



**The Maryland Institute *for*
Emergency Medical Services Systems**

2025-2026

ANNUAL REPORT

FY 2026 MIEMSS *Annual Report*

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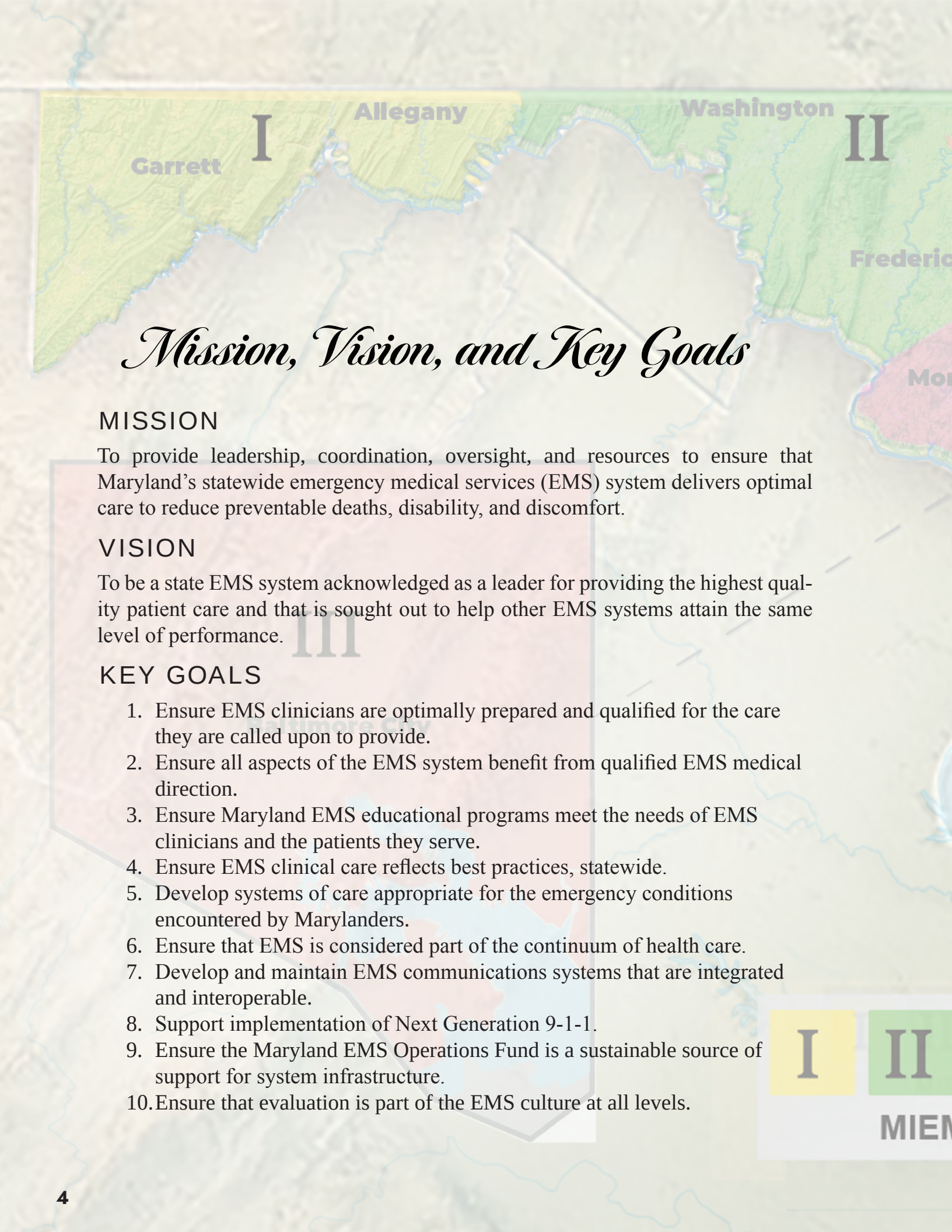
About MIEMSS

The Maryland Institute for Emergency Medical Services Systems (MIEMSS) oversees and coordinates all components of the statewide EMS system, including planning, operations, evaluation, and research; provides leadership and medical direction; certifies and licenses EMS clinicians; conducts and supports EMS educational programs; operates and maintains a statewide communications system; designates trauma and specialty centers; licenses and regulates commercial ambulance services, and participates in EMS-related public education and prevention programs. MIEMSS provides the executive support for the EMS Board in reviewing and approving the budgets for agencies receiving funds from the Maryland EMS Operations Fund, developing and promulgating regulations and protocols, proposing EMS system legislation, and conducting other EMS Board business. MIEMSS also provides the administrative and staff support for the Statewide EMS Advisory Council (SEMSAC) and five EMS regional councils.



**Maryland Institute for
Emergency Medical Services Systems**

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Mission, Vision, and Key Goals

MISSION

To provide leadership, coordination, oversight, and resources to ensure that Maryland's statewide emergency medical services (EMS) system delivers optimal care to reduce preventable deaths, disability, and discomfort.

VISION

To be a state EMS system acknowledged as a leader for providing the highest quality patient care and that is sought out to help other EMS systems attain the same level of performance.

KEY GOALS

1. Ensure EMS clinicians are optimally prepared and qualified for the care they are called upon to provide.
2. Ensure all aspects of the EMS system benefit from qualified EMS medical direction.
3. Ensure Maryland EMS educational programs meet the needs of EMS clinicians and the patients they serve.
4. Ensure EMS clinical care reflects best practices, statewide.
5. Develop systems of care appropriate for the emergency conditions encountered by Marylanders.
6. Ensure that EMS is considered part of the continuum of health care.
7. Develop and maintain EMS communications systems that are integrated and interoperable.
8. Support implementation of Next Generation 9-1-1.
9. Ensure the Maryland EMS Operations Fund is a sustainable source of support for system infrastructure.
10. Ensure that evaluation is part of the EMS culture at all levels.

Maryland Emergency Medical Services Regions

Maryland's EMS system is composed of five regions. Each region has a Regional EMS Advisory Council defined by regulation. Each council focuses on grants, training, EMS policies and protocols, legislation, and communications. Input from each Regional EMS Advisory Council is provided to the Statewide EMS Advisory Council for recommendation to the EMS Board. MIEMSS' regional coordinators support the councils, facilitate communication, and address regional EMS issues.



State Emergency Medical Services Board

Chair's Message

It is a privilege to serve as Chair of the Maryland State EMS Board and to recognize the remarkable people who make Maryland's emergency medical services system one of the finest in the nation.

That distinction has never belonged to one agency or one organization. It belongs to the thousands of dedicated people who answer the call every day. EMS clinicians. Dispatchers. Firefighters. Law enforcement officers. Nurses. Physicians. Hospital teams. Educators. Volunteers. And the many partners who work together to serve the citizens of Maryland.

For more than 50 years, Maryland has built an EMS system grounded in partnership, professionalism, and a shared commitment to patient care. Every generation has accepted the responsibility of leaving the system stronger than they found it. That tradition continues today through a spirit of cooperative excellence that has become the hallmark of Maryland's EMS system.

The EMS Board remains committed to providing thoughtful oversight and strategic direction that support a strong, responsive, and accountable statewide EMS system. Working closely with MIEMSS leadership, our regional advisory councils, state and local Fire and EMS agencies, hospitals, and healthcare partners, we continue to strengthen a system that evolves alongside the needs of Maryland's diverse communities.

Over the past year, we have continued to make meaningful progress. Mobile Integrated Health programs are expanding access to care while helping ensure the right patient receives the right care at the right time. The continued advancement of prehospital whole blood administration, made possible through the collaboration of MIEMSS, the Maryland State Police Aviation Command, trauma centers, blood banks, and jurisdictional EMS programs, is improving care for some of our most critically injured patients. These accomplishments reflect our commitment to evidence-based care, innovation, and better patient outcomes.

We also recognize that caring for patients begins with supporting the people who provide that care. Continued improvements to the MIEMSS website and digital resources have simplified access to licensure, license renewal, recertification, and critical information, making it easier for EMS clinicians to access the services they need.

Still, our greatest strength has never been technology or equipment.

It has always been our people.

Every day, somewhere in Maryland, someone calls 9-1-1 on what may be the worst day of their life. A trained professional answers that call with knowledge, compassion, skill, and calm. That moment is what this system is built to support.

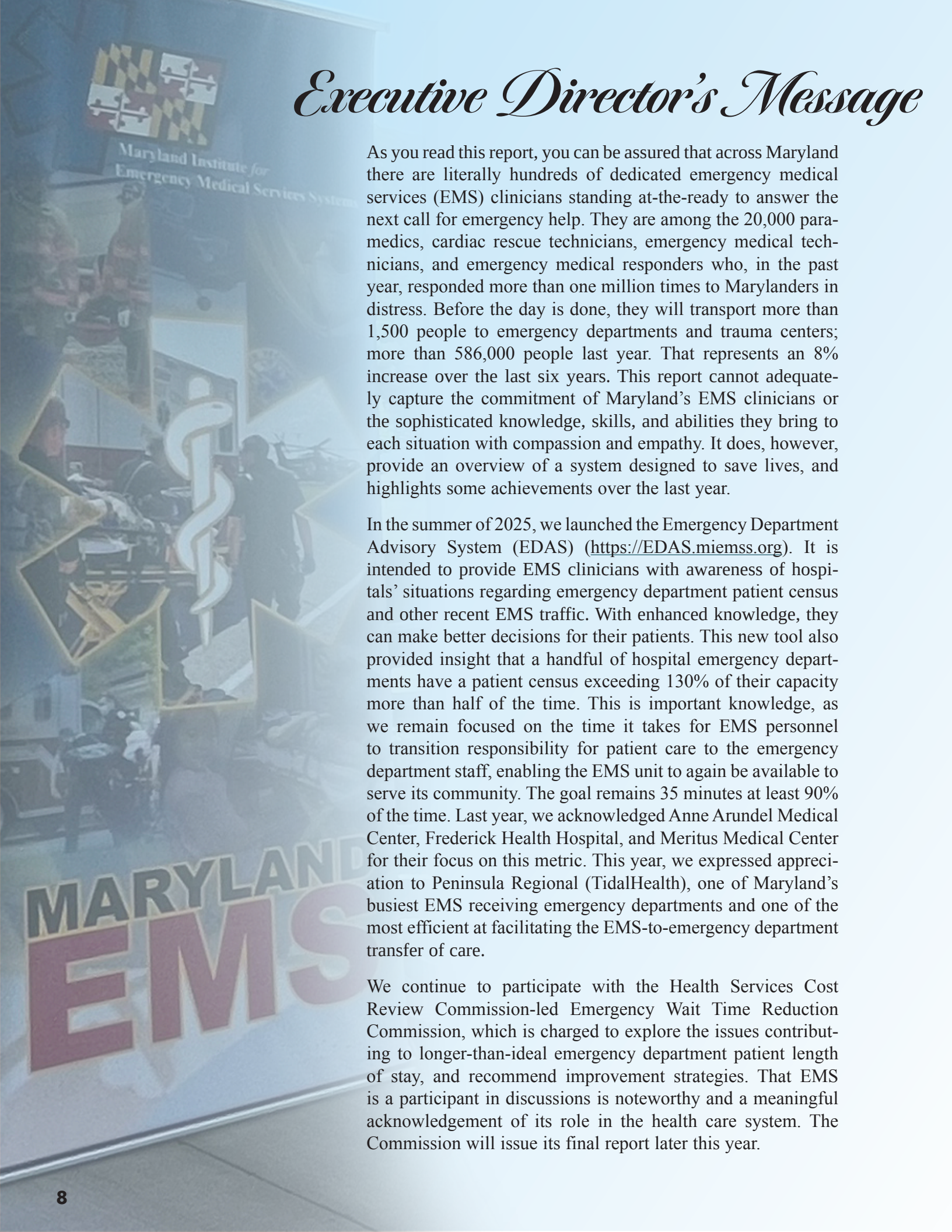
The Board also recognizes the organizations whose partnership strengthens Maryland's EMS system every day, including the Maryland State Firefighters Association, the Maryland Fire and Rescue Institute, the Maryland State Police, our trauma and specialty centers, volunteer and career EMS agencies, hospitals, local governments, and the many organizations that contribute to the success of Maryland's EMS system.

As we look ahead, the EMS Board remains committed to preparing Maryland's EMS system for the challenges of tomorrow while maintaining the high standards of care our citizens have come to expect. Through sound planning, continued innovation, and cooperative excellence, we will continue building upon the remarkable foundation established over the past five decades.

On behalf of the Maryland State EMS Board, thank you for your dedication, your professionalism, and your service. Every advancement we celebrate is ultimately a reflection of the people who answer the call. It is an honor to serve beside you.



*Clay B. Stamp, NRP
Chair, Maryland State EMS Board*



Executive Director's Message

As you read this report, you can be assured that across Maryland there are literally hundreds of dedicated emergency medical services (EMS) clinicians standing at-the-ready to answer the next call for emergency help. They are among the 20,000 paramedics, cardiac rescue technicians, emergency medical technicians, and emergency medical responders who, in the past year, responded more than one million times to Marylanders in distress. Before the day is done, they will transport more than 1,500 people to emergency departments and trauma centers; more than 586,000 people last year. That represents an 8% increase over the last six years. This report cannot adequately capture the commitment of Maryland's EMS clinicians or the sophisticated knowledge, skills, and abilities they bring to each situation with compassion and empathy. It does, however, provide an overview of a system designed to save lives, and highlights some achievements over the last year.

In the summer of 2025, we launched the Emergency Department Advisory System (EDAS) (<https://EDAS.miemss.org>). It is intended to provide EMS clinicians with awareness of hospitals' situations regarding emergency department patient census and other recent EMS traffic. With enhanced knowledge, they can make better decisions for their patients. This new tool also provided insight that a handful of hospital emergency departments have a patient census exceeding 130% of their capacity more than half of the time. This is important knowledge, as we remain focused on the time it takes for EMS personnel to transition responsibility for patient care to the emergency department staff, enabling the EMS unit to again be available to serve its community. The goal remains 35 minutes at least 90% of the time. Last year, we acknowledged Anne Arundel Medical Center, Frederick Health Hospital, and Meritus Medical Center for their focus on this metric. This year, we expressed appreciation to Peninsula Regional (TidalHealth), one of Maryland's busiest EMS receiving emergency departments and one of the most efficient at facilitating the EMS-to-emergency department transfer of care.

We continue to participate with the Health Services Cost Review Commission-led Emergency Wait Time Reduction Commission, which is charged to explore the issues contributing to longer-than-ideal emergency department patient length of stay, and recommend improvement strategies. That EMS is a participant in discussions is noteworthy and a meaningful acknowledgement of its role in the health care system. The Commission will issue its final report later this year.

EMS has also been recognized for its role in improving the health of rural Marylanders. Working with Maryland's Rural Health Transformation Program, 13 jurisdictions collectively received more than \$960,000 to initiate or expand prehospital administration of whole blood to rural patients in need. Currently, more than a dozen EMS operational programs in Maryland are able to administer blood products, typically type O positive (O+) whole blood, to severely bleeding patients. More programs will be starting soon. To better track blood administration and associated patient outcomes, we will be launching a whole blood registry that will help us assess the difference being made in people's lives.

Also in the realm of rural health transformation, several EMS operational programs have collaborated with their local health departments to receive funding for Mobile Integrated Health initiatives. Across Maryland, the heterogeneous nature of Mobile Integrated Health efforts reflects local system goals, funding sources, and other resource availability and collaborations. As an important aspect of integration of health services, a focus area of Vision 2030, Plan for the EMS System, this will be an area of attention for the upcoming year.

Maryland is a leader in the development and maintenance of systems of care, including trauma, stroke, and cardiac care. Over the past year, several hospitals have taken advantage of the opportunity to be recognized for their preparedness to care for our youngest patients. They have been designated as pediatric ready, pediatric resource, or comprehensive pediatric emergency departments/hospitals. We look forward to more hospitals joining this voluntary effort being championed by the Emergency Medical Services for Children program.

This report, redesigned with an emphasis on graphics and conciseness to align with Vision 2030, tells the story of an amazing system that changes people's lives and makes Maryland a better place to be. Thank you for your interest in Maryland EMS. We welcome your feedback (tdelbridge@miemss.org).



Theodore R. Delbridge, MD, MPH
Executive Director, MIEMSS

Medical Direction



The State EMS Medical Director provides leadership and coordination for state medical programs, protocols, and quality assurance in Maryland's EMS system. In addition, the Aeromedical Director, Associate State EMS Medical Director for Pediatrics, and Regional EMS Medical Directors for each of the five regions collaborate with the State EMS Medical Director to update *The Maryland Medical Protocols for Emergency Medical Services* on an annual basis. Regional EMS Medical Directors also assist the Jurisdictional EMS Medical Directors in each of Maryland's 28 jurisdictional EMS operational programs with protocol implementation and quality assurance initiatives. Fourteen of Maryland's EMS Medical Directors are board-certified in EMS medicine. A network of 49 EMS base stations located in emergency departments provide online medical direction through Emergency Medical Resource Center and Systems Communications (EMRC/SYSCOM).

