

Montana

Although Montana has worked to create a favorable *Medical Liability Environment*, the state must address an array of serious problems including high rates of fatal occupational injuries and traffic fatalities, and a lack of disaster training requirements for EMS and essential hospital personnel.

Strengths. With regard to the *Medical Liability Environment*, Montana has average medical liability insurance premiums for primary care physicians (\$14,256) and specialists (\$68,279) that are slightly lower than the averages across the states (\$16,042 and \$65,489, respectively). The state has also passed a variety of liability reforms. Montana has imposed a \$250,000 medical liability cap on non-economic damages, has partially abolished joint and several liability, requires expert witnesses to be of the same specialty as the defendant, and has imposed mandatory pretrial screening panels.

Despite its vast frontier areas, Montana has a number of positive indicators regarding *Access to Emergency Care*. The state ranks among the top 10 for its high rates of emergency departments (54.9 per 1 million people), pediatric specialty centers (8.4 per 1 million people), and staffed inpatient beds (495.4 per 100,000 people). The state also has relatively high rates of orthopedists and hand surgeons (11.7 per 100,000 people)

and neurosurgeons (2.2 per 100,000). In contrast, however, the state has low rates of emergency physicians, including board-certified emergency physicians; plastic surgeons; ear, nose, and throat specialists; and registered nurses per capita.

Challenges. The state's poor performance with regard to the *Quality and Patient Safety Environment* reflects numerous issues, including the lack of a funded state EMS medical director position and a uniform

system for providing pre-arrival instructions, as well as a disproportionately low percentage of counties that have Enhanced 911 capability. In addition, the state lacks adverse event and hospital-based infections reporting requirements. Montana hospitals have also shown relatively low use of computerized practitioner order entry and electronic medical records, for which the state ranks 48th.

Montana faces numerous challenges related to *Public Health and Injury Prevention*. The state has among the five highest rates of traffic fatalities (27.8 per 100,000 people), homicides and suicides (25.6 per 100,000), and fatal occupational injuries (103.1 per 1 million workers). Despite the state's high immunization rates for influenza and pneumonia among the older adult population, Montana has the third lowest percentage of children aged 19-35 months who are up-to-date on their immunizations (73.6 percent).

While Montana benefits from a relatively high level of federal funding for *Disaster Preparedness* (\$14.90 per capita), this category poses a number of problems for the state. The state has an all-hazards medical response plan; however, there is no written plan for the coordination of the State Emergency Operations Center or local emergency management agencies to provide security to hospitals during an emergency event. The state also lacks written plans specifically for patients with special needs, dialysis patients, and those needing medications for chronic conditions. Montana has also failed to implement a "just-in-time" training system and statewide patient and victim tracking systems. While the state ranks first in the nation for bed surge capacity (1,761.2 per 1 million people), Montana lacks any burn unit beds and has an average number of ICU beds (294.7 per 1 million).




Montana faces numerous challenges related to public health and injury prevention.

	RANK	GRADE
ACCESS TO EMERGENCY CARE	24	C-
QUALITY & PATIENT SAFETY ENVIRONMENT	40	D+
MEDICAL LIABILITY ENVIRONMENT	7	B
PUBLIC HEALTH & INJURY PREVENTION	46	F
DISASTER PREPAREDNESS	44	D-
OVERALL	35	C-

Recommendations. To improve the state of emergency medicine throughout Montana, the state should invest more fully in tools, programs, and systems to promote greater disaster preparedness and coordination, improve injury prevention and public health outcomes, and effectively monitor the quality and safety environment.

Despite the strong effort Montana has made to institute effective and meaningful medical liability reforms, the state's average malpractice award remains slightly higher than the average across the states (\$287,944 versus \$285,218). The state should consider instituting further reforms, such as providing additional liability protections for EMTALA-mandated emergency care, which could also help draw more specialists and emergency physicians to the state, filling that critical need.

