



Michigan

With significant shortages of primary care physicians and specialists, low Medicaid reimbursement rates, and few medical liability reforms, Michigan’s emergency care environment is threatened by a multitude of vexing problems.

Strengths. Michigan’s grade in *Disaster Preparedness* is largely due to the multiple systems and plans that have been put in place. The state has an all-hazards medical response plan, as well as written plans specifically for special needs patients. Michigan has statewide “just-in-time” training systems and statewide patient and victim tracking systems.

With respect to *Public Health and Injury Prevention*, Michigan fared quite well regarding injury prevention funding and traffic safety. The state invests more money in intentional injury prevention than do most states (\$171 per 1,000 people versus an average of \$158 across the states). The state has multiple child restraint and seat belt laws, a universal motorcycle helmet law, and a higher-than-average use of seat belts among front seat occupants (93.7 percent). Michigan also has the 11th lowest traffic fatality rate in the nation (10.8 per 100,000 people).

Challenges. Michigan has been especially affected by the current economic downturn, which may have played an important role in the state’s poor performance on several key indicators. For instance, *Access to Emergency Care* poses serious problems for the state. The state experienced two hospital closures in 2006 and has relatively low rates of inpatient and psychiatric care beds (289.3 and 23.5 per 100,000 people, respectively). Michigan faces significant shortages of primary care providers and specialists, such as ear, nose, and throat specialists; neurosurgeons; orthopedists; and hand surgeons. Contributing to these barriers to medical care are relatively low Medicaid reimbursement

rates for office visits (79.9 percent of the national average).

Michigan received a poor grade for its *Medical Liability Environment*. While the state has implemented a cap on non-economic damages, it has not been successful in reducing insurance premiums: The state has among the six highest medical liability insurance premiums for primary care physicians and specialists (\$29,712 and \$98,951, respectively). The state also ranks 46th for the low number of insurers writing medical liability policies (2.4 per 1,000 physicians). This may be indicative of the state’s failure to enact numerous reforms, including additional liability protections for EMTALA-mandated emergency care, mandatory pretrial screening panels, and joint and several liability reform.

Michigan’s grade in the *Quality and Patient Safety Environment* stems from a lack of systems to ensure uniform quality controls and measures. There are no reporting requirements for adverse events or hospital-based infections. In addition, the state does not maintain a statewide trauma registry. The state also lacks funding for quality improvement within the EMS system and a state EMS medical director position.

Recommendations. Michigan suffers from a lack of specialists of all types. Emergency physicians in the state report significant shortages of specialists willing to provide on-call services to emergency patients. The on-call crisis, combined with hospital closures and low rates of inpatient beds, may all contribute to other serious problems reported by emergency physicians, including hospital crowding, boarding of patients in emergency departments, and ambulance diversion. It is imperative that the state work with the medical community to address these issues in order to continue providing quality care to those most in need. The state should also begin collecting data on ambulance diversion.









Michigan suffers from a lack of specialists of all types.

	RANK	GRADE
ACCESS TO EMERGENCY CARE	37	D-
QUALITY & PATIENT SAFETY ENVIRONMENT	47	D-
MEDICAL LIABILITY ENVIRONMENT	41	D-
PUBLIC HEALTH & INJURY PREVENTION	21	C
DISASTER PREPAREDNESS	12	B+
OVERALL	43	D+


Systems must be instituted to ensure the quality controls and uniformity needed to improve *Access to Emergency Care* and the *Quality and Patient Safety Environment*. For example, while the state legislature has approved a plan for a statewide trauma system, the state needs to provide appropriate funding to develop and implement such a system. The state also should fund a state EMS medical director position and provide funding for quality improvement within the EMS system.

Michigan must enact medical liability reforms. In order to help encourage specialists to provide emergency on-call services, legislators should reduce the current medical liability cap on non-economic damages and enact additional liability protections for EMTALA-mandated emergency care. The *Medical Liability Environment* would benefit significantly from increasing the threshold for medical liability suits from “simple negligence” to “gross negligence” for licensed health care professionals and facilities providing emergency care.






