

# Kansas

Kansas has one of the most favorable *Medical Liability Environments* in the nation and outperforms most states with its low percentage of uninsured residents, high rates of critical health care facilities, and increasing Medicaid reimbursement rates for office visits. However, the area of *Disaster Preparedness* needs significant attention.

**Strengths.** Kansas enjoys a highly favorable *Medical Liability Environment*. The average malpractice award payment in the state (\$181,675) is the fourth lowest in the nation. Likewise, the average medical liability insurance premium for primary care physicians and specialists (\$10,367 and \$46,060, respectively) situate Kansas among the 15 states with the lowest rates. The state boasts a \$250,000 cap on non-economic damages, and in 2008, it implemented pretrial screening panels.

The state's high rank in *Access to Emergency Care* is largely attributable to relatively low rates of uninsured residents, high rates of hospital beds and facilities, and Medicaid fee levels for office visits that are above the national average and that have increased 54.3 percent from 2004 to 2007. Only 14.0 percent of adults and 7.3 percent of children are uninsured in Kansas, compared to 17.2 and 11.7 percent, respectively, nationwide. Kansas is among the top five states for its high rates of psychiatric care beds and emergency departments per capita, as well as its low daily hospital occupancy rate.

While overall Kansas did not fare well with regard to *Disaster Preparedness*, the state has an all-hazards medical response plan, as well as a plan for the coordination of the State Emergency Operations Center or local emergency management agencies to provide security to hospitals during a disaster event. In addition, the state benefits

from the second highest bed surge capacity in the nation (1,489.6 beds per 1 million people).

**Challenges.** The *Quality and Patient Safety Environment* in Kansas faces a number of challenges including a lack of emergency medicine residents, no funding for quality improvement within the EMS system or for a state EMS medical director position, and the absence of a uniform system for providing pre-arrival instructions.

Although Kansas has suffered multiple devastating natural disasters in recent years, including major tornadoes, floods, and severe storms, the state receives only \$7.93 per person in federal disaster preparedness funds compared to an average of \$13.82 per capita across the states. The state lacks specific written plans for special needs patients, for those on dialysis, and for supplying medications for chronic conditions in the event of a disaster. In addition, while Kansas does have an Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program, the state has failed to register any physicians.

While Kansas ranks among the top 12 states in terms of influenza and pneumococcal vaccination rates among residents aged 65 years or older, there were a few notable issues of concern related to *Public Health and Injury Prevention*. The percentage of children who receive the recommended schedule of immunizations is slightly below the national rate (79.0 percent versus 80.5 percent, respectively). The state also has a below average rate of front occupant restraint use (75.0 percent) and a relatively high rate of fatal occupational injuries (60.3 per 1 million people).

**Recommendations.** Kansas has already begun to improve the *Quality and Patient Safety Environment*. The University of

## There is a clear need for increased investment in disaster planning in Kansas.

	RANK	GRADE
ACCESS TO EMERGENCY CARE	7	B-
QUALITY & PATIENT SAFETY ENVIRONMENT	38	D+
MEDICAL LIABILITY ENVIRONMENT	3	A
PUBLIC HEALTH & INJURY PREVENTION	22	C
DISASTER PREPAREDNESS	37	D+
OVERALL	8	C+

Kansas School of Medicine is establishing an emergency medicine residency program, which is expected to admit its first group of residents in 2009–2010. Other efforts to address deficiencies in this category should include providing funding for quality improvement within the EMS system and a state EMS medical director position.

With the state's vulnerability to natural disasters, there is a clear need for increased investment in disaster planning in Kansas, along with continued efforts to expand planning, implement disaster training requirements, develop strike teams or medical assistance teams, and enroll physicians in the ESAR-VHP system.

Furthermore, Kansas could improve its *Public Health and Injury Prevention* grade by promoting and enforcing front occupant restraint use and making efforts to help employers decrease the likelihood of fatal occupational injuries.

**ACCESS TO EMERGENCY CARE** **B-**

Board-certified emergency physicians per 100,000 pop.	<b>7.1</b>
Emergency physicians per 100,000 pop.	<b>7.9</b>
Neurosurgeons per 100,000 pop.	<b>1.3</b>
Orthopedists and hand surgeon specialists per 100,000 pop.	<b>9.0</b>
Plastic surgeons per 100,000 pop.	<b>2.1</b>
ENT specialists per 100,000 pop.	<b>3.2</b>
Registered nurses per 100,000 pop.	<b>873.4</b>
Additional primary care FTEs needed	<b>65.8</b>
Additional mental health FTEs needed	<b>22.8</b>
Level I or II trauma centers per 1M pop.	<b>1.8</b>
% of population within 60 minutes of Level I or II trauma center	<b>75.4</b>
Accredited chest pain centers per 1M pop.	<b>2.5</b>
% of population with an unmet need for substance abuse treatment	<b>8.8</b>
Pediatric specialty centers per 1M pop.	<b>4.7</b>
Physicians accepting Medicare per 100 beneficiaries	<b>3.1</b>
Medicaid fee levels for office visits as a % of the national average	<b>109.4</b>
% change in Medicaid fees for office visits (2004-05 to 2007)	<b>54.3</b>
% of adults with no health insurance	<b>14.0</b>
% of children with no health insurance	<b>7.3</b>
% of adults with Medicaid	<b>5.7</b>
Emergency departments per 1M pop.	<b>46.4</b>
Hospital closures in 2006	<b>1</b>
Staffed inpatient beds per 100,000 pop.	<b>446.0</b>
Hospital occupancy rate per 100 staffed beds	<b>57.2</b>
Psychiatric care beds per 100,000 pop.	<b>46.6</b>
State collects data on diversion	<b>Yes</b>

