Maryland

B-

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 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.

Maryland should act immediately to improve access to emergency care.

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.

	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-

Back to the report

New Report: Maryland Earns Grade of 5 out of 10 on Disaster Preparedness

Economic Crisis Hurting U.S. Preparedness for Health Emergencies; More Than Half of States Score 7 or Lower out of 10 in Readiness Rankings

Washington, D.C., December 9, 2008 - Trust for America's Health (TFAH) and the Robert Wood Johnson Foundation (RWJF) today released the sixth annual *Ready or Not? Protecting the Public's Health from Diseases, Disasters, and Bioterrorism* report, which finds that progress made to better protect the country from disease outbreaks, natural disasters, and bioterrorism is now at risk, due to budget cuts and the economic crisis. In addition, the report concludes that major gaps remain in many critical areas of preparedness, including surge capacity, rapid disease detection, and food safety.

Maryland achieved 5 out of 10 possible indicators for health emergency preparedness capabilities. More than half of states and D.C. achieved a score of seven or less out of 10 key indicators. Louisiana, New Hampshire, North Carolina, Virginia, and Wisconsin scored highest with 10 out of 10. Arizona, Connecticut, Florida, Maryland, Montana, and Nebraska tied for the lowest score with five out of 10.

Over the past six years, the *Ready or Not?* report has documented steady progress toward improved public health preparedness. This year however, TFAH found that federal funding for state and local preparedness has been cut 25 percent since 2005, and that these cut backs coupled with the cuts states are making to their budgets in response to the economic crisis, put that progress at risk. In the coming year, according to the Center on Budget and Policy Priorities, 33 states are facing shortfalls in the 2009 budgets and 16 states are already projecting shortfalls to their 2010 budgets.

"The economic crisis could result in a serious rollback of the progress we've made since September 11, 2001 and Hurricane Katrina to better prepare the nation for emergencies," said Jeff Levi, PhD, Executive Director of TFAH. "The 25 percent cut in federal support to protect Americans from diseases, disasters, and bioterrorism is already hurting state response capabilities. The cuts to state budgets in the next few years could lead to a disaster for the nation's disaster preparedness."

The report contains preparedness scores for all 50 states and Washington, D.C. States received one point for each indicator they achieved and zero points for each indicator they did not achieve, therefore zero is the lowest possible overall score and 10 the highest. Data for the public health indicators were collected from publicly available sources or public officials in 2007.

	Indicator	**Maryland**	Number of States Receiving Points
	A checkmark means the state received a point for that indicator		
1	Has adequate plans to distribute emergency vaccines, antidotes, and medical supplies from the Strategic National Stockpile	✔	50 and D.C.

2	Purchased 50 percent or more of its share of federally-subsidized antiviral medications to prepare for a potential pandemic flu outbreak		34 and D.C.
3	Public health lab has an intra-state courier system that operates 24 hours a day for specimen pick up and delivery	✔	26
4	State public health lab can meet the expectations of the state's pandemic flu plan	✔	47 and D.C.
5	Uses a disease surveillance system that is compatible with CDC's National Electronic Disease Surveillance System (NEDSS)	✔	44 and D.C.
6	Has laws that reduce or limit the liability exposure for health care volunteers who serve in a public health emergency		42 and D.C.
7	Has laws that reduce or limit the liability for businesses and non-profit organizations that serve in a public health emergency		24 and D.C.
8	State has a Medical Reserve Corps Coordinator	✔	33 and D.C.
9	State identified the pathogen responsible for reported foodborne disease outbreaks at a rate that met or exceeded the national average of 44 percent		30
10	Increased or maintained level of funding for public health services from FY 2006-07 to FY 2007-08		39
	Total	**5**	

Some serious 2008 health emergencies include a Salmonella outbreak in jalapeno and Serrano peppers that sickened 1,442 people in 43 states, the largest beef recall in history in February, Hurricanes Gustav and Ike, severe flooding in the Midwest, major wildfires in California in June and November, and a ricin scare in Las Vegas.

"States are being asked to do more with less, jeopardizing our safety, security, and health," said Risa Lavizzo-Mourey, M.D., M.B.A., president and CEO of the Robert Wood Johnson Foundation. "We all have a stake in strengthening America's public health system, because it is our first line of defense against health emergencies."

The report also offers a series of recommendations for improving preparedness, including:

- Restoring Full Funding. At a minimum, federal, state, and local funding for public health emergency preparedness capabilities should be restored to FY 2005 levels.
- Strengthening Leadership and Accountability. The next administration must clarify the public health emergency preparedness roles and responsibilities at the U.S. Department of Health and Human Services and U.S. Department of Homeland Security.
- Enhancing Surge Capacity and the Public Health Workforce. Federal, state, and local governments and health care providers must better address altered standards of care, alternative care sites, legal concerns to

protect community assistance, and surge workforce issues.
- Modernizing Technology and Equipment. Communications and surveillance systems and laboratories need increased resources for modernization.
- Improving Community Engagement. Additional measures must be taken to engage communities in emergency planning and to improve protections for at-risk communities.
- Incorporating Preparedness into Health Care Reform and Creating an Emergency Health Benefit. This is needed to contain the spread of disease by providing care to the uninsured and underinsured Americans during major disasters and disease outbreaks.