**Office of the State EMS Medical Director:
Timothy P. Chizmar, MD, FAEMS, FACEP**

The Office of the State EMS Medical Director (OMD) ensures that patients who interact with the Maryland EMS system receive consistent, high-quality out-of-hospital medical care. Dr. Chizmar leads the statewide Protocol Review Committee (PRC) and EMS Quality Improvement Committee (QIC) and provides medical direction to the Jurisdictional Advisory Committee. The office closely coordinates efforts with the Regional Medical Directors, Regional Coordinators, and MIEMSS Office of Care Integration staff. OMD promotes creative, responsive, and evidence-based programs for the delivery of medical care to Maryland residents and visitors.

In the fall of 2025, Dr. Chizmar modernized the MIEMSS Base Station Communications Course for Emergency Department Professionals. The course materials have been comprehensively updated to include concise guidance for physicians who provide online medical consultation for EMS clinicians. Additionally, the online format allows hospital clinicians to take the training at a convenient time or revisit topics, as often as needed. Since the December, 2025 launch on the statewide Online Training Center, a total of 566 emergency physicians and nurses have completed the new online course. With in-person courses earlier in the year, a total of 952 physicians and nurses completed base station training in FY 2026.

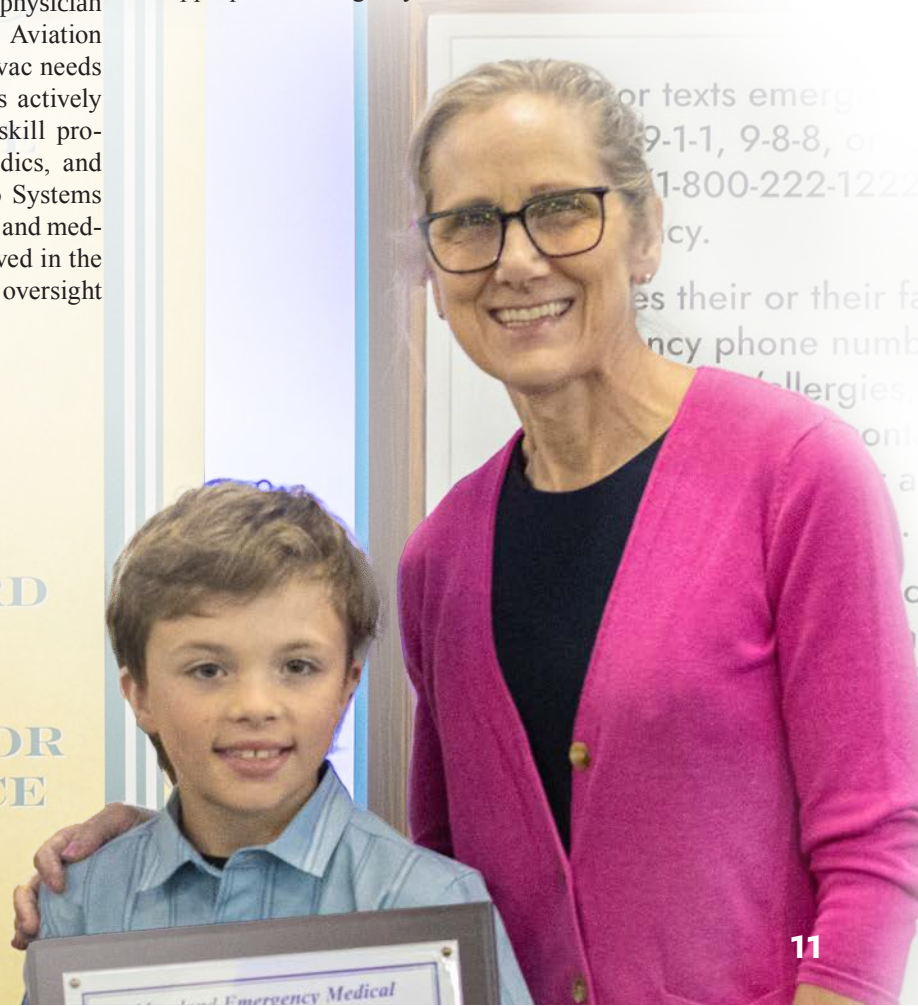


**Office of the Aeromedical Director:
Douglas J. Floccare, MD, MPH**

The Office of the Aeromedical Director, under the leadership of Dr. Floccare, provides the necessary physician medical support to the Maryland State Police Aviation Command (MSPAC) to meet the emergency medevac needs of Maryland's citizens. Aeromedical Operations is actively involved in ongoing training and verification of skill proficiency for Maryland State Police flight paramedics, and provides around-the-clock consultation support to Systems Communications (SYSCOM) for medevac requests and medical direction. Aeromedical staff are actively involved in the development of new patient care protocols and the oversight of ongoing care.

**Associate State EMS Medical Director for Pediatrics:
Jennifer F. Anders, MD, FAAP, FAEMS**

Dr. Anders plays a vital role in ensuring that the state's EMS system effectively addresses the unique needs of pediatric patients. She provides medical oversight and leadership for the EMS for Children (EMSC) Program, guiding the development and implementation of pediatric-specific EMS protocols, emergency care clinical guidelines, education, and quality improvement initiatives, and provides continuing education to EMS and ED clinicians across the state. Dr. Anders serves on the national Pediatric Education for Prehospital Professionals (PEPP) steering committee and is the lead author for the PEPP 5th Edition course to be published in 2026. Pediatric Readiness across EMS agencies and emergency departments is a major focal point for EMSC with the launch of a formal recognition for Pediatric Facility Program that includes ED applications, site visits, and ongoing pediatric champion forums. Dr. Anders leads efforts to standardize pediatric equipment, protocols, and interfacility transfer practices. Leading a team of pediatric EMS medical directors for each Region, she helps to ensure that children across Maryland receive high-quality, developmentally appropriate emergency medical care.



Maryland Regional

Regional Medical Direction

MIEMSS coordinates a network of Regional EMS medical directors, who serve as the principal medical advisors for their respective regional councils, hospitals in the region, and jurisdictional medical directors. As members of the MIEMSS Protocol Review Committee, these physicians propose new protocols and revisions to existing protocols. They assist the jurisdictional medical directors with Quality Assurance and Quality Improvement (QA/QI), and support educational efforts with a particular focus on new protocol implementation.

In conjunction with the MIEMSS Office of Care Integration and MIEMSS Regional Coordinators, the Regional EMS medical directors conduct hospital base station site surveys. They also assist the State EMS Medical Director with the development of base station education and credentialing of hospital base station instructors.

Region I

Janelle Martin, MD
EMS Medical Director

UPMC Western
Maryland

Meritus Medi
Center

Frederick Regional
Center

Johns Hopkins Howard Cou
General Hospital

MedStar Me
Med

Holy Cross

Adventis
Germantown Emer

MedStar Good
Samaritan Hospital

LifeBridge
Sinai Hospital

The Johns Hopkins
Hospital Adult / Pediatric

MedStar Union
Memorial Hospital

The Johns Hopkins
Bayview Medical Center

Medical Direction



Region II

Jeffrey Fillmore, MD
EMS Medical Director

Rupal Udeshi, MD
EMS Medical Director for Pediatrics

Northwest
Hospital Center

Region III

Matthew Levy, DO, MSc,
FACEP, FAEMS
EMS Medical Director

Jennifer Guyther, MD
Associate EMS Medical Director

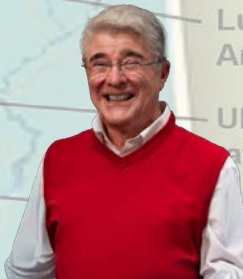
Corina Noje, MD, FAAP
EMS Medical Director for Pediatrics



Region V

Roger Stone, MD
EMS Medical Director

Karen O'Connell, MD, FAAP
EMS Medical Director for Pediatrics



Region IV

Thomas Chiccone, MD,
FACEP
EMS Medical Director

Steve White, MD, FACEP
EMS Medical Director for Pediatrics



and Base Stations

Clinical Care

Maryland's EMS clinicians respond to more than one million calls for help each year, and transport more than 586,000 patients to emergency departments for their continuing care. Statewide EMS protocols guide the preponderance of care provided. The protocols are continually evaluated to identify opportunities to improve care and resulting outcomes. Data-informed decisions drive protocol development and revisions using a variety of data sources and medical evidence-based practice.

2026 Maryland EMS Protocol Updates

The following are significant additions and modifications to *The Maryland Medical Protocols for Emergency Medical Services*, effective on July 1, 2026:

Abuse / Neglect: This revision adds the new statewide hotline for child and vulnerable adult abuse and neglect reporting, 1-800-91PREVENT, pursuant to a recent change in Maryland law.

Angioedema: This new protocol addresses an adverse reaction associated with ACE inhibitor medications. Patients may experience isolated but severe swelling of the lips, tongue, or throat. The protocol defines treatment with epinephrine and tranexamic acid (TXA) after medical consultation.

Chest Pain: This protocol revision includes guidance for the treatment of suspected aortic syndrome (aortic dissection). Labetalol may be given with medical consultation.

Choking / Foreign Body Airway Obstruction: This addition to the GPC incorporates new American Heart Association guidelines for the treatment of choking in patients of all ages.

Critically Unstable Patient: This revision adds a pediatric section that describes immediate interventions for critically ill pediatric patients prior to initiating transport.

Crush Syndrome (Hyperkalemia): This protocol modification simplifies the dosing of sodium bicarbonate (bolus only) and removes the consultation requirement for high-dose albuterol. The timing of medication administration for patients with hyperkalemia due to crush syndrome is further defined (e.g., pre- and post-extrication).

MODEL-T (Buprenorphine): This protocol revision enables Cardiac Rescue Technicians (CRTs) who have additional training to administer buprenorphine.

Newly Born Protocol: The ALS and BLS protocols have been consolidated into a single protocol. A Newly Born resuscitation checklist has been added.

Patient-Initiated Refusal of Care: The protocol has been revised to focus on the assessment of a patient's capacity to make an informed medical decision. The checklist has been reconfigured for clarity.

Seizure – Adult and Pediatric: This protocol modification increases the maximum patient dose of midazolam to 10 mg IV/IM/IN and removes the medical consultation for a second IV dose. Ketamine has been added as a second-line medication for seizures that continue after the maximum dose of midazolam.

Stroke: In the revised stroke protocol, patients with severely elevated blood pressure (SBP ≥ 220 and DBP ≥ 120) may be treated with labetalol 10 mg IV x2 doses. Higher doses of labetalol may be given with medical consultation.

Trauma, Multiple/Severe & Traumatic Arrest: This protocol revision adds the "X-ABC" approach to the initial management of a trauma patient, which focuses on prompt hemorrhage control. The use of the abdominal aortic and junctional tourniquet (AAJT) has been added for ALS clinicians who have additional jurisdictional-provided training. A tourniquet conversion to pressure dressing procedure has been added.



eMEDS® and CARES Information Systems

The eMEDS® and Cardiac Arrest Registry to Enhance Survival (CARES) information systems allow us to measure the impact of our clinical care. For example, the number of out-of-hospital cardiac arrests increased from 6,796 in CY 2019 to 7,850 in CY 2020, which represented an increase of 15.5% during the COVID-19 pandemic. However, the number of out-of-hospital arrests has decreased over subsequent years. In CY 2025, there were 6,877 out-of-hospital cardiac arrests.

Two factors have demonstrated a significant impact on survival from sudden cardiac arrest: early cardiopulmonary resuscitation

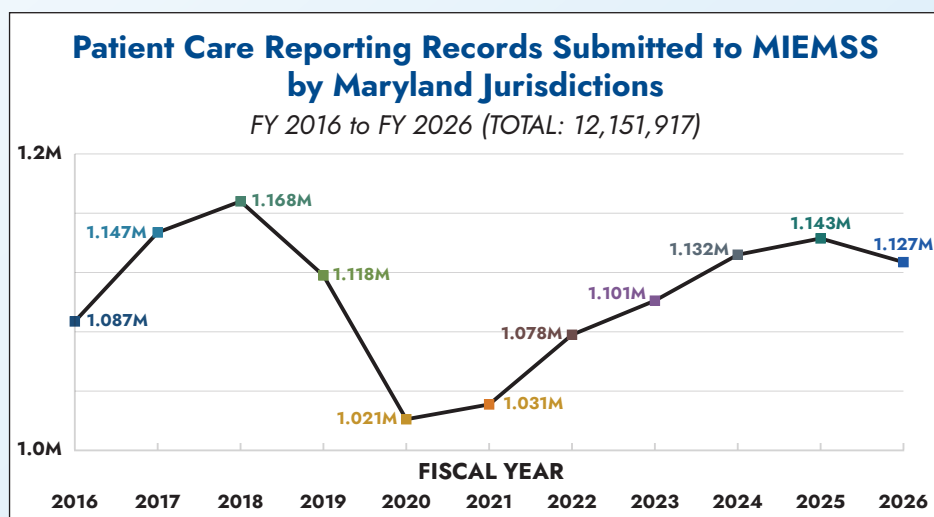
eMEDS® Records Submitted to MIEMSS for FY 2026

EMSOP	Total
Airports: BWI & Martin	6,050
Allegany County	15,851
Annapolis, City of	9,817
Anne Arundel County	73,726
Baltimore City	217,497
Baltimore County	143,895
Calvert County	17,306
Caroline County	7,612
Carroll County	25,760
Cecil County	17,604
Charles County	34,408
Dorchester County	7,725
Frederick County	58,272
Garrett County	5,462
Harford County	34,916
Howard County	37,093
Kent County	5,215
Montgomery County	96,781
MSP Aviation Command	2,123
Ocean City, Town of	6,747
Other EMSOPs*	5,636
Prince George's County	185,489
Queen Anne's County	9,270
Salisbury, City of	13,564
Somerset County	4,444
St. Mary's County	24,238
Talbot County	7,898
Washington County	36,757
Wicomico County	7,481
Worcester County	8,551
TOTAL	1,127,188

(CPR) and early defibrillation. CPR training is required for all Maryland high school students prior to graduation. Additionally, nearly every EMS operational program offers layperson CPR and automated external defibrillator (AED) courses. Using the CARES data, it is clear that patient outcomes in Maryland are significantly improved by early bystander CPR and the use of public access AEDs.

A third factor that demonstrates a significant impact on survival from sudden cardiac arrests is Telecommunicator CPR (T-CPR). The 9-1-1 telecommunicators are a critical link in the Chain of Survival in the first few minutes after a cardiac arrest. They provide CPR instructions and coaching for bystanders until the arrival of EMS.

Finally, the integration of data between the eMEDS® and CARES information systems saves valuable time for clinicians and EMS CARES coordinators. Maryland hospitals contribute valuable patient outcome data to the CARES report for cardiac arrest patients who receive ongoing care in the ED.



Source: electronic Maryland EMS Data System (eMEDS®), Reporting Period: July 1, 2025 to June 30, 2026

*Other EMSOPs: Other state and federal entities using eMEDS to document patient care in Maryland.

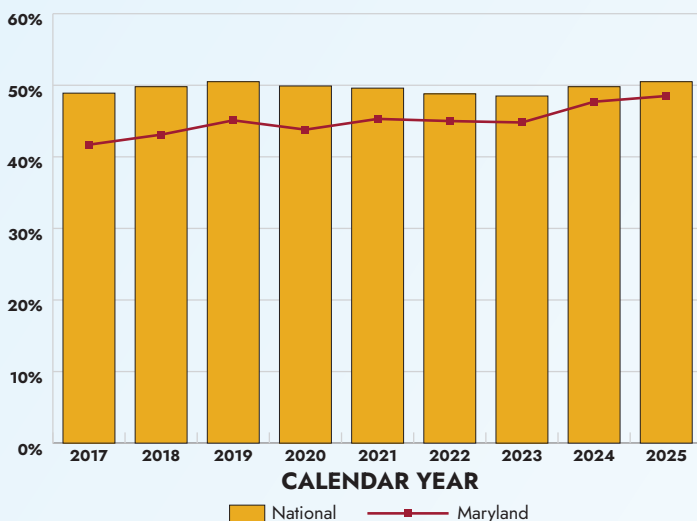
Cardiac Arrest Registry to Enhance Survival (CARES) – CY 2025 Registry Data

Source: CARES Registry

Demographic Information	Maryland	National
Mean Age (years)	65.1	63.6
% Males	60.8%	62.7%
% Females	39.2%	37.3%
Arrest Witnessed	Maryland	National
Witnessed by Bystander	35.4%	37.9%
Witnessed by 9-1-1 Responder	13.1%	12.6%
Unwitnessed	51.5%	49.5%
Who Initiated CPR?	Maryland	National
Bystander	42.2%	42.6%
First Responder	22.1%	29.9%
Emergency Medical Services (EMS)	35.7%	27.4%
Who First Defibrillated the Patient?	Maryland	National
Not Applicable	72.3%	68.8%
Bystander	1.9%	1.8%
First Responder	3.9%	8.2%
Emergency Medical Services (EMS)	21.9%	21.2%

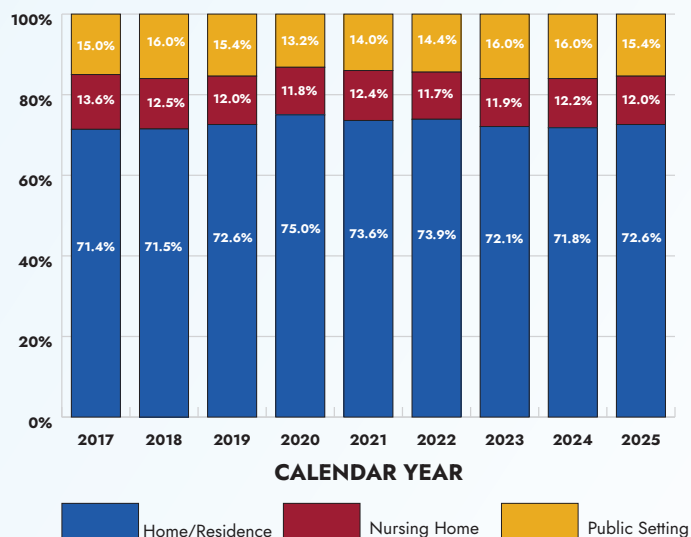
Percentage of Cardiac Arrests That Were Witnessed by Bystanders and/or First Responders/EMS by Calendar Year

