

Washington

Washington earns the highest rank in the nation for its *Quality and Patient Safety Environment* and ranks among the top five in *Public Health and Injury Prevention*. However, some serious issues remain, including the state's worst-in-the-nation rankings for per capita rates of inpatient and psychiatric care beds.

Strengths. Washington leads the nation with regard to the *Quality and Patient Safety Environment*. The state has a uniform system for providing pre-arrival instructions, and every county in the state has Enhanced 911 capability. The state also has shown commitment to quality and patient safety through funding for quality improvement within the EMS system, as well as supporting a funded state EMS medical director position. Washington is implementing a stroke system of care and maintains a statewide trauma registry.

Washington ranks fourth in *Public Health and Injury Prevention*, showing a strong performance in a number of areas. The state has a relatively low rate of traffic fatalities (9.9 per 100,000 people), combined with a high rate of seat belt use (96.4 percent of front occupants). In addition, the state has the second lowest infant mortality rate in the nation (5.1 deaths per 1,000 live births), as well as the fifth lowest percentage of adult smokers (17.1 percent).

Challenges. *Access to Emergency Care* should be a major concern for Washington, given the state's poor performance in this category. The state ranks 51st for rates of staffed inpatient and psychiatric care beds (208.7 and 8.2 per 100,000 people, respectively). In addition, the state has a great need for primary care and mental health providers: 144.0 primary care and 40.5 mental health full-time equivalent providers are needed to serve the state's growing population. Finally, the state has

only 10.0 emergency departments per 1 million people, which is nearly half the average across the states.

While the state's average malpractice award is slightly less than the average state, Washington performs poorly with regard to the *Medical Liability Environment* for having failed to implement a number of reforms. The state is one of only 20 that have not instituted a medical liability cap on non-economic damages. In addition, the state has only partially abolished joint and several liability and does not require expert witnesses to be of the same specialty as the defendant.

In some respects, the state appears to be ill-prepared for a major disaster event. Washington receives a relatively low level of federal funding for disaster preparedness (\$7.09 per capita) and lacks victim and patient tracking systems, as well as a statewide real-time or near real-time syndromic surveillance system. The state also has the lowest rate of ICU beds available to serve its population during a crisis (184.5 per 1 million people). Washington also is one of only 18 states without a requirement that EMS personnel and essential hospital personnel be trained in disaster management and response to bio- and chemical terrorism.

Recommendations. Washington needs to address critical shortages of staffed inpatient beds and psychiatric care beds, as well as the shortage of health care professionals to improve *Access to Emergency Care* throughout the state.

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A more favorable *Medical Liability Environment* may help the state address its serious shortfall of physicians. Liability reforms could include a cap on non-economic damages, pretrial screening panels, expert witness rules requiring

	RANK	GRADE
ACCESS TO EMERGENCY CARE	43	F
QUALITY & PATIENT SAFETY ENVIRONMENT	1	A
MEDICAL LIABILITY ENVIRONMENT	40	D-
PUBLIC HEALTH & INJURY PREVENTION	4	A
DISASTER PREPAREDNESS	33	C
OVERALL	19	C

the witness to be of the same specialty as the defendant, and a provision for witnesses to be licensed to practice medicine in the state. To help encourage specialists to provide needed on-call services for emergency patients, the state could also consider special liability protections for providers of EMTALA-mandated emergency care.

The state also could improve its *Disaster Preparedness* grade by increasing bed surge capacity from 188.8 per 1 million people to more closely align with the average across the states: 673.4 per 1 million. Similarly, Washington also would benefit from a greater number of ICU beds in case of a disaster event, as noted above. The state, which is capable of verifying the credentials of volunteer health professionals and assigning them to one of four levels within the Emergency System for Advance Registration of Volunteer Health Professionals, could benefit greatly from increasing registration among nurses and physicians.

