

Oklahoma

A wide array of problems plagues the emergency care environment in Oklahoma which receives poor or failing scores in four of the five categories and ranks among the bottom 10 states in *Disaster Preparedness* and the *Quality and Patient Safety Environment*.

Strengths. Oklahoma supports a relatively favorable *Medical Liability Environment*. The state deserves to be credited as being one of only six that provide some additional liability protections for EMTALA-mandated emergency care. The state also requires case certification by an expert witness to determine whether the case has merit. The average malpractice award payment (\$230,787) is significantly lower than average across the states (\$285,218).

While Oklahoma fares poorly overall with respect to *Public Health and Injury Prevention*, there are some noteworthy high points. The state has a relatively low percentage of adults who engage in binge drinking (13.4 percent) as well as a low percentage of traffic fatalities involving alcohol (34.0 percent). The state also has a relatively high percentage of adults aged 65 and older who have ever received the pneumococcal vaccine (70.2 percent).

Challenges. The *Quality and Patient Safety Environment* in Oklahoma could benefit from substantial improvement. The state does not provide funding for quality improvement within the EMS system. Perhaps reflective of the lack of financial support is the low percentage of counties with Enhanced 911 capability (76.9 percent) and the lack of a uniform system for providing pre-arrival instructions. The state should be credited, however, for the establishment of an allopathic emergency medicine residency program since the release of the 2006 Report Card. (The data presented reflect the 2006-2007 school year, prior to residents entering the new program).

Access to emergency care in Oklahoma is plagued by a workforce shortage.

Access to Emergency Care in Oklahoma is plagued by a workforce shortage and a high rate of uninsured adults. While the new emergency medicine residency program may improve the workforce issue in the future, the state currently ranks among the bottom 10 for low rates of emergency physicians; orthopedists and hand surgeons; plastic surgeons; ear, nose, and throat specialists; and registered nurses. Oklahoma ranks in the bottom ten for the number of Level I or II trauma centers per 1 million people and almost one-third of the population does not live within 60 minutes of a Level I or II trauma center. More than 21 percent of Oklahoma’s adult population is uninsured compared to 17.2 percent of adults nationwide.

Oklahoma’s *Disaster Preparedness* grade suffers from a lack of real-time surveillance and communication systems, as well as a lack of planning for special needs patients. Oklahoma does not have patient or victim tracking systems or a real-time syndromic surveillance system. The state also lacks a statewide medical communication system with one layer of redundancy. Oklahoma could also benefit from implementing written plans specifically for special needs patients, for supplying medications for chronic conditions, and for supplying dialysis to patients during a disaster event.




Recommendations. As noted above, Oklahoma suffers from a severe shortage of specialists and nurses. These issues have likely contributed to hospital crowding and the boarding of patients in emergency departments, which have been reported as serious concerns by emergency physicians in the state. Oklahoma should act immediately to address these issues and work toward attracting, recruiting, and maintaining a broader workforce. The state should also continue to support the maintenance and expansion of emergency medicine residency programs in the state.

	RANK	GRADE
ACCESS TO EMERGENCY CARE	40	F
QUALITY & PATIENT SAFETY ENVIRONMENT	46	D-
MEDICAL LIABILITY ENVIRONMENT	10	B-
PUBLIC HEALTH & INJURY PREVENTION	36	D
DISASTER PREPAREDNESS	45	D-
OVERALL	50	D






The state must take action with regard to the high rates of uninsured children and adults. Patients who are unable to find affordable health insurance are less likely to be able to access preventive care and treatments and may delay necessary care until it has reached emergency status, further contributing to crowding. Access to preventive care, however, is also dependent upon a workforce sizeable enough to care for the entire population.

While the *Medical Liability Environment* is generally favorable compared to other states, Oklahoma may further improve in this area by implementing additional expert witness rules and a \$250,000 hard cap on non-economic damages. Such actions may decrease insurance premiums and encourage specialists to remain in or relocate to the state. The state may want to strengthen existing liability protections for providers of EMTALA mandated-care to help encourage specialists to provide on-call services to emergency patients.