Source: CARES Registry

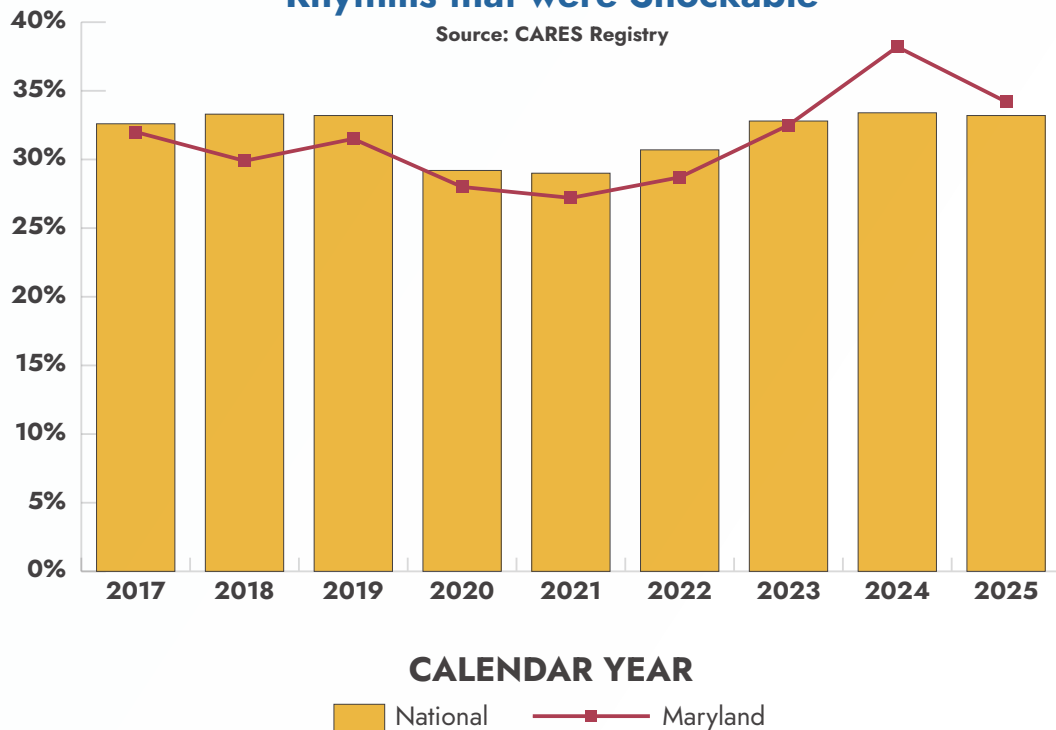


Location of Cardiac Arrest in Maryland

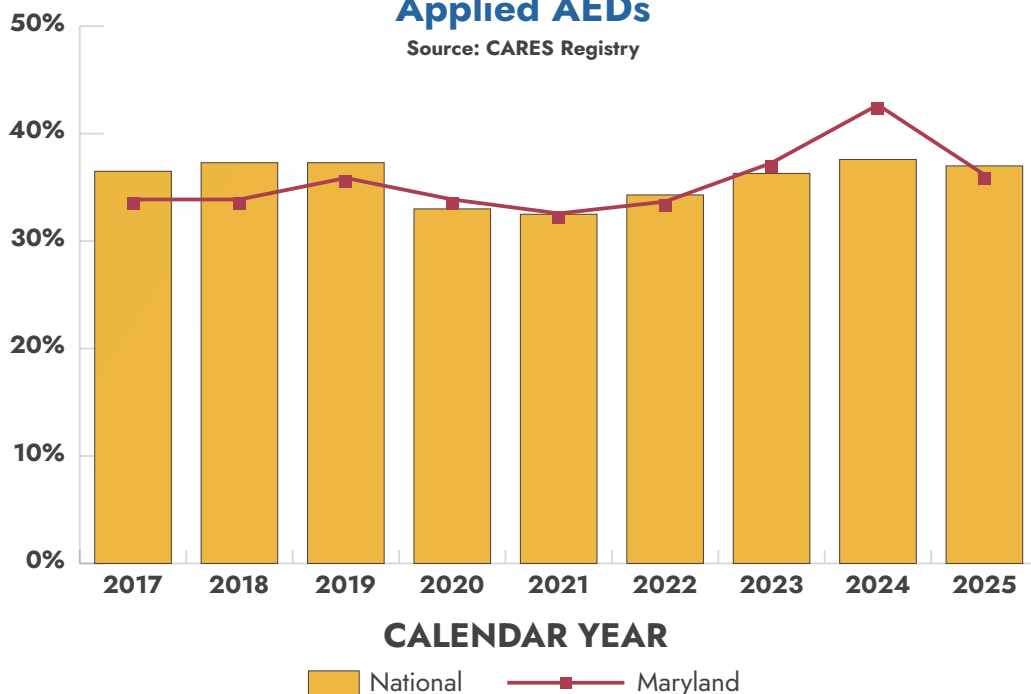
Source: CARES Registry



Survival Rates for Patients with Out-of-Hospital Cardiac Arrests that were Witnessed by Bystanders and Had First Arrest Rhythms that were Shockable



Survival Rates for Patients with Out-of-Hospital Cardiac Arrests with First Arrest Rhythms that were Shockable and Witnessed by Bystanders and Bystanders Either Performed CPR and/or Applied AEDs



See page 77 for additional CARES data.

Maryland State Police Aviation Command (FY 2026)

The Maryland State Police Aviation Command (MSPAC) offers life-saving and mission-critical air support for medevac, law enforcement, disaster assessment, and search and rescue operations across the state. Pilots, flight paramedics, and operations and support staff work together to keep Marylanders safe.



2,102
Patients Served

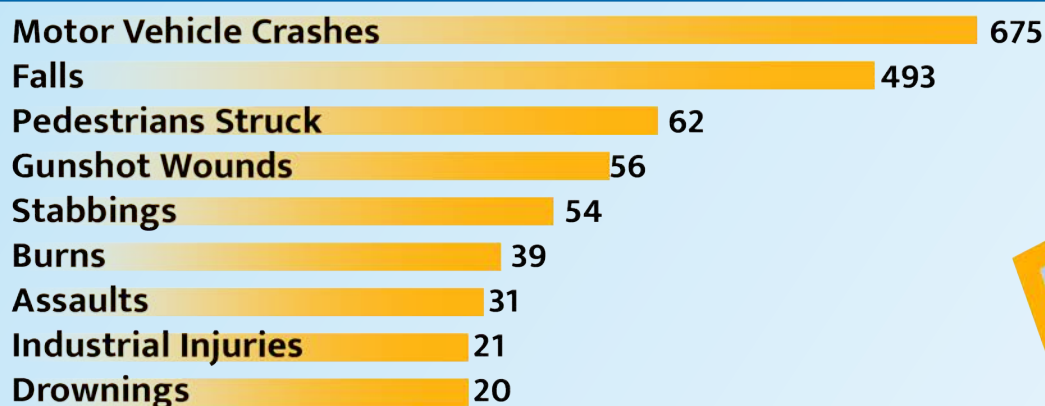


99%
Prehospital Care
at the request of
local EMS
(2,086 Patients)



1%
Interfacility Transport
to a higher level of care
(16 Patients)

MSPAC Responses by Incident Type



Rapid Sequence Intubation (RSI)

Adult and pediatric Rapid Sequence Intubation (RSI) programs as defined in *The Maryland Medical Protocols for Emergency Medical Services* are designed to address the needs of patients whose airways are otherwise difficult to secure, including those with severe head injuries.

Flight paramedics administer neuromuscular blocking medications that facilitate endotracheal intubation for patients who are not breathing adequately. Scenario-based simulation training modeled after real-life incidents enhances the knowledge and skills of flight paramedics and provides an effective method for recertification in Advanced Cardiac Life Support (ACLS), International Trauma Life Support (ITLS), and Pediatric Advanced Life Support (PALS).

Blood on Board Program

This cooperative effort between MIEMSS, Maryland State Police Aviation Command (MSPAC), and the University of Maryland Medical Center (UMMC) Blood Bank launched in May 2023 as a pilot program aboard Trooper 1. Early success led to its expansion to Trooper 2 by July 2023, and it is now a statewide program. All seven MSPAC helicopters carry two units of whole blood to provide service to patients in all five EMS regions across Maryland.

All MSPAC flight paramedics are trained and prepared to transfuse low-titer O+ whole blood to critically injured patients in accordance with a statewide pilot medical protocol. This whole blood is intended for the treatment of patients who are in severe hemorrhagic shock, because whole blood contains all clotting factors needed to help slow bleeding and restore oxygenation to vital organs.

In FY 2026, MSPAC flight paramedics provided potentially life-saving transfusions of whole blood to 125 patients. Many of these patients immediately showed dramatic improvement while en route to the hospital.

Emergency Medical Services For Children

MIEMSS Office of EMS for Children (EMSC) continues to advance pediatric clinical care by strengthening evidence-based practices, clinical education, quality improvement, and medical direction across Maryland's emergency medical services system.

Through EMSC, MIEMSS supports statewide pediatric EMS, coordinates state-level advisory committees, and collaborates with state and local agencies on childhood health emergency care.

EMSC coordinates Maryland's Pediatric Emergency Medical Advisory Committee (PEMAC) and its subcommittees, the State Pediatric Quality Improvement Committee (QIC), and the Pediatric Data Analysis and Research Team (DART).

PEMAC, the Pediatric QIC, and DART meet bimonthly and support the PEMAC Annual Research Forum each November. PEMAC, with its interdisciplinary membership, develops and revises guidelines, legislation, policies, and protocols affecting emergency medical care for children and youth. Current PEMAC working groups focus on the Family Advisory Network, injury prevention, and pediatric disaster preparedness. EMSC provides educational resources for families in partnership with other professional organizations.

The Pediatric QIC coordinates the online Pediatric Base Station Course for Maryland's two Pediatric Base Stations, which offer statewide pediatric medical direction and community education.

Pediatric DART provides support for focus groups, pilot research projects, funded multicentered studies, and quality improvement initiatives.

Maryland EMSC and the Family Advisory Network Council (FAN) Council annually recognize children and youth in Maryland who have demonstrated "the right steps to take" in an emergency or preparedness for an emergency. This year, three children and youth were recognized for their actions to assist another citizen during an emergency or to provide education to other children and youth on what to do when an emergency happens. The Right Care When It Counts awards were presented in Regions I, II, IV, and V to children and youth for calling 9-1-1 and providing care until paramedics arrived, recognizing a dangerous situation at home and helping family members escape, and for starting CPR after a sudden emergency. The FAN Council updated the Right Care criteria in 2025 to simplify the nomination process. FAN Council members attended the EMS Conferences to promote Right Care nominations, which are open year-round as of June 2025.

Three Advisory Committees, One Shared Mission



PEMAC

Pediatric Emergency Medical Advisory Committee

- Interdisciplinary membership
- Develops and updates guidelines, legislation, policies, and protocols
- Current working groups:
 - Family Advisory Network
 - Injury Prevention
 - Pediatric Disaster Preparedness



PEDIATRIC QIC

Pediatric Quality Improvement Committee

- Coordinates quality improvement initiatives
- Supports the online Pediatric Base Station Course
- Delivers statewide pediatric medical direction and community education



DART

Pediatric Data Analysis and Research Team

- Supports focus groups, pilot research projects, and multicenter studies
- Conducts data analysis
- Coordinates quality improvement initiatives



EMS Clinicians

The dedicated volunteer and career clinicians who underpin Maryland's EMS system strive to deliver state-of-the-art, out-of-hospital/prehospital emergency care at every hour of the day and night. Maryland EMS clinicians continually work to maintain best practices that reflect excellence in patient care. Recruitment and retention of a qualified workforce require continuous attention, and occupational stressors demand enhanced awareness of and focus on clinician wellness.

Office of Clinician Services

Through the Office of EMS Clinician Services (OCS), MIEMSS coordinates Maryland's EMS educational programs. With a goal to advance the knowledge and skills of EMS clinicians who provide prehospital emergency care throughout the state, MIEMSS supports clinicians through four primary functions:

Educational Oversight: Ensures EMS educational programs and opportunities meet state and national requirements for certification and licensure.

Clinician Support: Assists clinicians with initial certification, registration, renewals, reciprocity, and other credentialing needs.

System Management: Maintains the statewide eLicensure® system and Online Training Center (OTC), providing clinicians with access to required education and credentialing services.

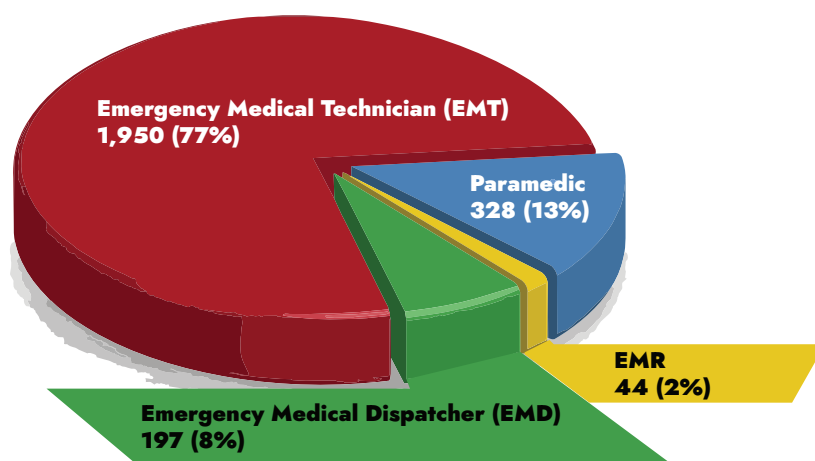
Professional Readiness: Supports continuing education, annual protocol updates, and other resources that help clinicians maintain clinical competency and provide consistent, evidence-based care.

Clinician Preparedness and Qualifications

Maryland's EMS clinician preparation focuses on robust educational standards that require training and effective medical oversight. This approach helps ensure clinicians are prepared to handle the demanding work of prehospital emergency care.

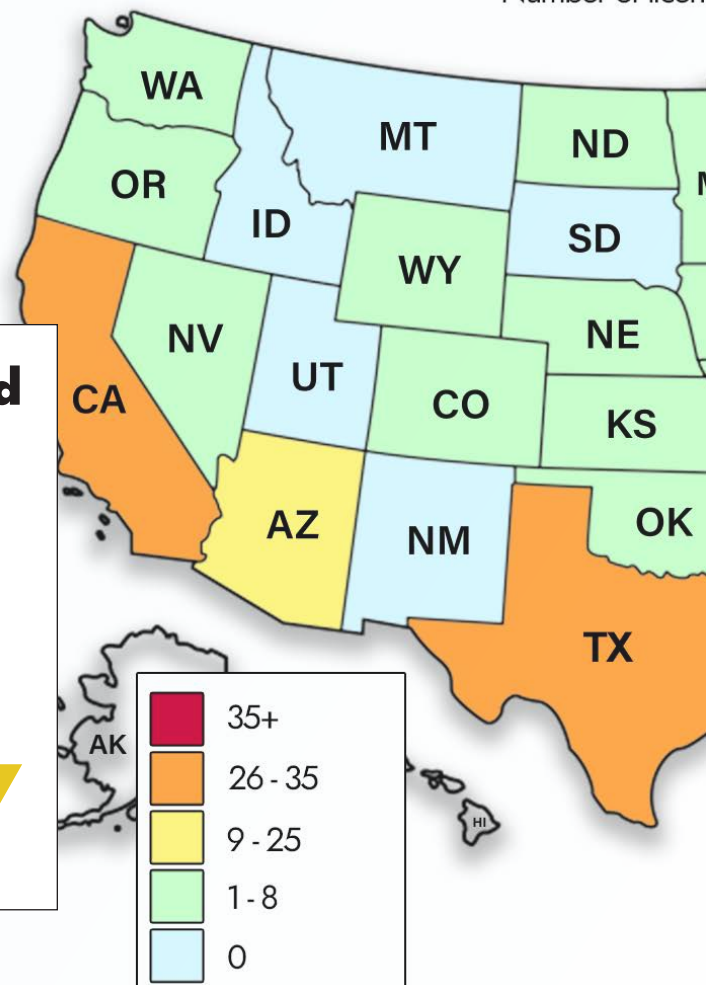
Educational Foundation: Maryland EMS programs maintain alignment with both National Registry of Emergency Medical Technicians (NREMT) standards and Committee on Accreditation for EMS Professions (CoAEMSP) requirements. CoAEMSP holds the distinction of being the only recognized accreditation organization for Paramedic programs under the Commission on Accreditation of Allied Health Education Programs, the largest programmatic accreditor of health sciences professions education.

