

California

While California’s landmark Medical Injury Compensation Reform Act continues to provide a favorable liability environment, access to medical care in the state is seriously threatened by a number of troubling factors including a severe shortage of providers and facilities.

Strengths. California has created a favorable *Medical Liability Environment*. The state is one of only four that have a hard \$250,000 medical liability cap on non-economic damages. In addition, California has abolished joint and several liability and provides for periodic payments of awards at the request of one or both parties. The state also deserves to be recognized for having the fifth lowest average malpractice award payment in the nation (\$181,782), which is more than \$100,000 less than the average across the states.

California also fares well with respect to *Public Health and Injury Prevention*. Fewer than 15 percent of adults in the state smoke cigarettes, compared to 20.1 percent nationwide. The state’s infant mortality rate is 5.3 per 1,000 live births, significantly lower than that of the nation as a whole. The state also experiences relatively low rates of fatal occupational injuries, as well as unintentional fatal injuries due to falls and fires or burns.

Challenges. *Access to Emergency Care* in California suffers from a serious lack of specialists, registered nurses, primary care providers, and mental health providers. The state also fares poorly with regard to the number of medical facilities. California has only 7.1 emergency departments per 1 million people, compared to an average of 19.9 among the states. The state also has a critical lack of staffed inpatient and psychiatric care beds (237.7 and 16.9 per 100,000, respectively). Contributing

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to the problems are high rates of uninsured adults and children and relatively low Medicaid reimbursement rates for office visits (66.7 percent of the national average).

The state’s poor grades in *Disaster Preparedness* and the *Quality and Patient Safety Environment* were significantly affected by the state’s inability to respond to ACEP’s survey questions regarding state-led efforts in each of these areas. This is due to California’s unique public health structure, in which counties have been charged with many of the responsibilities other states maintain at the state level. (Information provided for indicators related to the survey were gathered through phone calls with state officials and via the Internet.)

Recommendations. *Access to Emergency Care* throughout California is in crisis. As noted above, the state is desperately in need of specialists. Emergency physicians in the state report problems in finding specialists to provide critical on-call services to emergency patients. They also note problems with hospital crowding and boarding of patients in emergency departments. This problem may be further exacerbated by the relatively low number of staffed inpatient beds combined with the high daily hospital occupancy rate, which leaves little room for admissions from the emergency department.

The state should implement measures to draw more medical professionals to California. Increasing Medicaid fee levels would likely be an important step in attracting physicians, as well as ensuring that beneficiaries have access to and receive adequate primary medical care. Implementing additional liability protections for EMTALA-mandated

	RANK	GRADE
ACCESS TO EMERGENCY CARE	51	F
QUALITY & PATIENT SAFETY ENVIRONMENT	44	D-
MEDICAL LIABILITY ENVIRONMENT	9	B-
PUBLIC HEALTH & INJURY PREVENTION	6	B+
DISASTER PREPAREDNESS	40	D+
OVERALL	37	D+

emergency care, may also help to encourage specialists to provide on-call services for emergency patients.

While the lack of information with regard to the *Quality and Patient Safety Environment* and *Disaster Preparedness* clearly affected the state’s grades in these areas, it is not clear that California is doing all that it can to ensure that effective and appropriate systems are in place in each of its counties. Given California’s large size and population, the county-based system is not a detriment in itself, but without state level oversight, it is unclear that the state has an organized system for improving the state’s *Quality and Patient Safety Environment* or handling disaster events on a massive scale that cross county lines. The state should investigate ways to comprehensively evaluate and ensure the adequacy of county-level administration of EMS services and disaster preparedness programs.