Score Summary:

For the state-by-state scoring, states received one point for achieving an indicator or zero points if they did not achieve the indicator. Zero is the lowest possible overall score, 10 is the highest. The data for the indicators are from publicly available sources or were provided from public officials. More information on each indicator is available in the full report on TFAH's Web site at www.healthyamericans.org and RWJF's Web site at www.rwjf.org. The report was supported by a grant from RWJF.

10 out of 10: Louisiana, New Hampshire, North Carolina, Virginia, Wisconsin
9 out of 10: Alabama, Indiana, Michigan, Pennsylvania, South Carolina, Tennessee, Vermont
8 out of 10: Arkansas, Delaware, Georgia, Hawaii, Iowa, Minnesota, North Dakota, Ohio, South Dakota, Washington
7 out of 10: California, Colorado, D.C., Illinois, Kentucky, Missouri, New Jersey, New Mexico, New York, Oklahoma, Oregon, Rhode Island, Utah, West Virginia, Wyoming
6 out of 10: Alaska, Idaho, Kansas, Maine, Massachusetts, Mississippi, Nevada, Texas
5 out of 10: Arizona, Connecticut, Florida, Maryland, Nebraska, Montana

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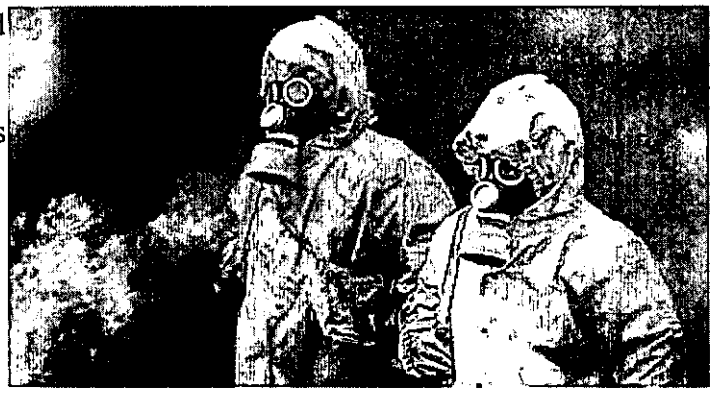
Trust for America's Health is a non-profit, non-partisan organization dedicated to saving lives by protecting the health of every community and working to make disease prevention a national priority.

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, meaningful and timely change. For more than 35 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. Helping Americans lead healthier lives and get the care they need--the Foundation expects to make a difference in our lifetime. For more information, visit rwjf.org

Ready or Not? 2008

Protecting the Public's Health from Disease, Disasters, and Bioterrorism

December 2008



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The report contains state-by-state health preparedness scores based on 10 key indicators to assess health emergency preparedness capabilities. More than half of states and D.C. achieved a score of seven or less out of 10 key indicators. Louisiana, New Hampshire, North Carolina, Virginia, and Wisconsin scored the highest with 10 out of 10. Arizona, Connecticut, Florida, Maryland, Montana, and Nebraska tied for the lowest score with five out of 10.

Over the past six years, the *Ready or Not?* report has documented steady progress toward improved public health preparedness. This year however, TFAH found that cuts in federal funding for state and local preparedness since 2005, coupled with the cuts states are making to their budgets in response to the economic crisis, put that progress at risk.

"The economic crisis could result in a serious rollback of the progress we've made since September 11, 2001 and Hurricane Katrina to better prepare the nation for emergencies," said Jeff Levi, PhD, Executive Director of TFAH. "The 25 percent cut in federal support to protect Americans from diseases, disasters, and bioterrorism is already hurting state response capabilities. The cuts to state budgets in the next few years could lead to a disaster for the nation's disaster preparedness."

Some serious 2008 health emergencies include a Salmonella outbreak in jalapeno and Serrano peppers that sickened 1,442 people in 43 states, the largest beef recall in history in February, Hurricanes Gustav and Ike, severe flooding in the Midwest, major wildfires in California in June and November, and a ricin scare in Las Vegas.

Among the key findings:

Budget Cuts: Federal funding for state and local preparedness has been cut more than 25 percent from fiscal year (FY) 2005, and states are no longer receiving any supplemental funding for pandemic flu preparedness, despite increased responsibilities.

- In addition to the federal decreases, 11 states and D.C. cut their public health budgets in the past year. In the coming year, according to the Center on Budget and Policy and Priorities, 33 states are facing shortfalls in their 2009 budgets and 16 states are already projecting shortfalls to their 2010 budgets.

Rapid Disease Detection: Since September 11, 2001, the country has made significant progress in improving disease detection capabilities, but major gaps still remain.