NEW EMS Clinicians in Maryland



EMS Clinician Recip

Number of licenses



Initial Certification requires EMT students to complete an accredited EMS education program. Once they have completed the educational program, students are required to pass the NREMT exam and MIEMSS-administered psychomotor examinations, which comply with NREMT standards. Upon meeting these requirements, MIEMSS issues and updates the students' credentials in eLicensure®.

Clinician Certification Renewal requires clinicians to complete continuing education to maintain competencies and technical skills. EMS clinicians must stay current with annual updates to *The Maryland Medical Protocols for Emergency Medical Services*. Training videos and online verification are developed by the State Office of the EMS Medical Director, Media Services, and Clinician Services, and EMS clinicians are required to complete their work in the Online Training Center to ensure consistent, evidence-based care delivery.

Reciprocity is the process by which EMS clinicians transfer their certifications or licenses from other states to Maryland. All candidates for reciprocity must hold an equivalent state

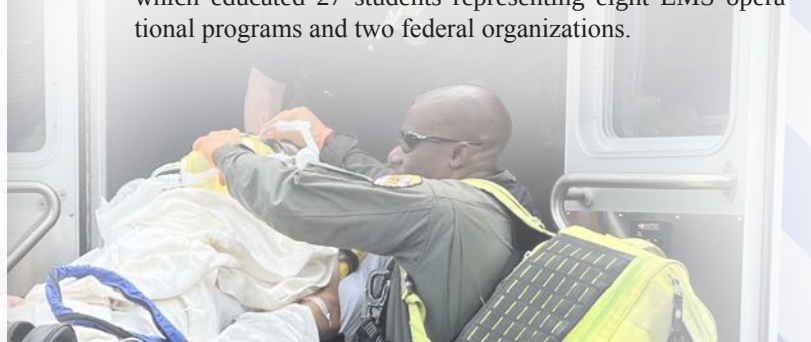
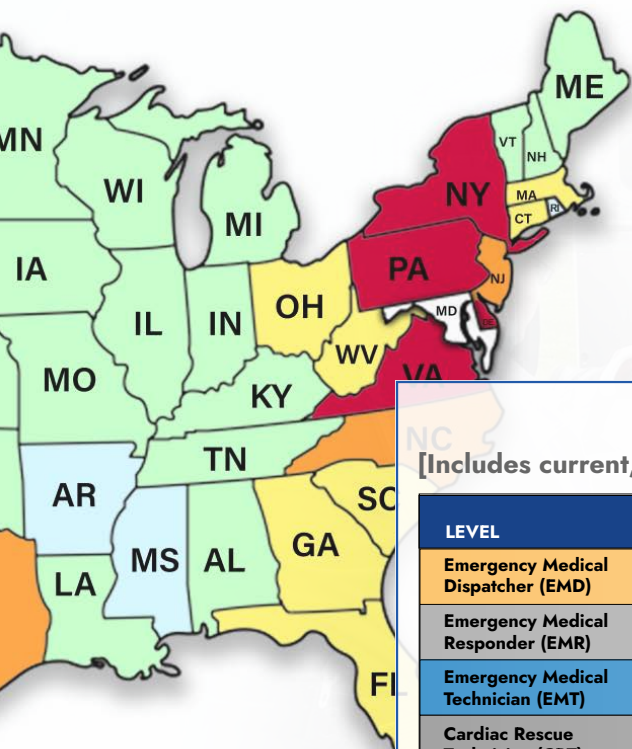
EMS license, certificate, or National Registry credential, and must demonstrate knowledge of the current *Maryland Medical Protocols for Emergency Medical Services*.

The reciprocity process has been streamlined significantly over this reporting period. MIEMSS put clinicians to work more quickly by reducing its process from weeks to days. The speed of the process lies in the hands of the clinician and their jurisdiction. Applicants who hold a current National Registry credential and complete the required two-hour protocol orientation have everything they need to expedite the process.

Clinician Wellness and Support: Recognizing the demanding nature of emergency medical services work, Maryland offers wellness support and mental health resources for all clinicians. The Critical Incident Stress Management (CISM) program fosters a healthy and responsive workforce that is prepared to deliver optimal patient care. CISM teams deliver crisis support services to EMS clinicians, firefighters, law enforcement officers, dispatchers, and other emergency personnel faced with stressful incidents. The program accelerates recovery for those experiencing stress reactions. Multidisciplinary interventions delivered by trained teams of behavioral health professionals and EMS peers may include activities such as education, peer support, defusing, and debriefings to help emergency services personnel cope with the effects of critical incidents. MIEMSS enhances CISM capabilities statewide through collaboration with local CISM, peer-support teams, and the International Critical Incident Stress Foundation. MIEMSS offered a three-day Critical Incident Stress Management course in May 2026, which educated 27 students representing eight EMS operational programs and two federal organizations.

Reciprocity in Maryland

licensed clinicians coming to Maryland from other states



Maryland Clinician Workforce

[Includes current, extended, and military status; Excludes lapsed (inactive and expired)]

LEVEL	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026
Emergency Medical Dispatcher (EMD)	1,066	1,110	1,210	1,052	869	953	1,093	1,118
Emergency Medical Responder (EMR)	662	603	653	464	498	469	433	369
Emergency Medical Technician (EMT)	14,853	14,875	15,501	14,763	14,456	14,363	14,573	14,871
Cardiac Rescue Technician (CRT)	575	546	509	441	404	381	359	328
Paramedic	3,491	3,573	3,787	3,824	3,774	3,893	3,951	4,026
TOTAL	20,647	20,707	21,660	20,544	20,001	20,059	20,409	20,712

Clinician Licensure and Certification Records Management

eLicensure® is MIEMSS' statewide clinician credentialing and records management system, used to process and track certifications, affiliations, testing records, and continuing education. Hosted by ImageTrend, the secure web-based platform enables EMS clinicians to apply for certification, renew credentials, and manage licensure requirements online while allowing EMS agencies, training programs, and medical directors to verify credentials and monitor compliance in real time.

eLicensure® integrates with the National Registry of Emergency Medical Technicians (NREMT) and the MIEMSS Online Training Center (OTC), supporting automated verification of national certification and tracking of online continuing education.

During FY 2026, MIEMSS continued to enhance clinician support through improved online resources that provide clear guidance on certification, renewal, and reciprocity processes, increasing transparency and accessibility for Maryland EMS clinicians.

Occupational Communication and Support

MIEMSS' website, social media platforms, and *Maryland EMS News* support a culture of safety by providing timely information to EMS clinicians across the state. These communication platforms are used to share clinical protocol updates, safety advisories, medical alerts, policy changes, and continuing education opportunities that promote best practices and risk reduction.

The MIEMSS website serves as a centralized resource for infection control guidance, mental health and wellness resources, clinical alerts, and decision-support tools that help EMS clinicians deliver safe and effective patient care. During FY 2026, the Office of the State EMS Medical Director and Media Services continued to update clinical alerts with emergent issues affecting EMS operations.

Social media and electronic communications are used to rapidly disseminate critical information, including public health advisories, severe weather notifications, and protocol updates, while also highlighting safety initiatives and exemplary practices within the EMS community. Together, these communication platforms promote transparency, continual learning, and system-wide awareness, reinforcing Maryland EMS's commitment to safety and quality patient care.

Office of Integrity / Clinician Professionalism and Accountability

The Office of Integrity works to ensure the health, safety, and welfare of the public as related to the delivery of emergency medical services by Maryland-licensed and certified EMS clinicians. This ensures the quality of patient care by investigating complaints and allegations of prohibited conduct as defined by COMAR Title 30.02.04.01.

EMS Clinician Professionalism and Accountability

The Office of Integrity works closely with the State EMS Board, Attorney General's Office, Incident Review Committee (IRC), Peer-Review Panel (PRP), and EMS operational program (EMSOP) quality assurance officers statewide. The 13-member PRP consists of physicians representing the Maryland Board of Physicians, Maryland Medical Chirurgical Society, EMSOP medical directors, and clinicians representing advanced life support, basic life support, Emergency Medical Responders, and Emergency Medical Dispatchers, as well as a clinician of the same certification level as the clinician on review. After reviewing complaints, the PRP communicates the results of investigations presented by the Office of Integrity, then recommends corrective and disciplinary actions to the State EMS Board.



Office of Integrity Activity

Initial and renewal background investigations completed	11,358
Reciprocity background investigations completed	785
Total background investigations completed	12,143
IRC investigations conducted	54
IRC complaints issued	51
IRC complaints forwarded to PRP	55
Complaints forwarded to EMS Board	44



EMS Board Actions

Reprimands	9
Probation	39
Suspensions	4
Revocations	5
Remedial Training	4
Surrenders	1
Random Drug/Alcohol Testing	3
Case Resolution Conferences	7
OAH Hearings Conducted	1
OAH Hearings Defaulted	0
Settlement Agreements	6

EMS Clinician Awards (Maryland Stars of Life)

The 2026 Maryland Stars of Life Awards, presented during EMS Week, honored exceptional individuals and teams in Maryland's emergency medical services (EMS) community. These awards recognize extraordinary acts of heroism, clinical excellence, and teamwork in the line of duty.

Notable 2026 Awardees

During EMS Week 2026, MIEMSS recognized outstanding EMS clinicians, programs, and emergency services personnel whose actions exemplified excellence in emergency care, leadership, innovation, and community preparedness.

Program of the Year

Montgomery County Fire and Rescue Service was recognized for developing and implementing the Advanced Ventilator Treatment Program, which brings hospital-grade ventilatory management to the prehospital setting to improve patient outcomes.

EMS for Children (EMSC) Clinician of the Year

Paramedic Caitland Kelshaw of the Charles County Department of Emergency Services was recognized for her commitment to pediatric emergency care, EMS education, and leadership as a Pediatric EMS Champion.

EMS Clinician of the Year

Battalion Chief Peter Dugan of the Montgomery County Fire and Rescue Service was recognized for nearly 30 years of leadership, mentorship, patient advocacy, and contributions to advancing prehospital care, including whole blood initiatives.

Star of Life Award

This award recognized EMS clinicians, dispatchers, first responders, and aviation personnel whose coordinated efforts and advanced clinical care resulted in lifesaving outcomes for critically injured or ill patients. Honored incidents included severe trauma, penetrating injuries, and pediatric drowning resuscitation, highlighting the effectiveness of Maryland's Chain of Survival and multidisciplinary teamwork.



Clinician Education and Training

There are 55 educational programs across Maryland delivering EMS clinician education, which includes initial and recertification training. Programs approved by the State EMS Board include the University of Maryland Baltimore County, 12 community colleges, seven public safety training academies, the Maryland Fire and Rescue Institute (MFRI), and jurisdictional/fire station-based recertification programs. Initial certification programs for EMS clinicians include Emergency Medical Responder, Emergency Medical Technician, and Paramedic. Continuing education required for certification and licensure is offered year-round, throughout the state by EMS programs through MFRI, various academies, educational programs, conferences, seminars, and the Online Training Center.

Clinician Resources

The MIEMSS website, social media outlets, and *Maryland EMS News* serve as comprehensive resources, providing the state's EMS clinicians with essential tools and information to support their professional practice.

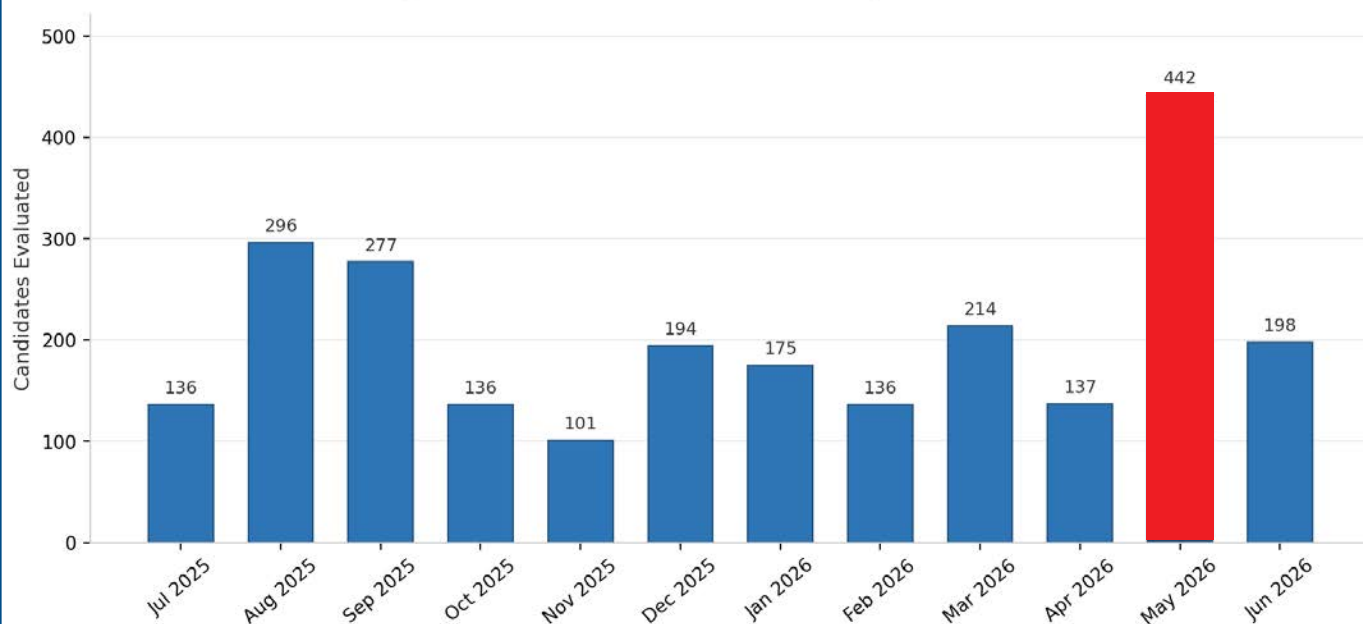
Clinical Resources and Protocols. Clinicians have immediate access to the current *Maryland Medical Protocols for Emergency Medical Services*, including regular updates, instructional videos, and supplementary guidance materials. This ensures that all clinicians have access to and can maintain current knowledge of state-approved treatment standards and clinical procedures.

Communication and Updates. Real-time alerts, protocol updates, newsletters, and public health notices keep clinicians informed about important developments affecting their practice and patient care responsibilities.

Educational Opportunities. Comprehensive listings of approved continuing education programs and online learning opportunities are available on the MIEMSS website at <https://www.miemss.org/home/ems-providers#How-To>, providing a simple way for clinicians to identify and access training that meets their professional development needs and certification requirements.

Administrative Support. Essential forms and applications for recertification, scope of practice modifications, and special waiver requests are readily accessible, streamlining administrative processes for both clinicians and their employing agencies.

EMT Psychomotor Exam Candidates by Month — FY 2026



FY 2026 total: 2,442 candidates evaluated across 185 exam sessions statewide

MIEMSS Online Training Center (OTC)

The MIEMSS Online Training Center (OTC) delivers high-quality continuing education courses and training modules that are accessible anytime and anywhere. The OTC platform has over 72,451 registered users, including nearly 20,000 active clinicians. The system hosts more than 95 active courses that include Hospital Base Station Course exams, EMT psychomotor remediation, and the ALS protocol orientation.

The OTC is integrated with the eLicensure® system, automatically giving clinicians access to their records upon course completion. This delivers timely notification of credit for immediate application towards licensure, certification, and renewal. The OTC is the primary platform for delivering essential modules to clinicians for education related to the Maryland EMS protocols, pediatric care, and base station operations.

EMS for Children Education

During FY 2026, pediatric education opportunities were expanded through continuing education programs, conferences, and specialty training focused on pediatric critical care presentations, pediatric airway management, anaphylaxis, cannabis exposure, vehicle crash assessment, injury prevention, and the care and transport of newborns and infants.

The inaugural Pediatric Ready 2026 Conference brought together more than 75 EMS clinicians, emergency nurses, physicians, advanced practice providers, and pharmacists for interdisciplinary education focused on emerging pediatric emergency care practices, simulation, and evidence-based care.

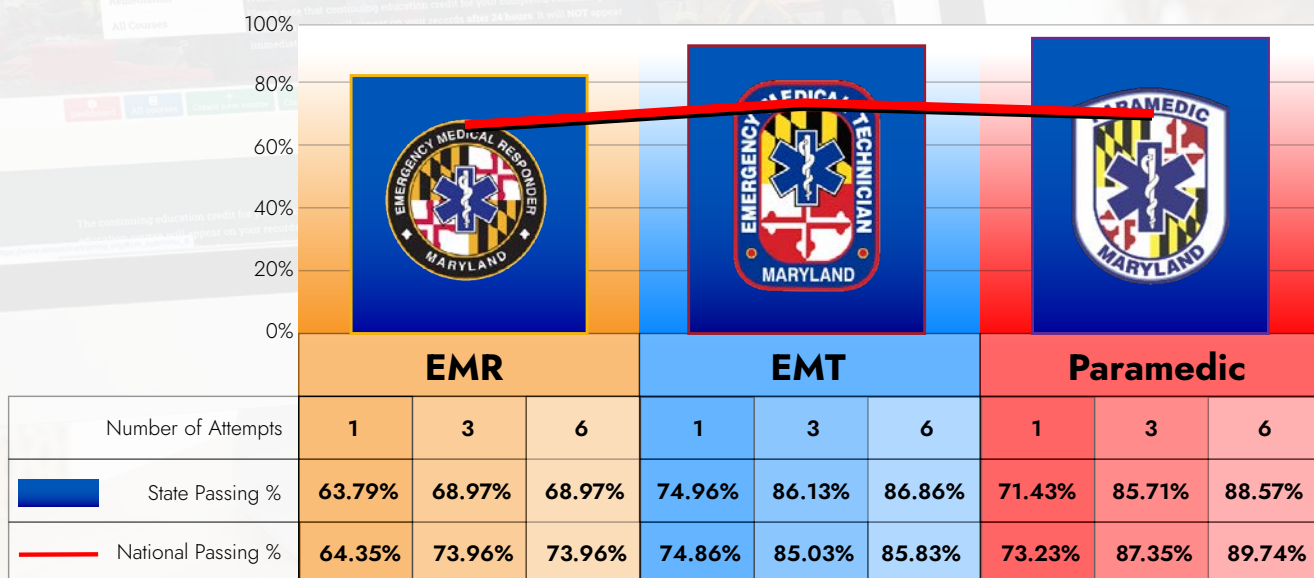
Pediatric Readiness in Emergency Departments – Pediatric Nurse and Physician Champions

Initiated in 2022, the Pediatric Readiness Emergency Department collaborative holds quarterly webinars for nurse and physician champions. This group includes the designated Pediatric Champion from each of the 52 emergency departments in Maryland along with members from the Maryland Emergency Nursing Association (ENA), the Maryland American Academy of Pediatrics (AAP), and the Maryland American College of Emergency Physicians (ACEP).

