,000 pop.		11.8
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)		0
% of tobacco settlement funds spent on health-related services and programs		100.0
Total injury prevention funds per 1,000 pop.		$18.42
Unintentional injury prevention funds per 1,000 pop.		$18.42
Intentional injury prevention funds per 1,000 pop.		$18.42
Fall injury prevention funds per 1,000 pop.		$0.00
Infant mortality rate per 1,000 live births		6.9
% of adults with BMI > 30		22.9
Current smokers, % of adults		18.2
Binge alcohol drinkers, % of adults		15.2

DISASTER PREPAREDNESS — A-

Indicator	Value
Per capita federal disaster preparedness funds	$9.51
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, No
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	12
Accredited by the Emergency Management Accreditation Program	Yes
Written plan specifically for special needs patients	Yes
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	Yes
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.	304.9
Burn unit beds per 1M pop.	7.9
ICU beds per 1M pop.	256.7
Verified burn centers per 1M pop.	0.2
State able to verify credentials and assign volunteer health professionals to four ESAR-VHP levels	Yes
Nurses registered in ESAR-VHP per 1M pop.	139.9
Physicians registered in ESAR-VHP per 1M pop.	28.6
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	Yes
Additional liability protections for health care workers during a disaster	Civil, not clearly defined
% of RNs that received any emergency training	40.4
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*