

West Virginia

With an above-average percentage of insured residents and high per capita rates of emergency departments and staffed inpatient beds, West Virginia scores well in *Access to Emergency Care*, but substantial improvement is needed in *Public Health and Injury Prevention*.

Strengths. West Virginia has a number of characteristics that support *Access to Emergency Care* among its population. The state has the eighth highest rate of emergency departments (31.0 per 1 million people) and similarly high rankings for rates of staffed inpatient and psychiatric care beds (490.8 and 44.5 per 100,000 people, respectively). The state has lower than average rates of uninsured adults and children, as well as a relatively high percentage of adults with insurance through Medicaid. West Virginia also receives credit for collecting and reviewing data on ambulance diversion, though this is done on a regional basis, not at the state level.

West Virginia has instituted a number of important medical liability reforms, including additional liability protections for EMTALA-mandated emergency care, case certification by an expert witness, and the requirement that expert witnesses be of the same specialty as the defendant. In addition, the state has the eighth lowest average malpractice award which is significantly lower than the average across the states (\$209,564 versus \$285,218, respectively).

West Virginia also has shown some commitment toward improving its *Quality and Patient Safety Environment* through developing a stroke system of care and a PCI network or STEMI system of care, as well as maintaining a statewide trauma registry. The state also provides funding for a state EMS medical director position and quality improvement within the EMS system.

Challenges. *Public Health and Injury Prevention* indicators pose the greatest challenge to the state. West Virginia ranks 41st in the nation in infant mortality (8.1 deaths per 1,000 live births) and 50th with regard to both obesity and smoking: 31.0 percent of adults are obese and 25.7 percent are current smokers. In addition, the state has high rates of fatal occupational injuries (81.6 per 1 million workers) and traffic fatalities (22.6 per 100,000 people).

While faring well overall with regard to *Access to Emergency Care*, West Virginia, along with many states, is facing a workforce shortage. The state has relatively low rates of orthopedists and hand surgeons (7.8 per 100,000 people) and plastic surgeons (1.5 per 100,000). There also are only 2.4 physicians accepting Medicare per 100 beneficiaries, which may pose particular barriers for the elderly population in accessing needed medical care. In addition, only 71.0 percent of the state's population is within 60 minutes of a Level I or II trauma center, despite the relatively high rate of Level I or II trauma centers in the state (3.3 per 1 million people).

West Virginia has taken steps to prepare for a disaster event, but there are some aspects of *Disaster Preparedness* in which the state is lacking.

The state has no verified burn centers, and only 2.2 burn unit beds per 1 million people. West Virginia does not have a statewide real-time or near real-time syndromic surveillance system. The state's score also was affected by the lack of written plans for special needs patients, as well as the lack of written plans to supply medications for chronic conditions and dialysis for patients in the event of a disaster.

Recommendations. West Virginia needs to redouble its efforts to promote healthier lifestyles among its population, improve

| | RANK | GRADE |
|---|------|-------|
| ACCESS TO EMERGENCY CARE | 5 | B |
| QUALITY & PATIENT SAFETY ENVIRONMENT | 30 | C- |
| MEDICAL LIABILITY ENVIRONMENT | 20 | C |
| PUBLIC HEALTH & INJURY PREVENTION | 43 | D- |
| DISASTER PREPAREDNESS | 38 | D+ |
| OVERALL | 25 | C |

traffic safety, and reduce the number of work-related fatalities.

The state could improve the *Quality and Patient Safety Environment* by instituting mechanisms to monitor the quality of hospital care statewide. This could be accomplished through mandatory quality reporting requirements and requiring adverse event or hospital-based infections reporting.

While West Virginia has enacted considerable medical liability reforms, the state could still improve the *Medical Liability Environment* in a number of ways. The state could implement mandatory pretrial screening panels and require or provide for expert witnesses to be licensed in the state. The state also could institute further reforms, including reducing the maximum medical liability cap on non-economic damages and requiring periodic payment of awards.

