

# Arkansas

Arkansas is ranked last in the country for its overall emergency care environment. The state faces a wide range of significant challenges including an insufficient supply of physicians, numerous public health concerns, and inadequacies in the areas of trauma care, disaster preparedness, and quality initiatives.

**Strengths.** Arkansas' *Medical Liability Environment* is in relatively good shape due to the enactment of a few important medical liability reforms. The state enjoys average medical liability insurance premiums that are among the lowest in the country; premiums for primary care physicians and specialists are less than half the average across the states (\$7,632 and \$32,637, respectively).

Despite the state's poor score in *Access to Emergency Care*, Arkansas has some resources and facilities available to serve its population. For instance, only 7.4 percent of the population has an unmet need for substance abuse treatment. The state also ranked seventh for its relatively high rate of psychiatric care beds (45.3 per 100,000 people).

**Challenges.** Arkansas faces considerable challenges regarding *Access to Emergency Care* due to a severe workforce shortage. The state ranks among the worst five states in the nation in per capita access to emergency physicians, plastic surgeons, and orthopedists and hand surgeons. Arkansas is the only state in the nation with no Level I or II trauma centers and only 12.6 percent of the state's population lives within 60 minutes of a Level I or II trauma center in a neighboring state.

Compounding the shortages of emergency care services and specialists is the fact that many people in Arkansas have no health insurance coverage. More than 22.1 percent of adults are uninsured, compared to 17.2 percent nationally.

Both *Disaster Preparedness* and the *Quality and Patient Safety Environment* pose significant problems for Arkansas. These grades point to the need to enhance the state's infrastructure and capacity on a number of levels. Arkansas has neither a patient nor victim tracking system nor a statewide medical communication system with one layer of redundancy. The state also lacks a real-time syndromic surveillance system. Similarly, the state's *Quality and Patient Safety Environment* is compromised by the low percentage of hospitals using electronic health records or computerized practitioner order entry systems, as well as the lack of a mandatory quality reporting requirement.

Arkansas has the third lowest seat belt use rate in the country. The state also has the second highest rate of unintentional burn-related fatalities (2.7 per 100,000 people). The levels of cigarette smoking, infant mortality, traffic fatalities, fatal occupational injuries, and deaths from firearms are above average as well, contributing to the state's poor grade in *Public Health and Injury Prevention*.

**Recommendations.** The high proportion of uninsured adults and the severe shortage of specialists, physicians, nurses, and facilities in the state may be contributing to problems such as hospital crowding, emergency department patient boarding, and ambulance diversion, all of which have been reported as serious concerns by emergency physicians in the state. Arkansas policy-makers should act immediately to address these issues to ensure that timely and adequate care is available to the entire population.

As the only state without a Level I or II trauma center, Arkansas needs to invest in trauma care and develop a statewide trauma system. Additional medical liability reforms such as caps on non-economic damages and special liability protection for

## Arkansas has a critical need for wide-scale improvements in the state's public health, disaster preparedness, and emergency care systems.

	RANK	GRADE
ACCESS TO EMERGENCY CARE	35	D-
QUALITY & PATIENT SAFETY ENVIRONMENT	50	F
MEDICAL LIABILITY ENVIRONMENT	12	C+
PUBLIC HEALTH & INJURY PREVENTION	47	F
DISASTER PREPAREDNESS	48	F
OVERALL	51	D-

EMTALA-mandated emergency care should also be considered to help recruit and retain physicians and encourage specialists to provide on-call emergency care.

While the state continues to have higher than average rates of obesity, Arkansas has made active efforts to reverse the trend with outreach, education, and surveillance initiatives, particularly among school-age children. The state should continue these efforts in full force and apply these lessons to address the relatively high rates of fatal injury and infant mortality in the state.

The multitude of low marks in Arkansas suggests a critical need for wide-scale investments and improvements in the state's public health, disaster preparedness, and emergency care systems. The application of information technologies and automated systems could be used to improve coordination, tracking, and communications across numerous areas of disaster planning and quality control.

**ACCESS TO EMERGENCY CARE** **D-**

Board-certified emergency physicians per 100,000 pop.	<b>4.0</b>
Emergency physicians per 100,000 pop.	<b>6.9</b>
Neurosurgeons per 100,000 pop.	<b>1.8</b>
Orthopedists and hand surgeon specialists per 100,000 pop.	<b>6.7</b>
Plastic surgeons per 100,000 pop.	<b>1.1</b>
ENT specialists per 100,000 pop.	<b>3.0</b>
Registered nurses per 100,000 pop.	<b>780.3</b>
Additional primary care FTEs needed	<b>61.8</b>
Additional mental health FTEs needed	<b>23.4</b>
Level I or II trauma centers per 1M pop.	<b>0.0</b>
% of population within 60 minutes of Level I or II trauma center	<b>12.6</b>
Accredited chest pain centers per 1M pop.	<b>0.4</b>
% of population with an unmet need for substance abuse treatment	<b>7.4</b>
Pediatric specialty centers per 1M pop.	<b>3.9</b>
Physicians accepting Medicare per 100 beneficiaries	<b>2.4</b>
Medicaid fee levels for office visits as a % of the national average	<b>103.0</b>
% change in Medicaid fees for office visits (2004-05 to 2007)	<b>9.8</b>
% of adults with no health insurance	<b>22.1</b>
% of children with no health insurance	<b>9.3</b>
% of adults with Medicaid	<b>6.3</b>
Emergency departments per 1M pop.	<b>28.8</b>
Hospital closures in 2006	<b>0</b>
Staffed inpatient beds per 100,000 pop.	<b>392.2</b>
Hospital occupancy rate per 100 staffed beds	<b>60.4</b>
Psychiatric care beds per 100,000 pop.	<b>45.3</b>
State collects data on diversion	<b>NR</b>