This year, Pediatric Nurse Champions attended an in-person forum that launched the Maryland Pediatric Facility Recognition program. The workshop reviewed application materials, the site-visit agenda, and shared pediatric reference tools at the forum, as well as the State ACEP annual conference in April and the ENA by the Bay conference in May. A new pediatric trauma and burn reference tool and poster were created and disseminated. Pediatric Physician Champion forums continue virtually each quarter and feature specific clinical presentation to emergency departments and provide guidance on assessment and management updates.

The EMS for Children team and faculty from pediatric specialty centers hosted a Pediatric Simulation training workshop in the winter. This event piloted six scenarios and introduced manikin and simulation monitors, provided by Maryland EMSC, for physician and nurse Pediatric Champions.

Clinician Passing State and NREMT Exams (Cumulative)



Maryland EMS Education – Conferences and Events

EMS Pediatric Champions Forums

Pediatric EMS Champions are clinicians who work within the EMS Operational Programs. These Champions are selected for their commitment and passion for pediatric care, play a key role in advancing pediatric EMS practices, and represent their communities.

Pediatric EMS Champions promote and deliver continuing education to support safety and prevention programs and promote adherence to the current pediatric care guidelines.

Champions provide local education and expand access to pediatric skill training and simulation experiences using Sim-on-the-Go equipment, aligning Maryland EMS pediatric readiness with federal performance measures. Forums were conducted to present EMS protocol updates and training tools, support statewide quality improvement, and develop additional Sim-on-the-Go scenarios and injury prevention resources.

Pediatric Emergency Department Training

The EMS for Children program provides pediatric-focused EMS and emergency department training, nursing seminars, and continuing education conferences throughout Maryland. Core topics during FY 2026 included critical field care, crash scene evaluation, airway management, anaphylaxis, cannabis exposure, and community injury prevention. Additionally, the Winterfest and Miltenberger conferences featured a full-day pre-conference curriculum on newborn care and safe maternal-infant transport. Partnering with the Johns Hopkins Children's Center and child passenger safety technicians, these hands-on sessions utilized the S.T.A.B.L.E.® framework to focus on critical post-resuscitation and stabilization care, specifically targeting sugar, temperature, airway, blood pressure, lab work, and emotional support.

Pediatric Ready Conference

An inaugural Pediatric Ready 2026 conference was launched to serve over 75 EMS clinicians, emergency nurses, emergency physicians, advanced practice providers, and pharmacists. This interdisciplinary and collaborative conference focused on education of emerging trends and best practices in pediatric emergency care. The conference strengthened collaboration across the continuum of care while advancing pediatric readiness through evidence-based education, critical thinking, and hands-on skills training.

EMS Conferences

Maryland's regional EMS advisory and education councils play a critical role in supporting EMS clinician education by coordinating training opportunities, facilitating certification and recertification requirements, and promoting continuing education throughout the state.

MIEMSS Media Services supports EMS education through the development of instructional content, online learning resources, and multimedia products in collaboration with subject matter experts. Educational materials support *The Maryland Medical Protocols for Emergency Medical Services*, emergency preparedness initiatives, hospital programs, and continuing education activities. Additionally, Media Services provides audiovisual, print, and production support for statewide conferences, seminars, and educational events.

During FY 2026, MIEMSS and its regional partners supported numerous educational conferences and professional development programs, including the Mid-Atlantic Life Safety Conference, the TidalHealth Topics in Trauma Conference, Winterfest EMS Conference, Miltenberger Emergency Services Seminar, EMS Medical Directors' Symposium, Lifesavers Conference on Roadway Safety, American College of Surgeons Maryland Committee on Trauma Point/Counterpoint Conference, Be Ready Maryland: A Family Safety Day, the Maryland Emergency Management Association Conference, and the Maryland State Firefighters Association



Annual Convention and Conference. These events provided multidisciplinary education, hands-on training, and opportunities for collaboration among EMS, healthcare, public safety, and emergency management professionals.

Additionally, MIEMSS delivered educational webinars on emerging safety and clinical topics, including child passenger safety and maternal-fetal injury prevention, providing continuing education opportunities for EMS clinicians, nurses, and other healthcare professionals.

The Maryland EMS for Children (EMSC) Program continued to provide pediatric-focused education through conferences,

seminars, and specialized training programs. Educational offerings addressed critical pediatric emergency care topics, including trauma, respiratory and diabetic emergencies, neonatal assessment, poison exposures, and injury prevention. Additionally, EMSC supported Pediatric Education for Prehospital Professionals (PEPP) courses for both ALS and BLS clinicians across Maryland.

In addition, MIEMSS represented Maryland's EMS system at numerous stakeholder events, strengthening partnerships and promoting collaboration across the public safety, healthcare, and emergency management communities.

Miltenberger Emergency Services Seminar and Conference



177 attendees



9 Firefighters, 115 EMS, and 53 Nurses



Pre-Conference Credit Hours – 6.5

Conference Credit Hours – 7.5

S.T.A.B.L.E. Pediatric Readiness – 7.75

Winterfest EMS Conference



138 attendees



60 EMTs, 62 Paramedics, and 11 Nurses



MIH Credit Hours – 6

Conference Credit Hours – 9.75

S.T.A.B.L.E. Pediatric Readiness – 7.75

**EMS clinicians complete
>500,000 education hours**

Initial EMT Training & Certification

165–220 hours of coursework to complete a program

EMT Certification Renewals

Complete 24 hours over 3 years

Those with National Registry Certification complete 40 hours over a 2-year period

Paramedic & Cardiac Rescue Technician

Complete 60 hours over 2 years

1,895 New EMTs

Increased from 1,583 in 2024

637 by reciprocity

290 New Paramedics

97 by reciprocity

Trauma and Specialty Center Clinician Education

Maryland's trauma and specialty centers play an important, system-wide role in maintaining clinician knowledge and skills. Common educational efforts include continuing education for EMS clinicians, nurses, physicians, and other healthcare professionals; trauma conferences and lectures; case reviews and feedback to referring and prehospital clinicians; simulation and hands-on training; and support for students, residents, and fellows. Centers provide nationally recognized programs such as Trauma Nursing Core Courses (TNCC), Advanced Trauma and Life Support (ATLS), Advanced Trauma Care for Nurses (ATCN), Emergency Nursing Pediatric Course (ENPC), Advanced Cardiac Life Support (ACLS), and Pediatric Advanced Life Support (PALS), and use quality-improvement findings and actual trauma cases to identify educational needs. These activities strengthen clinical competency, promote consistent evidence-based practices and reinforce coordination between prehospital and hospital clinicians. Collectively, Maryland's trauma system supports a comprehensive network of educational opportunities that promote evidence-based care, strengthen prehospital and hospital partnerships, and advance trauma expertise throughout the state and beyond.

The R Adams Cowley Shock Trauma Center has a particularly broad statewide and national educational role. In FY 2026, its Center for Critical Care Training and Education delivered 649 course sessions to 6,743 participants, including EMS clinicians, nurses, students, residents, fellows, and physicians. The center hosted 270 observers from 48 countries and provided education through EMS conferences, professional presentations, and its trauma observation program.

The Johns Hopkins Hospital supports clinician education through its integrated trauma system, with opportunities for multidisciplinary education, clinical training, and professional development. Its programs emphasize sharing trauma knowledge and best practices across the health system and with external partners.

Johns Hopkins Bayview Medical Center provides semiannual Topics in EMS conferences and additional trauma conferences for Johns Hopkins clinicians and international partners. Nursing and ancillary staff participate in programs including TNCC, advanced trauma care, mass-casualty response and disaster preparedness, and the first annual Johns Hopkins Trauma System Conference, developed in partnership with other hospitals.

University of Maryland Capital Region Medical Center supports physician and surgical education through rotating acute care surgery fellows and surgery residents from multiple institutions, including Howard University, Walter Reed National Military Medical Center, and other regional programs. Its multidisciplinary case reviews, peer reviews, and loop-closure processes contribute to ongoing clinical learning and improvement.

Sinai Hospital of Baltimore has a new weekly EMS follow-up process that allows for case closure and targeted education after high-acuity events. Advanced airway training, a bimonthly MIEMSS-approved lecture series, and TNCC education are provided to support clinicians. Internal education includes simulation, hands-on skills training and topics identified through trauma performance improvement.

Suburban Hospital combines recurring internal education with

regional professional development. The hospital hosted more than 200 EMS clinicians, nurses, advanced practice providers, and physicians at a regional educational event. This serves as a training site for prehospital clinicians through partnerships with Montgomery County EMS and Montgomery College.

UPMC Western Maryland is an education hub for Region I, offering accredited courses including ACLS, PALS, NALS, Basic Trauma Nursing, ENPC, and TNCC. The hospital provides clinical training for paramedic students from multiple programs and consistently uses a high-fidelity simulation laboratory to train hundreds of learners.

Meritus Medical Center provides education through free trauma conferences, TNCC and ENPC courses, regional EMS case reviews, and monthly trauma clinical-care conference calls. Its bi-annual trauma conferences provide continuing education to more than 300 clinicians, while monthly sessions and journal clubs support ongoing best-practice learning among hospital staff.

Peninsula Regional (TidalHealth) serves as an education resource across the Delmarva Peninsula, sponsoring its annual Topics in Trauma Conference for EMS clinicians and nurses. In FY 2026, 38 nurses completed TNCC, 75.2% of ED nurses held TNCC certification, and the center provided ALS training, paramedic recertification, and clinical education for EMS students.

Johns Hopkins Children's Center delivers specialized pediatric trauma education through monthly lectures, case reviews, and simulation for prehospital clinicians and students. The center presents a seven-hour pediatric refresher program for Baltimore City paramedics every six months, a required Pediatric Base Station course, and an online medical direction and simulation-based training for referring and regional clinicians.

Johns Hopkins Children's Center Burn Team delivers ongoing education and training for EMS clinicians, nurses, physicians, students, and other healthcare professionals. Monthly lectures, case reviews, simulation, and refresher education support pediatric trauma and burn competency, including seven hours of pediatric continuing education provided every six months for Baltimore City paramedics. JHCC offers online Pediatric Base Station education, clinical learning opportunities for paramedic students, and an interdisciplinary Pediatric Trauma Bootcamp using simulation to strengthen assessment, decision-making, and teamwork. Advanced training is made available through the Pediatric Surgery Fellowship and Advanced Burn Life Support education.

Johns Hopkins Adult Burn Center developed an extensive regional burn-education program that includes Advanced Burn Life Support, an EMS/Firefighter Burn Course, and presentations at EMS regional conferences. The center hosts clinical rotations for students in EMS, nursing, medicine, rehabilitation, psychology, and dietetics. Additionally, it offers fellowship and residency training in burn and critical care.

Children's National Hospital educates trauma and burn clinicians, nurses, EMS professionals, and community partners. Trauma and burn nurses complete eight hours of dedicated trauma education annually through certification courses and other educational programs. CNH faculty expand education through Emergency Nurses Association, EMS for Children events and extending current burn assessment and treatment practices to healthcare

professionals through Advanced Burn Life Support education.

Wilmer Eye Trauma Center provides specialized eye-trauma education across the Johns Hopkins Health System for clinicians who may encounter ophthalmic trauma as a first point of care. This year's efforts included lectures, conferences, online modules, article reviews, and new-staff orientation, supplemented by its 42nd Annual Nursing and Ophthalmic Technician Conference.

Emergency and Disaster Health Systems Department, UMBC

Housed at the University of Maryland Baltimore County (UMBC), the Department of Emergency and Disaster Health Systems (EDHS) is a center of excellence for EMS and emergency public health education and research. EDHS educates practitioners, clinicians, scholars, and leaders in community and emergency health and disaster management. It works to improve the well-being of individuals and communities and increase health equity by leading innovative research, education, policy development, practice, and service in community and emergency health and disaster management.

Many EDHS graduates have become federal, state, and local EMS leaders, physicians, medical directors, researchers, and

administrators. EDHS provides undergraduate, master's, and EDHS specialization study within a doctoral-level education to future and existing prehospital and emergency public health clinicians, emergency management, and disaster health leaders.

The Department's Professional and Continuing Education (PACE) operation provided professional education opportunities to local, regional, and national EMS responders this fiscal year. PACE's signature program, the Critical Care Emergency Medical Transport Program (CCEMTP), reached over 19,000 students through 985 courses offered at 50+ universities, community colleges, and other educational sites nationwide.

The Paramedic refresher and CCEMTP programs collaborate with University of Maryland Medical System EMS Residents and Fellows. The Pediatric and Neonatal Critical Care Transport Program (PNCCT), the pediatric equivalent of CCEMTP, has reached over 1,400 students through 114 courses across 12 sites. PACE continues its relationship with ICISF to support the CISM certification exam and CISM course offerings. PACE maintains the AHA Training Center; offers ACLS, PALS, and CPR; and serves as the State of Maryland ITLS Chapter for all ITLS courses statewide.

Hospital Education Highlights

R Adams Cowley Shock Trauma Center

649 Courses | 6,743 participants

Johns Hopkins Bayview Medical Center

Topics in EMS | Multidisciplinary/International Conferences

UM Capital Region Medical Center

Surgical fellow and resident training

Johns Hopkins Suburban Hospital

200+ clinicians at regional education event

UPMC Western Maryland

High-fidelity simulations and regional courses

Meritus Medical Center

300+ providers attended trauma conferences

Peninsula Regional (TidalHealth)

38 TNCC completions, 75.2% ED TNCC-certified

Johns Hopkins Children's Hospital

Monthly pediatric EMS education + simulation

Johns Hopkins Burn Center

ABLS + EMS/Firefighter Burn Course + fellowships

Children's National Hospital

8 hours annual trauma education for trauma/burn nurses

Johns Hopkins Wilmer Eye Institute

System-wide specialized eye-trauma education



Systems of Care

Specific systems of care refine the strategies to treat EMS patients optimally, including those with trauma, stroke, cardiac, and perinatal conditions. Each system defines appropriate EMS evaluation and treatment and indicates preferred patient receiving centers. These include trauma centers (one primary adult resource center, one level I center, four level II centers, three level III centers, two pediatric centers, a hand center, and an eye center), stroke centers (one acute stroke-ready, 31 primary stroke centers, four thrombectomy-capable stroke centers, and three comprehensive stroke centers), 24 cardiac interventional centers, one adult and two pediatric burn centers, and perinatal centers (13 level III and two level IV). Representatives from each designated specialty center actively participate in statewide quality improvement committees, initiatives, and regulation revisions to the Code of Maryland (COMAR) Title 30.

Office of Care Integration

The MIEMSS Office of Care Integration (OCI) ensures that Maryland's trauma and specialty care centers are properly designated and maintain the necessary standards and high levels of quality patient care. On-site verification of programs is conducted to ensure hospital programs operate to the specification of their designation (e.g., Level I, Level II, Level III) and meet the criteria necessary to maintain their designation(s).

Designation and verification processes for trauma and specialty referral centers require continuing evaluation to comply with the Code of Maryland Regulations (COMAR 30.08 et seq.) MIEMSS conducts periodic reviews with a growth-oriented mindset, and OCI leadership provides coaching, mentoring, and education. These activities, along with ongoing quality assurance and monitoring, make the Maryland trauma and specialty care system superior.

	Trauma Center Quarterly Site Visits	64
	Hospital Coaching Visits	48
	Burn/Trauma Consultation Visits	5
	Educational Lectures Presented	24
	EMS Agencies Mentored	13

Trauma Centers

The Maryland trauma system is designed regionally to provide timely access to the appropriate level of care based on a patient's injury severity. The system includes nine designated adult trauma centers and five specialty trauma center designations: pediatric

trauma, adult burn, pediatric burn, eye trauma, and hand/upper extremity trauma.

All Maryland adult and pediatric trauma centers submit data to the National Trauma Data Bank (NTDB), providing valuable benchmarking against trauma centers nationwide. MIEMSS teams partner with Maryland's trauma centers to analyze NTDB data, support statewide quality improvement, and compare clinical outcomes with national performance benchmarks.