- Only six states do not have a disease surveillance system compatible with the U.S. Centers for Disease Control and Prevention's (CDC) National Electronic Disease Surveillance System.
- Twenty-four states and D.C. lack the capacity to deliver and receive lab specimens, such as suspected bioterror agents or new disease outbreak samples, on a 24/7 basis.
- Only three state public health laboratories are not able to meet the expectations of their state's pandemic flu plans.

Food Safety: America's food safety system has not been fundamentally modernized in more than 100 years.

- Twenty states and D.C. did not meet or exceed the national average rate for being able to identify the pathogens responsible for foodborne disease outbreaks in their states.

Surge Capacity: Many states do not have mechanisms in place to support and protect the community assistance that is often required during a major emergency.

- Twenty-six states do not have laws that reduce or limit liability for businesses and non-profit organizations that help during a public health emergency.
- Only eight states do not have laws that limit or reduce liability exposure for health care workers who volunteer during a public health emergency.
- Seventeen states do not have State Medical Reserve Corps Coordinators.

Vaccine and Medication Supplies and Distribution: Ensuring the public can quickly and safely receive medications during a major health emergency is one of the most serious challenges facing public health officials.

- Sixteen states have purchased less than half of their share of federally-subsidized antivirals to use during a pandemic flu outbreak.
- Every state now has an adequate plan for distributing emergency vaccines, antidotes, and medical supplies from the Strategic National Stockpile, according to the CDC. In 2005, only seven states had adequate plans. The CDC changed to a different grading system in 2007. However, questions still remain about the contents of the federal stockpile.

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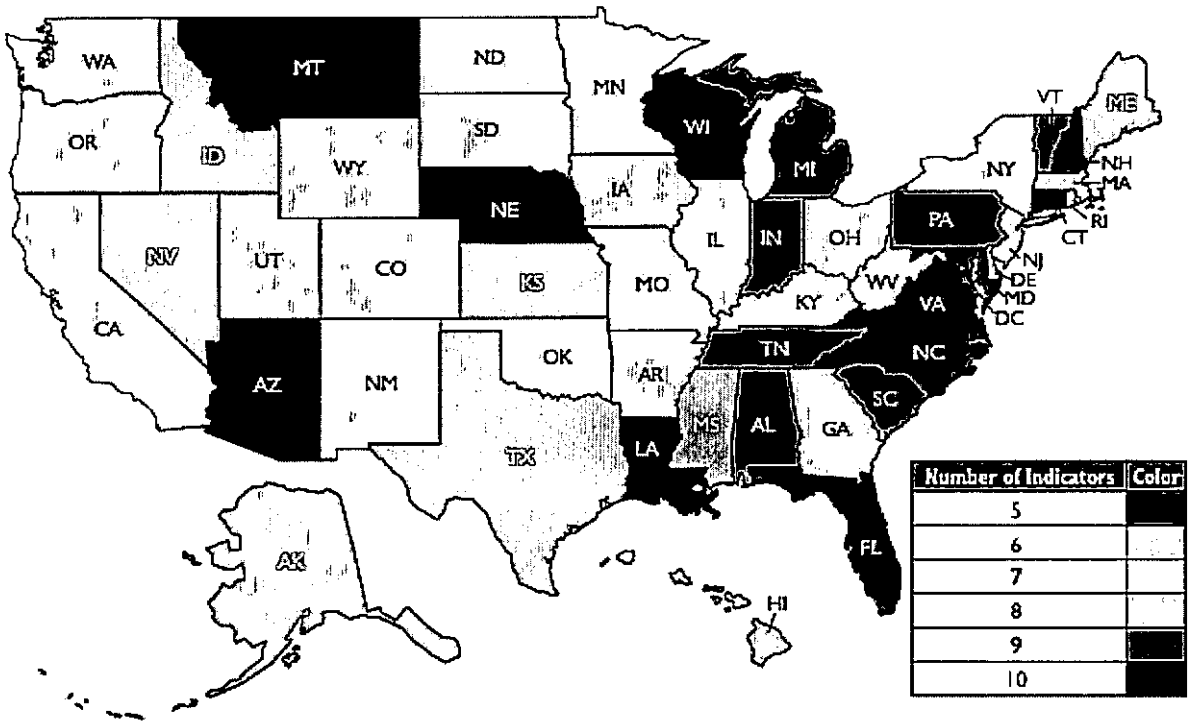

Click on a state below to access state-specific information and scores:

10	9	8	7	6	5
Louisiana	Alabama	Arkansas	California	Alaska	Arizona
New Hampshire	Indiana	Delaware	Colorado	Idaho	Connecticut
North Carolina	Michigan	Georgia	D.C.	Kansas	Florida
Virginia	Pennsylvania	Hawaii	Illinois	Maine	Maryland
Wisconsin	South Carolina	Iowa	Kentucky	Massachusetts	Nebraska
	Tennessee	Minnesota	Missouri	Mississippi	Montana
	Vermont	North Dakota	New Jersey	Nevada	
		Ohio	New Mexico	Texas	
		South Dakota	New York		
		Washington	Oklahoma		
			Oregon		
			Rhode Island		
			Utah		
			West Virginia		
			Wyoming		