Maryland

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Maryland has a statewide model of emergency care. The high grades in *Quality and Patient Safety Environment, Public Health and Injury Prevention*, and *Disaster Preparedness* reflect a relentless commitment to these areas. However, the state has not kept pace with other states regarding medical liability reform and faces some hospital capacity shortages.

Strengths. Maryland has the highest *Quality and Patient Safety Environment* ranking in the nation. The state has enacted multiple policies and procedures to ensure that its patients receive swift and effective care, including triage and destination policies for trauma, stroke, and ST-elevation myocardial infarction (STEMI) patients. Maryland maintains a statewide trauma registry, and nearly all its hospitals have adopted computerized practitioner order entry (93.9%) and electronic medical records (95.9%). To ensure that the state's diverse population receives quality care, more than half its hospitals have or are planning for a diversity strategy, and 60.9% collect data on patient race and ethnicity and primary language. Finally, Maryland has made a financial commitment to quality and patient safety, with dedicated funds for a state emergency medical services (EMS) medical director and for quality improvement in the EMS system.

Maryland is 10th in the nation in *Disaster Preparedness* and has incorporated many important state-level policies and procedures. The state has developed medical response plans that address the requirements of special needs patients and patients dependent on medication. Maryland's just-in-time training systems are in place statewide, and almost 40% of the state's registered nurses have received disaster training. Maryland's statewide patient tracking system and surveillance system for common emergency department (ED) presentations help ensure that the state is able to identify and respond to evolving disasters.

Maryland also rates highly in *Public Health and Injury Prevention* due to strong legislation aimed at improving public health and traffic safety, such as banning all smoking in bars, restaurants, and worksites; distracted driving bans; and child safety seat and seat belt legislation. The state also benefits from low rates of unintentional injury. Maryland has the lowest rate of poisoning deaths, which include drug overdoses, in the nation.

Challenges. Maryland has not, however, kept pace with developments in the *Medical Liability Environment*, slipping to 47th in the nation. Although the state has implemented some needed medical liability reforms, such as a cap on non-economic damages and pretrial screening panels, it has relatively high average malpractice awards ($374,121) and a high per capita number of malpractice award payments (3.4 per 100,000 people). Maryland has one of the highest average medical liability insurance premiums for specialists at $96,807, more than 1.7 times the national average, and a relatively high average medical liability insurance premium for primary care physicians ($18,089).

Maryland should support efforts to increase capacity for emergency care and alleviate crowding in the emergency department.

In *Access to Emergency Care*, there are signs that Maryland's emergency medicine infrastructure is strained. The state has one of the longest median ED wait times (367 minutes from ED arrival to departure for admitted patients) and a high hospital occupancy rate (74.7 per 100 staffed beds). Maryland also has few EDs per capita (8.3 per 1 million people), despite relatively high rates of emergency physicians.

	2009		2014	
	Rank	Grade	Rank	Grade
Access to Emergency Care	25	C-	23	D
Quality & Patient Safety Environment	2	A	1	A
Medical Liability Environment	39	D-	47	F
Public Health & Injury Prevention	11	B	9	B+
Disaster Preparedness	2	A	10	B-
OVERALL	4	B-	10	C

Recommendations. Maryland would benefit most from reforms aimed at lowering the state's high medical liability insurance rates and malpractice awards. Adopting structured settlements would better match the award to the ongoing needs of the plaintiff. Collateral source rule reform would help to ensure that plaintiffs are not doubly compensated and be advantageous to the state. Strengthening the state's currently weak apology law would protect physician apologies from being admissible in liability cases.

Maryland should support efforts to increase capacity for emergency care and alleviate crowding in EDs. A failure to address this growing issue may result in loss of quality of care and poor health outcomes for patients.

Although Maryland fared well in *Public Health and Injury Prevention* overall, the state lags in some traffic safety indicators. Maryland must work to reduce its high proportion of traffic fatalities that are alcohol-related (40.0%) and high rates of bicyclist and pedestrian fatalities. Maryland should concentrate on ensuring the safety of all road users, educating drivers on the dangers of drinking and driving.

ACCESS TO EMERGENCY CARE	D
Board-certified emergency physicians per 100,000 pop.	12.7
Emergency physicians per 100,000 pop.	15.1
Neurosurgeons per 100,000 pop.	2.9
Orthopedists and hand surgeon specialists per 100,000 pop.	12.0
Plastic surgeons per 100,000 pop.	3.3
ENT specialists per 100,000 pop.	4.9
Registered nurses per 100,000 pop.	849.7
Additional primary care FTEs needed per 100,000 pop.	2.8
Additional mental health FTEs needed per 100,000 pop.	0.5
% of children able to see provider	95.8
Level I or II trauma centers per 1M pop.	0.7
% of population within 60 minutes of Level I or II trauma center	99.3
Accredited chest pain centers per 1M pop.	1.5
% of population with an unmet need for substance abuse treatment	7.9
Pediatric specialty centers per 1M pop.	2.7
Physicians accepting Medicare per 100 beneficiaries	3.1
Medicaid fee levels for office visits as a % of the national average	99.4
% change in Medicaid fees for office visits (2007 to 2012)	5.7
% of adults with no health insurance	15.0
% of adults underinsured	6.5
% of children with no health insurance	10.0
% of children underinsured	17.4
% of adults with Medicaid	7.5
Emergency departments per 1M pop.	8.3
Hospital closures in 2011	0
Staffed inpatient beds per 100,000 pop.	270.1
Hospital occupancy rate per 100 staffed beds	74.7
Psychiatric care beds per 100,000 pop.	29.4
Median minutes from ED arrival to ED departure for admitted patients	367
State collects data on diversion	Yes

