Washington

D+

Washington has made a strong commitment to the *Quality and Patient Safety Environment* and *Public Health and Injury Prevention*. However, the state lacks coordination for *Disaster Preparedness* and faces a challenging *Medical Liability Environment*.

Strengths. Washington earns an A- in *Public Health and Injury Prevention*, the fifth highest score in the nation. The state boasts low rates of fatal injuries and generally low levels of chronic disease risk factors. Traffic fatality rates in Washington are particularly low, thanks in part to its strong child safety seat and adult seatbelt legislation and strict laws against distracted driving. The state is first in the nation for seatbelt use, with 97.5% of vehicle front-seat occupants using seatbelts. The infant mortality rate (4.5 deaths per 1,000 live births) is the 6th lowest in the nation. Only 17.5% of the state's adults are current smokers and strong anti-smoking legislation keeps secondhand smoke out of bars, restaurants, and workplaces.

Washington continues to be a leader in the *Quality and Patient Safety Environment*, with patient care procedures, protocols, and triage guidelines in place for ST-elevation myocardial infarction (STEMI), trauma, and stroke patients. The state has a uniform system for providing pre-arrival instructions. Washington has a strong prescription drug monitoring program, which has been implemented statewide and monitors drug schedules II to V. While the state continues to fund quality improvement efforts within the emergency medical services (EMS) system, it does not have a funded state EMS medical director.

Washington has worked to improve some aspects of *Access to Emergency Care*. It has improved its Medicaid fee levels, with a 61.2% increase between 2007 and 2012 that has lifted the state's fees to 125.1% of the national average. A recent collaboration between state officials and the medical community resulted in implementation of best practices that protect Medicaid patients' access to emergency care while better ensuring that Medicaid patients seek and receive treatment in appropriate care settings.

Challenges. Washington's *Disaster Preparedness* rank fell, largely because the state did not implement improvements made in other states. Per capita federal disaster preparedness funds have dropped from $7.09 in the 2009 Report Card to $5.31, and the state does not have a budget line item for disaster preparedness funding specific for health care surge. Washington lacks many policies and procedures that ensure that medically vulnerable patients receive care in a disaster and that help coordinate responses between different responders. However, the state is conducting a pilot project for statewide electronic patient tracking software, which is a step in the right direction.

Washington has a challenging *Medical Liability Environment*, with few protections in place for the state's medical practitioners. Although the state maintains below-average medical liability insurance premiums for both primary care physicians ($11,128) and specialists ($52,935), practitioners are vulnerable to unfounded lawsuits. Washington does not provide for case certification or for pretrial screening panels, both of which can weed out frivolous or unsubstantiated lawsuits. It remains in the minority of states without any cap on non-economic damages in medical liability cases, which can lead to exorbitant malpractice award payments.

The lack of resources and inpatient capacity for mental health patients is a major concern.

Despite some improvements noted above, Washington continues to receive a failing grade for *Access to Emergency Care*. One major area of concern is the lack of resources and inpatient capacity for mental health patients. The state ranks third worst in the nation for the number of psychiatric care beds (8.3 per 100,000 people).

Recommendations. Washington is a home rule state with authority for local response held by local health officers. While this is a logical setup for disaster response in a large and rural state, Washington could benefit from more attention to statewide planning and processes. A statewide medical communication system with redundancy would help ensure that different authorities can coordinate their response to an unfolding disaster. Washington also has some of the lowest rates of physicians, nurses, and behavioral health professionals registered in the Emergency System for Advance Registration of Volunteer Health Professionals and should focus on recruiting these professionals in advance of a disaster event.

Washington should work to reform its *Medical Liability Environment* by passing a medical liability cap on non-economic damages to ensure that award payments do not rise uncontrollably. Another vital reform is special liability protection for care mandated by the Emergency Medical Treatment and Labor Act, which would protect emergency care workers who provide care in life-threatening situations, often to high-risk patients, without knowledge of their medical histories.

