

Florida

Florida’s emergency care environment is a dichotomy, blessed with considerable strengths but also beset with glaring weaknesses. Although the state performs admirably in the *Quality and Patient Safety Environment* and *Disaster Preparedness* categories, it is plagued by such major concerns as high numbers of uninsured residents, a poor record of vaccination for its substantial elderly population, a significant shortfall of primary care providers, and a medical liability system that threatens to further erode the physician supply.

Strengths. Florida’s numerous statewide systems positively affected the state’s grade with regard to the *Quality and Patient Safety Environment*. For example, the state has adverse event and hospital-based infections reporting requirements, and has a stroke system of care. Florida also maintains a statewide trauma registry and provides funding for quality improvement within the EMS system and an EMS medical director position.

Florida has made significant efforts to improve *Disaster Preparedness* in the state. It has the 11th highest rate of physicians registered in the state-based Emergency System for Advance Registration of Volunteer Health Professionals (39.8 physicians per 1 million people), has an all-hazards medical response plan, and receives emergency physician and public health input into the state planning process. Florida also has statewide “just-in-time” training systems and real-time syndromic surveillance systems.

Challenges. *Access to Emergency Care* is a serious problem for Florida patients. A large proportion of Florida’s population is uninsured with 21.9 and 18.9 percent of adults and children, respectively, lacking any health insurance coverage. The state also has relatively few psychiatric care beds (12.6 per 100,000 people), fewer than

half the average across the states. Florida is also in need of 755.8 full-time equivalent primary care providers, compared with an average across the states of only 136.3 providers. The state also has a low number of physicians accepting Medicare (2.1 per 100 beneficiaries).

Florida fared poorly with regard to the *Medical Liability Environment* for a variety of reasons, including the state’s average medical liability insurance premiums (\$41,946 for primary care physicians and \$171,231 for specialists), which are more than twice the average across the states. In addition, there are an especially low number of insurers writing medical liability policies in Florida (2.1 per 1,000 physicians compared to an average of 9.2 per 1,000 across the states).

Florida’s poor performance in *Public Health and Injury Prevention* leaves significant room for improvement. The state’s total injury prevention funds (\$58.36 per 1,000 people) fall well below the average among the states (\$455.12 per 1,000). Limited funding may impede efforts to improve the state’s higher than average rate of unintentional fall-related fatal injuries (9.4 per 100,000 people). The state also ranks among the bottom 10 for both yearly influenza vaccines and pneumococcal vaccines among adults aged 65 years and older (61.5 and 62.9, respectively).

Recommendations. Florida should act immediately to address its severe shortage of physicians. A significant step in that direction would be to reduce the \$500,000 soft cap on non-economic damages that currently applies to non-emergency care providers. While the state has instituted a \$150,000 cap on non-economic damages for emergency care providers, emergency physicians in the state report continuing problems with getting specialists to provide critical on-call services to emergency

	RANK	GRADE
ACCESS TO EMERGENCY CARE	50	F
QUALITY & PATIENT SAFETY ENVIRONMENT	10	A-
MEDICAL LIABILITY ENVIRONMENT	27	C-
PUBLIC HEALTH & INJURY PREVENTION	37	D-
DISASTER PREPAREDNESS	10	A-
OVERALL	30	C-




patients. To address this problem and help ensure that patients have access to on-call specialists, the state should consider extending sovereign immunity protection to providers of state and federally mandated emergency care

Florida would benefit greatly from efforts to increase the number of emergency medicine residents in the state. Providing additional residency training opportunities may encourage more physicians to enter emergency medicine as their primary specialty, which may be particularly important as a significant percentage of the current emergency medicine workforce nears retirement.


Access to medical care in Florida would benefit significantly from increased Medicaid reimbursement rates. The state’s reimbursement rate for office visits is less than 71 percent of the national average, and the trend over time has shown declining rates (10.1 percent decrease from 2004 to 2007).

Access to emergency care is a serious problem for Florida patients.


