

# Pennsylvania

Pennsylvania tied for 8<sup>th</sup> in the nation overall, receiving high marks for the *Quality and Patient Safety Environment* and *Disaster Preparedness*. However, a need for more providers and a troubled *Medical Liability Environment* may be hindering *Access to Emergency Care*.

**Strengths.** Pennsylvania has made a number of noteworthy accomplishments with regard to the state’s *Quality and Patient Safety Environment*. The state provides funding for quality improvement within the EMS system, as well as a state EMS medical director position. Pennsylvania also has implemented a statewide trauma registry and has a uniform system for providing pre-arrival instructions.

*Disaster Preparedness* in Pennsylvania ranks fourth best in the country, and the state leads the nation with the numbers of disaster drills and exercises conducted involving hospital personnel, equipment, or facilities (1,535). EMS and essential hospital personnel are required by the state to be trained in disaster management and response to bio- and chemical terrorism. Additionally, the state has medical assistance teams or strike teams in place in the event of a disaster.

Pennsylvania has shown some success with regard to *Access to Emergency Care* as well. Slightly more than 7 percent of children in Pennsylvania are uninsured and fewer than 11 percent of adults are uninsured, compared with 11.7 and 17.2 percent, respectively, nationwide. In addition, a study conducted by the Commonwealth Fund and the Pennsylvania Insurance Department estimates the actual rate of uninsured adults to be even lower.

**Challenges.** Pennsylvania’s *Medical Liability Environment* has improved somewhat, but additional work is needed. Average malpractice awards, or payouts, are among the highest in the nation (\$415,167), as

are the average medical liability insurance premiums for primary care physicians and specialists (\$23,711 and \$107,733, respectively). The joint and several liability reform that Pennsylvania previously enjoyed was declared unconstitutional. Further exacerbating the liability problem is the status of the state’s MCARE program, which provides physicians with half of their required liability insurance coverage and discounts premiums up to 100 percent for certain high-risk specialists. Authorization for the MCARE fund was allowed to lapse in 2008, and although the future of the program remains unclear at the time of this report, failure to revive it or to responsibly phase it out will result in physician premiums immediately increasing by thousands of dollars and could lead to more physicians leaving the state.

The state’s grade for *Access to Emergency Care* was held down by the need for primary care and mental health providers, a high hospital occupancy rate, and low Medicaid reimbursement rates for office visits. Medicaid reimbursement for office visits are only 54.5 percent of the national average, despite a 38.1 percent increase between 2004 and 2007. In *Public Health and Injury Prevention*, the infant mortality rate is higher than that of the nation (7.3 versus 6.9 deaths per 1,000 live births), as are the rates of smoking and binge drinking among adults.

**Recommendations.** Recruiting and retaining an adequate medical workforce is becoming of utmost importance as the physician population in Pennsylvania ages. The state should continue increasing Medicaid reimbursement levels for office visits which may encourage more physicians to see Medicaid beneficiaries.

Pennsylvania should work to create a more favorable *Medical Liability Environment*.

	RANK	GRADE
<b>ACCESS TO EMERGENCY CARE</b>	23	C-
<b>QUALITY &amp; PATIENT SAFETY ENVIRONMENT</b>	4	A
<b>MEDICAL LIABILITY ENVIRONMENT</b>	38	D-
<b>PUBLIC HEALTH &amp; INJURY PREVENTION</b>	17	B-
<b>DISASTER PREPAREDNESS</b>	4	A
<b>OVERALL</b>	8	C+

As mandated, the state should ensure that the pace of the phase-out of the MCARE program is conducted in a way that won’t further increase the excessively high liability premiums paid by the state’s physicians. The state should also consider additional reforms such as enacting special liability protections for EMTALA-mandated emergency care.

Instituting such reforms might also help increase the number of specialists who are willing to provide on-call services for emergency patients. Emergency physicians in Pennsylvania have reported a severe shortage of on-call specialists as well as significant problems with hospital crowding and boarding of admitted patients in emergency departments. State officials recently began working with the Pennsylvania Chapter of ACEP and other key stakeholders to address this problem and efforts need to continue to effectively resolve the serious consequences related to boarding and crowding.

