

Utah

Utah ranked among the top five states in the nation for both the *Public Health and Injury Prevention* and the *Quality and Patient Safety Environment* categories. However, high rates of uninsured residents and low facility capacity helped lead to poor marks in *Access to Emergency Care*.

Strengths. Utah has invested in the *Quality and Patient Safety Environment* through funding of quality improvement within the EMS system, as well as a state EMS medical director position. The state also has or is working on a stroke system of care and a PCI network or STEMI system of care and maintains a statewide trauma registry. Utah hospitals also demonstrate high usage of computerized practitioner order entry and electronic medical records (39.0 and 64.3 percent, respectively).

Utah fares quite well regarding *Public Health and Injury Prevention* indicators, with the nation's lowest infant mortality rate (4.5 deaths per 1,000 live births), as well as a relatively low percentage of obese adults (21.9 percent). Less than 10 percent of Utah's adult population are current smokers or binge drinkers, for which the state ranked first and third in the nation, respectively. On a related indicator, the state has the lowest percentage of traffic fatalities that are alcohol-related (24.0 percent).

Utah also has a relatively low percentage of persons needing, but not receiving, treatment for substance abuse services (7.6 percent). Other highlights with regard to *Access to Emergency Care* include relatively high rates of physicians accepting Medicare (3.5 per 100 beneficiaries) and pediatric specialty centers (5.0 per 1 million people).

Challenges. *Access to Emergency Care* in Utah is cause for concern. The state's grade

on this indicator was strongly affected by high rates of uninsured children and adults, as well as a relatively low percentage of adults insured through Medicaid. In addition, the state lacks any accredited chest pain centers and has the second lowest rate of staffed inpatient beds in the nation (210.2 per 100,000 people). Utah also has the fifth lowest rate of registered nurses currently in the workforce (646.2 per 100,000).

While Utah's average malpractice award payment is the 10th lowest in the nation, the average medical liability insurance premiums for specialists (\$68,352) are still higher than the average across the states. In addition, the state has not implemented expert witness rules such as case certification, requiring the witness to be of the same specialty as the defendant, or requiring witnesses to be licensed to practice medicine in the state. The state's \$400,000 medical liability cap on non-economic damages (indexed for inflation) is above the recommended hard \$250,000 cap.

While Utah has demonstrated initiative in planning for *Disaster Preparedness*, the state still lacks written plans for special needs patients, statewide patient and victim tracking systems, and a real-time or near real-time syndromic surveillance system. The state also lacks a real-time surveillance system for common emergency department presentations. Utah has a relatively low level of federal funding for disaster preparedness (\$8.05 per capita) and falls below average with regard to bed surge capacity and burn unit beds (366.7 and 4.5 per 1 million people, respectively).

Recommendations. Utah could improve access to medical care by increasing the percentage of the population with health insurance coverage, thereby encouraging preventive care and decreasing the like-




	RANK	GRADE
ACCESS TO EMERGENCY CARE	32	D-
QUALITY & PATIENT SAFETY ENVIRONMENT	3	A
MEDICAL LIABILITY ENVIRONMENT	23	C
PUBLIC HEALTH & INJURY PREVENTION	2	A
DISASTER PREPAREDNESS	25	C+
OVERALL	10	C+

likelihood that patients will present to the emergency department with more severe illnesses.


Utah should focus efforts on improving its *Medical Liability Environment* by providing additional liability protections for EMTALA-mandated emergency care and reducing the medical liability cap on non-economic damages. Doing so may help attract and retain more physicians and encourage more specialists to provide on-call services for emergency patients.

Investing further in *Disaster Preparedness* planning and infrastructure would improve the state's grade in this category significantly. The state should prepare plans for special needs patients, including plans to supply medications for chronic conditions or dialysis to patients during a disaster. Instituting patient and victim tracking systems also would enhance preparedness throughout the state.