Cardiac Intervention Centers

Hospitals meeting Maryland's standards for the treatment of ST-Elevation Myocardial Infarction (STEMI) are designated as Cardiac Intervention Centers (CICs). Maryland's cardiac system includes 24 designated CICs and four out-of-state CICs serving Maryland patients. These centers provide timely access to primary percutaneous coronary intervention (PCI), the guideline-recommended treatment to restore blood flow and improve outcomes for patients experiencing STEMI.

All CICs submit data to the American Heart Association Get With The Guidelines®—Coronary Artery Disease Registry, which are used to monitor statewide performance, evaluate evidence-based quality measures, and identify opportunities for improvement. In CY 2025, Maryland achieved primary PCI within 90 minutes of arrival at a designated CIC for 95.2% of eligible STEMI patients. Among patients transported by EMS, 74.8% achieved first medical contact-to-PCI within 90 minutes, and cardiac catheterization laboratories were activated prior to patient arrival in 77.0% of cases, reflecting strong collaboration between EMS and hospital teams.

During FY 2026, efforts continued to strengthen Maryland's Cardiac System of Care through expanded stakeholder collaboration, quality improvement initiatives, and refinement of CIC designation standards. The Maryland Cardiac Center Consortium (MC3) and Maryland Cardiac Quality Improvement Council (MC-QIC) brought together cardiac care leaders, clinicians, EMS partners, and state stakeholders to identify priorities, share best practices, and advance statewide improvements.

OCI also conducted 31 annual CIC check-in visits and participated in five EMS-led CIC site visits to provide technical assistance, support quality improvement efforts, and strengthen coordination between hospitals and EMS agencies across Maryland's STEMI system of care.

Perinatal and Neonatal Programs

Maryland's perinatal and neonatal systems follow care standards established by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP), with designations ranging from Level I (basic care) to Level IV (high-risk care). MIEMSS oversees Level III and Level IV perinatal and neonatal referral centers, including 15 hospitals providing obstetric services—13 Level III centers and two Level IV centers.

Designated Trauma Center Categorization

Differences in Standards Based on Physician Availability and Dedicated Resources	PARC	Level I	Level II	Level III
For the “most critical patients”, an in-house fellowship-trained attending trauma surgeon, trauma fellow, or trauma equivalent/PGY5+ general surgery resident should be at the bedside upon arrival, documented at least 80% of the time.	X			
Dedicated facilities (Resuscitation Unit, Operating Room, and Intensive Care Unit) 24 hours a day	X			
Facilities (Resuscitation Area, Operating Room, and Intensive Care Unit) 24 hours a day		X	X	X
Trauma Surgeon available in-house at all times shall be at the bedside within 15 minutes of call request, documented at least 80% of the time		X	X	
On-call Trauma Surgeon shall be at the bedside within 30 minutes of call request, documented at least 80% of the time of call request				X
Anesthesiologist in-house dedicated 24 hours a day to trauma care, should be at the bedside upon arrival, documented at least 80% of the time	X			
Anesthesiologist in-house at all times but shared with other services and shall be at the bedside within 15 minutes of call request		X	X	X
Orthopedic Surgeon in-house at all times and dedicated to trauma care	X	X		
Orthopedic Surgeon on-call shall be at the bedside within 30 minutes of call request, documented at least 80% of the time of call request			X	X
Neurosurgeon in-house at all times and dedicated to trauma care	X			
Neurosurgeon in the hospital at all times but shared with other services		X		
Neurosurgeon on-call shall be at the bedside within 30 minutes of call request, documented at least 80% of the time of call request			X	X
A designated fellowship-trained/board-certified in surgery or critical care surgical director of the Intensive Care Unit	X	X	Desired	
An organized trauma research program with a designated physician director and documented research plan	X	X		
Education – Fellowship Training in Trauma	X			
Surgical Residency Program	X	X		
Injury Prevention and Public Education Program	X	X	X	X

These referral centers use annual quality reports to evaluate clinical excellence, patient safety, and reliability while identifying opportunities to reduce preventable adverse outcomes. Regional and national data support monitoring of maternal and infant health indicators, and the MIEMSS Perinatal Advisory Committee meets quarterly to establish improvement priorities and promote best practices.

To improve maternal outcomes and reduce preventable deaths, MIEMSS supports EMS education focused on recognizing life-threatening perinatal conditions and providing culturally re-

sponsive care. During this reporting period, MIEMSS and perinatal program leaders developed and published an EMS educational video and Online Learning Center module focused on maternal care.

Additionally, MIEMSS completed 26 on-site visits with perinatal programs to provide coaching, mentoring, support patient care improvement efforts, and prepare centers for re-designation. In FY 2026, perinatal program leaders shared best practices through five nationally recognized conferences and six regional and national presentations.

Stroke Centers

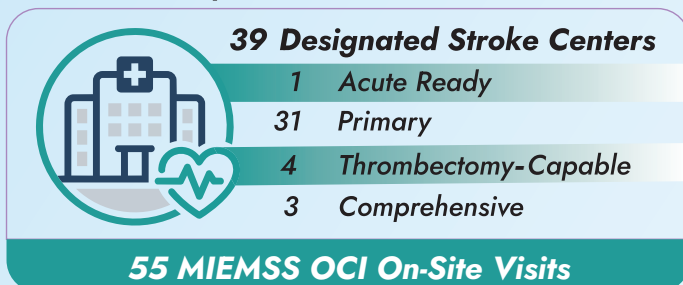
The Office of Care Integration (OCI) supports the continued advancement of stroke care across Maryland by promoting evidence-based practices, quality improvement, and collaboration among designated stroke centers. The Stroke Quality Improvement Committee (Stroke QIC), comprised of stroke program coordinators and medical directors from Maryland hospitals, leads statewide initiatives to improve stroke care and support evolving best practices.

During FY 2026, OCI supported updates to COMAR regulations for acute stroke-ready, primary, thrombectomy-capable, and comprehensive stroke center designations. Two primary stroke centers and one comprehensive stroke center renewed their designations, bringing the statewide total to 31 primary stroke centers, one acute stroke-ready center, three comprehensive stroke centers, and four thrombectomy-capable stroke centers.

Maryland stroke centers submit data monthly to the American

Heart Association (AHA) Get With The Guidelines®–Stroke Registry. OCI uses this data to evaluate performance, benchmark compliance with AHA/American Stroke Association (ASA) standards, and identify opportunities for improvement. In CY 2025, Maryland stroke centers achieved 88.7% or higher compliance across all core performance measures, exceeding the national 80% benchmark.

Maryland Stroke Care 2026



Stroke Core Measures (5-Year Comparison)

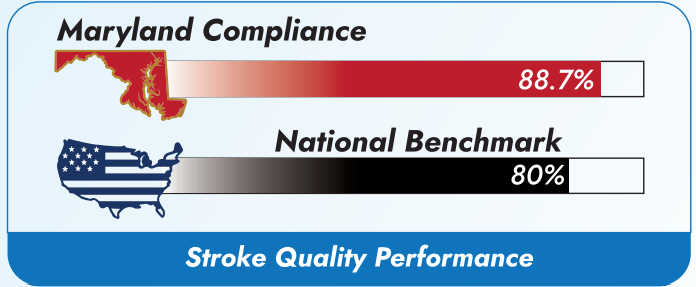
Core Measure	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
Percent of ischemic stroke patients who arrive at the hospital within 2 hours of time last known well and for whom IV t-PA is initiated within 3 hours of time last known well	91.8%	91.2%	91.8%	93.7%	94.8%
Percent of patients with ischemic stroke or TIA who receive antithrombotic therapy by the end of hospital day two	97.7%	97.5%	97.8%	93.9%	97.5%
Percent of patients with an ischemic stroke, or hemorrhagic stroke, who receive VTE prophylaxis the day of or the day after hospital admission	97.3%	97.6%	97.7%	97.7%	98.2%
Percent of patients with an ischemic stroke or TIA prescribed antithrombotic therapy at discharge	99.4%	99.6%	99.6%	100%	99.4%
Percent of patients with an ischemic stroke or TIA with atrial fibrillation/flutter discharged on anticoagulation therapy	97.8%	98.5%	96.8%	97.9%	98.3%
Percent of patients with ischemic or hemorrhagic stroke, or TIA with a history of smoking cigarettes, who are, or whose caregivers are, given smoking cessation advice or counseling during hospital stay	98.6%	99.1%	99.2%	90.9%	98.5%
Percent of ischemic stroke or TIA patients with a cholesterol LDL level=100, or LDL not measured, or on cholesterol-reducer prior to admission who are discharged on statin medication	99.0%	99.3%	95.9%	93.9%	97.9%
Percent of stroke patients who undergo screening for dysphagia (difficulty swallowing) with an evidence-based bedside testing protocol approved by the hospital before being given any food, fluids, or medication by mouth	89.8%	90.0%	88.4%	73.5%	88.7%
Percent of patients with stroke or TIA, or their caregivers, who were given education and/or educational materials during the hospital stay addressing all of the following: personal risk factors for stroke, warning signs for stroke, activation of emergency medical system, the need for follow-up after discharge, and medications prescribed	96.8%	96.4%	93.2%	87.9%	97.0%
Percent of patients with stroke who were assessed for rehabilitation services	99.4%	99.6%	98.8%	98.9%	99.5%

Source: Get With the Guidelines-Stroke Registry

IV t-PA = Intravenous Tissue Plasminogen Activator
VTE = Venous Thromboembolism
LDL = Low Density Lipoprotein (bad cholesterol)
TIA = Transient Ischemic Attack

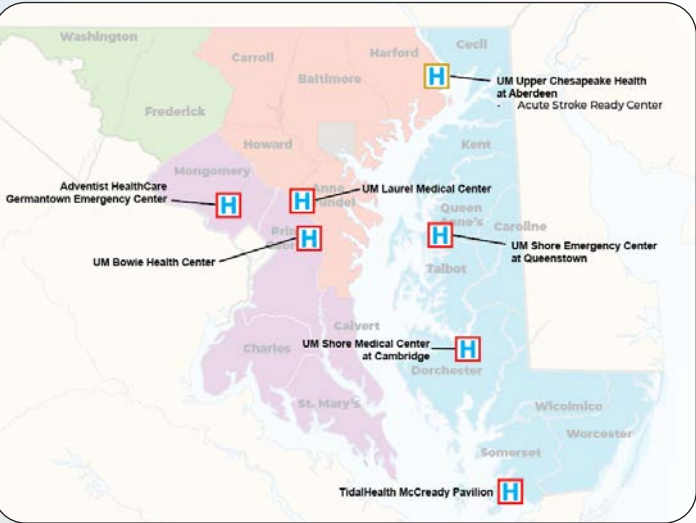
Data-driven improvement efforts contributed to faster stroke treatment times. In CY 2025, Maryland’s median door-to-needle time for intravenous tissue plasminogen activator (IV t-PA) was 45.8 minutes, with 88.7% of eligible acute ischemic stroke patients receiving treatment within the recommended 60-minute standard.

During this reporting period, OCI conducted approximately 55 on-site visits to support stroke centers through coaching, mentoring, and quality improvement consultation. Additionally, the OCI stroke team continued to share best practices through local, regional, and national education programs and conferences.



Freestanding Emergency Medical Facilities

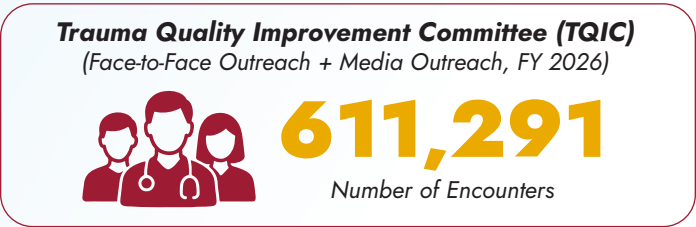
Freestanding Emergency Medical Facilities (FEMF) are licensed facilities that are structurally separate and distinct from a hospital and provide emergency care. FEMFs differ from hospitals in that they do not provide inpatient care. FEMFs are required to have specific medical equipment and staffing available for trauma care.



Trauma Care Improvement

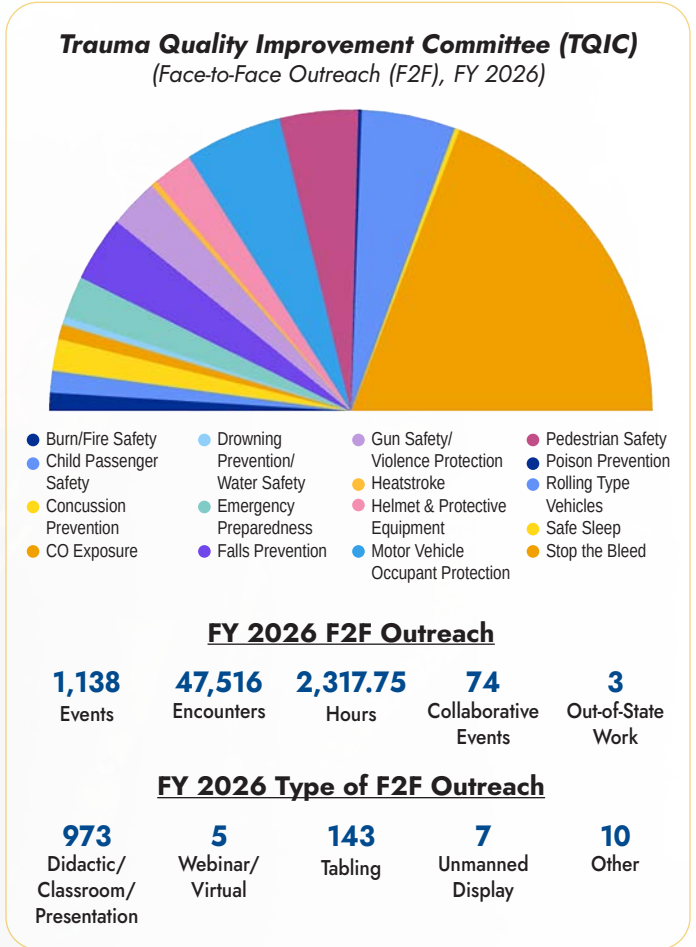
The Maryland Trauma Quality Improvement Committee (TQIC) brings together trauma leaders, performance improvement staff, registrars, and injury prevention professionals to monitor statewide trauma system performance. The committee reviews trends and compliance with key quality indicators, including documentation of Glasgow Coma Scale assessments, pain assessments, unplanned operating room visits, trauma bypass hours, and other performance measures.

In collaboration with ESO Solutions, Inc., trauma, burn, eye, hand, and upper extremity registries have been integrated with eMEDS® patient care records to enhance data quality and support statewide performance improvement efforts.



The Maryland Burn Collaborative analyzes burn registry data, audit indicators, and performance measures to improve burn care across the state. The Burn Center Scorecard tracks statewide compliance with critical quality indicators and supports ongoing improvements in burn care practices and EMS protocols.

During this reporting year, TQIC and the Burn Collaborative used Maryland Trauma Registry data to identify injury prevention priorities. Designated trauma, burn, hand, and eye centers participated in statewide initiatives addressing injury prevention topics including Stop the Bleed®, falls, firearm and interpersonal violence, bicycle and pedestrian safety, motor vehicle safety, child passenger safety, drowning prevention, concussion prevention, and burn prevention.



See page 83 for additional TQIC data.