**ACCESS TO EMERGENCY CARE** **C-**

Board-certified emergency physicians per 100,000 pop.	<b>10.1</b>
Emergency physicians per 100,000 pop.	<b>14.8</b>
Neurosurgeons per 100,000 pop.	<b>2.2</b>
Orthopedists and hand surgeon specialists per 100,000 pop.	<b>9.9</b>
Plastic surgeons per 100,000 pop.	<b>2.3</b>
ENT specialists per 100,000 pop.	<b>3.7</b>
Registered nurses per 100,000 pop.	<b>1,018.9</b>
Additional primary care FTEs needed	<b>103.4</b>
Additional mental health FTEs needed	<b>24.1</b>
Level I or II trauma centers per 1M pop.	<b>1.9</b>
% of population within 60 minutes of Level I or II trauma center	<b>98.8</b>
Accredited chest pain centers per 1M pop.	<b>0.6</b>
% of population with an unmet need for substance abuse treatment	<b>8.1</b>
Pediatric specialty centers per 1M pop.	<b>3.5</b>
Physicians accepting Medicare per 100 beneficiaries	<b>2.6</b>
Medicaid fee levels for office visits as a % of the national average	<b>54.5</b>
% change in Medicaid fees for office visits (2004-05 to 2007)	<b>38.1</b>
% of adults with no health insurance	<b>10.8</b>
% of children with no health insurance	<b>7.3</b>
% of adults with Medicaid	<b>7.7</b>
Emergency departments per 1M pop.	<b>12.0</b>
Hospital closures in 2006	<b>2</b>
Staffed inpatient beds per 100,000 pop.	<b>383.5</b>
Hospital occupancy rate per 100 staffed beds	<b>72.0</b>
Psychiatric care beds per 100,000 pop.	<b>35.1</b>
State collects data on diversion	<b>No</b>

**MEDICAL LIABILITY ENVIRONMENT** **D-**

Lawyers per 10,000 pop.	<b>18.4</b>
Lawyers per physician	<b>0.5</b>
Lawyers per emergency physician	<b>12.4</b>
ATRA judicial hellholes (range 0 to -7)	<b>-2</b>
Malpractice award payments/100,000 pop.	<b>0.9</b>
Average malpractice award payments	<b>\$415,167</b>
Databank reports per 1,000 physicians	<b>26.7</b>
Patient compensation fund	<b>Yes</b>
Health court pilot project grant	<b>Yes</b>
Number of insurers writing medical liability policies per 1,000 physicians	<b>2.7</b>
Average medical liability insurance premium for primary care physicians	<b>\$23,711</b>
Average medical liability insurance premiums for specialists	<b>\$107,733</b>
Pretrial screening panels	<b>No</b>
Are pretrial screening panels' findings admissible as evidence?	<b>N/A</b>
Periodic payments	<b>Upon request or agreement of party(ies)</b>
Medical liability cap on non-economic damages	<b>No</b>
Additional liability protection for EMTALA-mandated emergency care	<b>No</b>
Joint and several liability abolished	<b>No</b>
State provides for case certification	<b>Yes</b>
Expert witness required to be of the same specialty as the defendant	<b>Yes</b>
Expert witness must be licensed to practice medicine in the state	<b>No</b>

**QUALITY & PATIENT SAFETY ENVIRONMENT** **A**

Funding for quality improvement within the EMS system	<b>Yes</b>
Funded state EMS medical director	<b>Yes</b>
Emergency medicine residents per 1M pop.	<b>29.1</b>
Adverse event reporting required	<b>Yes</b>
Hospital-based infections reporting required	<b>Yes</b>
Mandatory quality reporting requirement	<b>Yes</b>
% of counties with E-911 capability	<b>97.0</b>
Uniform system for providing pre-arrival instructions	<b>Yes</b>
State has or is working on a stroke system of care	<b>Yes</b>
State has or is working on a PCI network or a STEMI system of care	<b>Yes</b>
Statewide trauma registry	<b>Yes</b>
% of hospitals with computerized practitioner order entry	<b>28.4</b>
% of hospitals with electronic medical records	<b>47.3</b>
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	<b>49</b>
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	<b>16</b>

