Illinois

D

Illinois's fall from 27th to 45th place for its overall emergency care environment is largely due to major setbacks in its already challenging *Medical Liability Environment* and a failure to keep pace with other states in improving *Disaster Preparedness*.

Strengths. Illinois's strongest performance was for the *Quality and Patient Safety Environment*, largely due to a number of important policies and procedures that have been put in place. Illinois has a strong prescription drug monitoring program and a statewide trauma registry, which help ensure patient safety and quality improvement. It has also developed or is developing a system of care for stroke patients and ST-elevation myocardial infarction patients. These plans, along with triage and destination policies, help ensure that these patients receive prompt care in the most appropriate setting to enhance their chances for favorable outcomes. The state is currently adopting the new trauma triage guidelines for pre-hospital and trauma center activation, using the Centers for Disease Control and Prevention recommendations as baseline criteria.

Illinois has improved slightly in *Access to Emergency Care* over the past 5 years, having increased its per capita rates of emergency physicians, neurosurgeons, plastic surgeons, and registered nurses. It also has better-than-average health insurance coverage for children, with only 6.2% of children lacking insurance and 16.5% underinsured.

Illinois has several strengths in *Public Health and Injury Prevention*, especially in traffic safety. The state has one of the lowest rates of traffic fatalities (6.1 per 100,000 people) and a high rate of seatbelt use (92.9% of front-seat occupants). Strong child safety seat and seatbelt legislation and distracted driving laws are currently in place, and the state has below-average rates of bicyclist and pedestrian deaths.

Challenges. Illinois's ranking for its *Medical Liability Environment* fell sharply, from 34th to 50th in the nation, placing it near the bottom for medical liability support for emergency care. The state has fallen behind in the types of medical liability reforms enacted in other states over the past 5 years and has earned a reputation as a litigation environment unfavorable to defendants and prone to excessive verdicts. Compounding these issues, provisions for periodic payments and the state's medical liability cap on non-economic damages were ruled unconstitutional in 2010. Currently, Illinois has the second highest average malpractice award payments in the nation ($599,439). Average medical liability insurance premiums for primary care physicians are also second highest in the country and premiums for specialists are $36,000 more per year than the national average. Illinois currently has virtually no medical liability reforms in place to discourage frivolous lawsuits.

In *Public Health and Injury Prevention*, Illinois could do more to combat causes of chronic disease and illness in its population. The state has very low rates of immunization against influenza and pneumonia for older adults and a relatively high rate of binge drinking among adults (23%). Despite an average rate of adult obesity, the child obesity rate in Illinois is among the highest in the country (19.3%). Illinois also has a high cardiovascular disease disparity ratio, indicating that there are populations in the state who may not be receiving adequate preventive care.

Without medical liability reform, the state risks losing its most qualified doctors and medical professionals.

Recommendations. The most pressing problem in Illinois is the state of its *Medical Liability Environment*. Without reform and a reversal of recent trends, the state risks losing its most qualified doctors and medical professionals to states where there is more protection against unnecessary lawsuits and excessive verdicts. Unfortunately, medical liability reform has not fared well in the Illinois court system to date.

	2009		2014	
	Rank	Grade	Rank	Grade
Access to Emergency Care	39	D-	24	D
Quality & Patient Safety Environment	8	A-	22	C+
Medical Liability Environment	34	D	50	F
Public Health & Injury Prevention	28	D+	29	D+
Disaster Preparedness	8	A-	43	F
OVERALL	27	C	45	D

While changes in a number of *Disaster Preparedness* indicators from 2009 may partially explain the significant grade drop, Illinois now ranks well below most other states in this category. In 2012, the state's Department of Public Health sought legislation to enhance immunity for its health care responders during an emergency but was unsuccessful. Adopting liability protections might help the state increase the per capita numbers of physicians, nurses, and behavioral health professionals registered in the Emergency System for Advance Registration of Volunteer Health Professionals, which are currently among the lowest in the nation.

