

Maryland

Ranking second in the nation in *Disaster Preparedness* and the *Quality and Patient Safety Environment*, Maryland's overall score is marred only by inadequate medical liability reforms and key access-related issues, including a low rate of emergency departments and a high hospital occupancy rate.

Strengths. Maryland's grade in the *Quality and Patient Safety Environment* is a reflection of the many reporting requirements and systems the state has put into place. The state has adverse event, hospital-based infections, and mandatory quality reporting requirements, as well as funding for quality improvement within the EMS system and a funded state EMS medical director position. Maryland ranks third for the high percentage of hospitals that use electronic medical records (81.3 percent).

Maryland has taken significant strides to incorporate important *Disaster Preparedness* planning into state operations and to implement policies that enhance the state's ability to respond to a disaster. Maryland has an all-hazards medical response or ESF-8 plan that is shared with all EMS and essential hospital personnel. Likewise, the state has written plans specifically for special needs patients and for supplying dialysis to patients, as well as for the coordination of the State Emergency Operations Center or local emergency management agencies to provide security to hospitals in case of a disaster event. Maryland also has a real-time notification system in place to notify identified health care providers of an event, as well as statewide "just-in-time" training systems.

Challenges. In *Access to Emergency Care*, Maryland ranks 44th for both its relatively low number of emergency departments (8.4 per 1 million people) and its high daily hospital occupancy rate (75.1 per 100

staffed beds). These indicators substantiate current concerns reported by emergency physicians in the state regarding hospital crowding. Physicians also report problems in finding specialists to provide on-call services for emergency patients, despite the state's relatively high rates of neurosurgeons; plastic surgeons; and ear, nose and throat specialists.

Maryland's poor grade with respect to the *Medical Liability Environment* is largely due to the state's failure to enact meaningful and effective tort reforms. The state does not provide additional liability protection for EMTALA-mandated emergency care and has not abolished joint and several liability. Furthermore, Maryland does not require expert witnesses to be of the same specialty as the defendant or to be licensed to practice medicine in the state. Reflective of the overall liability environment, Maryland's average malpractice award payment is \$319,977, nearly \$35,000 more than the average state. The state also has a high average medical liability premium for specialists (\$100,625), compared to the average across the states (\$65,489).

Recommendations. Maryland should act immediately to improve *Access to Emergency Care*. Addressing hospital crowding has been declared a top priority among emergency physicians in Maryland. The state must work with the health care community

to increase the number and availability of staffed inpatient beds. Hospital crowding may be worsening due to a workforce shortage identified in a recent local study by the Maryland Medical Society

and Maryland Hospital Association. A shortage could also affect access to on-call specialty services. The state should consider additional steps to recruit and retain on-call specialists and emergency physicians to cope with this overburdened system. The state could encourage current and future

	RANK	GRADE
ACCESS TO EMERGENCY CARE	25	C-
QUALITY & PATIENT SAFETY ENVIRONMENT	2	A
MEDICAL LIABILITY ENVIRONMENT	39	D-
PUBLIC HEALTH & INJURY PREVENTION	11	B
DISASTER PREPAREDNESS	2	A
OVERALL	4	B-

specialists to take call by passing critical medical liability reforms, such as additional liability protections for EMTALA-mandated emergency care or a lower medical liability cap on non-economic damages. These reforms may also help decrease the relatively high medical liability insurance premiums that may discourage specialists from working in Maryland.

Despite faring better than most states with regard to Medicaid reimbursement levels for office visits, the state has seen only a 2.9 percent increase in reimbursement rates since 2004. This, combined with the provision of services to uninsured and underinsured patients, has resulted in reports of poor third-party reimbursement throughout the state. As Maryland addresses the workforce issue noted above, ensuring that physicians and specialists are adequately compensated for their services may be an important step in maintaining a broader workforce.

Maryland should act immediately to improve access to emergency care.

