Rhode Island

B-

Rhode Island ties for second overall, due to high scores in all categories with the exception of the *Medical Liability Environment*, for which the state received a failing grade.

Strengths. Rhode Island's grade with regard to *Access to Emergency Care* is due in part to an extensive workforce. Rhode Island has the second highest rate of emergency physicians per capita (18.4 per 100,000 people) and similarly high rates of specialists such as neurosurgeons (2.7 per 100,000) and orthopedists and hand surgeons (12.9 per 100,000). While the state has only one Level I or II trauma center per 1 million people, virtually the entire population of the state (99.9 percent) lives within 60 minutes of a Level I or II trauma center. The state has the third lowest percentage of uninsured adults and the lowest percentage of uninsured children in the country (9.9 and 4.1 percent, respectively). However, with the recent cuts to the State Children's Health Insurance Program (SCHIP), Rhode Island has now eliminated coverage for 1,000 low-income parents, and the number of uninsured children is expected to rise dramatically in the next year.

Rhode Island fares better than most states with regard to the *Quality and Patient Safety Environment*, despite not providing funding for quality improvement within the EMS system. This good performance is due to a number of factors, including the relatively high rate of emergency medicine residents (44.4 per 1 million people) and a funded state EMS medical director position. The state also maintains a statewide trauma registry and has or is working on a stroke system of care and a PCI network or STEMI system of care.

High immunization rates among older adults, adequate funding for injury prevention programs, and the low rates of fatal occupation injuries and homicides and suicides, all contribute to Rhode Island's strong performance in *Public Health and Injury Prevention*.

Challenges. The *Medical Liability Environment* in Rhode Island is among the worst in the nation. The state suffers from a high rate of malpractice award payments (4.0 per 100,000 people) and lacks many significant medical liability reforms. For example, Rhode Island lacks any medical liability cap on non-economic damages, joint and several liability reform, and pretrial screening panels. In addition, the state's average annual medical liability insurance premium for specialists ($82,426) is significantly higher than the average across the states ($65,489).

While Rhode Island fares well with regard to *Disaster Preparedness* overall, there are some aspects of preparedness that could be significantly improved. While the state is capable of verifying the credentials of volunteer health professionals and assigning them to one of four levels within the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program, Rhode Island has relatively low rates of nurses and physicians registered in ESAR-VHP (45.4 and 4.7 per 1 million people, respectively). Anecdotal evidence suggests that many nurses and physicians are unaware that they can register in the system.

The medical liability environment is among the worst in the nation.

Recommendations. Despite Rhode Island's superior grade in *Access to Emergency Care*, the state faces numerous issues with regard to Medicaid reimbursement. The state ranks 49th for its low Medicaid fee levels for office visits (less than 50 percent of the national average) and has experienced a 21.0 percent decline in Medicaid reimbursements for office visits from 2004 to 2007. This issue should be addressed to maintain and improve Medicaid recipients' access to quality care.

Emergency physicians in the state identified a severe lack of on-call specialists as a priority concern, despite the relatively high rates of specialists living in the state. As a first step to addressing this issue, Rhode Island should consider implementing medical liability reforms aimed at reducing medical liability risk. The state could provide additional liability protections for all EMTALA-mandated emergency care and implement a medical liability cap on non-economic damages or pretrial screening panels.

While Rhode Island has an above average number of psychiatric care beds (37.2 per 100,000 people), the state has a shortage of mental health professionals and a relatively high percentage of the population with an unmet need for substance abuse treatment (9.3 percent). A lack of resources for psychiatric care and substance abuse treatment may contribute to such problems as psychiatric holds in the emergency department. Again, addressing the state's medical liability issues and increasing the pool of on-call specialists, including psychiatrists, may help to alleviate this issue somewhat.

	RANK	GRADE
ACCESS TO EMERGENCY CARE	10	B-
QUALITY & PATIENT SAFETY ENVIRONMENT	7	A
MEDICAL LIABILITY ENVIRONMENT	49	F
PUBLIC HEALTH & INJURY PREVENTION	8	B+
DISASTER PREPAREDNESS	13	B+
OVERALL	2	B-