MEDICAL LIABILITY ENVIRONMENT	F
Lawyers per 10,000 pop.	18.7
Lawyers per physician	0.4
Lawyers per emergency physician	12.4
ATRA judicial hellholes (range 2 to -6)	-3
Malpractice award payments/ 100,000 pop.	3.4
Average malpractice award payments	$374,121
Databank reports per 1,000 physicians	27.6
Provider apology is inadmissible as evidence	Yes
Patient compensation fund	No
Number of insurers writing medical liability policies per 1,000 physicians	3.8
Average medical liability insurance premium for primary care physicians	$18,089
Average medical liability insurance premium for specialists	$96,807
Presence of pretrial screening panels	Mandatory
Pretrial screening panel's findings admissible as evidence	No
Periodic payments	At 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
Collateral source rule, provides for awards to be offset	No
State provides for case certification	Yes
Expert witness must 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.	14.1
Adverse event reporting required	Yes
% of counties with E-911 capability	100.0
Uniform system for providing pre-arrival instructions	Yes
CDC guidelines are basis for state field triage protocols	Yes (2011)
State has or is working on a stroke system of care	Yes
Triage and destination policy in place for stroke patients	Yes
State has or is working on a PCI network or a STEMI system of care	Yes
Triage and destination policy in place for STEMI patients	Yes
Statewide trauma registry	Yes
Triage and destination policy in place for trauma patients	Yes
Prescription drug monitoring program (range 0-4)	2
% of hospitals with computerized practitioner order entry	93.9
% of hospitals with electronic medical records	95.9
% of patients with AMI given PCI within 90 minutes of arrival	91
Median time to transfer to another facility for acute coronary intervention	NR
% of patients with AMI who received aspirin within 24 hours	99
% of hospitals collecting data on race/ ethnicity and primary language	60.9
% of hospitals having or planning to develop a diversity strategy/plan	53.6

PUBLIC HEALTH & INJURY PREVENTION	B+
Traffic fatalities per 100,000 pop.	6.6
Bicyclist fatalities per 100,000 cyclists	4.9
Pedestrian fatalities per 100,000 pedestrians	8.1
% of traffic fatalities alcohol related	40
Front occupant restraint use (%)	94.2
Helmet use required for all motorcycle riders	Yes
Child safety seat/seat belt legislation (range 0-10)	8
Distracted driving legislation (range 0-4)	4
Graduated drivers' license legislation (range 0-5)	1
% of children immunized, aged 19-35 months	81.1
% of adults aged 65+ who received flu vaccine in past year	62.8
% of adults aged 65+ who ever received pneumococcal vaccine	69.9
Fatal occupational injuries per 1M workers	22.6
Homicides and suicides (non-motor vehicle) per 100,000 pop.	17.3
Unintentional fall-related fatal injuries per 100,000 pop.	7.8
Unintentional fire/burn-related fatal injuries per 100,000 pop.	1.0
Unintentional firearm-related fatal injuries per 100,000 pop.	0.1
Unintentional poisoning-related fatal injuries per 100,000 pop.	2.1
Total injury prevention funds per 1,000 pop.	$281.39
Dedicated child injury prevention funding	Yes
Dedicated elderly injury prevention funding	No
Dedicated occupational injury prevention funding	No
Gun-purchasing legislation (range 0-6)	3
Anti-smoking legislation (range 0-3)	3
Infant mortality rate per 1,000 live births	6.8
Binge alcohol drinkers, % of adults	18.0
Current smokers, % of adults	19.1
% of adults with BMI >30	28.3
% of children obese	15.1
Cardiovascular disease disparity ratio	1.9
HIV diagnoses disparity ratio	NR
Infant mortality disparity ratio	2.8

DISASTER PREPAREDNESS	B-
Per capita federal disaster preparedness funds	$6.20
State budget line item for health care surge	No
ESF-8 plan shared with all EMS and essential hospital personnel	Yes
Emergency physician input into the state planning process	Yes
Public health and emergency physician input during an ESF-8 response	Yes
Drills, exercises conducted with hospital personnel, equipment, facilities per hospital	1.3
Accredited by the Emergency Management Accreditation Program	Yes
Special needs patients in medical response plan	Yes
Patients on medication for chronic conditions in medical response plan	Yes
Medical response plan for supplying dialysis	Yes
Mental health patients in medical response plan	Yes
Medical response plan for supplying psychotropic medication	Yes
Mutual aid agreements with behavioral health providers	State-level
Long-term care and nursing home facilities must have written disaster plan	Yes
State able to report number of exercises with long-term care or nursing home facilities	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 real-time or near real-time syndromic surveillance system	Yes
Real-time surveillance system in place for common ED presentations	Statewide
Bed surge capacity per 1M pop.	537.5
ICU beds per 1M pop.	255.6
Burn unit beds per 1M pop.	3.4
Verified burn centers per 1M pop.	0.2
Physicians in ESAR-VHP per 1M pop.	47.8
Nurses in ESAR-VHP per 1M pop.	165.2
Behavioral health professionals in ESAR-VHP per 1M pop.	29.6
Strike teams or medical assistance teams	Yes
Disaster training required for essential hospital, EMS personnel	NR
Liability protections for health care workers during a disaster (range 0-4)	4
% of RNs received disaster training	39.2

NR = Not reported
N/A = Not applicable