

Georgia

Despite receiving an *A* for its *Medical Liability Environment*, Georgia faces numerous challenges ranging from provider shortages and high numbers of uninsured residents to inadequate support for key quality and disaster preparedness initiatives.

Strengths. Georgia has enacted significant liability reform laws that are already helping to reduce frivolous lawsuits and lower medical liability insurance premiums, as well as attract and retain physicians, especially in high-demand specialties, such as surgery and obstetrics. The state has a medical liability cap on non-economic damages in addition to having eliminated joint and several liability. The state also provides additional liability protections for EMTALA-mandated emergency care. Georgia has implemented a number of expert witness rules, including requiring case certification by an expert witness and requiring witnesses to be of the same specialty as the defendant. The state is also one of only four to have mandated that expert witnesses be licensed to practice medicine in the state.

Though Georgia faces important challenges in *Access to Emergency Care*, the state ranks first in the nation for patient access to substance abuse treatment services. The vast majority of the population (83.8 percent) lives within 60 minutes of a Level I or II trauma center. In addition, the Medicaid reimbursement rate for office visits is slightly higher than the national average (109.0 percent).

Challenges. Despite enacting numerous liability reforms, Georgia continues to face serious shortages of health care providers. The state ranked among the bottom 12 for its low rates of registered nurses, emergency physicians, primary care physicians, and specialists, such as orthopedists and

hand surgeons, neurosurgeons, and mental health providers. Georgia also faces challenges regarding the financial health of the state's largest hospital. Further affecting access issues in Georgia are higher than average rates of uninsured adults (19.5 percent compared to 17.2 percent nationally) and children (12.8 percent compared to 11.7 percent nationally).

The *Quality and Patient Safety Environment* in Georgia is also challenged. The state lacks funding for quality improvement within the EMS system, as well as a uniform system for providing pre-arrival instructions. In addition, Georgia has a relatively low rate of emergency medicine residents (8.8 per 1 million people) and does not require hospital-based infections reporting.

Georgia demonstrates a number of limitations with regard to *Disaster Preparedness*. The number of nurses and physicians registered with the state-based Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP; 23.6 and 2.7 per 1 million people, respectively) falls well below the average across the states (125.5 and 44.2 per 1 million, respectively). The state has neither patient nor victim tracking systems, and it lacks a written plan for the coordination of the State Emergency Operations Center or local emergency management agencies to provide security to hospitals during an emergency event.

Recommendations. Georgia has made great progress in improving its *Medical Liability Environment*. It is vital that policymakers do not roll back this progress as a result of the continuous pressure from medical liability reform opponents.

In order to address the state's poor grade regarding *Access to Emergency Care*, Georgia will need to explore multiple strate-




	RANK	GRADE
ACCESS TO EMERGENCY CARE	44	F
QUALITY & PATIENT SAFETY ENVIRONMENT	37	D+
MEDICAL LIABILITY ENVIRONMENT	4	A
PUBLIC HEALTH & INJURY PREVENTION	24	C-
DISASTER PREPAREDNESS	22	C+
OVERALL	31	C-

gies for recruiting and retaining more registered nurses, emergency physicians and residents, primary care providers, and critical medical specialists. Though the Medicaid reimbursement rate for office visits is slightly higher than the national average, that rate has remained unchanged since 2004–2005 (not accounting for inflation). Raising Medicaid reimbursement for a wide range of specialty services may also encourage and attract a broader workforce.

Georgia will benefit from development of uniform systems for pre-hospital instructions, hospital-based infections reporting, and further preparation for responding to disasters. The latter should consist of taking an active role in registering nurses and physicians with ESAR-VHP and developing uniform patient and victim tracking systems.

Georgia continues to face serious shortages of health care providers.