ACCESS TO EMERGENCY CARE **B**

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| Board-certified emergency physicians per 100,000 pop. | 8.2 |
| Emergency physicians per 100,000 pop. | 12.3 |
| Neurosurgeons per 100,000 pop. | 1.9 |
| Orthopedists and hand surgeon specialists per 100,000 pop. | 7.8 |
| Plastic surgeons per 100,000 pop. | 1.5 |
| ENT specialists per 100,000 pop. | 3.5 |
| Registered nurses per 100,000 pop. | 938.2 |
| Additional primary care FTEs needed | 34.2 |
| Additional mental health FTEs needed | 6.0 |
| Level I or II trauma centers per 1M pop. | 3.3 |
| % of population within 60 minutes of Level I or II trauma center | 71.0 |
| Accredited chest pain centers per 1M pop. | 2.9 |
| % of population with an unmet need for substance abuse treatment | 7.9 |
| Pediatric specialty centers per 1M pop. | 2.8 |
| Physicians accepting Medicare per 100 beneficiaries | 2.4 |
| Medicaid fee levels for office visits as a % of the national average | 108.4 |
| % change in Medicaid fees for office visits (2004-05 to 2007) | 6.9 |
| % of adults with no health insurance | 14.9 |
| % of children with no health insurance | 8.5 |
| % of adults with Medicaid | 11.1 |
| Emergency departments per 1M pop. | 31.0 |
| Hospital closures in 2006 | 0 |
| Staffed inpatient beds per 100,000 pop. | 490.8 |
| Hospital occupancy rate per 100 staffed beds | 63.6 |
| Psychiatric care beds per 100,000 pop. | 44.5 |
| State collects data on diversion | Yes |

MEDICAL LIABILITY ENVIRONMENT **C**

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| Lawyers per 10,000 pop. | 11.2 |
| Lawyers per physician | 0.4 |
| Lawyers per emergency physician | 9.1 |
| ATRA judicial hellholes (range 0 to -7) | -2 |
| Malpractice award payments/100,000 pop. | 3.5 |
| Average malpractice award payments | \$209,564 |
| Databank reports per 1,000 physicians | 30.1 |
| Patient compensation fund | Yes |
| Health court pilot project grant | No |
| Number of insurers writing medical liability policies per 1,000 physicians | 13.1 |
| Average medical liability insurance premium for primary care physicians | \$23,599 |
| Average medical liability insurance premiums for specialists | \$93,828 |
| Pretrial screening panels | No |
| Are pretrial screening panels' findings admissible as evidence? | N/A |
| Periodic payments | No |
| 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 **C-**

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| Funding for quality improvement within the EMS system | Yes |
| Funded state EMS medical director | Yes |
| Emergency medicine residents per 1M pop. | 9.9 |
| Adverse event reporting required | No |
| Hospital-based infections reporting required | No |
| Mandatory quality reporting requirement | No |
| % of counties with E-911 capability | 98.2 |
| 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 | 13.5 |
| % of hospitals with electronic medical records | 34.7 |
| % of patients with acute myocardial infarction given PCI within 90 minutes of arrival | 61 |
| Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006) | 12 |

PUBLIC HEALTH & INJURY PREVENTION **D-**

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| Traffic fatalities per 100,000 pop. | 22.6 |
| % of traffic fatalities alcohol related | 39.0 |
| Front occupant restraint use (%) | 89.6 |
| 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 | 77.7 |
| % of adults aged 65+ who received flu vaccine in the last 12 months | 66.4 |
| % of adults aged 65+ who ever received pneumococcal vaccine | 65.4 |
| Fatal occupational injuries per 1M workers | 81.6 |
| Homicides and suicides (non-motor vehicle) per 100,000 pop. | 19.2 |
| Unintentional fall-related fatal injuries per 100,000 pop. | 7.6 |
| Unintentional fire/burn-related fatal injuries per 100,000 pop. | 1.7 |
| Unintentional firearm-related fatal injuries per 100,000 pop. | 0.6 |
| Gun-purchasing legislation (8 points possible) | 0 |
| % of tobacco settlement funds spent on health-related services and programs | 50.0 |
| Total injury prevention funds per 1,000 pop. | \$212.47 |
| Unintentional injury prevention funds per 1,000 pop. | \$52.43 |
| Intentional injury prevention funds per 1,000 pop. | \$160.04 |
| Fall injury prevention funds per 1,000 pop. | \$0.00 |
| Infant mortality rate per 1,000 live births | 8.1 |
| % of adults with BMI > 30 | 31.0 |
| Current smokers, % of adults | 25.7 |
| Binge alcohol drinkers, % of adults | 11.2 |

DISASTER PREPAREDNESS **D+**

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| Per capita federal disaster preparedness funds | \$9.41 |
| 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? | NR |
| 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 | No |
| Number of drills and exercises conducted involving hospital personnel, equipment, or facilities | 58 |
| Accredited by the Emergency Management Accreditation Program | No |
| 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 | Yes |
| Statewide victim tracking system | Yes |
| Statewide real-time or near real-time syndromic surveillance system | No |
| Real-time surveillance system in place for common ED presentations | NR |
| Bed surge capacity per 1M pop. | 612.6 |
| Burn unit beds per 1M pop. | 2.2 |
| ICU beds per 1M pop. | 384.3 |
| 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. | 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 | No, 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 | 39.3 |
| State requires EMS and essential ED personnel to be NIMS compliant | Yes |

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