

Delaware

Comprehensive programs in the areas of *Disaster Preparedness* and the *Quality and Patient Safety Environment* helped propel Delaware to high marks in those categories, but a paucity of medical liability reforms and troubling statistics related to infant mortality leaves the state with opportunities for improvement.

Strengths. Delaware has a number of strengths with regard to *Disaster Preparedness*. The state has a greater bed surge capacity than most; it is capable of surging beyond 1,156.4 beds per 1 million people within 24 hours of a disaster event. The state also supports a statewide real-time or near real-time syndromic surveillance system, as well as a surveillance system for common emergency department presentations. The state receives relatively high federal funding for disaster preparedness (\$16.50 per capita) and supports a statewide “just-in-time” training system.

Delaware’s above average score in *Access to Emergency Care* is primarily the result of very high rankings for a few key indicators within the category, such as Medicaid reimbursement rates for office visits (154 percent of the national average, the third highest in the country). The state also has the fourth highest rate of psychiatric care beds (47.0 per 100,000 people), well above the average among the states (29.9 per 100,000).

Indicators of the *Quality and Patient Safety Environment* in Delaware are consistently positive, as well, with

the state having the third highest rate of emergency medicine residents (42.8 per 1 million people) and the fourth highest percentage of hospitals using electronic medical records (75.0 percent compared to an average of 43.8 percent across the states).

Delaware desperately needs to institute medical liability reforms.

Challenges. The *Medical Liability Environment* in Delaware is among the worst in the nation. Delaware has the second highest average malpractice award payment (\$457,750), which is significantly more than the average across the states (\$285,218). Delaware also lacks any medical liability caps on non-economic damages, additional liability protections for EMTALA-mandated emergency care, and expert witness rules requiring the witness to be of the same specialty as the defendant.

Delaware has significant room for improvement in *Public Health and Injury Prevention*. The state ranked 46th in the country in infant mortality, with a rate of 9.0 deaths per 1,000 live births. The state also has a disproportionately high percentage of adults who are binge drinkers (19.0 percent) compared to the nation (15.4 percent).

Recommendations. Despite Delaware’s relatively high score with regard to *Access to Emergency Care*, there are strong warning signs that the state may be experiencing significant issues related to access. Emergency physicians in the state report that emergency department and hospital crowding has increasingly become a barrier to accessing quality care. In order to help alleviate crowding, Delaware should address its high hospital occupancy rate: 85.3 percent of staffed beds are occupied

on an average day, the highest of any state. The state also lacks any accredited chest pain centers and has a low rate of emergency departments (7.0 per 1 million people), which may contribute to crowding and related issues.

Additionally, emergency physicians report difficulties in getting specialists to provide on-call services to the emergency department.

	RANK	GRADE
ACCESS TO EMERGENCY CARE	8	B-
QUALITY & PATIENT SAFETY ENVIRONMENT	9	A-
MEDICAL LIABILITY ENVIRONMENT	45	F
PUBLIC HEALTH & INJURY PREVENTION	26	C-
DISASTER PREPAREDNESS	11	A-
OVERALL	10	C+

Delaware could try to alleviate that problem by enacting special liability protections for EMTALA-mandated emergency care. This would be one step among several that the state should take to reform a medical liability system that is in desperate need of improvement. Other actions the state should consider include enacting a cap on non-economic damages and strengthening expert witness rules.

To improve upon *Public Health and Injury Prevention*, the state should enact legislation requiring all motorcycle riders to wear helmets and implement new programs designed to reduce the high level of binge drinking. Delaware residents would also benefit from programs intended to address the problem of infant mortality.

