Maine

C+

With a relatively large health care workforce and low rates of uninsured residents, Maine is second in the nation in terms of *Access to Emergency Care*, but high grades in this and other categories are tempered by poor marks in *Disaster Preparedness* and a lack of medical liability reforms.

Strengths. Maine ranks fourth in the nation in emergency physicians per capita and fifth for board-certified emergency physicians. The state also has a relatively healthy supply of registered nurses, orthopedists and hand surgeons, mental health professionals, and primary care physicians. Only 10.1 percent of adults and 6.4 percent of children in Maine have no health insurance, compared to 17.2 and 11.7 percent, respectively, nationwide. The state also has the second highest rate of adults covered by Medicaid (14.9 percent) and ranks eighth for the proportion of physicians accepting Medicare. The state has 39.0 psychiatric care beds per 100,000 people, compared to an average of 29.9 per 100,000 across the states.

The *Quality and Patient Safety Environment* in Maine benefits from a number of positive factors, including a funded state EMS medical director position, a uniform system for providing pre-arrival instructions, mandatory quality reporting requirements, statewide Enhanced 911 capability, and a relatively high rate of emergency medicine residents. Perhaps reflective of the state's investment in systems and infrastructure, Maine has the seventh highest proportion of patients presenting with acute myocardial infarction being treated with PCI within 90 minutes of arrival (74 percent).

Contributing to the state's grade in *Public Health and Injury Prevention*, Maine has among the highest per capita rates of injury prevention funding in the nation. Deaths from occupational injuries are lower than in most states, and Maine has relatively low rates of unintentional firearm-related fatalities and homicides and suicides. The traffic fatality rate is lower than in the average state (14.2 versus 16.2 per 100,000 people). Maine has enacted legislation regarding seat belt and child safety seat use, including primary seat belt law enforcement, but the state has failed to enact a universal motorcycle helmet law covering all riders. Despite traffic safety efforts, the rate of front occupant seat belt use is lower than the national rate (79.8 versus 82 percent).

Challenges. The state's grade in *Disaster Preparedness* includes some positive indicators but they are offset by numerous negative ones. For example, the state has in place medical strike teams or medical assistance teams, but it lacks the ability to verify the credentials of volunteer health professionals and assign them to one of four levels in a state-based Emergency System for Advance Registration of Volunteer Health Professionals program. While Maine has systems in place for "just-in-time" training, as well as patient and victim tracking, the state does not have an all-hazards medical response plan or a written plan for the coordination of the State Emergency Operations Center or local emergency management agencies to provide security to hospitals in the event of disaster. Hospital capacity is also an issue: the state lacks any verified burn centers and has relatively low rates of burn unit beds and ICU beds (3.0 and 275.3 per 1 million people, respectively).

Maine must continue to build disaster response capacity.

The state receives a low rank for its *Medical Liability Environment* due to a paucity of medical liability reforms. Maine has not enacted additional liability protection for EMTALA-mandated emergency care or expert witness rules requiring the witness to be of the same specialty as the defendant or to be licensed in the state. The state has also failed to enact joint and several liability reform.

	RANK	GRADE
ACCESS TO EMERGENCY CARE	2	B+
QUALITY & PATIENT SAFETY ENVIRONMENT	15	B+
MEDICAL LIABILITY ENVIRONMENT	28	D+
PUBLIC HEALTH & INJURY PREVENTION	16	B-
DISASTER PREPAREDNESS	46	D-
OVERALL	7	C+

Recommendations. Maine must continue to build disaster response capacity through formal written plans and greater preparation to deploy volunteer health professionals during a disaster event. The state also needs to address specialist shortages with regard to neurosurgeons; ear, nose, and throat specialists; and plastic surgeons. The implementation of additional liability reforms and protections, along with increasing Medicaid reimbursement rates, are two strategies the state could use to attract more specialists. The state should also further strengthen its commitment to *Public Health and Injury Prevention* by requiring all motorcycle riders to wear helmets.

