

Illinois

Illinois has implemented comprehensive systems and programs that reflect well on the state’s commitment to *Disaster Preparedness* and the *Quality and Patient Safety Environment*. However, serious problems exist elsewhere, including a shortage of health care providers, poor Medicaid reimbursement policies, and a highly unfavorable *Medical Liability Environment*.

Strengths. Illinois’ commitment to improving the *Quality and Patient Safety Environment* has been demonstrated through funding for quality improvement of the emergency medical system, implementation of a uniform system for providing pre-arrival instructions, maintenance of a statewide trauma registry, and ongoing efforts to develop a stroke system of care. In addition, the state requires reporting of adverse events and hospital-based infections.

Illinois also appears to have accomplished a great deal in the area of *Disaster Preparedness*, especially with regard to the ability to manage volunteer health professionals. The state provides additional civil liability protections to health care workers during a disaster, and is capable of verifying credentials and assigning volunteers to one of the four Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) levels in the state. Illinois had 42.3 physicians registered with ESAR-VHP per 1 million people, ranking 10th among the states. In addition, the Illinois Medical Emergency Response Team has received state and federal recognition for numerous disaster response efforts.

Challenges. The *Medical Liability Environment* in Illinois fares quite poorly. The average malpractice award payment (\$543,983) is the highest of any state, as is the average medical liability premium for primary care physicians (\$71,467). Illinois lacks pretrial screening panels and liability

protections for EMTALA-mandated emergency care. In addition, compared with other states, Illinois has a very low number of insurers writing medical liability policies (2.6 per 1,000 physicians), which may be indicative of the reluctance of insurers to maintain their share in the market due to the high malpractice payments that have been awarded.

Illinois is facing a shortage of primary care and mental health professionals, as well as certain specialists. An additional 448 full-time primary care providers and 75 full-time mental health professionals are needed to serve the Illinois population in those two categories of providers alone. The shortage of health care workers may be exacerbated by the low Medicaid reimbursement rates for office visits. Illinois’ Medicaid fee levels for office visits are 71.1 percent of the national average.

There are a few noteworthy problems in Illinois related to *Public Health and Injury Prevention*. Illinois ranks 48th among the states for the percentage of people who are binge drinkers (19.3 percent). The high rate of binge drinkers may be reflected in the relatively high percentage of traffic fatalities that are alcohol-related: 47.0 percent compared to a national rate of 42 percent.

Recommendations. Above all, Illinois must maintain the medical liability reforms that have been enacted and strive to further improve its *Medical Liability Environment*. While the state faces a challenge to its medical liability cap on non-economic damages, policymakers must keep in mind the positive effects this and other reforms have on the state’s ability to attract and maintain an adequate health professional workforce, in essence improving the quality and timeliness of care. In addition to maintaining current reforms, Illinois should strive to implement additional li-

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	RANK	GRADE
ACCESS TO EMERGENCY CARE	39	D-
QUALITY & PATIENT SAFETY ENVIRONMENT	8	A-
MEDICAL LIABILITY ENVIRONMENT	34	D
PUBLIC HEALTH & INJURY PREVENTION	28	D+
DISASTER PREPAREDNESS	8	A-
OVERALL	27	C

ability reforms such as instituting pretrial screening panels and abolishing joint and several liability.

Increasing Medicaid reimbursement rates should be strongly considered to help attract and retain much needed primary care physicians and specialists, while at the same time improving the quality and accessibility of care for Medicaid beneficiaries.

Illinois should take steps to address hospital crowding and the boarding of patients in emergency departments, which have been identified by emergency physicians in the state as priority concerns. One possible contributor to the problem is the state’s low rate of emergency departments (12.4 per 1 million people compared to an average across the states of 19.9 per 1 million people). The state could also work to increase the numbers of inpatient and psychiatric care beds (309.5 and 20.0 per 100,000 people, respectively), both of which are less than the average state (358.3 and 29.9 per 100,000, respectively).