Washington needs greater investments in its hospital infrastructure. In addition to the paucity of psychiatric care beds, the state has some of the lowest levels of staffed inpatient and intensive care unit beds. There is also very low access to level I or II trauma centers, with only 83.2% of the population within 60 minutes of one.

	2009		2014	
	Rank	Grade	Rank	Grade
Access to Emergency Care	43	F	37	F
Quality & Patient Safety Environment	1	A	8	B
Medical Liability Environment	40	D-	42	F
Public Health & Injury Prevention	4	A	5	A-
Disaster Preparedness	33	C	50	F
OVERALL	19	C	35	D+

ACCESS TO EMERGENCY CARE	F
Board-certified emergency physicians per 100,000 pop.	11.7
Emergency physicians per 100,000 pop.	13.8
Neurosurgeons per 100,000 pop.	1.7
Orthopedists and hand surgeon specialists per 100,000 pop.	9.1
Plastic surgeons per 100,000 pop.	2.1
ENT specialists per 100,000 pop.	3.7
Registered nurses per 100,000 pop.	798.6
Additional primary care FTEs needed per 100,000 pop.	3.1
Additional mental health FTEs needed per 100,000 pop.	0.9
% of children able to see provider	94.2
Level I or II trauma centers per 1M pop.	0.7
% of population within 60 minutes of Level I or II trauma center	83.2
Accredited chest pain centers per 1M pop.	1.3
% of population with an unmet need for substance abuse treatment	8.6
Pediatric specialty centers per 1M pop.	2.8
Physicians accepting Medicare per 100 beneficiaries	3.5
Medicaid fee levels for office visits as a % of the national average	125.1
% change in Medicaid fees for office visits (2007 to 2012)	61.2
% of adults with no health insurance	16.2
% of adults underinsured	8.1
% of children with no health insurance	8.8
% of children underinsured	14.8
% of adults with Medicaid	9.0
Emergency departments per 1M pop.	11.2
Hospital closures in 2011	0
Staffed inpatient beds per 100,000 pop.	208.3
Hospital occupancy rate per 100 staffed beds	65.2
Psychiatric care beds per 100,000 pop.	8.3
Median minutes from ED arrival to ED departure for admitted patients	260
State collects data on diversion	N/A

MEDICAL LIABILITY ENVIRONMENT	F
Lawyers per 10,000 pop.	15.2
Lawyers per physician	0.6
Lawyers per emergency physician	11.0
ATRA judicial hellholes (range 2 to -6)	-1
Malpractice award payments/ 100,000 pop.	2.0
Average malpractice award payments	$248,890
Databank reports per 1,000 physicians	27.9
Provider apology is inadmissible as evidence	Yes
Patient compensation fund	No
Number of insurers writing medical liability policies per 1,000 physicians	4.7
Average medical liability insurance premium for primary care physicians	$11,128
Average medical liability insurance premium for specialists	$52,935
Presence of pretrial screening panels	No
Pretrial screening panel's findings admissible as evidence	N/A
Periodic payments	Upon request
Medical liability cap on non-economic damages	None
Additional liability protection for EMTALA-mandated emergency care	No
Joint and several liability abolished	Partially
Collateral source rule, provides for awards to be offset	Yes, No offset
State provides for case certification	No
Expert witness must 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	B
Funding for quality improvement within the EMS system	Yes
Funded state EMS medical director	No
Emergency medicine residents per 1M pop.	7.8
Adverse event reporting required	Yes
% of counties with E-911 capability	100.0
Uniform system for providing pre-arrival instructions	Yes
CDC guidelines are basis for state field triage protocols	Yes (2011)
State has or is working on a stroke system of care	Yes
Triage and destination policy in place for stroke patients	Yes
State has or is working on a PCI network or a STEMI system of care	Yes
Triage and destination policy in place for STEMI patients	Yes
Statewide trauma registry	Yes
Triage and destination policy in place for trauma patients	Yes
Prescription drug monitoring program (range 0-4)	3
% of hospitals with computerized practitioner order entry	81.1
% of hospitals with electronic medical records	93.7
% of patients with AMI given PCI within 90 minutes of arrival	91
Median time to transfer to another facility for acute coronary intervention	50
% of patients with AMI who received aspirin within 24 hours	99
% of hospitals collecting data on race/ ethnicity and primary language	44.9
% of hospitals having or planning to develop a diversity strategy/plan	34.6