**PUBLIC HEALTH & INJURY PREVENTION** **B-**

Traffic fatalities per 100,000 pop.	<b>12.3</b>
% of traffic fatalities alcohol related	<b>39.0</b>
Front occupant restraint use (%)	<b>86.7</b>
Helmet use required for all motorcycle riders	<b>No</b>
Child safety seat/seat belt legislation (10 points possible)	<b>4</b>
% of children immunized, aged 19-35 months	<b>84.4</b>
% of adults aged 65+ who received flu vaccine in the last 12 months	<b>68.3</b>
% of adults aged 65+ who ever received pneumococcal vaccine	<b>68.8</b>
Fatal occupational injuries per 1M workers	<b>39.2</b>
Homicides and suicides (non-motor vehicle) per 100,000 pop.	<b>17.6</b>
Unintentional fall-related fatal injuries per 100,000 pop.	<b>7.7</b>
Unintentional fire/burn-related fatal injuries per 100,000 pop.	<b>1.3</b>
Unintentional firearm-related fatal injuries per 100,000 pop.	<b>0.2</b>
Gun-purchasing legislation (8 points possible)	<b>2.5</b>
% of tobacco settlement funds spent on health-related services and programs	<b>92.0</b>
Total injury prevention funds per 1,000 pop.	<b>\$445.11</b>
Unintentional injury prevention funds per 1,000 pop.	<b>\$146.67</b>
Intentional injury prevention funds per 1,000 pop.	<b>\$286.43</b>
Fall injury prevention funds per 1,000 pop.	<b>\$12.01</b>
Infant mortality rate per 1,000 live births	<b>7.3</b>
% of adults with BMI > 30	<b>24.0</b>
Current smokers, % of adults	<b>21.5</b>
Binge alcohol drinkers, % of adults	<b>16.6</b>

**DISASTER PREPAREDNESS** **A**

Per capita federal disaster preparedness funds	<b>\$9.01</b>
Disaster preparedness funds used specifically for health care-related preparedness are tracked	<b>Yes</b>
All-hazards medical response plan or ESF-8 plan?	<b>Yes</b>
Plan shared with all EMS and essential hospital personnel?	<b>No</b>
Public health and emergency physician input into the state planning process	<b>Yes, Yes</b>
Public health and emergency physician input into the daily operations of the SEOC	<b>Yes, Yes</b>
Written plan for the coordination of the SEOC or local EMAs to provide security to hospitals in case of emergency events	<b>Yes</b>
Number of drills and exercises conducted involving hospital personnel, equipment, or facilities	<b>1,535</b>
Accredited by the Emergency Management Accreditation Program	<b>Yes</b>
Written plan specifically for special needs patients	<b>Yes</b>
Written plan to supply medications for chronic conditions	<b>No</b>
Written plan to supply dialysis for patients	<b>No</b>
Real-time notification system in place to notify identified health care providers of an event	<b>Yes</b>
"Just-in-time" training systems in place	<b>Statewide</b>
Statewide medical communication system with one layer of redundancy	<b>Yes</b>
Statewide patient tracking system	<b>Yes</b>
Statewide victim tracking system	<b>Yes</b>
Statewide real-time or near real-time syndromic surveillance system	<b>Yes</b>
Real-time surveillance system in place for common ED presentations	<b>Yes</b>
Bed surge capacity per 1M pop.	<b>693.9</b>
Burn unit beds per 1M pop.	<b>5.8</b>
ICU beds per 1M pop.	<b>328.7</b>
Verified burn centers per 1M pop.	<b>0.3</b>
State able to verify credentials and assign volunteer health professionals to four ESAR-VHP levels	<b>Yes</b>
Nurses registered in ESAR-VHP per 1M pop.	<b>11.2</b>
Physicians registered in ESAR-VHP per 1M pop.	<b>3.0</b>
Training required in disaster management and response to bio- and chem terrorism for essential hospital personnel, EMS personnel	<b>Yes, Yes</b>
State or regional strike teams or medical assistance teams	<b>Yes</b>
Additional liability protections for health care workers during a disaster	<b>Yes, civil</b>
% of RNs that received any emergency training	<b>38.1</b>
State requires EMS and essential ED personnel to be NIMS compliant	<b>Yes</b>

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