Dwindling Medicaid reimbursement rates are another challenge for accessing needed care, especially with full implementation of the Patient Protection and Affordable Care Act and Medicaid expansion underway. The state has one of the lowest Medicaid fee levels for office visits, at only 57.9% of the national average, and rates have been stagnant since 2007. Illinois needs to increase Medicaid payments to attract more physicians to serve the Medicaid population and meet the state's growing need for primary care.

ACCESS TO EMERGENCY CARE	D
Board-certified emergency physicians per 100,000 pop.	12.1
Emergency physicians per 100,000 pop.	15.1
Neurosurgeons per 100,000 pop.	2.2
Orthopedists and hand surgeon specialists per 100,000 pop.	8.6
Plastic surgeons per 100,000 pop.	2.3
ENT specialists per 100,000 pop.	3.2
Registered nurses per 100,000 pop.	962.5
Additional primary care FTEs needed per 100,000 pop.	3.2
Additional mental health FTEs needed per 100,000 pop.	0.6
% of children able to see provider	94.1
Level I or II trauma centers per 1M pop.	3.3
% of population within 60 minutes of Level I or II trauma center	95.8
Accredited chest pain centers per 1M pop.	3.2
% of population with an unmet need for substance abuse treatment	9.0
Pediatric specialty centers per 1M pop.	2.4
Physicians accepting Medicare per 100 beneficiaries	2.5
Medicaid fee levels for office visits as a % of the national average	57.9
% change in Medicaid fees for office visits (2007 to 2012)	0.0
% of adults with no health insurance	17.5
% of adults underinsured	6.7
% of children with no health insurance	6.2
% of children underinsured	16.5
% of adults with Medicaid	9.7
Emergency departments per 1M pop.	12.9
Hospital closures in 2011	1
Staffed inpatient beds per 100,000 pop.	288.6
Hospital occupancy rate per 100 staffed beds	64.1
Psychiatric care beds per 100,000 pop.	21.1
Median minutes from ED arrival to ED departure for admitted patients	265
State collects data on diversion	Yes

MEDICAL LIABILITY ENVIRONMENT	F
Lawyers per 10,000 pop.	22.0
Lawyers per physician	0.7
Lawyers per emergency physician	14.6
ATRA judicial hellholes (range 2 to -6)	-4
Malpractice award payments/ 100,000 pop.	1.4
Average malpractice award payments	$599,439
Databank reports per 1,000 physicians	17.6
Provider apology is inadmissible as evidence	No
Patient compensation fund	No
Number of insurers writing medical liability policies per 1,000 physicians	2.9
Average medical liability insurance premium for primary care physicians	$27,593
Average medical liability insurance premium for specialists	$94,220
Presence of pretrial screening panels	No
Pretrial screening panel's findings admissible as evidence	N/A
Periodic payments	No
Medical liability cap on non-economic damages	None
Additional liability protection for EMTALA-mandated emergency care	No
Joint and several liability abolished	No
Collateral source rule, provides for awards to be offset	Yes
State provides for case certification	Yes
Expert witness must 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	C+
Funding for quality improvement within the EMS system	No
Funded state EMS medical director	Yes
Emergency medicine residents per 1M pop.	30.1
Adverse event reporting required	No
% of counties with E-911 capability	85.4
Uniform system for providing pre-arrival instructions	Yes
CDC guidelines are basis for state field triage protocols	NR
State has or is working on a stroke system of care	Yes
Triage and destination policy in place for stroke patients	Yes
State has or is working on a PCI network or a STEMI system of care	Yes
Triage and destination policy in place for STEMI patients	Yes
Statewide trauma registry	Yes
Triage and destination policy in place for trauma patients	Yes
Prescription drug monitoring program (range 0-4)	3
% of hospitals with computerized practitioner order entry	85.0
% of hospitals with electronic medical records	95.0
% of patients with AMI given PCI within 90 minutes of arrival	94
Median time to transfer to another facility for acute coronary intervention	45
% of patients with AMI who received aspirin within 24 hours	99
% of hospitals collecting data on race/ ethnicity and primary language	67.0
% of hospitals having or planning to develop a diversity strategy/plan	50.2