ACCESS TO EMERGENCY CARE **C-**

Board-certified emergency physicians per 100,000 pop.	11.0
Emergency physicians per 100,000 pop.	13.9
Neurosurgeons per 100,000 pop.	2.7
Orthopedists and hand surgeon specialists per 100,000 pop.	11.6
Plastic surgeons per 100,000 pop.	3.2
ENT specialists per 100,000 pop.	5.1
Registered nurses per 100,000 pop.	871.8
Additional primary care FTEs needed	60.8
Additional mental health FTEs needed	22.4
Level I or II trauma centers per 1M pop.	1.1
% of population within 60 minutes of Level I or II trauma center	97.0
Accredited chest pain centers per 1M pop.	1.2
% of population with an unmet need for substance abuse treatment	7.3
Pediatric specialty centers per 1M pop.	2.5
Physicians accepting Medicare per 100 beneficiaries	4.0
Medicaid fee levels for office visits as a % of the national average	115.6
% change in Medicaid fees for office visits (2004-05 to 2007)	2.9
% of adults with no health insurance	15.1
% of children with no health insurance	9.9
% of adults with Medicaid	5.2
Emergency departments per 1M pop.	8.4
Hospital closures in 2006	0
Staffed inpatient beds per 100,000 pop.	273.6
Hospital occupancy rate per 100 staffed beds	75.1
Psychiatric care beds per 100,000 pop.	27.0
State collects data on diversion	Yes

MEDICAL LIABILITY ENVIRONMENT **D-**

Lawyers per 10,000 pop.	17.7
Lawyers per physician	0.4
Lawyers per emergency physician	12.7
ATRA judicial hellholes (range 0 to -7)	-2
Malpractice award payments/100,000 pop.	1.3
Average malpractice award payments	\$319,977
Databank reports per 1,000 physicians	13.4
Patient compensation fund	No
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	3.1
Average medical liability insurance premium for primary care physicians	\$17,664
Average medical liability insurance premiums for specialists	\$100,625
Pretrial screening panels	Mandatory
Are pretrial screening panels' findings admissible as evidence?	Yes
Periodic payments	At judge's or court's discretion
Medical liability cap on non-economic damages	>\$500,000
Additional liability protection for EMTALA-mandated emergency care	No
Joint and several liability abolished	No
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.	11.7
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	33.3
% of hospitals with electronic medical records	81.3
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	37
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	22

PUBLIC HEALTH & INJURY PREVENTION **B**

Traffic fatalities per 100,000 pop.	11.6
% of traffic fatalities alcohol related	41.0
Front occupant restraint use (%)	93.1
Helmet use required for all motorcycle riders	Yes
Child safety seat/seat belt legislation (10 points possible)	7
% of children immunized, aged 19-35 months	79.9
% of adults aged 65+ who received flu vaccine in the last 12 months	66.1
% of adults aged 65+ who ever received pneumococcal vaccine	66.0
Fatal occupational injuries per 1M workers	35.3
Homicides and suicides (non-motor vehicle) per 100,000 pop.	18.8
Unintentional fall-related fatal injuries per 100,000 pop.	5.5
Unintentional fire/burn-related fatal injuries per 100,000 pop.	1.0
Unintentional firearm-related fatal injuries per 100,000 pop.	0.1
Gun-purchasing legislation (8 points possible)	3.5
% of tobacco settlement funds spent on health-related services and programs	92.6
Total injury prevention funds per 1,000 pop.	\$169.33
Unintentional injury prevention funds per 1,000 pop.	\$53.61
Intentional injury prevention funds per 1,000 pop.	\$54.26
Fall injury prevention funds per 1,000 pop.	\$2.67
Infant mortality rate per 1,000 live births	7.3
% of adults with BMI > 30	24.9
Current smokers, % of adults	17.7
Binge alcohol drinkers, % of adults	13.9

DISASTER PREPAREDNESS **A**

Per capita federal disaster preparedness funds	\$11.15
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, Yes
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	26
Accredited by the Emergency Management Accreditation Program	Yes
Written plan specifically for special needs patients	Yes
Written plan to supply medications for chronic conditions	No
Written plan to supply dialysis for patients	Yes
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.	1,233.3
Burn unit beds per 1M pop.	3.6
ICU beds per 1M pop.	288.5
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.	541.8
Physicians registered in ESAR-VHP per 1M pop.	116.4
Training required in disaster management and response to bio- and chem terrorism for essential hospital personnel, EMS personnel	No, Yes
State or regional strike teams or medical assistance teams	No
Additional liability protections for health care workers during a disaster	Civil, not clearly defined
% of RNs that received any emergency training	39.1
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