

Virginia

Virginia scores high marks in *Disaster Preparedness* and has invested in both patient safety and injury prevention. However, low numbers of emergency departments per capita, a shortage of nurses, and a lack of physicians participating in the Medicare program may indicate significant problems in *Access to Emergency Care*.

Strengths. Virginia is rated highly in *Disaster Preparedness*, ranking among the top five states for the number of volunteer nurses and physicians registered in the state-based Emergency System for Advance Registration of Volunteer Health Professionals program (369.5 and 107.1 per 1 million people, respectively). The state also has civil liability protections for health care workers during a disaster event. In addition, the state has a written plan specifically for patients with special needs, as well as plans to supply medications for chronic conditions and dialysis for patients during a disaster. Virginia also is one of only 17 states to be accredited by the Emergency Management Accreditation Program.

The state also managed noteworthy successes with regard to the *Quality and Patient Safety Environment*. For instance, Virginia is developing a stroke system of care, as well as a PCI network or STEMI system of care. The state also maintains a statewide trauma registry and provides funding for quality improvement within the EMS system as well as a state EMS medical director position. Virginia also has a slightly higher than average rate of emergency medicine residents (13.1 per 1 million people).

Virginia fares quite well with regard to *Public Health and Injury Prevention*. The state ranked among the top 10 states in all areas of injury prevention funding, with total injury prevention funds of \$636.40 per 1,000 people, unintentional injury prevention funds of \$345.78 per 1,000,

and intentional injury prevention funds of \$282.57 per 1,000. In addition, the state has a relatively low rate of unintentional fall-related fatal injuries (4.8 per 100,000).

Challenges. *Access to Emergency Care* remains an issue in Virginia. The state ranks among the worst 10 states for low rates of physicians accepting Medicare (2.5 per 100 beneficiaries) and emergency departments (8.5 per 1 million people). Virginia also has a below-average rate of registered nurses (755.7 per 100,000 people).

While Virginia has made strides in the area of medical liability reform, including voluntary pretrial screening panels whose findings are admissible as evidence and requiring that expert witnesses be of the same specialty as the defendant, the state still lacks some important reforms. Virginia has not abolished joint and several liability. The state also lacks additional liability protections for EMTALA-mandated emergency care, and there is no requirement or provision for expert witnesses to be licensed in the state.

Recommendations. Virginia needs to improve access to health care for the uninsured and underinsured. The state must also ensure that Medicaid reimbursement policies are not unfairly reducing payment for emergency care that is deemed non-emergent after care has already been provided. While no hospitals have closed since the last Report Card, there are fewer emergency departments per 1 million people and fewer nurses to care for patients. This may represent a market decision not to expand emergency services because of concerns of inadequate compensation.

Virginia also could improve its standing with regard to the *Quality and Patient Safety Environment* by developing and implementing a uniform system for providing

	RANK	GRADE
ACCESS TO EMERGENCY CARE	38	D-
QUALITY & PATIENT SAFETY ENVIRONMENT	22	C+
MEDICAL LIABILITY ENVIRONMENT	24	C-
PUBLIC HEALTH & INJURY PREVENTION	14	B
DISASTER PREPAREDNESS	15	B+
OVERALL	23	C




pre-arrival instructions and increasing the percentage of hospitals with computerized practitioner order entry.

Virginia should focus on implementing specific medical liability reforms, including additional liability protections for EMTALA-mandated emergency care and a patient compensation fund, in addition to maintaining the Neurological Birth-Related Injury Compensation Program. The state should pursue reform efforts to reduce liability insurance premiums and increase the low rate of insurers writing medical liability policies (3.5 per 1,000 physicians).

Finally, while Virginia fares well in *Disaster Preparedness*, the state would benefit from increasing the number of intensive care unit beds available to accommodate victims of a major disaster (225.9 beds per 1 million people, compared with the average across the states of 299.0 per 1 million).

Access to emergency care remains an issue in Virginia.

