

Vermont

A strong commitment to *Public Health and Injury Prevention* helped elevate Vermont’s overall ranking, countering a *Medical Liability Environment* that ranks among the bottom ten in the nation.

Strengths. Vermont performed well throughout the *Public Health and Injury Prevention* category. The state has a low percentage of traffic fatalities that are alcohol-related (33.0 percent), for which it ranked fifth among the states. In addition, the state has a universal helmet requirement for all riders on all motorized cycles. The state ranks third in funding for fall-related injury prevention (\$19.32 per 1,000 people), possibly indicating a commitment to addressing the high rate of fatal fall-related injuries in the state (14.0 per 100,000 people). The state also has relatively low rates of obese adults (21.2 percent) and smokers (18.0 percent).

The state fares well in most areas of *Disaster Preparedness*, showing a high level of state coordination and capacity to deploy volunteers. The state has a victim tracking system, a syndromic surveillance system, and a real-time surveillance system in place for common emergency department presentations. In addition, there are statewide “just-in-time” training systems in place and a real-time notification system to notify identified health care workers of an event. The state supports medical strike teams or medical assistance teams and requires EMS and essential emergency department personnel to be compliant with the National Incident Management System.

Vermont has a number of noteworthy successes in *Access to Emergency Care*, as well. The state has the fifth highest Medicaid reimbursement rates for office visits in the nation (136.8 percent of the national aver-

age), which is the result of a 62.2 percent increase since 2004. Vermont also has the fourth highest rate of physicians accepting Medicare (4.5 per 100 beneficiaries). The state has the eighth lowest rate of uninsured adults (10.8 percent), which is likely due in part to the state insuring 13.6 percent of adults through Medicaid (fifth highest among the states). Finally, the state’s primary care and mental health provider capacity exceeds that of nearly all other states.

Challenges. While Vermont scores well overall in *Access to Emergency Care*, there also are some problems worth noting. The state has only 1.6 pediatric specialty centers per 1 million people and no accredited chest pain centers. In addition, Vermont has a relatively high level of unmet need for substance abuse treatment (9.7 percent).

Vermont’s *Medical Liability Environment* is among the worst in the nation. Vermont is among only 20 states that have not implemented a medical liability cap on non-economic damages and only 15 states that have not abolished joint and several liability. The state also has the third highest rate of malpractice award payments with 7.2 per 100,000 people.

While Vermont provides funding for quality improvement within the EMS system, the state has not invested in developing systems for improving the *Quality and Patient Safety Environment* in other areas. The state lacks a stroke system of care, as well as a PCI network or STEMI system of care. Vermont does not maintain a statewide trauma registry and has no emergency medicine residents. The state also has a relatively low percentage of hospitals with computerized practitioner order entry (9.1 percent).

Vermont could drastically improve the medical liability environment by enacting reforms.

	RANK	GRADE
ACCESS TO EMERGENCY CARE	17	C
QUALITY & PATIENT SAFETY ENVIRONMENT	33	C-
MEDICAL LIABILITY ENVIRONMENT	44	F
PUBLIC HEALTH & INJURY PREVENTION	7	B+
DISASTER PREPAREDNESS	16	B
OVERALL	21	C

Recommendations. Above all, Vermont could drastically improve the *Medical Liability Environment* by enacting any number of reforms. The state could implement expert witness rules requiring the witness to be of the same specialty as the defendant and pretrial screening panels to ensure more fair and reasonable outcomes in the best interest of both practitioners and patients. Vermont may also consider enacting liability protections for EMTALA-mandated emergency care in order to encourage specialists to provide on-call services for emergency patients.

In addition, Vermont would do well to institute an infrastructure for providing a stroke system of care or a PCI network or STEMI system of care and seek other opportunities to support the *Quality and Patient Safety Environment* in the state.