PUBLIC HEALTH & INJURY PREVENTION	A-
Traffic fatalities per 100,000 pop.	5.8
Bicyclist fatalities per 100,000 cyclists	1.9
Pedestrian fatalities per 100,000 pedestrians	2.6
% of traffic fatalities alcohol related	40
Front occupant restraint use (%)	97.5
Helmet use required for all motorcycle riders	Yes
Child safety seat/seat belt legislation (range 0-10)	8
Distracted driving legislation (range 0-4)	4
Graduated drivers' license legislation (range 0-5)	0
% of children immunized, aged 19-35 months	76.0
% of adults aged 65+ who received flu vaccine in past year	60.7
% of adults aged 65+ who ever received pneumococcal vaccine	74.0
Fatal occupational injuries per 1M workers	22.7
Homicides and suicides (non-motor vehicle) per 100,000 pop.	16.9
Unintentional fall-related fatal injuries per 100,000 pop.	11.6
Unintentional fire/burn-related fatal injuries per 100,000 pop.	0.7
Unintentional firearm-related fatal injuries per 100,000 pop.	0.1
Unintentional poisoning-related fatal injuries per 100,000 pop.	11.2
Total injury prevention funds per 1,000 pop.	$214.28
Dedicated child injury prevention funding	Yes
Dedicated elderly injury prevention funding	Yes
Dedicated occupational injury prevention funding	No
Gun-purchasing legislation (range 0-6)	0.5
Anti-smoking legislation (range 0-3)	3
Infant mortality rate per 1,000 live births	4.5
Binge alcohol drinkers, % of adults	17.8
Current smokers, % of adults	17.5
% of adults with BMI >30	26.5
% of children obese	11.0
Cardiovascular disease disparity ratio	2.8
HIV diagnoses disparity ratio	7.5
Infant mortality disparity ratio	2.2

DISASTER PREPAREDNESS	F
Per capita federal disaster preparedness funds	$5.31
State budget line item for health care surge	No
ESF-8 plan shared with all EMS and essential hospital personnel	No
Emergency physician input into the state planning process	Yes
Public health and emergency physician input during an ESF-8 response	Yes, No
Drills, exercises conducted with hospital personnel, equipment, facilities per hospital	3.0
Accredited by the Emergency Management Accreditation Program	No
Special needs patients in medical response plan	Yes
Patients on medication for chronic conditions in medical response plan	No
Medical response plan for supplying dialysis	No
Mental health patients in medical response plan	No
Medical response plan for supplying psychotropic medication	No
Mutual aid agreements with behavioral health providers	None
Long-term care and nursing home facilities must have written disaster plan	Yes
State able to report number of exercises with long-term care or nursing home facilities	No
"Just-in-time" training systems in place	Statewide
Statewide medical communication system with one layer of redundancy	No
Statewide patient tracking system	No
Statewide real-time or near real-time syndromic surveillance system	Yes
Real-time surveillance system in place for common ED presentations	In metro areas
Bed surge capacity per 1M pop.	747.4
ICU beds per 1M pop.	200.5
Burn unit beds per 1M pop.	7.2
Verified burn centers per 1M pop.	0.1
Physicians in ESAR-VHP per 1M pop.	3.0
Nurses in ESAR-VHP per 1M pop.	45.7
Behavioral health professionals in ESAR-VHP per 1M pop.	2.9
Strike teams or medical assistance teams	No
Disaster training required for essential hospital, EMS personnel	No
Liability protections for health care workers during a disaster (range 0-4)	1
% of RNs received disaster training	40.5

NR = Not reported
N/A = Not applicable