ACCESS TO EMERGENCY CARE	B+
Board-certified emergency physicians per 100,000 pop.	12.8
Emergency physicians per 100,000 pop.	16.6
Neurosurgeons per 100,000 pop.	1.8
Orthopedists and hand surgeon specialists per 100,000 pop.	10.5
Plastic surgeons per 100,000 pop.	1.3
ENT specialists per 100,000 pop.	2.6
Registered nurses per 100,000 pop.	1,053.3
Additional primary care FTEs needed	15.5
Additional mental health FTEs needed	3.6
Level I or II trauma centers per 1M pop.	2.3
% of population within 60 minutes of Level I or II trauma center	79.1
Accredited chest pain centers per 1M pop.	0.8
% of population with an unmet need for substance abuse treatment	8.8
Pediatric specialty centers per 1M pop.	2.3
Physicians accepting Medicare per 100 beneficiaries	3.9
Medicaid fee levels for office visits as a % of the national average	74.1
% change in Medicaid fees for office visits (2004-05 to 2007)	5.4
% of adults with no health insurance	10.1
% of children with no health insurance	6.4
% of adults with Medicaid	14.9
Emergency departments per 1M pop.	26.6
Hospital closures in 2006	0
Staffed inpatient beds per 100,000 pop.	304.3
Hospital occupancy rate per 100 staffed beds	68.7
Psychiatric care beds per 100,000 pop.	39.0
State collects data on diversion	Yes

MEDICAL LIABILITY ENVIRONMENT	D+
Lawyers per 10,000 pop.	14.5
Lawyers per physician	0.5
Lawyers per emergency physician	8.8
ATRA judicial hellholes (range 0 to -7)	0
Malpractice award payments/100,000 pop.	3.4
Average malpractice award payments	$275,626
Databank reports per 1,000 physicians	19.1
Patient compensation fund	● No
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	10.9
Average medical liability insurance premium for primary care physicians	$9,389
Average medical liability insurance premiums for specialists	$37,942
Pretrial screening panels	● Mandatory
Are pretrial screening panels' findings admissible as evidence?	No
Periodic payments	Upon request or agreement of party(ies)
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	B+
Funding for quality improvement within the EMS system	No
Funded state EMS medical director	Yes
Emergency medicine residents per 1M pop.	17.5
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	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	No
% of hospitals with computerized practitioner order entry	24.3
% of hospitals with electronic medical records	21.6
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	74
Number of Joint Commission reviewed sentinel events per 1M pop. (1995–2006)	10

PUBLIC HEALTH & INJURY PREVENTION	B-
Traffic fatalities per 100,000 pop.	14.2
% of traffic fatalities alcohol related	39.0
Front occupant restraint use (%)	79.8
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	79.8
% of adults aged 65+ who received flu vaccine in the last 12 months	72.0
% of adults aged 65+ who ever received pneumococcal vaccine	67.9
Fatal occupational injuries per 1M workers	26.5
Homicides and suicides (non-motor vehicle) per 100,000 pop.	14.9
Unintentional fall-related fatal injuries per 100,000 pop.	6.9
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)	0.5
% of tobacco settlement funds spent on health-related services and programs	78.2
Total injury prevention funds per 1,000 pop.	$1,529.61
Unintentional injury prevention funds per 1,000 pop.	$1,218.80
Intentional injury prevention funds per 1,000 pop.	$806.02
Fall injury prevention funds per 1,000 pop.	$0.00
Infant mortality rate per 1,000 live births	6.9
% of adults with BMI > 30	23.1
Current smokers, % of adults	20.9
Binge alcohol drinkers, % of adults	16.1

DISASTER PREPAREDNESS	D-
Per capita federal disaster preparedness funds	$11.55
Disaster preparedness funds used specifically for health care-related preparedness are tracked	Yes
All-hazards medical response plan or ESF-8 plan?	No
Plan shared with all EMS and essential hospital personnel?	NR
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	NR
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	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.	NR
Burn unit beds per 1M pop.	3.0
ICU beds per 1M pop.	275.3
Verified burn centers per 1M pop.	0.0
State able to verify credentials and assign volunteer health professionals to four ESAR-VHP levels	No
Nurses registered in ESAR-VHP per 1M pop.	NR
Physicians registered in ESAR-VHP per 1M pop.	NR
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	Yes, civil
% of RNs that received any emergency training	36.8
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*