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

Lawyers per 10,000 pop.	<b>10.5</b>
Lawyers per physician	<b>0.5</b>
Lawyers per emergency physician	<b>15.1</b>
ATRA judicial hellholes (range 0 to -7)	<b>0</b>
Malpractice award payments/100,000 pop.	<b>2.0</b>
Average malpractice award payments	<b>\$239,127</b>
Databank reports per 1,000 physicians	<b>16.8</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>9.8</b>
Average medical liability insurance premium for primary care physicians	<b>\$7,632</b>
Average medical liability insurance premiums for specialists	<b>\$32,637</b>
Pretrial screening panels	<b>No</b>
Are pretrial screening panels' findings admissible as evidence?	<b>N/A</b>
Periodic payments	<b>Upon request or agreement of party(ies)</b>
Medical liability cap on non-economic damages	<b>No</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>Yes</b>
Expert witness must be licensed to practice medicine in the state	<b>No</b>

**QUALITY & PATIENT SAFETY ENVIRONMENT** **F**

Funding for quality improvement within the EMS system	<b>NR</b>
Funded state EMS medical director	<b>Yes</b>
Emergency medicine residents per 1M pop.	<b>8.8</b>
Adverse event reporting required	<b>No</b>
Hospital-based infections reporting required	<b>Yes</b>
Mandatory quality reporting requirement	<b>No</b>
% of counties with E-911 capability	<b>94.7</b>
Uniform system for providing pre-arrival instructions	<b>NR</b>
State has or is working on a stroke system of care	<b>NR</b>
State has or is working on a PCI network or a STEMI system of care	<b>NR</b>
Statewide trauma registry	<b>Yes</b>
% of hospitals with computerized practitioner order entry	<b>4.0</b>
% of hospitals with electronic medical records	<b>23.3</b>
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	<b>49</b>
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	<b>10</b>

**PUBLIC HEALTH & INJURY PREVENTION** **F**

Traffic fatalities per 100,000 pop.	<b>23.7</b>
% of traffic fatalities alcohol related	<b>38.0</b>
Front occupant restraint use (%)	<b>69.9</b>
Helmet use required for all motorcycle riders	<b>No</b>
Child safety seat/seat belt legislation (10 points possible)	<b>2</b>
% of children immunized, aged 19-35 months	<b>74.9</b>
% of adults aged 65+ who received flu vaccine in the last 12 months	<b>68.6</b>
% of adults aged 65+ who ever received pneumococcal vaccine	<b>64.4</b>
Fatal occupational injuries per 1M workers	<b>60.6</b>
Homicides and suicides (non-motor vehicle) per 100,000 pop.	<b>22.3</b>
Unintentional fall-related fatal injuries per 100,000 pop.	<b>4.9</b>
Unintentional fire/burn-related fatal injuries per 100,000 pop.	<b>2.7</b>
Unintentional firearm-related fatal injuries per 100,000 pop.	<b>0.7</b>
Gun-purchasing legislation (8 points possible)	<b>0</b>
% of tobacco settlement funds spent on health-related services and programs	<b>98.8</b>
Total injury prevention funds per 1,000 pop.	<b>\$125.82</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>NR</b>
Infant mortality rate per 1,000 live births	<b>7.9</b>
% of adults with BMI > 30	<b>26.9</b>
Current smokers, % of adults	<b>23.7</b>
Binge alcohol drinkers, % of adults	<b>12.4</b>

**DISASTER PREPAREDNESS** **F**

Per capita federal disaster preparedness funds	<b>\$7.34</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, Yes</b>
Public health and emergency physician input into the daily operations of the SEOC	<b>NR</b>
Written plan for the coordination of the SEOC or local EMAs to provide security to hospitals in case of emergency events	<b>NR</b>
Number of drills and exercises conducted involving hospital personnel, equipment, or facilities	<b>252</b>
Accredited by the Emergency Management Accreditation Program	<b>No</b>
Written plan specifically for special needs patients	<b>NR</b>
Written plan to supply medications for chronic conditions	<b>NR</b>
Written plan to supply dialysis for patients	<b>NR</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>No</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>No</b>
Real-time surveillance system in place for common ED presentations	<b>NR</b>
Bed surge capacity per 1M pop.	<b>NR</b>
Burn unit beds per 1M pop.	<b>3.5</b>
ICU beds per 1M pop.	<b>427.5</b>
Verified burn centers per 1M pop.	<b>0.4</b>
State able to verify credentials and assign volunteer health professionals to four ESAR-VHP levels	<b>Yes</b>
Nurses registered in ESAR-VHP per 1M pop.	<b>70.6</b>
Physicians registered in ESAR-VHP per 1M pop.	<b>17.6</b>
Training required in disaster management and response to bio- and chem terrorism for essential hospital personnel, EMS personnel	<b>Yes, No</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>39.9</b>
State requires EMS and essential ED personnel to be NIMS compliant	<b>NR</b>

	Improved since 2006
	Worsened since 2006
	No change since 2006
<b>NR</b>	Not reported
<b>N/A</b>	Not applicable
See Summary Statistics for State Comparisons	