PUBLIC HEALTH & INJURY PREVENTION	D+
Traffic fatalities per 100,000 pop.	6.1
Bicyclist fatalities per 100,000 cyclists	3.0
Pedestrian fatalities per 100,000 pedestrians	3.4
% of traffic fatalities alcohol related	35
Front occupant restraint use (%)	92.9
Helmet use required for all motorcycle riders	No
Child safety seat/seat belt legislation (range 0-10)	8
Distracted driving legislation (range 0-4)	4
Graduated drivers' license legislation (range 0-5)	0
% of children immunized, aged 19-35 months	77.3
% of adults aged 65+ who received flu vaccine in past year	54.7
% of adults aged 65+ who ever received pneumococcal vaccine	62.5
Fatal occupational injuries per 1M workers	29.2
Homicides and suicides (non-motor vehicle) per 100,000 pop.	15.9
Unintentional fall-related fatal injuries per 100,000 pop.	7.0
Unintentional fire/burn-related fatal injuries per 100,000 pop.	0.8
Unintentional firearm-related fatal injuries per 100,000 pop.	0.2
Unintentional poisoning-related fatal injuries per 100,000 pop.	9.0
Total injury prevention funds per 1,000 pop.	$162.29
Dedicated child injury prevention funding	No
Dedicated elderly injury prevention funding	No
Dedicated occupational injury prevention funding	No
Gun-purchasing legislation (range 0-6)	3.5
Anti-smoking legislation (range 0-3)	3
Infant mortality rate per 1,000 live births	6.8
Binge alcohol drinkers, % of adults	23.0
Current smokers, % of adults	20.9
% of adults with BMI >30	27.1
% of children obese	19.3
Cardiovascular disease disparity ratio	2.8
HIV diagnoses disparity ratio	11.0
Infant mortality disparity ratio	2.7

DISASTER PREPAREDNESS	F
Per capita federal disaster preparedness funds	$8.47
State budget line item for health care surge	Yes
ESF-8 plan shared with all EMS and essential hospital personnel	No
Emergency physician input into the state planning process	Yes
Public health and emergency physician input during an ESF-8 response	Yes, No
Drills, exercises conducted with hospital personnel, equipment, facilities per hospital	15.4
Accredited by the Emergency Management Accreditation Program	Yes
Special needs patients in medical response plan	Yes
Patients on medication for chronic conditions in medical response plan	No
Medical response plan for supplying dialysis	No
Mental health patients in medical response plan	No
Medical response plan for supplying psychotropic medication	No
Mutual aid agreements with behavioral health providers	Local-level
Long-term care and nursing home facilities must have written disaster plan	Yes
State able to report number of exercises with long-term care or nursing home facilities	No
"Just-in-time" training systems in place	NR
Statewide medical communication system with one layer of redundancy	Yes
Statewide patient tracking system	No
Statewide real-time or near real-time syndromic surveillance system	Yes
Real-time surveillance system in place for common ED presentations	NR
Bed surge capacity per 1M pop.	290.0
ICU beds per 1M pop.	248.5
Burn unit beds per 1M pop.	5.0
Verified burn centers per 1M pop.	0.2
Physicians in ESAR-VHP per 1M pop.	3.1
Nurses in ESAR-VHP per 1M pop.	20.0
Behavioral health professionals in ESAR-VHP per 1M pop.	1.4
Strike teams or medical assistance teams	Yes
Disaster training required for essential hospital, EMS personnel	No
Liability protections for health care workers during a disaster (range 0-4)	3
% of RNs received disaster training	36.4

NR = Not reported
N/A = Not applicable