ACCESS TO EMERGENCY CARE C-

Board-certified emergency physicians per 100,000 pop.	 9.2
Emergency physicians per 100,000 pop.	10.6
Neurosurgeons per 100,000 pop.	2.2
Orthopedists and hand surgeon specialists per 100,000 pop.	11.7
Plastic surgeons per 100,000 pop.	1.7
ENT specialists per 100,000 pop.	3.1
Registered nurses per 100,000 pop.	 756.2
Additional primary care FTEs needed	67.5
Additional mental health FTEs needed	12.4
Level I or II trauma centers per 1M pop.	4.2
% of population within 60 minutes of Level I or II trauma center	37.9
Accredited chest pain centers per 1M pop.	1.0
% of population with an unmet need for substance abuse treatment	9.8
Pediatric specialty centers per 1M pop.	8.4
Physicians accepting Medicare per 100 beneficiaries	3.0
Medicaid fee levels for office visits as a % of the national average	112.6
% change in Medicaid fees for office visits (2004-05 to 2007)	6.5
% of adults with no health insurance	17.9
% of children with no health insurance	14.5
% of adults with Medicaid	7.5
Emergency departments per 1M pop.	 54.9
Hospital closures in 2006	0
Staffed inpatient beds per 100,000 pop.	495.4
Hospital occupancy rate per 100 staffed beds	65.6
Psychiatric care beds per 100,000 pop.	30.8
State collects data on diversion	No





MEDICAL LIABILITY ENVIRONMENT B

Lawyers per 10,000 pop.	17.2
Lawyers per physician	0.8
Lawyers per emergency physician	16.0
ATRA judicial hellholes (range 0 to -7)	0
Malpractice award payments/100,000 pop.	5.4
Average malpractice award payments	\$287,944
Databank reports per 1,000 physicians	30.6
Patient compensation fund	No
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	24.4
Average medical liability insurance premium for primary care physicians	\$14,256
Average medical liability insurance premiums for specialists	\$68,279
Pretrial screening panels	Mandatory
Are pretrial screening panels' findings admissible as evidence?	No
Periodic payments	Upon request or agreement of party(ies)
Medical liability cap on non-economic damages	\$250,000
Additional liability protection for EMTALA-mandated emergency care	No
Joint and several liability abolished	Partially
State provides for case certification	No
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 D+


Funding for quality improvement within the EMS system	Yes
Funded state EMS medical director	No
Emergency medicine residents per 1M pop.	0.0
Adverse event reporting required	No
Hospital-based infections reporting required	No
Mandatory quality reporting requirement	Yes
% of counties with E-911 capability	81.7
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	5.5
% of hospitals with electronic medical records	18.5
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	73
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	18


PUBLIC HEALTH & INJURY PREVENTION F


Traffic fatalities per 100,000 pop.	27.8
% of traffic fatalities alcohol related	 48.0
Front occupant restraint use (%)	79.6
Helmet use required for all motorcycle riders	No
Child safety seat/seat belt legislation (10 points possible)	3
% of children immunized, aged 19-35 months	 73.6
% of adults aged 65+ who received flu vaccine in the last 12 months	 72.6
% of adults aged 65+ who ever received pneumococcal vaccine	 71.5
Fatal occupational injuries per 1M workers	103.1
Homicides and suicides (non-motor vehicle) per 100,000 pop.	25.6
Unintentional fall-related fatal injuries per 100,000 pop.	12.2
Unintentional fire/burn-related fatal injuries per 100,000 pop.	1.0
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	49.0
Total injury prevention funds per 1,000 pop.	\$49.07
Unintentional injury prevention funds per 1,000 pop.	\$0.00
Intentional injury prevention funds per 1,000 pop.	\$0.00
Fall injury prevention funds per 1,000 pop.	\$0.00
Infant mortality rate per 1,000 live births	7.0
% of adults with BMI > 30	21.2
Current smokers, % of adults	18.9
Binge alcohol drinkers, % of adults	16.0

DISASTER PREPAREDNESS D-

Per capita federal disaster preparedness funds	\$14.90
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, No
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	No
Number of drills and exercises conducted involving hospital personnel, equipment, or facilities	116
Accredited by the Emergency Management Accreditation Program	Yes
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	No
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.	1,761.2
Burn unit beds per 1M pop.	0.0
ICU beds per 1M pop.	294.7
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.	108.6
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	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