

District of Columbia

A commitment to *Disaster Preparedness* and a high concentration of facilities and providers within a small geographic area helped propel the District of Columbia to the second highest ranking in the country. But significant problems abound, including a high rate of violent fatalities, insufficient immunizations of the elderly, a lack of EMS funding, and the worst *Medical Liability Environment* in the country.

Strengths. The District of Columbia enjoys the highest rates of emergency physicians; neurosurgeons; orthopedists and hand surgeons; plastic surgeons; ear, nose and throat specialists; and registered nurses. In addition, the District has the highest rate of physicians accepting Medicare (11.3 per 100 beneficiaries) and the highest rate of staffed inpatient beds (891.9 per 100,000 people). In addition to lower than average rates of uninsured adults and children, the District has shown commitment to insuring adults with the fourth highest percentage of adults covered by Medicaid (13.7 percent).

The District of Columbia also scores well with regard to *Disaster Preparedness*, as one would expect of the nation’s capital. The District has more ICU and burn unit beds, as well as more verified burn centers per 1 million people than any single state. The District also receives the highest level of federal funding in the country designated for disaster preparedness (\$160.57 per capita). With regard to deployment of medical professionals, the District has medical strike teams or medical assistance teams and requires EMS and essential emergency department personnel to be compliant with the National Incident Management System (NIMS).

Challenges. The *Medical Liability Environment* in the District of Columbia is not

supportive of the medical community. The District ranks 50th with regard to the number of malpractice awards (8.0 per 100,000 people). In comparison, the average across the states was 2.4 awards per 100,000. The average amount for a malpractice award in the District is \$366,131, compared with the average across the states of \$285,218. At the same time, the average medical liability insurance premiums for primary care physicians and specialists are among the highest in the country (\$24,010 and \$110,306, respectively). The District also lacks significant liability reforms including a medical liability cap on non-economic damages and expert witness rules requiring witnesses to be of the same specialty as the defendant.

The District of Columbia gave a mixed performance with regard to the *Quality and Patient Safety Environment*. While the District demonstrates high rates of information technology use in hospitals, it ranks among the worst with regard to the percent of patients with acute myocardial infarction given PCI within 90 minutes of arrival (41 percent). In addition, there is no funding for quality improvement within the EMS system.

The District’s grade in *Public Health and Injury Prevention* is due to poor rankings on a number of indicators. While it has a relatively high percentage of children who are immunized, the District of Columbia

ranks among the worst with regard to immunizations for older adults. Only 61.2 percent of adults aged 65 and older receive

yearly influenza vaccines, and just 52.0 percent have ever received the pneumococcal vaccine. The percentage of traffic fatalities that are alcohol related is disproportionately high (48.0 percent), compared to the national rate (42 percent).

Policymakers in the District of Columbia need to develop a more supportive medical liability environment.

	RANK	GRADE
ACCESS TO EMERGENCY CARE	1	A
QUALITY & PATIENT SAFETY ENVIRONMENT	28	C
MEDICAL LIABILITY ENVIRONMENT	51	F
PUBLIC HEALTH & INJURY PREVENTION	25	C-
DISASTER PREPAREDNESS	1	A
OVERALL	2	B-

Recommendations. Policymakers in the District of Columbia need to develop a more supportive *Medical Liability Environment* by taking action to reduce liability insurance premiums in the District. Positive steps in this direction would be to institute a \$250,000 medical liability cap on non-economic damages and implementation of expert witness rules, such as providing for case certification by an expert witness and requiring the witness to be of the same specialty as the defendant.

The *Public Health and Injury Prevention* grade could be significantly improved by addressing a number of concerns. First, the District should address the relatively low rate of immunizations among the older adult population. In addition, the District of Columbia government, residents, and law enforcement need to work together to address the high rate of homicides and suicides (36.6 per 100,000 people).

