

Massachusetts

Massachusetts leads the nation with regard to the overall emergency care environment. While the state demonstrates leadership in a majority of the categories studied, significant opportunities for improvement exist, particularly within the *Medical Liability Environment*.

Strengths. Massachusetts consistently ranks among the top four states for numerous *Public Health and Injury Prevention* measures, including childhood immunizations, fatal unintentional injuries, and traffic fatalities. The state has relatively low rates of obesity (20.3 percent) and smoking among adults (17.8 percent), as well as the fourth lowest infant mortality rate in the nation.

The state's strong performance with regard to the *Quality and Patient Safety Environment* reflects the quality control and improvement systems in place or under development, such as a statewide trauma registry, a stroke system of care, and a PCI network or STEMI system of care.

With regard to *Disaster Preparedness*, Massachusetts earns positive scores in relation to planning, coordination, tracking systems, burn treatment capacity, and surveillance. The state ranks among the top 10 for enrollment of physicians and nurses in the state-based Emergency System for Advance Registration of Volunteer Health Professionals program.

Massachusetts also fared well in the *Access to Emergency Care* category. The state deserves special acknowledgment with regard to the rates of uninsured. The data presented indicate that 11.4 and 7.0 percent of adults and children, respectively, lack health insurance. However, these rates have dropped even further since implementation of the universal health insurance mandate. Additionally, state health officials are to be commended for efforts to end ambulance diversion. The state will effectively prohibit diversion as of January 2009. Acknowledging that diversion does

not address the causes of hospital crowding, the state is also encouraging hospitals to improve patient flow and to document efforts to reduce patient boarding in emergency departments.

Challenges. Massachusetts' *Medical Liability Environment* is in need of reform. The average malpractice award payment is among the highest in the nation: \$437,000 compared to the \$285,218 average across the states. Massachusetts also has the fourth lowest number of insurers writing medical liability policies (1.9 per 1,000 physicians).

In the *Disaster Preparedness* category, the state lacks liability protection for alternative standards of care in the event of a disaster and does not have well defined plans for special populations. Although Massachusetts requires some training in disaster management and response to bio- and chemical terrorism for all EMS providers, there is no standardized training requirement for all EMS and essential hospital personnel.

While Massachusetts fared well overall with regard to *Access to Emergency Care*, the state faces a high hospital occupancy rate (75.4 per 100 staffed beds) and a comparatively low number of emergency departments per capita (9.8 per 1 million people).

Recommendations. Although Massachusetts benefits from a relatively substantial workforce, emergency physicians in the state have reported difficulties in obtaining on-call services from specialists who appear to be moving from in-hospital practice toward more lucrative specialty clinics and hospitals. This move may also be driven by a reluctance to provide on-call services that might entail greater medical liability risks.

The decreasing on-call workforce, combined with a high hospital occupancy rate and lack of emergency departments statewide, has also contributed to the practice of emergency department patient boarding

	RANK	GRADE
ACCESS TO EMERGENCY CARE	3	B
QUALITY & PATIENT SAFETY ENVIRONMENT	6	A
MEDICAL LIABILITY ENVIRONMENT	33	D
PUBLIC HEALTH & INJURY PREVENTION	1	A
DISASTER PREPAREDNESS	19	B
OVERALL	1	B

and hospital crowding. These practices create the potential for compromised patient care. The state's recent decision to begin prohibiting ambulance diversion and to encourage hospitals to more effectively address crowding and boarding should be a positive step in helping to address some of these critical issues.




Massachusetts must enact appropriate medical liability reforms to decrease insurance premiums, and, above all, encourage specialists to be available on-call for what are generally high-risk cases in the emergency department. Failure to take action in this area may result in decreased quality and access to care for those presenting in the emergency department.

Of further concern regarding access to services is a growing shortage of primary care physicians, which may lead to increases in the time that it takes patients to obtain primary care appointments. This is an especially important issue given the increasing percentage of the population that now has health insurance coverage.

Massachusetts must work with the medical community to enact appropriate medical liability reforms.

For additional information, visit www.acep.org.