ACCESS TO EMERGENCY CARE **F**

Board-certified emergency physicians per 100,000 pop.	 6.1
Emergency physicians per 100,000 pop.	7.4
Neurosurgeons per 100,000 pop.	1.8
Orthopedists and hand surgeon specialists per 100,000 pop.	7.4
Plastic surgeons per 100,000 pop.	1.2
ENT specialists per 100,000 pop.	2.5
Registered nurses per 100,000 pop.	 718.4
Additional primary care FTEs needed	66.9
Additional mental health FTEs needed	6.7
Level I or II trauma centers per 1M pop.	0.8
% of population within 60 minutes of Level I or II trauma center	67.9
Accredited chest pain centers per 1M pop.	0.8
% of population with an unmet need for substance abuse treatment	8.4
Pediatric specialty centers per 1M pop.	2.8
Physicians accepting Medicare per 100 beneficiaries	2.0
Medicaid fee levels for office visits as a % of the national average	128.9
% change in Medicaid fees for office visits (2004-05 to 2007)	12.1
% of adults with no health insurance	21.2
% of children with no health insurance	12.5
% of adults with Medicaid	5.3
Emergency departments per 1M pop.	 30.5
Hospital closures in 2006	0
Staffed inpatient beds per 100,000 pop.	363.7
Hospital occupancy rate per 100 staffed beds	60.6
Psychiatric care beds per 100,000 pop.	36.9
State collects data on diversion	No






MEDICAL LIABILITY ENVIRONMENT **B-**

Lawyers per 10,000 pop.	13.8
Lawyers per physician	0.7
Lawyers per emergency physician	18.4
ATRA judicial hellholes (range 0 to -7)	-1
Malpractice award payments/100,000 pop.	1.7
Average malpractice award payments	\$230,787
Databank reports per 1,000 physicians	29.6
Patient compensation fund	 No
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	7.6
Average medical liability insurance premium for primary care physicians	\$12,809
Average medical liability insurance premiums for specialists	\$51,811
Pretrial screening panels	 No
Are pretrial screening panels' findings admissible as evidence?	N/A
Periodic payments	No
Medical liability cap on non-economic damages	 \$250,001-350,000
Additional liability protection for EMTALA-mandated emergency care	 Yes
Joint and several liability abolished	 Partially
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 **D-**




Funding for quality improvement within the EMS system	No
Funded state EMS medical director	Yes
Emergency medicine residents per 1M pop.	 2.2
Adverse event reporting required	No
Hospital-based infections reporting required	Yes
Mandatory quality reporting requirement	Yes
% of counties with E-911 capability	76.9
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	No
Statewide trauma registry	Yes
% of hospitals with computerized practitioner order entry	9.3
% of hospitals with electronic medical records	19.8
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	52
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	16

PUBLIC HEALTH & INJURY PREVENTION **D**

Traffic fatalities per 100,000 pop.	21.4
% of traffic fatalities alcohol related	 34.0
Front occupant restraint use (%)	83.1
Helmet use required for all motorcycle riders	 No
Child safety seat/seat belt legislation (10 points possible)	5
% of children immunized, aged 19-35 months	 80.4
% of adults aged 65+ who received flu vaccine in the last 12 months	 70.6
% of adults aged 65+ who ever received pneumococcal vaccine	 70.2
Fatal occupational injuries per 1M workers	57.1
Homicides and suicides (non-motor vehicle) per 100,000 pop.	20.8
Unintentional fall-related fatal injuries per 100,000 pop.	6.2
Unintentional fire/burn-related fatal injuries per 100,000 pop.	2.0
Unintentional firearm-related fatal injuries per 100,000 pop.	0.5
Gun-purchasing legislation (8 points possible)	0
% of tobacco settlement funds spent on health-related services and programs	0.0
Total injury prevention funds per 1,000 pop.	\$479.14
Unintentional injury prevention funds per 1,000 pop.	\$283.57
Intentional injury prevention funds per 1,000 pop.	\$195.57
Fall injury prevention funds per 1,000 pop.	\$0.00
Infant mortality rate per 1,000 live births	8.1
% of adults with BMI > 30	28.8
Current smokers, % of adults	25.1
Binge alcohol drinkers, % of adults	13.4

DISASTER PREPAREDNESS **D-**

Per capita federal disaster preparedness funds	\$8.69
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?	No
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	No, No
Written plan for the coordination of the SEOC or local EMAs to provide security to hospitals in case of emergency events	NR
Number of drills and exercises conducted involving hospital personnel, equipment, or facilities	20
Accredited by the Emergency Management Accreditation Program	No
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	Statewide
Statewide medical communication system with one layer of redundancy	No
Statewide patient tracking system	No
Statewide victim tracking system	No
Statewide real-time or near real-time syndromic surveillance system	No
Real-time surveillance system in place for common ED presentations	NR
Bed surge capacity per 1M pop.	444.8
Burn unit beds per 1M pop.	9.1
ICU beds per 1M pop.	312.5
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.	265.9
Physicians registered in ESAR-VHP per 1M pop.	57.5
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	Yes
Additional liability protections for health care workers during a disaster	Civil, not clearly defined
% of RNs that received any emergency training	44.7
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	