ACCESS TO EMERGENCY CARE **F**

Board-certified emergency physicians per 100,000 pop.	9.2
Emergency physicians per 100,000 pop.	11.5
Neurosurgeons per 100,000 pop.	1.7
Orthopedists and hand surgeon specialists per 100,000 pop.	8.7
Plastic surgeons per 100,000 pop.	3.0
ENT specialists per 100,000 pop.	3.2
Registered nurses per 100,000 pop.	643.3
Additional primary care FTEs needed	743.6
Additional mental health FTEs needed	208.9
Level I or II trauma centers per 1M pop.	1.2
% of population within 60 minutes of Level I or II trauma center	96.7
Accredited chest pain centers per 1M pop.	0.2
% of population with an unmet need for substance abuse treatment	8.5
Pediatric specialty centers per 1M pop.	3.5
Physicians accepting Medicare per 100 beneficiaries	2.6
Medicaid fee levels for office visits as a % of the national average	66.7
% change in Medicaid fees for office visits (2004-05 to 2007)	9.1
% of adults with no health insurance	20.9
% of children with no health insurance	12.8
% of adults with Medicaid	10.7
Emergency departments per 1M pop.	7.1
Hospital closures in 2006	1
Staffed inpatient beds per 100,000 pop.	237.7
Hospital occupancy rate per 100 staffed beds	73.9
Psychiatric care beds per 100,000 pop.	16.9
State collects data on diversion	NR

MEDICAL LIABILITY ENVIRONMENT **B-**

Lawyers per 10,000 pop.	17.8
Lawyers per physician	0.7
Lawyers per emergency physician	15.4
ATRA judicial hellholes (range 0 to -7)	-2
Malpractice award payments/100,000 pop.	0.2
Average malpractice award payments	\$181,782
Databank reports per 1,000 physicians	17.0
Patient compensation fund	No
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	0.9
Average medical liability insurance premium for primary care physicians	\$13,391
Average medical liability insurance premiums for specialists	\$53,132
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	\$250,000
Additional liability protection for EMTALA-mandated emergency care	No
Joint and several liability abolished	Yes
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 **D-**

Funding for quality improvement within the EMS system	NR
Funded state EMS medical director	NR
Emergency medicine residents per 1M pop.	11.6
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	NR
State has or is working on a stroke system of care	NR
State has or is working on a PCI network or a STEMI system of care	NR
Statewide trauma registry	NR
% of hospitals with computerized practitioner order entry	15.8
% of hospitals with electronic medical records	37.3
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	55
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	10

PUBLIC HEALTH & INJURY PREVENTION **B+**

Traffic fatalities per 100,000 pop.	11.6
% of traffic fatalities alcohol related	42.0
Front occupant restraint use (%)	94.6
Helmet use required for all motorcycle riders	Yes
Child safety seat/seat belt legislation (10 points possible)	6
% of children immunized, aged 19-35 months	80.2
% of adults aged 65+ who received flu vaccine in the last 12 months	66.9
% of adults aged 65+ who ever received pneumococcal vaccine	60.0
Fatal occupational injuries per 1M workers	27.5
Homicides and suicides (non-motor vehicle) per 100,000 pop.	15.9
Unintentional fall-related fatal injuries per 100,000 pop.	4.6
Unintentional fire/burn-related fatal injuries per 100,000 pop.	0.6
Unintentional firearm-related fatal injuries per 100,000 pop.	0.2
Gun-purchasing legislation (8 points possible)	7
% of tobacco settlement funds spent on health-related services and programs	0.0
Total injury prevention funds per 1,000 pop.	\$286.20
Unintentional injury prevention funds per 1,000 pop.	\$65.56
Intentional injury prevention funds per 1,000 pop.	\$220.65
Fall injury prevention funds per 1,000 pop.	\$0.00
Infant mortality rate per 1,000 live births	5.3
% of adults with BMI > 30	23.3
Current smokers, % of adults	14.9
Binge alcohol drinkers, % of adults	15.4

DISASTER PREPAREDNESS **D+**

Per capita federal disaster preparedness funds	\$10.28
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	No
Number of drills and exercises conducted involving hospital personnel, equipment, or facilities	NR
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	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.	NR
Burn unit beds per 1M pop.	6.0
ICU beds per 1M pop.	232.6
Verified burn centers per 1M pop.	0.2
State able to verify credentials and assign volunteer health professionals to four ESAR-VHP levels	NR
Nurses registered in ESAR-VHP per 1M pop.	NR
Physicians registered in ESAR-VHP per 1M pop.	NR
Training required in disaster management and response to bio- and chem terrorism for essential hospital personnel, EMS personnel	Yes, Yes
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	46.4
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	