ACCESS TO EMERGENCY CARE **F**

Board-certified emergency physicians per 100,000 pop.	10.4
Emergency physicians per 100,000 pop.	11.9
Neurosurgeons per 100,000 pop.	1.7
Orthopedists and hand surgeon specialists per 100,000 pop.	9.4
Plastic surgeons per 100,000 pop.	1.8
ENT specialists per 100,000 pop.	3.5
Registered nurses per 100,000 pop.	782.9
Additional primary care FTEs needed	144.0
Additional mental health FTEs needed	40.5
Level I or II trauma centers per 1M pop.	1.1
% of population within 60 minutes of Level I or II trauma center	80.2
Accredited chest pain centers per 1M pop.	0.8
% of population with an unmet need for substance abuse treatment	8.9
Pediatric specialty centers per 1M pop.	2.8
Physicians accepting Medicare per 100 beneficiaries	3.4
Medicaid fee levels for office visits as a % of the national average	95.4
% change in Medicaid fees for office visits (2004-05 to 2007)	-26.0
% of adults with no health insurance	13.4
% of children with no health insurance	6.9
% of adults with Medicaid	8.4
Emergency departments per 1M pop.	10.0
Hospital closures in 2006	0
Staffed inpatient beds per 100,000 pop.	208.7
Hospital occupancy rate per 100 staffed beds	65.4
Psychiatric care beds per 100,000 pop.	8.2
State collects data on diversion	Yes

MEDICAL LIABILITY ENVIRONMENT **D-**

Lawyers per 10,000 pop.	17.4
Lawyers per physician	0.7
Lawyers per emergency physician	14.5
ATRA judicial hellholes (range 0 to -7)	0
Malpractice award payments/100,000 pop.	1.0
Average malpractice award payments	\$259,302
Databank reports per 1,000 physicians	20.7
Patient compensation fund	No
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	4.1
Average medical liability insurance premium for primary care physicians	\$15,271
Average medical liability insurance premiums for specialists	\$61,316
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	No
Additional liability protection for EMTALA-mandated emergency care	No
Joint and several liability abolished	Partially
State provides for case certification	Yes
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 **A**

Funding for quality improvement within the EMS system	Yes
Funded state EMS medical director	Yes
Emergency medicine residents per 1M pop.	5.7
Adverse event reporting required	Yes
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	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	20.5
% of hospitals with electronic medical records	50.0
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	65
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	30

PUBLIC HEALTH & INJURY PREVENTION **A**

Traffic fatalities per 100,000 pop.	9.9
% of traffic fatalities alcohol related	47.0
Front occupant restraint use (%)	96.4
Helmet use required for all motorcycle riders	Yes
Child safety seat/seat belt legislation (10 points possible)	8
% of children immunized, aged 19-35 months	77.6
% of adults aged 65+ who received flu vaccine in the last 12 months	70.6
% of adults aged 65+ who ever received pneumococcal vaccine	69.6
Fatal occupational injuries per 1M workers	27.8
Homicides and suicides (non-motor vehicle) per 100,000 pop.	16.7
Unintentional fall-related fatal injuries per 100,000 pop.	9.1
Unintentional fire/burn-related fatal injuries per 100,000 pop.	0.9
Unintentional firearm-related fatal injuries per 100,000 pop.	0.1
Gun-purchasing legislation (8 points possible)	1.5
% of tobacco settlement funds spent on health-related services and programs	73.8
Total injury prevention funds per 1,000 pop.	\$606.20
Unintentional injury prevention funds per 1,000 pop.	\$116.95
Intentional injury prevention funds per 1,000 pop.	\$195.35
Fall injury prevention funds per 1,000 pop.	\$3.50
Infant mortality rate per 1,000 live births	5.1
% of adults with BMI > 30	24.2
Current smokers, % of adults	17.1
Binge alcohol drinkers, % of adults	14.2

DISASTER PREPAREDNESS **C**

Per capita federal disaster preparedness funds	\$7.09
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	NR
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	129
Accredited by the Emergency Management Accreditation Program	No
Written plan specifically for special needs patients	Yes
Written plan to supply medications for chronic conditions	Yes
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	No
Real-time surveillance system in place for common ED presentations	NR
Bed surge capacity per 1M pop.	188.8
Burn unit beds per 1M pop.	7.7
ICU beds per 1M pop.	184.5
Verified burn centers per 1M pop.	0.2
State able to verify credentials and assign volunteer health professionals to four ESAR-VHP levels	Yes
Nurses registered in ESAR-VHP per 1M pop.	77.1
Physicians registered in ESAR-VHP per 1M pop.	26.9
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	47.2
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	