ACCESS TO EMERGENCY CARE **D-**

Board-certified emergency physicians per 100,000 pop.	 9.9
Emergency physicians per 100,000 pop.	13.3
Neurosurgeons per 100,000 pop.	1.9
Orthopedists and hand surgeon specialists per 100,000 pop.	8.1
Plastic surgeons per 100,000 pop.	2.0
ENT specialists per 100,000 pop.	3.0
Registered nurses per 100,000 pop.	 815.0
Additional primary care FTEs needed	447.7
Additional mental health FTEs needed	75.3
Level I or II trauma centers per 1M pop.	4.4
% of population within 60 minutes of Level I or II trauma center	92.5
Accredited chest pain centers per 1M pop.	1.0
% of population with an unmet need for substance abuse treatment	8.8
Pediatric specialty centers per 1M pop.	3.0
Physicians accepting Medicare per 100 beneficiaries	2.7
Medicaid fee levels for office visits as a % of the national average	71.1
% change in Medicaid fees for office visits (2004-05 to 2007)	0.1
% of adults with no health insurance	15.6
% of children with no health insurance	9.5
% of adults with Medicaid	6.6
Emergency departments per 1M pop.	 12.4
Hospital closures in 2006	0
Staffed inpatient beds per 100,000 pop.	309.5
Hospital occupancy rate per 100 staffed beds	66.6
Psychiatric care beds per 100,000 pop.	20.0
State collects data on diversion	Yes






MEDICAL LIABILITY ENVIRONMENT **D**

Lawyers per 10,000 pop.	25.2
Lawyers per physician	0.9
Lawyers per emergency physician	18.9
ATRA judicial hellholes (range 0 to -7)	-7
Malpractice award payments/100,000 pop.	0.7
Average malpractice award payments	\$543,983
Databank reports per 1,000 physicians	14.9
Patient compensation fund	No
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	2.6
Average medical liability insurance premium for primary care physicians	\$71,467
Average medical liability insurance premiums for specialists	\$77,494
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	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	No

QUALITY & PATIENT SAFETY ENVIRONMENT **A-**


Funding for quality improvement within the EMS system	Yes
Funded state EMS medical director	Yes
Emergency medicine residents per 1M pop.	 22.2
Adverse event reporting required	Yes
Hospital-based infections reporting required	Yes
Mandatory quality reporting requirement	Yes
% of counties with E-911 capability	83.5
Uniform system for providing pre-arrival instructions	Yes
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	31.4
% of hospitals with electronic medical records	51.9
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	48
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	21


PUBLIC HEALTH & INJURY PREVENTION **D+**


Traffic fatalities per 100,000 pop.	 9.8
% of traffic fatalities alcohol related	 47.0
Front occupant restraint use (%)	90.1
Helmet use required for all motorcycle riders	No
Child safety seat/seat belt legislation (10 points possible)	7
% of children immunized, aged 19-35 months	 79.6
% of adults aged 65+ who received flu vaccine in the last 12 months	 66.4
% of adults aged 65+ who ever received pneumococcal vaccine	 60.0
Fatal occupational injuries per 1M workers	33.3
Homicides and suicides (non-motor vehicle) per 100,000 pop.	15.3
Unintentional fall-related fatal injuries per 100,000 pop.	4.8
Unintentional fire/burn-related fatal injuries per 100,000 pop.	1.2
Unintentional firearm-related fatal injuries per 100,000 pop.	0.2
Gun-purchasing legislation (8 points possible)	4
% of tobacco settlement funds spent on health-related services and programs	78.0
Total injury prevention funds per 1,000 pop.	\$162.61
Unintentional injury prevention funds per 1,000 pop.	\$21.55
Intentional injury prevention funds per 1,000 pop.	\$9.96
Fall injury prevention funds per 1,000 pop.	\$0.00
Infant mortality rate per 1,000 live births	7.4
% of adults with BMI > 30	25.1
Current smokers, % of adults	20.5
Binge alcohol drinkers, % of adults	19.3

DISASTER PREPAREDNESS **A-**

Per capita federal disaster preparedness funds	\$10.90
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, 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	1,047
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	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.	576.3
Burn unit beds per 1M pop.	5.1
ICU beds per 1M pop.	250.5
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.	32.2
Physicians registered in ESAR-VHP per 1M pop.	42.3
Training required in disaster management and response to bio- and chem terrorism for essential hospital personnel, EMS personnel	Yes, 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	42.2
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*