ACCESS TO EMERGENCY CARE F

Board-certified emergency physicians per 100,000 pop.	 8.0
Emergency physicians per 100,000 pop.	10.5
Neurosurgeons per 100,000 pop.	1.9
Orthopedists and hand surgeon specialists per 100,000 pop.	8.3
Plastic surgeons per 100,000 pop.	3.3
ENT specialists per 100,000 pop.	3.3
Registered nurses per 100,000 pop.	 820.6
Additional primary care FTEs needed	755.8
Additional mental health FTEs needed	71.7
Level I or II trauma centers per 1M pop.	1.0
% of population within 60 minutes of Level I or II trauma center	97.2
Accredited chest pain centers per 1M pop.	1.6
% of population with an unmet need for substance abuse treatment	8.6
Pediatric specialty centers per 1M pop.	2.2
Physicians accepting Medicare per 100 beneficiaries	2.1
Medicaid fee levels for office visits as a % of the national average	70.8
% change in Medicaid fees for office visits (2004-05 to 2007)	-10.1
% of adults with no health insurance	21.9
% of children with no health insurance	18.9
% of adults with Medicaid	5.7
Emergency departments per 1M pop.	 7.2
Hospital closures in 2006	0
Staffed inpatient beds per 100,000 pop.	320.3
Hospital occupancy rate per 100 staffed beds	67.8
Psychiatric care beds per 100,000 pop.	12.6
State collects data on diversion	No






MEDICAL LIABILITY ENVIRONMENT C-

Lawyers per 10,000 pop.	21.3
Lawyers per physician	0.8
Lawyers per emergency physician	20.1
ATRA judicial hellholes (range 0 to -7)	-4
Malpractice award payments/100,000 pop.	0.5
Average malpractice award payments	\$231,736
Databank reports per 1,000 physicians	22.9
Patient compensation fund	No
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	2.1
Average medical liability insurance premium for primary care physicians	\$41,946
Average medical liability insurance premiums for specialists	\$171,231
Pretrial screening panels	 No
Are pretrial screening panels' findings admissible as evidence?	N/A
Periodic payments	Upon request or agreement of party(ies)
Medical liability cap on non-economic damages	>\$500,000
Additional liability protection for EMTALA-mandated emergency care	Yes
Joint and several liability abolished	Yes
State provides for case certification	Yes
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-




Funding for quality improvement within the EMS system	Yes
Funded state EMS medical director	Yes
Emergency medicine residents per 1M pop.	 6.4
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	16.7
% of hospitals with electronic medical records	47.7
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	55
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	14

PUBLIC HEALTH & INJURY PREVENTION D-

Traffic fatalities per 100,000 pop.	 18.7
% of traffic fatalities alcohol related	 41.0
Front occupant restraint use (%)	79.1
Helmet use required for all motorcycle riders	No
Child safety seat/seat belt legislation (10 points possible)	1
% of children immunized, aged 19-35 months	 81.4
% of adults aged 65+ who received flu vaccine in the last 12 months	 61.5
% of adults aged 65+ who ever received pneumococcal vaccine	 62.9
Fatal occupational injuries per 1M workers	44.9
Homicides and suicides (non-motor vehicle) per 100,000 pop.	18.8
Unintentional fall-related fatal injuries per 100,000 pop.	9.4
Unintentional fire/burn-related fatal injuries per 100,000 pop.	0.8
Unintentional firearm-related fatal injuries per 100,000 pop.	0.1
Gun-purchasing legislation (8 points possible)	2
% of tobacco settlement funds spent on health-related services and programs	93.3
Total injury prevention funds per 1,000 pop.	\$58.36
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	7.2
% of adults with BMI > 30	23.1
Current smokers, % of adults	21.0
Binge alcohol drinkers, % of adults	13.8

DISASTER PREPAREDNESS A-

Per capita federal disaster preparedness funds	\$8.26
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	Yes, Yes
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	10
Accredited by the Emergency Management Accreditation Program	Yes
Written plan specifically for special needs patients	Yes
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	Yes
Real-time surveillance system in place for common ED presentations	Yes
Bed surge capacity per 1M pop.	489.1
Burn unit beds per 1M pop.	3.5
ICU beds per 1M pop.	272.9
Verified burn centers per 1M pop.	0.2
State able to verify credentials and assign volunteer health professionals to four ESAR-VHP levels	Yes
Nurses registered in ESAR-VHP per 1M pop.	53.9
Physicians registered in ESAR-VHP per 1M pop.	39.8
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	45.5
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	