Maryland Trauma and Specialty Referral Centers

TRAUMA CENTERS

(For explanation of differences in levels, see Trauma Center Categorization chart on page 31)

Primary Adult Resource Center

- R Adams Cowley Shock Trauma Center (UM)

Adult Level I Trauma Center

- The Johns Hopkins Hospital

Adult Level II Trauma Centers

- Bayview Medical Center (JHM)
- Capital Region Medical Center (UM)
- Sinai Hospital of Baltimore (LifeBridge)
- Suburban Hospital (JHM)

Adult Level III Trauma Centers

- Meritus Medical Center
- Peninsula Regional (TidalHealth)
- UPMC Western Maryland

Pediatric Level I Trauma Center

- The Johns Hopkins Children's Center

Adult Burn Center

- Bayview Medical Center (JHM)

Pediatric Burn Center

- The Johns Hopkins Children's Center

Eye Trauma Center

- The Johns Hopkins Wilmer Eye Institute

Hand and Upper Extremity Trauma Center

- Union Memorial Hospital (MedStar)

Neurotrauma Center

- R Adams Cowley Shock Trauma Center (UM)

Out-of-State Trauma Centers (MOUs)

- Children's National Hospital
- Christiana Hospital (ChristianaCare)
- Washington Hospital Center (MedStar)

Out-of-State Burn Centers

- Children's National Hospital
- Washington Hospital Center (MedStar)

CARDIAC INTERVENTION CENTERS

Cardiac Intervention Centers

- Anne Arundel Medical Center (Luminis)
- Baltimore Washington Medical Center (UM)
- Bayview Medical Center (JHM)
- Capital Region Medical Center (UM)
- Carroll Hospital (LifeBridge)
- Franklin Square Medical Center (MedStar)
- Frederick Health Hospital
- Holy Cross Hospital
- Howard County Medical Center (JHM)
- Meritus Medical Center

- Peninsula Regional (TidalHealth)
- Shady Grove Medical Center (Adventist HealthCare)
- Shore Medical Center at Easton (UM)
- Sinai Hospital of Baltimore (LifeBridge)
- Southern Maryland Medical Center (MedStar)
- St. Agnes Medical Center (Ascension)
- St. Joseph's Medical Center (UM)
- Suburban Hospital (JHM)
- The Johns Hopkins Hospital
- Union Memorial Hospital (MedStar)
- University of Maryland Medical Center
- Upper Chesapeake Medical Center (UM)
- UPMC Western Maryland
- White Oak Medical Center (Adventist HealthCare)

Out-of-State Cardiac Intervention Centers

- Bayhealth Hospital, Kent Campus
- Christiana Hospital (ChristianaCare)
- TidalHealth Nanticoke
- Washington Hospital Center (MedStar)

STROKE CENTERS

Comprehensive Stroke Centers

- Franklin Square Medical Center (MedStar)
- The Johns Hopkins Hospital
- University of Maryland Medical Center

Thrombectomy-Capable Stroke Centers

- Bayview Medical Center (JHM)
- Shady Grove Medical Center (Adventist HealthCare)
- Sinai Hospital of Baltimore (LifeBridge)
- Suburban Hospital (JHM)

Primary Stroke Centers

- Anne Arundel Medical Center (Luminis)
- Atlantic General Hospital
- Baltimore Washington Medical Center (UM)
- CalvertHealth Medical Center
- Capital Region Medical Center (UM)
- Carroll Hospital Center (LifeBridge)
- Charles Regional Medical Center (UM)
- Doctor's Community Hospital (Luminis)
- Frederick Health Hospital
- Good Samaritan Hospital (MedStar)
- Greater Baltimore Medical Center
- Harbor Hospital (MedStar)
- Holy Cross Hospital – Germantown
- Holy Cross Hospital – Silver Spring
- Howard County Medical Center (JHM)
- Mercy Medical Center
- Meritus Medical Center
- Midtown Campus (UM)
- Montgomery Medical Center (MedStar)
- Northwest Hospital (LifeBridge)
- Peninsula Regional (TidalHealth)
- Saint Agnes Health (Ascension)

- Saint Joseph Medical Center (MedStar)
- Saint Mary's Hospital (MedStar)
- Shore Medical Center at Easton (UM)
- Southern Maryland Hospital Center (MedStar)
- Union Hospital (ChristianaCare)
- Union Memorial Hospital (MedStar)
- Upper Chesapeake Medical Center (UM)
- UPMC Western Maryland
- White Oak Medical Center (Adventist HealthCare)

Acute Stroke Ready Centers

- Upper Chesapeake Medical Center at Aberdeen (UM)

PERINATAL AND NEONATAL REFERRAL CENTERS

- Anne Arundel Medical Center (Luminis)
- Capital Region Medical Center (UM)
- Frederick Health Hospital
- Greater Baltimore Medical Center
- Holy Cross Hospital – Silver Spring
- Howard County Medical Center (JHM)
- Mercy Medical Center
- Saint Agnes Health (Ascension)
- Saint Joseph Medical Center (UM)
- Shady Grove Medical Center (Adventist HealthCare)
- Bayview Medical Center (JHM)
- Sinai Hospital of Baltimore (LifeBridge)
- Franklin Square Medical Center (MedStar)
- The Johns Hopkins Hospital
- University of Maryland Medical Center

POISON CONSULTATION CENTER

- Maryland Poison Center, UM School of Pharmacy

Adult Trauma Centers

Maryland's trauma system is designed to provide timely access to specialized care and improve outcomes for injured patients. The statewide network includes the R Adams Cowley Shock Trauma Center as the Primary Adult Resource Center, designated Level I-IV trauma centers, and specialty referral partnerships with MedStar Washington Hospital Center, ChristianaCare, and Children's National Hospital to ensure access to higher-level trauma services in border and remote regions. Data collected through the Maryland State Trauma Registry informs quality initiatives, research, and performance evaluation that strengthen trauma care statewide.

R Adams Cowley Shock Trauma Center Primary Adult Resource Center

The R Adams Cowley Shock Trauma Center (RACSTC), located within the University of Maryland Medical Center, serves as the state's Primary Adult Resource Center. As a multidisciplinary clinical, educational, and research institution, RACSTC is dedicated to world-class standards in the prevention and management of critical injury and illness.

RACSTC provides leadership within Maryland's statewide trauma system by delivering specialized care for critically injured patients and supporting trauma system improvement initiatives. From June 1, 2025, through May 31, 2026, RACSTC treated 6,145 primary trauma patients reported through the Maryland State Trauma Registry. During this period, 83% of patients arrived by ground transportation and 17% arrived by air. The majority of patients admitted were male (64%), with patients aged 56 years and older representing the largest age group (43%).

The GO-TEAM at RACSTC continues to serve as a specialized component of Maryland's EMS system, bringing advanced physician-led trauma care, rescue, stabilization, and critical care

capabilities directly to patients in complex environments. In FY 2026, the GO-TEAM responded to 14 activations, including five patient retrievals, and participated in statewide training activities to strengthen partnerships with EMS agencies and improve pre-hospital care.

RACSTC maintains a comprehensive quality management program focused on evaluating care across the continuum, from prehospital consultation through hospital outcomes. Quality improvement initiatives during FY 2026 included efforts to improve outcomes for older trauma patients, reduce length of stay, decrease venous thromboembolism events, and strengthen post-discharge follow-up through programs such as the Trauma Survivors Network.

The Center for Hyperbaric and Dive Medicine serves as Maryland's statewide referral center for patients requiring hyperbaric oxygen therapy, including those experiencing decompression illness, carbon monoxide poisoning, gas embolism, smoke inhalation injuries, radiation-related injuries, diabetic wounds, and severe infections. The internationally recognized center is the only 24/7 critical care-capable hyperbaric chamber in the region. In FY 2026, the Center provided 5,707.5 hours of therapeutic hyperbaric oxygen treatment, supporting both inpatient and outpatient care. The program maintained Accreditation with Distinction from the Undersea and Hyperbaric Medical Society and continued participation in research initiatives, including the Hyperbaric Oxygen Brain Injury Trial (HOBIT).

Level I Adult Trauma Centers

The Johns Hopkins Hospital (JHH) is a designated Level I Adult Trauma Center, providing comprehensive trauma care for Baltimore City, surrounding counties, and patients across Maryland. Through an integrated trauma model encompassing clinical care, injury prevention, violence intervention, education, research, and quality improvement, JHH supports the goals of MIEMSS Vision

R Adams Cowley Shock Trauma Center

6,145

Primary Trauma Patients



43%

Age 56 and above

Patient Gender



64%
Male



36%
Female

Arrival by Transport



83%
GROUND



17%
AIR

2030 while strengthening trauma care throughout the region.

JHH continues to strengthen an integrated trauma system that supports patients throughout the continuum of care—from injury prevention and emergency response to rehabilitation and long-term recovery. In CY 2025, JHH treated 3,118 trauma patients, reflecting sustained growth and continued investment in trauma system infrastructure, registry modernization, performance improvement, and coordinated care across the Johns Hopkins Health System.

The trauma program expanded multidisciplinary performance improvement processes, strengthened transfer reliability, improved discharge continuity, and advanced collaboration through statewide participation in the Maryland Trauma Quality Improvement Committee (TQIC). The Trauma Survivors Network further enhanced continuity of care through peer support, survivor mentorship, and coordinated recovery services for patients and families.

Level II Adult Trauma Centers

Johns Hopkins Bayview Medical Center (JHBMC) is a designated Level II Adult Trauma Center serving eastern Baltimore City, eastern Baltimore County, Harford County, and Cecil County. JHBMC Emergency Department evaluated more than 5,000 trauma patients entered into the Maryland State Trauma Registry, making it one of Maryland’s busiest trauma centers. Adult trauma services are provided through the Johns Hopkins University School of Med-

icine Division of Acute Care Surgery, which delivers coordinated physician coverage across both Johns Hopkins Bayview Medical Center and The Johns Hopkins Hospital, enhancing regional access to trauma expertise. During FY 2026, JHBMC expanded care for older trauma patients through the development of a geriatric trauma order set and a standardized hip fracture pathway, supporting consistent, evidence-based care across the trauma system. JHBMC provided ongoing compliance with MIEMSS designation requirements, participation in the Maryland State Trauma Registry, and implementation of evidence-based clinical pathways that align with state and national trauma standards. The medical center’s American College of Surgeons designation as a Geriatric Surgery Verified Center of Excellence reflects its commitment to the care of older adult patients.

Sinai Hospital of Baltimore (LifeBridge Health) cared for 3,806 trauma patients in FY 2026, reflecting a 60.6% increase in patient volume since FY 2023. Continued investments in trauma registry staffing, quality infrastructure, and clinical resources have strengthened the hospital’s ability to support evidence-based care, performance improvement, and statewide trauma reporting. Sinai expanded its trauma capabilities through its Whole Blood Without Borders program, distributing more than 300 units of low-titer O positive (O+) whole blood to participating EMS agencies while supporting 120 prehospital transfusions for 95 patients with zero product waste. The program received international recognition as a model for trauma system innovation. The Emergency Depart-

Adult Trauma Center Statistics

Age Distribution of Patients: Patients Treated at Pediatric or Adult Trauma Centers (3-Year Comparison)			
Age Range	June 2023 to May 2024	June 2024 to May 2025	June 2025 to May 2026
Under 1 Year	275	243	279
1 to 4 Years	591	590	747
5 to 9 Years	673	787	982
10 to 14 Years	867	929	1,076
15 to 24 Years	3,672	3,549	3,723
25 to 44 Years	6,993	7,304	7,015
45 to 64 Years	5,702	5,834	5,830
65+ Years	11,666	13,523	14,499
Unknown	4	3	5
TOTAL	30,443	32,762	34,156

Source: Maryland State Trauma Registry
Note: For children who were burn patients at Children’s National Hospital or Johns Hopkins Pediatric Trauma Center, see Maryland Pediatric Burn Statistics.

Total Cases Reported by Trauma Centers (3-Year Comparison)			
Trauma Center	June 2023 to May 2024	June 2024 to May 2025	June 2025 to May 2026
JHBMC	3,634	5,308	5,094
JHH	2,835	3,129	3,229
Meritus	3,838	3,708	3,762
PRMC	2,662	3,154	3,296
Cap Region	3,245	2,471	2,302
RACSTC	5,922	5,722	5,602
Sinai	2,653	3,111	3,765
Suburban	2,508	2,893	3,051
UPMC	985	1,137	1,259
TOTAL	28,282	30,633	31,360

Source: Maryland State Trauma Registry

Adult Trauma Center Legend

JHBMC — Johns Hopkins Bayview Medical Center
JHH — The Johns Hopkins Hospital
Meritus — Meritus Medical Center

PRMC — Peninsula Regional (TidalHealth)
Cap Region — University of Maryland Capital Region Medical Center
RACSTC — R Adams Cowley Shock Trauma Center

Sinai — Sinai Hospital of Baltimore
Suburban — Suburban Hospital (Johns Hopkins Medicine)
UPMC — UPMC Western Maryland

ment added new ambulance access, expanded trauma resuscitation capacity, and enhanced the EMS lounge to strengthen emergency readiness and support for EMS. During FY 2026, the trauma program expanded care pathways for geriatric patients, strengthened multidisciplinary performance improvement processes, and integrated rehabilitation services. The trauma program completed enrollment in the American College of Surgeons Trauma Quality Improvement Program (TQIP), enhancing national benchmarking and performance evaluation. Registry infrastructure was expanded to support growing patient volumes while improving data quality, abstraction, validation, and reporting. During FY 2026, the hospital received approximately \$495,000 through the Maryland Health Care Commission Trauma Equipment Grant Program, supporting investments in trauma equipment, injury prevention, rehabilitation, staff education, and quality improvement initiatives that enhance trauma system readiness across the region.

University of Maryland Capital Region Medical Center (Cap Region) treated 2,296 trauma patients. Its modern trauma facility includes a dedicated trauma resuscitation unit, specialized operating rooms, and a multidisciplinary Acute Care Surgery team. Cap Region continued to strengthen patient outcomes through a multidisciplinary quality management program that emphasizes peer review, performance improvement, and evidence-based clinical practice. Cap Region provides coordinated trauma care through collaboration among trauma surgeons, rehabilitation specialists, nursing, and allied health professionals. Early mobilization and coordinated discharge planning remain priorities. Physical Medicine and Rehabilitation teams working alongside Acute Care Surgery to improve functional recovery and support successful transitions from hospital to home. This fiscal year, the medical center continued expanding specialized services, including its Sickie Cell Clinic to improve access to comprehensive care for patients.

Suburban Hospital (Johns Hopkins Medicine) treated more than 3,000 trauma patients during FY 2026. The trauma program

expanded regional system capabilities through its partnership with Montgomery County Fire and Rescue Service to support the Montgomery County Prehospital Whole Blood Program, helping ensure rapid access to lifesaving blood products for patients with severe hemorrhage. Suburban renewed its partnership with Adventist HealthCare Rehabilitation Center to support seamless transitions to post-acute rehabilitation services and joined the Trauma Survivors Network, further enhancing long-term recovery resources for trauma patients and their families. Suburban strengthened its performance improvement program through comprehensive multidisciplinary review of every trauma patient encounter to evaluate outcomes, identify opportunities for improvement, and ensure adherence to evidence-based practices. In March 2026, the trauma center joined the American College of Surgeons Trauma Quality Improvement Program (TQIP), enabling national benchmarking and data-driven performance evaluation to further improve trauma care.

Level III Adult Trauma Centers

UPMC Western Maryland serves Allegany and Garrett Counties and surrounding communities in Pennsylvania and West Virginia, providing coordinated trauma care across a rural, tri-state region and treated 1,258 trauma patients during this evaluation period. The program supports regional trauma system development through active participation in numerous local, regional, and statewide committees, including the MIEMSS Region I EMS Advisory Council, Maryland Trauma Center Network, Maryland EMS Protocol Revision Team for Trauma, and the MIEMSS Region I Prehospital Care and Quality Improvement Committee. These collaborative efforts strengthen trauma system coordination, protocol development, and patient care throughout Western Maryland. The hospital's Comprehensive Inpatient Rehabilitation Unit provides individualized rehabilitation services and coordinated discharge planning that supports patients throughout their recovery.

 Number of Injuries by Age (3-Year Comparison)			
Age Range	June 2023 to May 2024	June 2024 to May 2025	June 2025 to May 2026
Under 1 Year	71	77	73
1 to 4 Years	145	185	180
5 to 14 Years	299	406	413
15 to 24 Years	3,404	3,303	3,346
25 to 44 Years	6,991	7,302	7,014
45 to 64 Years	5,702	5,834	5,830
65+ Years	11,666	13,523	14,499
Unknown	4	3	5
TOTAL	28,282	30,633	31,360

Source: Maryland State Trauma Registry

Note: Only pediatric patients that were treated at adult trauma centers are included in this table. For patients treated at the pediatric trauma centers, see Pediatric Trauma Statistics.

 Number of Deaths by Age (3-Year Comparison)			
Age Range	June 2023 to May 2024	June 2024 to May 2025	June 2025 to May 2026
Under 1 Year	0	0	1
1 to 4 Years	2	1	0
5 to 14 Years	4	9	6
15 to 24 Years	101	70	54
25 to 44 Years	195	207	133
45 to 64 Years	153	130	95
65+ Years	354	356	351
Unknown	2	0	0
TOTAL	811	773	640
Deaths Overall as a % of Total Injuries Treated	2.9%	2.5%	2.0%

Source: Maryland State Trauma Registry

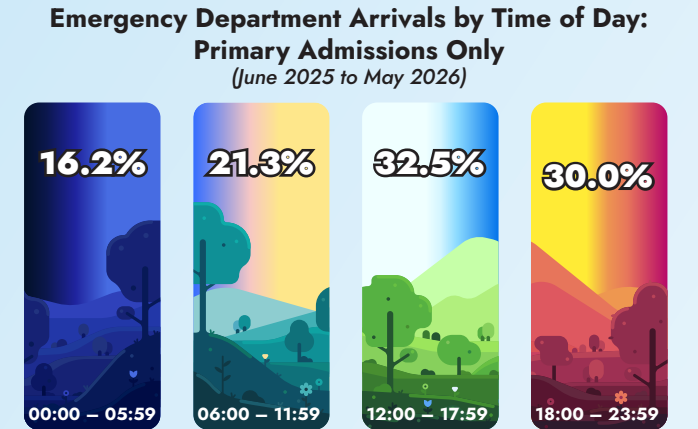
Note: Only pediatric patients that were treated at adult trauma centers are included in this table. For patients treated at the pediatric trauma centers, see Pediatric Trauma Statistics.

Peninsula Regional (TidalHealth) serves Maryland’s Eastern Shore and the Delmarva Peninsula, providing coordinated trauma services to patients from Maryland, Delaware, and Virginia and treated 3,294 trauma patients during this reporting period. The program continued to strengthen regional trauma system coordination through close collaboration with EMS agencies, community partners, and healthcare organizations. Performance monitoring initiatives, including EMS on-scene and emergency department off-load times, support ongoing improvements in patient flow, prehospital care, and system efficiency. The addition of a dedicated Trauma Quality Specialist in FY 2026 strengthened the Trauma Performance Improvement and Patient Safety (PIPS) program through real-time case review, multidisciplinary collaboration, trauma debriefings, and improved quality monitoring. The trauma program implemented standardized trauma carts to improve readiness and expedite care for critically injured patients in the emergency department and intensive care unit.