ACCESS TO EMERGENCY CARE **D-**

Board-certified emergency physicians per 100,000 pop.	 9.4
Emergency physicians per 100,000 pop.	12.5
Neurosurgeons per 100,000 pop.	1.9
Orthopedists and hand surgeon specialists per 100,000 pop.	8.8
Plastic surgeons per 100,000 pop.	2.2
ENT specialists per 100,000 pop.	3.4
Registered nurses per 100,000 pop.	 755.7
Additional primary care FTEs needed	103.5
Additional mental health FTEs needed	21.7
Level I or II trauma centers per 1M pop.	1.0
% of population within 60 minutes of Level I or II trauma center	93.0
Accredited chest pain centers per 1M pop.	1.6
% of population with an unmet need for substance abuse treatment	7.4
Pediatric specialty centers per 1M pop.	2.6
Physicians accepting Medicare per 100 beneficiaries	2.5
Medicaid fee levels for office visits as a % of the national average	99.6
% change in Medicaid fees for office visits (2004-05 to 2007)	8.2
% of adults with no health insurance	14.4
% of children with no health insurance	10.1
% of adults with Medicaid	3.9
Emergency departments per 1M pop.	 8.5
Hospital closures in 2006	0
Staffed inpatient beds per 100,000 pop.	302.2
Hospital occupancy rate per 100 staffed beds	70.7
Psychiatric care beds per 100,000 pop.	25.1
State collects data on diversion	Yes




MEDICAL LIABILITY ENVIRONMENT **C-**

Lawyers per 10,000 pop.	18.1
Lawyers per physician	0.7
Lawyers per emergency physician	14.3
ATRA judicial hellholes (range 0 to -7)	0
Malpractice award payments/100,000 pop.	0.9
Average malpractice award payments	\$280,513
Databank reports per 1,000 physicians	12.8
Patient compensation fund	No
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	3.5
Average medical liability insurance premium for primary care physicians	\$14,412
Average medical liability insurance premiums for specialists	\$59,963
Pretrial screening panels	Voluntary
Are pretrial screening panels' findings admissible as evidence?	Yes
Periodic payments	No
Medical liability cap on non-economic damages	>\$500,000
Additional liability protection for EMTALA-mandated emergency care	No
Joint and several liability abolished	No
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 **C+**




Funding for quality improvement within the EMS system	Yes
Funded state EMS medical director	Yes
Emergency medicine residents per 1M pop.	13.1
Adverse event reporting required	No
Hospital-based infections reporting required	Yes
Mandatory quality reporting requirement	No
% of counties with E-911 capability	98.5
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	9.8
% of hospitals with electronic medical records	37.0
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	60
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	16

PUBLIC HEALTH & INJURY PREVENTION **B**

Traffic fatalities per 100,000 pop.	12.6
% of traffic fatalities alcohol related	39.0
Front occupant restraint use (%)	79.9
Helmet use required for all motorcycle riders	Yes
Child safety seat/seat belt legislation (10 points possible)	4
% of children immunized, aged 19-35 months	 81.6
% of adults aged 65+ who received flu vaccine in the last 12 months	 69.1
% of adults aged 65+ who ever received pneumococcal vaccine	 66.8
Fatal occupational injuries per 1M workers	46.1
Homicides and suicides (non-motor vehicle) per 100,000 pop.	17.9
Unintentional fall-related fatal injuries per 100,000 pop.	4.8
Unintentional fire/burn-related fatal injuries per 100,000 pop.	1.3
Unintentional firearm-related fatal injuries per 100,000 pop.	0.2
Gun-purchasing legislation (8 points possible)	2
% of tobacco settlement funds spent on health-related services and programs	50.0
Total injury prevention funds per 1,000 pop.	\$636.40
Unintentional injury prevention funds per 1,000 pop.	\$345.78
Intentional injury prevention funds per 1,000 pop.	\$282.57
Fall injury prevention funds per 1,000 pop.	\$5.83
Infant mortality rate per 1,000 live births	7.5
% of adults with BMI > 30	25.1
Current smokers, % of adults	19.3
Binge alcohol drinkers, % of adults	13.5

DISASTER PREPAREDNESS **B+**

Per capita federal disaster preparedness funds	\$9.09
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, 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	199
Accredited by the Emergency Management Accreditation Program	Yes
Written plan specifically for special needs patients	Yes
Written plan to supply medications for chronic conditions	Yes
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	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.	910.6
Burn unit beds per 1M pop.	5.7
ICU beds per 1M pop.	225.9
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.	369.5
Physicians registered in ESAR-VHP per 1M pop.	107.1
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	Yes, civil
% of RNs that received any emergency training	35.2
State requires EMS and essential ED personnel to be NIMS compliant	No

	Improved since 2006
	Worsened since 2006
	No change since 2006
NR	Not reported
N/A	Not applicable
See Summary Statistics for State Comparisons	