**MEDICAL LIABILITY ENVIRONMENT** **A**

Lawyers per 10,000 pop.	<b>13.4</b>
Lawyers per physician	<b>0.6</b>
Lawyers per emergency physician	<b>16.8</b>
ATRA judicial hellholes (range 0 to -7)	<b>0</b>
Malpractice award payments/100,000 pop.	<b>2.1</b>
Average malpractice award payments	<b>\$181,675</b>
Databank reports per 1,000 physicians	<b>32.2</b>
Patient compensation fund	<b>Yes</b>
Health court pilot project grant	<b>No</b>
Number of insurers writing medical liability policies per 1,000 physicians	<b>9.1</b>
Average medical liability insurance premium for primary care physicians	<b>\$10,367</b>
Average medical liability insurance premiums for specialists	<b>\$46,060</b>
Pretrial screening panels	<b>Voluntary</b>
Are pretrial screening panels' findings admissible as evidence?	<b>Yes</b>
Periodic payments	<b>At judge's or court's discretion</b>
Medical liability cap on non-economic damages	<b>\$250,000</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>No</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** **D+**

Funding for quality improvement within the EMS system	<b>No</b>
Funded state EMS medical director	<b>No</b>
Emergency medicine residents per 1M pop.	<b>0.0</b>
Adverse event reporting required	<b>Yes</b>
Hospital-based infections reporting required	<b>No</b>
Mandatory quality reporting requirement	<b>Yes</b>
% of counties with E-911 capability	<b>99.1</b>
Uniform system for providing pre-arrival instructions	<b>No</b>
State has or is working on a stroke system of care	<b>Yes</b>
State has or is working on a PCI network or a STEMI system of care	<b>Yes</b>
Statewide trauma registry	<b>Yes</b>
% of hospitals with computerized practitioner order entry	<b>6.8</b>
% of hospitals with electronic medical records	<b>20.2</b>
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	<b>58</b>
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	<b>13</b>

**PUBLIC HEALTH & INJURY PREVENTION** **C**

Traffic fatalities per 100,000 pop.	<b>16.9</b>
% of traffic fatalities alcohol related	<b>36.0</b>
Front occupant restraint use (%)	<b>75.0</b>
Helmet use required for all motorcycle riders	<b>No</b>
Child safety seat/seat belt legislation (10 points possible)	<b>5</b>
% of children immunized, aged 19-35 months	<b>79.0</b>
% of adults aged 65+ who received flu vaccine in the last 12 months	<b>72.5</b>
% of adults aged 65+ who ever received pneumococcal vaccine	<b>69.5</b>
Fatal occupational injuries per 1M workers	<b>60.3</b>
Homicides and suicides (non-motor vehicle) per 100,000 pop.	<b>17.0</b>
Unintentional fall-related fatal injuries per 100,000 pop.	<b>7.6</b>
Unintentional fire/burn-related fatal injuries per 100,000 pop.	<b>1.3</b>
Unintentional firearm-related fatal injuries per 100,000 pop.	<b>0.3</b>
Gun-purchasing legislation (8 points possible)	<b>1</b>
% of tobacco settlement funds spent on health-related services and programs	<b>32.3</b>
Total injury prevention funds per 1,000 pop.	<b>\$533.86</b>
Unintentional injury prevention funds per 1,000 pop.	<b>\$371.04</b>
Intentional injury prevention funds per 1,000 pop.	<b>\$162.82</b>
Fall injury prevention funds per 1,000 pop.	<b>\$3.60</b>
Infant mortality rate per 1,000 live births	<b>7.4</b>
% of adults with BMI > 30	<b>25.9</b>
Current smokers, % of adults	<b>20.0</b>
Binge alcohol drinkers, % of adults	<b>15.4</b>

**DISASTER PREPAREDNESS** **D+**

Per capita federal disaster preparedness funds	<b>\$7.93</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>NR</b>
Public health and emergency physician input into the daily operations of the SEOC	<b>No, No</b>
Written plan for the coordination of the SEOC or local EMAs to provide security to hospitals in case of emergency events	<b>Yes</b>
Number of drills and exercises conducted involving hospital personnel, equipment, or facilities	<b>24</b>
Accredited by the Emergency Management Accreditation Program	<b>No</b>
Written plan specifically for special needs patients	<b>No</b>
Written plan to supply medications for chronic conditions	<b>No</b>
Written plan to supply dialysis for patients	<b>No</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>Yes</b>
Statewide patient tracking system	<b>Yes</b>
Statewide victim tracking system	<b>Yes</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>1,489.6</b>
Burn unit beds per 1M pop.	<b>8.3</b>
ICU beds per 1M pop.	<b>358.9</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>16.9</b>
Physicians registered in ESAR-VHP per 1M pop.	<b>0.0</b>
Training required in disaster management and response to bio- and chem terrorism for essential hospital personnel, EMS personnel	<b>No, No</b>
State or regional strike teams or medical assistance teams	<b>No</b>
Additional liability protections for health care workers during a disaster	<b>Yes, civil</b>
% of RNs that received any emergency training	<b>41.3</b>
State requires EMS and essential ED personnel to be NIMS compliant	<b>No</b>

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