ACCESS TO EMERGENCY CARE **C**

Board-certified emergency physicians per 100,000 pop.	10.8
Emergency physicians per 100,000 pop.	12.6
Neurosurgeons per 100,000 pop.	2.3
Orthopedists and hand surgeon specialists per 100,000 pop.	13.7
Plastic surgeons per 100,000 pop.	1.3
ENT specialists per 100,000 pop.	4.5
Registered nurses per 100,000 pop.	911.8
Additional primary care FTEs needed	1.8
Additional mental health FTEs needed	0.0
Level I or II trauma centers per 1M pop.	1.6
% of population within 60 minutes of Level I or II trauma center	67.3
Accredited chest pain centers per 1M pop.	0.0
% of population with an unmet need for substance abuse treatment	9.7
Pediatric specialty centers per 1M pop.	1.6
Physicians accepting Medicare per 100 beneficiaries	4.5
Medicaid fee levels for office visits as a % of the national average	136.8
% change in Medicaid fees for office visits (2004-05 to 2007)	62.2
% of adults with no health insurance	10.8
% of children with no health insurance	8.0
% of adults with Medicaid	13.6
Emergency departments per 1M pop.	24.2
Hospital closures in 2006	0
Staffed inpatient beds per 100,000 pop.	242.9
Hospital occupancy rate per 100 staffed beds	69.1
Psychiatric care beds per 100,000 pop.	34.0
State collects data on diversion	No

MEDICAL LIABILITY ENVIRONMENT **F**

Lawyers per 10,000 pop.	16.1
Lawyers per physician	0.5
Lawyers per emergency physician	12.8
ATRA judicial hellholes (range 0 to -7)	0
Malpractice award payments/100,000 pop.	7.2
Average malpractice award payments	\$131,877
Databank reports per 1,000 physicians	17.9
Patient compensation fund	No
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	19.7
Average medical liability insurance premium for primary care physicians	\$8,284
Average medical liability insurance premiums for specialists	\$37,045
Pretrial screening panels	No
Are pretrial screening panels' findings admissible as evidence?	N/A
Periodic payments	No
Medical liability cap on non-economic damages	No
Additional liability protection for EMTALA-mandated emergency care	No
Joint and several liability abolished	No
State provides for case certification	No
Expert witness required to be of the same specialty as the defendant	No
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.	0.0
Adverse event reporting required	No
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	Yes
State has or is working on a stroke system of care	No
State has or is working on a PCI network or a STEMI system of care	No
Statewide trauma registry	No
% of hospitals with computerized practitioner order entry	9.1
% of hospitals with electronic medical records	57.1
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	58
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	46

PUBLIC HEALTH & INJURY PREVENTION **B+**

Traffic fatalities per 100,000 pop.	13.9
% of traffic fatalities alcohol related	33.0
Front occupant restraint use (%)	87.1
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	86.1
% of adults aged 65+ who received flu vaccine in the last 12 months	72.8
% of adults aged 65+ who ever received pneumococcal vaccine	66.9
Fatal occupational injuries per 1M workers	30.7
Homicides and suicides (non-motor vehicle) per 100,000 pop.	14.5
Unintentional fall-related fatal injuries per 100,000 pop.	14.0
Unintentional fire/burn-related fatal injuries per 100,000 pop.	1.2
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	94.8
Total injury prevention funds per 1,000 pop.	\$230.18
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.	\$19.32
Infant mortality rate per 1,000 live births	6.7
% of adults with BMI > 30	21.2
Current smokers, % of adults	18.0
Binge alcohol drinkers, % of adults	16.8

DISASTER PREPAREDNESS **B**

Per capita federal disaster preparedness funds	\$22.11
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	No
Number of drills and exercises conducted involving hospital personnel, equipment, or facilities	138
Accredited by the Emergency Management Accreditation Program	No
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	Yes
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.	861.2
Burn unit beds per 1M pop.	14.5
ICU beds per 1M pop.	228.7
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.	8.0
Physicians registered in ESAR-VHP per 1M pop.	9.7
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	Civil, not clearly defined
% of RNs that received any emergency training	45.3
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	