ACCESS TO EMERGENCY CARE **D-**

Board-certified emergency physicians per 100,000 pop.	 11.0
Emergency physicians per 100,000 pop.	15.3
Neurosurgeons per 100,000 pop.	1.6
Orthopedists and hand surgeon specialists per 100,000 pop.	8.2
Plastic surgeons per 100,000 pop.	2.0
ENT specialists per 100,000 pop.	2.8
Registered nurses per 100,000 pop.	 836.2
Additional primary care FTEs needed	217.6
Additional mental health FTEs needed	19.9
Level I or II trauma centers per 1M pop.	1.6
% of population within 60 minutes of Level I or II trauma center	85.1
Accredited chest pain centers per 1M pop.	0.9
% of population with an unmet need for substance abuse treatment	8.4
Pediatric specialty centers per 1M pop.	2.8
Physicians accepting Medicare per 100 beneficiaries	2.7
Medicaid fee levels for office visits as a % of the national average	79.9
% 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	4.7
% of adults with Medicaid	8.2
Emergency departments per 1M pop.	 12.6
Hospital closures in 2006	2
Staffed inpatient beds per 100,000 pop.	289.3
Hospital occupancy rate per 100 staffed beds	67.0
Psychiatric care beds per 100,000 pop.	23.5
State collects data on diversion	No
MEDICAL LIABILITY ENVIRONMENT D-	
Lawyers per 10,000 pop.	14.4
Lawyers per physician	0.5
Lawyers per emergency physician	9.4
ATRA judicial hellholes (range 0 to -7)	-1
Malpractice award payments/100,000 pop.	0.7
Average malpractice award payments	\$122,875
Databank reports per 1,000 physicians	20.0
Patient compensation fund	 No
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	2.4
Average medical liability insurance premium for primary care physicians	\$29,712
Average medical liability insurance premiums for specialists	\$98,951
Pretrial screening panels	 No
Are pretrial screening panels' findings admissible as evidence?	N/A
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	Yes
Expert witness required to be of the same specialty as the defendant	Yes
Expert witness must be licensed to practice medicine in the state	No

QUALITY & PATIENT SAFETY ENVIRONMENT **D-**




Funding for quality improvement within the EMS system	No
Funded state EMS medical director	No
Emergency medicine residents per 1M pop.	 37.6
Adverse event reporting required	No
Hospital-based infections reporting required	No
Mandatory quality reporting requirement	Yes
% of counties with E-911 capability	98.8
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	No
Statewide trauma registry	No
% of hospitals with computerized practitioner order entry	24.8
% of hospitals with electronic medical records	45.6
% 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)	12

PUBLIC HEALTH & INJURY PREVENTION **C**

Traffic fatalities per 100,000 pop.	10.8
% of traffic fatalities alcohol related	 41.0
Front occupant restraint use (%)	93.7
Helmet use required for all motorcycle riders	 Yes
Child safety seat/seat belt legislation (10 points possible)	7
% of children immunized, aged 19-35 months	 80.0
% of adults aged 65+ who received flu vaccine in the last 12 months	 71.3
% of adults aged 65+ who ever received pneumococcal vaccine	 67.6
Fatal occupational injuries per 1M workers	28.5
Homicides and suicides (non-motor vehicle) per 100,000 pop.	17.7
Unintentional fall-related fatal injuries per 100,000 pop.	6.3
Unintentional fire/burn-related fatal injuries per 100,000 pop.	1.3
Unintentional firearm-related fatal injuries per 100,000 pop.	0.1
Gun-purchasing legislation (8 points possible)	3.5
% of tobacco settlement funds spent on health-related services and programs	62.4
Total injury prevention funds per 1,000 pop.	\$205.24
Unintentional injury prevention funds per 1,000 pop.	\$33.95
Intentional injury prevention funds per 1,000 pop.	\$171.29
Fall injury prevention funds per 1,000 pop.	\$0.00
Infant mortality rate per 1,000 live births	7.9
% of adults with BMI > 30	28.8
Current smokers, % of adults	22.4
Binge alcohol drinkers, % of adults	17.7

DISASTER PREPAREDNESS **B+**

Per capita federal disaster preparedness funds	\$8.10
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?	No
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, No
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	128
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.	871.2
Burn unit beds per 1M pop.	7.8
ICU beds per 1M pop.	288.1
Verified burn centers per 1M pop.	0.2
State able to verify credentials and assign volunteer health professionals to four ESAR-VHP levels	Yes
Nurses registered in ESAR-VHP per 1M pop.	77.1
Physicians registered in ESAR-VHP per 1M pop.	11.8
Training required in disaster management and response to bio- and chem terrorism for essential hospital personnel, EMS personnel	No, 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	38.5
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	