ACCESS TO EMERGENCY CARE **F**

Board-certified emergency physicians per 100,000 pop.	 7.0
Emergency physicians per 100,000 pop.	9.7
Neurosurgeons per 100,000 pop.	1.4
Orthopedists and hand surgeon specialists per 100,000 pop.	7.1
Plastic surgeons per 100,000 pop.	1.9
ENT specialists per 100,000 pop.	3.1
Registered nurses per 100,000 pop.	 666.1
Additional primary care FTEs needed	203.7
Additional mental health FTEs needed	53.0
Level I or II trauma centers per 1M pop.	1.2
% of population within 60 minutes of Level I or II trauma center	83.8
Accredited chest pain centers per 1M pop.	1.0
% of population with an unmet need for substance abuse treatment	6.4
Pediatric specialty centers per 1M pop.	2.9
Physicians accepting Medicare per 100 beneficiaries	2.8
Medicaid fee levels for office visits as a % of the national average	109.0
% change in Medicaid fees for office visits (2004-05 to 2007)	0.0
% of adults with no health insurance	19.5
% of children with no health insurance	12.8
% of adults with Medicaid	6.4
Emergency departments per 1M pop.	 11.3
Hospital closures in 2006	1
Staffed inpatient beds per 100,000 pop.	331.1
Hospital occupancy rate per 100 staffed beds	70.9
Psychiatric care beds per 100,000 pop.	22.9
State collects data on diversion	Yes






MEDICAL LIABILITY ENVIRONMENT **A**

Lawyers per 10,000 pop.	15.1
Lawyers per physician	0.7
Lawyers per emergency physician	15.3
ATRA judicial hellholes (range 0 to -7)	-1
Malpractice award payments/100,000 pop.	0.9
Average malpractice award payments	\$309,492
Databank reports per 1,000 physicians	18.1
Patient compensation fund	No
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	4.0
Average medical liability insurance premium for primary care physicians	\$15,112
Average medical liability insurance premiums for specialists	\$63,174
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	\$250,001-350,000
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	Yes

QUALITY & PATIENT SAFETY ENVIRONMENT **D+**




Funding for quality improvement within the EMS system	No
Funded state EMS medical director	Yes
Emergency medicine residents per 1M pop.	 8.8
Adverse event reporting required	Yes
Hospital-based infections reporting required	No
Mandatory quality reporting requirement	Yes
% of counties with E-911 capability	91.2
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	NR
Statewide trauma registry	Yes
% of hospitals with computerized practitioner order entry	20.8
% of hospitals with electronic medical records	47.6
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	53
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	18

PUBLIC HEALTH & INJURY PREVENTION **C-**

Traffic fatalities per 100,000 pop.	 18.1
% of traffic fatalities alcohol related	 36.0
Front occupant restraint use (%)	89.0
Helmet use required for all motorcycle riders	Yes
Child safety seat/seat belt legislation (10 points possible)	5
% of children immunized, aged 19-35 months	 83.3
% of adults aged 65+ who received flu vaccine in the last 12 months	 64.8
% of adults aged 65+ who ever received pneumococcal vaccine	 63.1
Fatal occupational injuries per 1M workers	45.1
Homicides and suicides (non-motor vehicle) per 100,000 pop.	17.2
Unintentional fall-related fatal injuries per 100,000 pop.	6.0
Unintentional fire/burn-related fatal injuries per 100,000 pop.	1.5
Unintentional firearm-related fatal injuries per 100,000 pop.	0.3
Gun-purchasing legislation (8 points possible)	0
% of tobacco settlement funds spent on health-related services and programs	69.8
Total injury prevention funds per 1,000 pop.	\$170.77
Unintentional injury prevention funds per 1,000 pop.	\$97.44
Intentional injury prevention funds per 1,000 pop.	\$47.15
Fall injury prevention funds per 1,000 pop.	\$0.00
Infant mortality rate per 1,000 live births	8.2
% of adults with BMI > 30	27.1
Current smokers, % of adults	19.9
Binge alcohol drinkers, % of adults	12.1

DISASTER PREPAREDNESS **C+**

Per capita federal disaster preparedness funds	\$8.33
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	No
Number of drills and exercises conducted involving hospital personnel, equipment, or facilities	42
Accredited by the Emergency Management Accreditation Program	Yes
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	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.	1,400.1
Burn unit beds per 1M pop.	8.6
ICU beds per 1M pop.	252.6
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.	23.6
Physicians registered in ESAR-VHP per 1M pop.	2.7
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	43.9
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	