ACCESS TO EMERGENCY CARE **B-**

Board-certified emergency physicians per 100,000 pop.	8.0
Emergency physicians per 100,000 pop.	14.7
Neurosurgeons per 100,000 pop.	1.6
Orthopedists and hand surgeon specialists per 100,000 pop.	8.3
Plastic surgeons per 100,000 pop.	2.7
ENT specialists per 100,000 pop.	3.1
Registered nurses per 100,000 pop.	987.4
Additional primary care FTEs needed	24.0
Additional mental health FTEs needed	0.0
Level I or II trauma centers per 1M pop.	1.2
% of population within 60 minutes of Level I or II trauma center	93.1
Accredited chest pain centers per 1M pop.	0.0
% of population with an unmet need for substance abuse treatment	7.7
Pediatric specialty centers per 1M pop.	3.5
Physicians accepting Medicare per 100 beneficiaries	3.1
Medicaid fee levels for office visits as a % of the national average	154.0
% change in Medicaid fees for office visits (2004-05 to 2007)	NR
% of adults with no health insurance	12.3
% of children with no health insurance	11.7
% of adults with Medicaid	6.2
Emergency departments per 1M pop.	7.0
Hospital closures in 2006	0
Staffed inpatient beds per 100,000 pop.	315.7
Hospital occupancy rate per 100 staffed beds	85.3
Psychiatric care beds per 100,000 pop.	47.0
State collects data on diversion	Yes

MEDICAL LIABILITY ENVIRONMENT **F**

Lawyers per 10,000 pop.	28.1
Lawyers per physician	1.0
Lawyers per emergency physician	18.9
ATRA judicial hellholes (range 0 to -7)	-2
Malpractice award payments/100,000 pop.	6.9
Average malpractice award payments	\$457,750
Databank reports per 1,000 physicians	22.7
Patient compensation fund	No
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	25.3
Average medical liability insurance premium for primary care physicians	\$13,786
Average medical liability insurance premiums for specialists	\$55,542
Pretrial screening panels	Voluntary
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	No
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.	42.8
Adverse event reporting required	No
Hospital-based infections reporting required	Yes
Mandatory quality reporting requirement	No
% 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	25.0
% of hospitals with electronic medical records	75.0
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	61
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	40

PUBLIC HEALTH & INJURY PREVENTION **C-**

Traffic fatalities per 100,000 pop.	17.3
% of traffic fatalities alcohol related	39.0
Front occupant restraint use (%)	86.6
Helmet use required for all motorcycle riders	No
Child safety seat/seat belt legislation (10 points possible)	8
% of children immunized, aged 19-35 months	84.2
% of adults aged 65+ who received flu vaccine in the last 12 months	70.3
% of adults aged 65+ who ever received pneumococcal vaccine	65.6
Fatal occupational injuries per 1M workers	29.5
Homicides and suicides (non-motor vehicle) per 100,000 pop.	16.4
Unintentional fall-related fatal injuries per 100,000 pop.	5.7
Unintentional fire/burn-related fatal injuries per 100,000 pop.	1.3
Unintentional firearm-related fatal injuries per 100,000 pop.	0.3
Gun-purchasing legislation (8 points possible)	2
% of tobacco settlement funds spent on health-related services and programs	80.8
Total injury prevention funds per 1,000 pop.	\$23.13
Unintentional injury prevention funds per 1,000 pop.	NR
Intentional injury prevention funds per 1,000 pop.	NR
Fall injury prevention funds per 1,000 pop.	NR
Infant mortality rate per 1,000 live births	9.0
% of adults with BMI > 30	26.0
Current smokers, % of adults	21.7
Binge alcohol drinkers, % of adults	19.0

DISASTER PREPAREDNESS **A-**

Per capita federal disaster preparedness funds	\$16.50
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	14
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	Yes
Real-time surveillance system in place for common ED presentations	Yes
Bed surge capacity per 1M pop.	1,156.4
Burn unit beds per 1M pop.	0.0
ICU beds per 1M pop.	300.2
Verified burn centers per 1M pop.	0.0
State able to verify credentials and assign volunteer health professionals to four ESAR-VHP levels	Yes
Nurses registered in ESAR-VHP per 1M pop.	82.1
Physicians registered in ESAR-VHP per 1M pop.	32.4
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	Civil, not clearly defined
% of RNs that received any emergency training	50.5
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	