ACCESS TO EMERGENCY CARE — B-

Indicator		Value
Board-certified emergency physicians per 100,000 pop.	👍	11.4
Emergency physicians per 100,000 pop.		18.4
Neurosurgeons per 100,000 pop.		2.7
Orthopedists and hand surgeon specialists per 100,000 pop.		12.9
Plastic surgeons per 100,000 pop.		2.6
ENT specialists per 100,000 pop.		3.3
Registered nurses per 100,000 pop.	👎	998.5
Additional primary care FTEs needed		12.1
Additional mental health FTEs needed		9.7
Level I or II trauma centers per 1M pop.		1.0
% of population within 60 minutes of Level I or II trauma center		99.9
Accredited chest pain centers per 1M pop.		0.0
% of population with an unmet need for substance abuse treatment		9.3
Pediatric specialty centers per 1M pop.		2.8
Physicians accepting Medicare per 100 beneficiaries		3.4
Medicaid fee levels for office visits as a % of the national average		49.1
% change in Medicaid fees for office visits (2004-05 to 2007)		-21.0
% of adults with no health insurance		9.9
% of children with no health insurance		4.1
% of adults with Medicaid		17.9
Emergency departments per 1M pop.	👍	11.3
Hospital closures in 2006		0
Staffed inpatient beds per 100,000 pop.		288.7
Hospital occupancy rate per 100 staffed beds		71.5
Psychiatric care beds per 100,000 pop.		37.2
State collects data on diversion		Yes

MEDICAL LIABILITY ENVIRONMENT — F

Indicator		Value
Lawyers per 10,000 pop.		19.1
Lawyers per physician		0.5
Lawyers per emergency physician		10.4
ATRA judicial hellholes (range 0 to -7)		-2
Malpractice award payments/100,000 pop.		4.0
Average malpractice award payments		$260,388
Databank reports per 1,000 physicians		19.2
Patient compensation fund	●	No
Health court pilot project grant		No
Number of insurers writing medical liability policies per 1,000 physicians		9.6
Average medical liability insurance premium for primary care physicians		$14,085
Average medical liability insurance premiums for specialists		$82,426
Pretrial screening panels	●	No
Are pretrial screening panels' findings admissible as evidence?		N/A
Periodic payments		No
Medical liability cap on non-economic damages	●	No
Additional liability protection for EMTALA-mandated emergency care	●	No
Joint and several liability abolished	●	No
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 — A

Indicator		Value
Funding for quality improvement within the EMS system		No
Funded state EMS medical director		Yes
Emergency medicine residents per 1M pop.	●	44.4
Adverse event reporting required		Yes
Hospital-based infections reporting required		Yes
Mandatory quality reporting requirement		Yes
% of counties with E-911 capability		100.0
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		27.3
% of hospitals with electronic medical records		81.8
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival		66
Number of Joint Commission reviewed sentinel events per 1M pop. (1995–2006)		20

PUBLIC HEALTH & INJURY PREVENTION — B+

Indicator		Value
Traffic fatalities per 100,000 pop.		7.6
% of traffic fatalities alcohol related	👍	51.0
Front occupant restraint use (%)		79.1
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	👎	82.2
% of adults aged 65+ who received flu vaccine in the last 12 months	👍	74.7
% of adults aged 65+ who ever received pneumococcal vaccine	👍	72.5
Fatal occupational injuries per 1M workers		15.1
Homicides and suicides (non-motor vehicle) per 100,000 pop.		9.6
Unintentional fall-related fatal injuries per 100,000 pop.		13.0
Unintentional fire/burn-related fatal injuries per 100,000 pop.		1.8
Unintentional firearm-related fatal injuries per 100,000 pop.		0.0
Gun-purchasing legislation (8 points possible)		6
% of tobacco settlement funds spent on health-related services and programs		0.0
Total injury prevention funds per 1,000 pop.		$331.62
Unintentional injury prevention funds per 1,000 pop.		$155.77
Intentional injury prevention funds per 1,000 pop.		$175.85
Fall injury prevention funds per 1,000 pop.		$36.79
Infant mortality rate per 1,000 live births		6.5
% of adults with BMI > 30		21.4
Current smokers, % of adults		19.2
Binge alcohol drinkers, % of adults		17.6

DISASTER PREPAREDNESS — B+

Indicator	Value
Per capita federal disaster preparedness funds	$19.03
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	Yes, No
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	NR
Accredited by the Emergency Management Accreditation Program	No
Written plan specifically for special needs patients	Yes
Written plan to supply medications for chronic conditions	No
Written plan to supply dialysis for patients	Yes
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	Yes
Statewide victim tracking system	Yes
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.	472.7
Burn unit beds per 1M pop.	5.7
ICU beds per 1M pop.	314.6
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.	45.4
Physicians registered in ESAR-VHP per 1M pop.	4.7
Training required in disaster management and response to bio- and chem terrorism for essential hospital personnel, EMS personnel	Yes, Yes
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	38.8
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*