ACCESS TO EMERGENCY CARE **B**

Board-certified emergency physicians per 100,000 pop.	 12.1
Emergency physicians per 100,000 pop.	16.9
Neurosurgeons per 100,000 pop.	2.4
Orthopedists and hand surgeon specialists per 100,000 pop.	13.0
Plastic surgeons per 100,000 pop.	3.1
ENT specialists per 100,000 pop.	4.2
Registered nurses per 100,000 pop.	 1,216.6
Additional primary care FTEs needed	94.4
Additional mental health FTEs needed	2.6
Level I or II trauma centers per 1M pop.	1.2
% of population within 60 minutes of Level I or II trauma center	97.0
Accredited chest pain centers per 1M pop.	0.2
% of population with an unmet need for substance abuse treatment	8.7
Pediatric specialty centers per 1M pop.	2.3
Physicians accepting Medicare per 100 beneficiaries	5.1
Medicaid fee levels for office visits as a % of the national average	111.8
% change in Medicaid fees for office visits (2004-05 to 2007)	10.0
% of adults with no health insurance	11.4
% of children with no health insurance	7.0
% of adults with Medicaid	10.9
Emergency departments per 1M pop.	 9.8
Hospital closures in 2006	0
Staffed inpatient beds per 100,000 pop.	353.9
Hospital occupancy rate per 100 staffed beds	75.4
Psychiatric care beds per 100,000 pop.	28.5
State collects data on diversion	Yes





MEDICAL LIABILITY ENVIRONMENT **D**

Lawyers per 10,000 pop.	22.4
Lawyers per physician	0.5
Lawyers per emergency physician	13.2
ATRA judicial hellholes (range 0 to -7)	0
Malpractice award payments/100,000 pop.	0.9
Average malpractice award payments	\$437,000
Databank reports per 1,000 physicians	13.7
Patient compensation fund	No
Health court pilot project grant	Yes
Number of insurers writing medical liability policies per 1,000 physicians	1.9
Average medical liability insurance premium for primary care physicians	\$12,627
Average medical liability insurance premiums for specialists	\$65,184
Pretrial screening panels	Mandatory
Are pretrial screening panels' findings admissible as evidence?	Yes
Periodic payments	No
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	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 **A**


Funding for quality improvement within the EMS system	Yes
Funded state EMS medical director	Yes
Emergency medicine residents per 1M pop.	30.2
Adverse event reporting required	Yes
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	No
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	43.5
% of hospitals with electronic medical records	61.9
% 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)	20


PUBLIC HEALTH & INJURY PREVENTION **A**


Traffic fatalities per 100,000 pop.	6.7
% of traffic fatalities alcohol related	 40.0
Front occupant restraint use (%)	68.7
Helmet use required for all motorcycle riders	Yes
Child safety seat/seat belt legislation (10 points possible)	5
% of children immunized, aged 19-35 months	 87.0
% of adults aged 65+ who received flu vaccine in the last 12 months	 73.1
% of adults aged 65+ who ever received pneumococcal vaccine	 70.8
Fatal occupational injuries per 1M workers	22.6
Homicides and suicides (non-motor vehicle) per 100,000 pop.	10.2
Unintentional fall-related fatal injuries per 100,000 pop.	4.2
Unintentional fire/burn-related fatal injuries per 100,000 pop.	0.8
Unintentional firearm-related fatal injuries per 100,000 pop.	0.0
Gun-purchasing legislation (8 points possible)	5
% of tobacco settlement funds spent on health-related services and programs	0.0
Total injury prevention funds per 1,000 pop.	\$499.71
Unintentional injury prevention funds per 1,000 pop.	\$104.66
Intentional injury prevention funds per 1,000 pop.	\$162.49
Fall injury prevention funds per 1,000 pop.	\$6.20
Infant mortality rate per 1,000 live births	5.2
% of adults with BMI > 30	20.3
Current smokers, % of adults	17.8
Binge alcohol drinkers, % of adults	17.7

DISASTER PREPAREDNESS **B**

Per capita federal disaster preparedness funds	\$10.53
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	648
Accredited by the Emergency Management Accreditation Program	Yes
Written plan specifically for special needs patients	NR
Written plan to supply medications for chronic conditions	NR
Written plan to supply dialysis for patients	NR
Real-time notification system in place to notify identified health care providers of an event	Yes
"Just-in-time" training systems in place	County-level
Statewide medical communication system with one layer of redundancy	Yes
Statewide patient tracking system	No
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.	305.6
Burn unit beds per 1M pop.	10.7
ICU beds per 1M pop.	290.9
Verified burn centers per 1M pop.	0.5
State able to verify credentials and assign volunteer health professionals to four ESAR-VHP levels	Yes
Nurses registered in ESAR-VHP per 1M pop.	232.7
Physicians registered in ESAR-VHP per 1M pop.	56.0
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	No
% of RNs that received any emergency training	33.8
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*