ACCESS TO EMERGENCY CARE **D-**

Board-certified emergency physicians per 100,000 pop.	 9.4
Emergency physicians per 100,000 pop.	11.8
Neurosurgeons per 100,000 pop.	2.0
Orthopedists and hand surgeon specialists per 100,000 pop.	8.7
Plastic surgeons per 100,000 pop.	2.9
ENT specialists per 100,000 pop.	3.2
Registered nurses per 100,000 pop.	 646.2
Additional primary care FTEs needed	61.4
Additional mental health FTEs needed	11.3
Level I or II trauma centers per 1M pop.	1.5
% of population within 60 minutes of Level I or II trauma center	85.0
Accredited chest pain centers per 1M pop.	0.0
% of population with an unmet need for substance abuse treatment	7.6
Pediatric specialty centers per 1M pop.	5.0
Physicians accepting Medicare per 100 beneficiaries	3.5
Medicaid fee levels for office visits as a % of the national average	93.8
% change in Medicaid fees for office visits (2004-05 to 2007)	23.0
% of adults with no health insurance	18.6
% of children with no health insurance	15.0
% of adults with Medicaid	5.3
Emergency departments per 1M pop.	 12.4
Hospital closures in 2006	0
Staffed inpatient beds per 100,000 pop.	210.2
Hospital occupancy rate per 100 staffed beds	62.0
Psychiatric care beds per 100,000 pop.	23.8
State collects data on diversion	Yes





MEDICAL LIABILITY ENVIRONMENT **C**

Lawyers per 10,000 pop.	14.7
Lawyers per physician	0.7
Lawyers per emergency physician	12.2
ATRA judicial hellholes (range 0 to -7)	0
Malpractice award payments/100,000 pop.	2.0
Average malpractice award payments	\$218,123
Databank reports per 1,000 physicians	20.7
Patient compensation fund	No
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	8.8
Average medical liability insurance premium for primary care physicians	\$10,791
Average medical liability insurance premiums for specialists	\$68,352
Pretrial screening panels	 Voluntary
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	\$350,001-500,000
Additional liability protection for EMTALA-mandated emergency care	No
Joint and several liability abolished	Yes
State provides for case certification	No
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 **A**




Funding for quality improvement within the EMS system	Yes
Funded state EMS medical director	Yes
Emergency medicine residents per 1M pop.	 5.7
Adverse event reporting required	Yes
Hospital-based infections reporting required	No
Mandatory quality reporting requirement	No
% of counties with E-911 capability	100.0
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	39.0
% of hospitals with electronic medical records	64.3
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	59
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	10

PUBLIC HEALTH & INJURY PREVENTION **A**

Traffic fatalities per 100,000 pop.	11.3
% of traffic fatalities alcohol related	 24.0
Front occupant restraint use (%)	86.8
Helmet use required for all motorcycle riders	No
Child safety seat/seat belt legislation (10 points possible)	6
% of children immunized, aged 19-35 months	 80.4
% of adults aged 65+ who received flu vaccine in the last 12 months	 72.1
% of adults aged 65+ who ever received pneumococcal vaccine	 65.9
Fatal occupational injuries per 1M workers	45.7
Homicides and suicides (non-motor vehicle) per 100,000 pop.	16.5
Unintentional fall-related fatal injuries per 100,000 pop.	4.7
Unintentional fire/burn-related fatal injuries per 100,000 pop.	0.5
Unintentional firearm-related fatal injuries per 100,000 pop.	0.1
Gun-purchasing legislation (8 points possible)	1
% of tobacco settlement funds spent on health-related services and programs	68.4
Total injury prevention funds per 1,000 pop.	\$683.98
Unintentional injury prevention funds per 1,000 pop.	\$473.31
Intentional injury prevention funds per 1,000 pop.	\$210.67
Fall injury prevention funds per 1,000 pop.	\$0.00
Infant mortality rate per 1,000 live births	4.5
% of adults with BMI > 30	21.9
Current smokers, % of adults	9.8
Binge alcohol drinkers, % of adults	9.3

DISASTER PREPAREDNESS **C+**

Per capita federal disaster preparedness funds	\$8.05
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	NR
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	101
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	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	No
Real-time surveillance system in place for common ED presentations	No
Bed surge capacity per 1M pop.	366.7
Burn unit beds per 1M pop.	4.5
ICU beds per 1M pop.	286.9
Verified burn centers per 1M pop.	0.4
State able to verify credentials and assign volunteer health professionals to four ESAR-VHP levels	Yes
Nurses registered in ESAR-VHP per 1M pop.	NR
Physicians registered in ESAR-VHP per 1M pop.	NR
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	Yes, civil
% of RNs that received any emergency training	47.3
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	