ACCESS TO EMERGENCY CARE **A**

Board-certified emergency physicians per 100,000 pop.	11.0
Emergency physicians per 100,000 pop.	25.2
Neurosurgeons per 100,000 pop.	5.9
Orthopedists and hand surgeon specialists per 100,000 pop.	18.7
Plastic surgeons per 100,000 pop.	7.1
ENT specialists per 100,000 pop.	7.1
Registered nurses per 100,000 pop.	1,385.2
Additional primary care FTEs needed	39.3
Additional mental health FTEs needed	0.8
Level I or II trauma centers per 1M pop.	5.1
% of population within 60 minutes of Level I or II trauma center	100.0
Accredited chest pain centers per 1M pop.	0.0
% of population with an unmet need for substance abuse treatment	10.0
Pediatric specialty centers per 1M pop.	8.5
Physicians accepting Medicare per 100 beneficiaries	11.3
Medicaid fee levels for office visits as a % of the national average	71.9
% change in Medicaid fees for office visits (2004-05 to 2007)	0.0
% of adults with no health insurance	12.4
% of children with no health insurance	8.7
% of adults with Medicaid	13.7
Emergency departments per 1M pop.	10.2
Hospital closures in 2006	0
Staffed inpatient beds per 100,000 pop.	891.9
Hospital occupancy rate per 100 staffed beds	76.4
Psychiatric care beds per 100,000 pop.	43.9
State collects data on diversion	Yes

MEDICAL LIABILITY ENVIRONMENT **F**

Lawyers per 10,000 pop.	496.4
Lawyers per physician	6.5
Lawyers per emergency physician	196.4
ATRA judicial hellholes (range 0 to -7)	-1
Malpractice award payments/100,000 pop.	8.0
Average malpractice award payments	\$366,131
Databank reports per 1,000 physicians	24.4
Patient compensation fund	No
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	9.4
Average medical liability insurance premium for primary care physicians	\$24,010
Average medical liability insurance premiums for specialists	\$110,306
Pretrial screening panels	No
Are pretrial screening panels' findings admissible as evidence?	N/A
Periodic payments	At judge's or court's discretion
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	No
Funded state EMS medical director	No
Emergency medicine residents per 1M pop.	62.9
Adverse event reporting required	No
Hospital-based infections reporting required	No
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	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	28.6
% of hospitals with electronic medical records	85.7
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	41
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	74

PUBLIC HEALTH & INJURY PREVENTION **C-**

Traffic fatalities per 100,000 pop.	6.4
% of traffic fatalities alcohol related	48.0
Front occupant restraint use (%)	87.1
Helmet use required for all motorcycle riders	Yes
Child safety seat/seat belt legislation (10 points possible)	9
% of children immunized, aged 19-35 months	82.8
% of adults aged 65+ who received flu vaccine in the last 12 months	61.2
% of adults aged 65+ who ever received pneumococcal vaccine	52.0
Fatal occupational injuries per 1M workers	34.3
Homicides and suicides (non-motor vehicle) per 100,000 pop.	36.6
Unintentional fall-related fatal injuries per 100,000 pop.	7.2
Unintentional fire/burn-related fatal injuries per 100,000 pop.	1.4
Unintentional firearm-related fatal injuries per 100,000 pop.	0.4
Gun-purchasing legislation (8 points possible)	3
% of tobacco settlement funds spent on health-related services and programs	NR
Total injury prevention funds per 1,000 pop.	\$849.92
Unintentional injury prevention funds per 1,000 pop.	\$0.00
Intentional injury prevention funds per 1,000 pop.	\$849.92
Fall injury prevention funds per 1,000 pop.	\$0.00
Infant mortality rate per 1,000 live births	14.1
% of adults with BMI > 30	22.5
Current smokers, % of adults	17.9
Binge alcohol drinkers, % of adults	15.9

DISASTER PREPAREDNESS **A**

Per capita federal disaster preparedness funds	\$160.57
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	No, No
Written plan for the coordination of the SEOC or local EMAs to provide security to hospitals in case of emergency events	Yes
Number of drills and exercises conducted involving hospital personnel, equipment, or facilities	4
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	Yes
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.	425.0
Burn unit beds per 1M pop.	28.9
ICU beds per 1M pop.	608.1
Verified burn centers per 1M pop.	1.7
State able to verify credentials and assign volunteer health professionals to four ESAR-VHP levels	Yes
Nurses registered in ESAR-VHP per 1M pop.	30.6
Physicians registered in ESAR-VHP per 1M pop.	6.8
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	48.1
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	