Meritus Medical Center serves Washington and Frederick Counties in Maryland, southern Pennsylvania, and the eastern panhandle of West Virginia. Driven by its mission to “Improve the Health of the Community” by delivering expert care, Meritus provides 24/7 comprehensive trauma care through an in-house team of surgeons, advanced practice providers, and nurses, with dedicated trauma bays, a 24/7 operating room and Interventional Radiology, a Surgical/Trauma ICU, and access to a broad range of surgical subspecialists. During FY 2026, Meritus treated more than 3,800 trauma patients, including approximately 1,900 admissions and 60 patients taken directly to the operating room for bleeding control. Meritus handles the highest volume of trauma patients in the Western Maryland region. The program strives to reduce out-of-facility transfers, ensuring patients receive the specialized trauma care they need, and closer to home.

Out-of-State Trauma Centers

MedStar Washington Hospital Center is an American College of Surgeons-verified Level I Adult Trauma Center serving as a regional referral center for critically injured patients from the District of Columbia, Maryland, Virginia, Delaware, Pennsylvania, and surrounding areas. During the reporting period, MedStar treated 2,020 trauma patients, supporting Maryland’s statewide trauma system through regional collaboration and specialty referral capabilities.



Source: Maryland State Trauma Registry
Note: “Primary Admissions” refers to all patients except those treated and released from the emergency department within six hours of emergency department arrival.

Final Disposition of Patients Primary Admissions Only (3-Year Comparison)			
Final Disposition	June 2023 to May 2024	June 2024 to May 2025	June 2025 to May 2026
Inpatient Rehab Facility	8.8%	8.8%	8.7%
Skilled Nursing Facility	13.6%	13.5%	14.1%
Residential Facility	0.9%	0.8%	0.5%
Specialty Referral Center	4.1%	3.6%	2.4%
Home with Services	9.7%	10.0%	10.1%
Home	50.8%	51.9%	52.9%
Acute Care Hospital	2.0%	2.0%	2.7%
Left Against Medical Advice	2.3%	2.3%	2.1%
Morgue/Died	3.9%	3.5%	2.8%
Hospice Care	1.2%	1.2%	1.2%
Jail	1.0%	0.7%	0.8%
Psychiatric Hospital	1.1%	1.0%	1.0%
Elopement	0.5%	0.5%	0.5%
Other	0.1%	0.2%	0.2%
TOTAL	100.0%	100.0%	100.0%

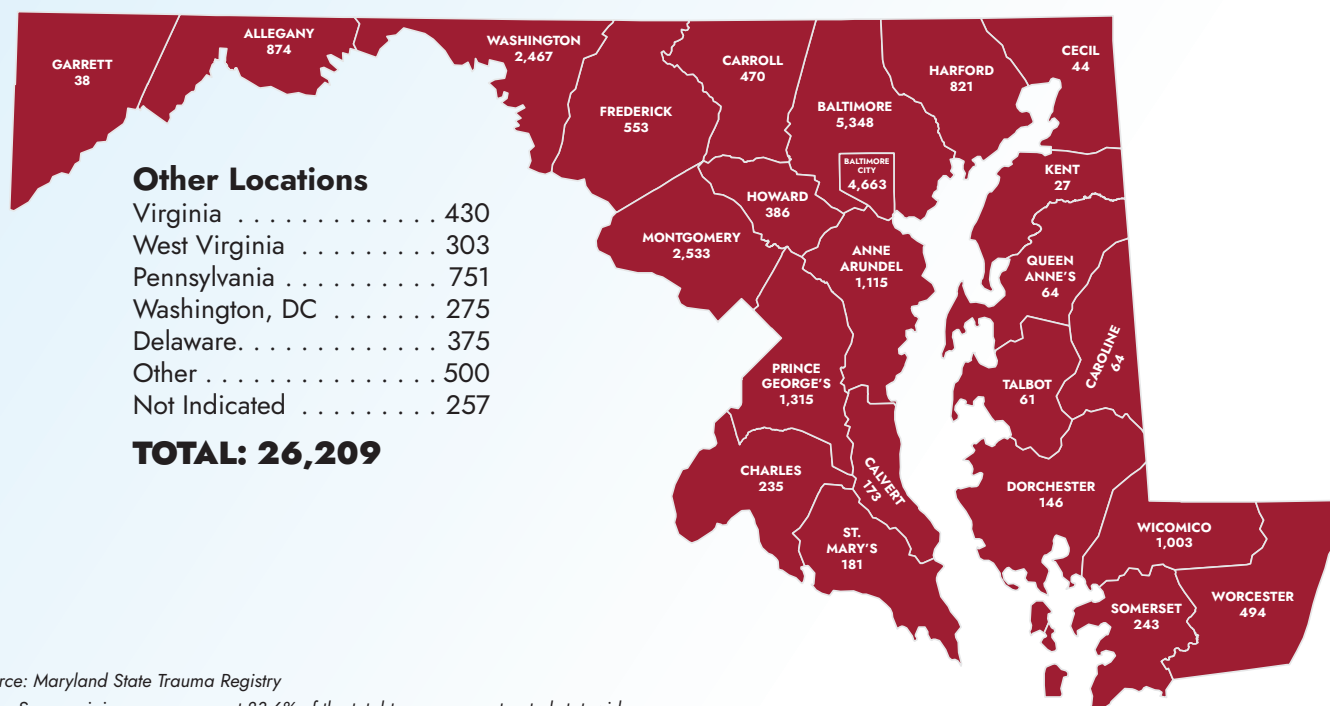
Source: Maryland State Trauma Registry
Note: “Primary Admissions” refers to all patients except those treated and released from the emergency department within six hours of emergency department arrival.

Number of Injuries and Deaths by Age: Total and Maryland Residents Only (June 2025 to May 2026)				
Age	Number of Injured Patients		Number of Deaths	
	Total	Maryland Residents	Total	Maryland Residents
Under 1 Year	73	59	1	0
1 to 4 Years	180	157	0	0
5 to 14 Years	413	346	6	5
15 to 24 Years	3,346	2,898	54	48
25 to 44 Years	7,014	6,204	133	115
45 to 64 Years	5,830	5,096	95	88
65+ Years	14,449	13,282	351	325
Unknown	5	2	0	0
TOTAL	31,360	28,044	640	581

Source: Maryland State Trauma Registry
Note: Only pediatric patients that were treated at adult trauma centers are included in this table. For patients treated at pediatric trauma centers, see Pediatric Trauma Statistics.

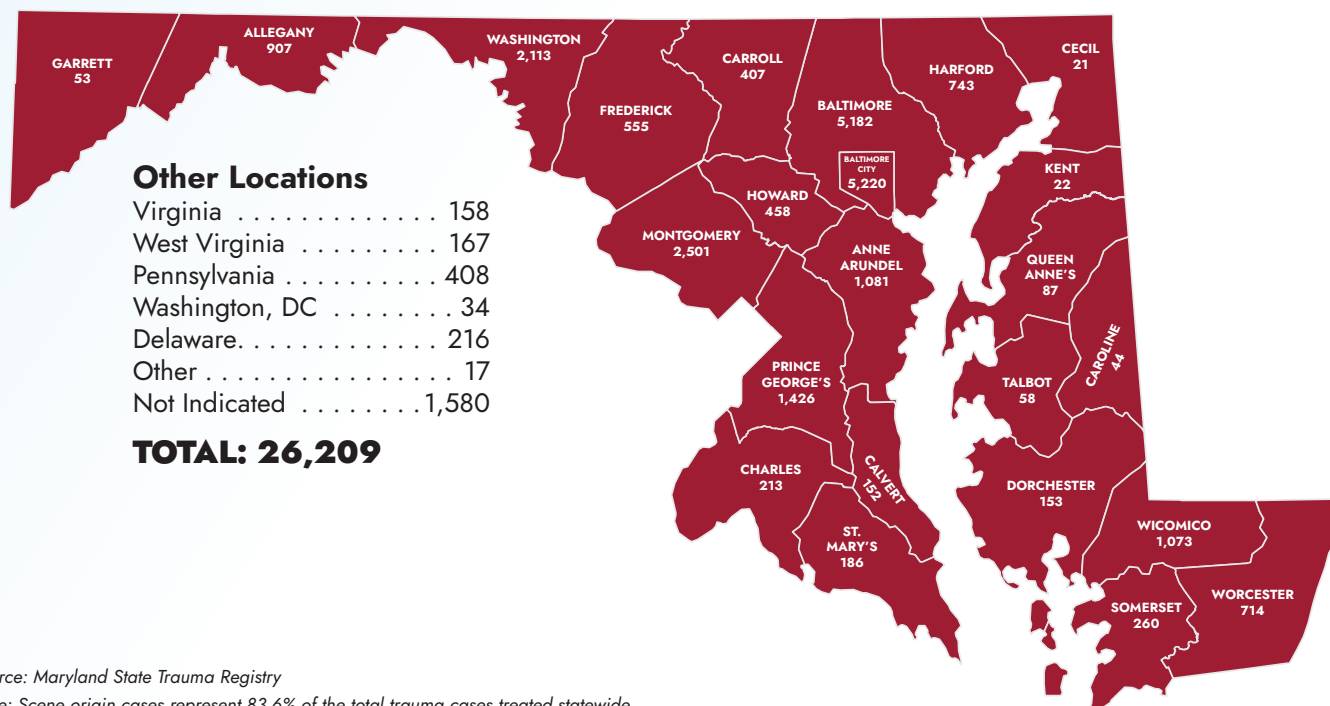
Residence of Patients by County: Scene Origin Cases Only

(June 2025 to May 2026)



Occurrence of Injury by County: Scene Origin Cases Only

(June 2025 to May 2026)





Patients with Protective Devices at Time of Trauma Incident

Primary Admissions Only
(3-Year Comparison)

Protective Device	June 2023 to May 2024	June 2024 to May 2025	June 2025 to May 2026
None	22.3%	25.2%	25.9%
Seatbelt	9.0%	8.9%	8.7%
Airbag & Seatbelt	38.9%	37.8%	37.1%
Airbag Only	14.7%	12.2%	12.4%
Infant/Child Seat	0.1%	0.1%	0.1%
Protective Helmet	14.7%	15.2%	14.6%
Padding/ Protective Clothing	0.1%	0.1%	0.0%
Other Protective Device	0.1%	0.0%	0.1%
Unknown	0.1%	0.5%	1.1%
TOTAL	100.0%	100.0%	100.0%

Source: Maryland State Trauma Registry

Note: Patients were involved in motor vehicle, motorcycle, bicycle and sports-related incidents only. "Primary Admissions" refers to all patients except those treated and released from the emergency department within six hours of emergency department arrival.



Blood Alcohol Content of Patients*: Primary Admissions Only

(3-Year Comparison)

Blood Alcohol Content	June 2023 to May 2024	June 2024 to May 2025	June 2025 to May 2026
Negative	63.1%	57.9%	65.0%
Positive	36.9%	42.1%	35.0%
TOTAL	100.0%	100.0%	100.0%

Source: Maryland State Trauma Registry

Note: "Primary Admissions" refers to all patients except those treated and released from the emergency department within six hours of emergency department arrival.

*These percentages include only patients brought to the hospital directly from the scene that needed a full team response excluding those patients that died in the Emergency Department. Therefore, the calculation has changed from what was reported in previous years to reflect current guidelines.



Injury Severity Scores (ISS) with Penetrating Injuries: Primary Admissions Only

(3-Year Comparison)

ISS	June 2023 to May 2024	June 2024 to May 2025	June 2025 to May 2026
1 to 8	52.2%	54.4%	58.1%
9 to 14	28.0%	26.7%	24.7%
16 to 24	8.1%	7.9%	6.2%
25 to 75	11.7%	11.0%	11.0%
TOTAL	100.0%	100.0%	100.0%

Source: Maryland State Trauma Registry

Note: "Primary Admissions" refers to all patients except those treated and released from the emergency department within six hours of emergency department arrival.



Injury Severity Scores (ISS) with Blunt Injuries: Primary Admissions Only

(3-Year Comparison)

ISS	June 2023 to May 2024	June 2024 to May 2025	June 2025 to May 2026
1 to 8	52.7%	55.1%	55.5%
9 to 14	33.5%	32.0%	32.6%
16 to 24	8.0%	7.5%	7.1%
25 to 75	5.8%	5.4%	4.8%
TOTAL	100.0%	100.0%	100.0%

Source: Maryland State Trauma Registry

Note: "Primary Admissions" refers to all patients except those treated and released from the emergency department within six hours of emergency department arrival.



Injury Severity Scores (ISS) with Either Blunt or Penetrating Injuries: Primary Admissions Only (3-Year Comparison)

ISS	June 2023 to May 2024	June 2024 to May 2025	June 2025 to May 2026
1 to 8	52.7%	55.1%	55.8%
9 to 14	32.9%	31.5%	32.0%
16 to 24	8.0%	7.5%	7.0%
25 to 75	6.4%	5.9%	5.2%
TOTAL	100.0%	100.0%	100.0%

Source: Maryland State Trauma Registry

Note: "Primary Admissions" refers to all patients except those treated and released from the emergency department within six hours of emergency department arrival.



Injury Severity Scores (ISS) by Injury Type: Primary Admissions Only

(June 2025 to May 2026)

ISS	Blunt	Penetrating	TOTAL
1 to 8	55.5%	58.1%	55.8%
9 to 14	32.6%	24.7%	32.0%
16 to 24	7.1%	6.2%	7.0%
25 to 75	4.8%	11.0%	5.2%
TOTAL	100.0%	100.0%	100.0%

Source: Maryland State Trauma Registry

Note: "Primary Admissions" refers to all patients except those treated and released from the emergency department within six hours of emergency department arrival.



Etiology of Injuries by Ages of Patients

Primary Admissions Only
(June 2025 to May 2026)



Age	Motor Vehicle Crash	Motorcycle	Pedestrian	Fall	Gunshot Wound	Stab Wound	Struck by Object	Bicyclist	Other	TOTAL
Under 1 Year	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.9%	0.1%
1 to 4 Years	0.1%	0.0%	0.1%	0.2%	0.0%	0.0%	0.3%	0.0%	2.3%	0.3%
5 to 14 Years	0.8%	0.2%	0.1%	0.5%	1.1%	0.6%	1.9%	2.0%	2.0%	0.8%
15 to 24 Years	20.2%	23.9%	15.6%	2.1%	33.2%	15.9%	14.6%	10.8%	11.2%	8.9%
25 to 44 Years	36.4%	40.9%	38.0%	6.9%	49.4%	56.0%	44.7%	25.0%	35.6%	20.5%
45 to 64 Years	21.7%	29.1%	27.4%	15.6%	13.1%	21.2%	25.0%	37.4%	28.4%	18.9%
65+ Years	20.8%	5.9%	18.7%	74.6%	3.2%	6.3%	13.5%	24.8%	19.6%	50.5%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Maryland State Trauma Registry

Note: "Primary Admissions" refers to all patients except those treated and released from the emergency department within six hours of emergency department arrival. Only pediatric patients that were treated at adult trauma centers are included in this table. For patients treated at the pediatric trauma centers, see pediatric trauma center tables and graphs.



Etiology of Injuries by Ages of Children

Children Treated at Trauma Centers
(June 2025 to May 2026)



Age	Motor Vehicle Crash	Motorcycle	Pedestrian	Fall	Gunshot Wound	Cut/Stab	Struck by Object	Bicyclist	Other	TOTAL
Under 1 Year	4.0%	0.0%	1.3%	12.2%	0.0%	0.0%	4.6%	0.9%	14.4%	8.9%
1 to 4 Years	19.9%	2.1%	16.2%	28.3%	13.3%	18.2%	13.7%	7.7%	33.1%	24.1%
5 to 9 Years	34.7%	20.8%	33.1%	34.6%	20.0%	36.4%	21.8%	37.6%	27.4%	32.0%
10 to 14 Years	41.4%	77.1%	49.4%	24.9%	66.7%	45.4%	59.9%	53.8%	25.1%	35.0%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Maryland State Trauma Registry

Note: Children's National Medical Center data include patients residing in Maryland and/or injured in Maryland. For children that were burn patients at each hospital, see Maryland Pediatric Burn Center Statistics.

Emergency Department Arrivals by Day of the Week: Primary Admissions Only

(June 2025 to May 2026)

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
June 2025–May 2026	June 2025–May 2026	June 2025–May 2026	June 2025–May 2026	June 2025–May 2026	June 2025–May 2026	June 2025–May 2026
14.7%	14.3%	14.1%	13.7%	13.5%	14.5%	15.2%

Source: Maryland State Trauma Registry

Note: "Primary Admissions" refers to all patients except those treated and released from the emergency department within six hours of emergency department arrival.



Etiology of Injuries to Patients

Primary Admissions Only
(3-Year Comparison)

Etiology	June 2023 to May 2024	June 2024 to May 2025	June 2025 to May 2026
Cut/Stab	4.1%	3.6%	3.3%
Drowning/Submersion	0.1%	0.1%	0.1%
Fall	52.8%	56.4%	58.7%
Fire or Flame	0.3%	0.2%	0.3%
Hot Object or Substance	0.2%	0.2%	0.2%
Gun Shot Wound	5.0%	3.8%	2.8%
Machinery/Mechanical	0.6%	0.6%	0.7%
Motor Vehicle Crash	20.6%	18.3%	17.3%
Motorcycle Crash	3.2%	3.3%	3.1%
Bicycle Crash	1.4%	1.6%	1.4%
Pedestrian Incident	4.1%	4.0%	4.0%
Other Transport*	0.1%	0.1%	0.1%
Natural or Environmental	0.7%	0.8%	1.0%
Poisoning	0.2%	0.3%	0.2%
Struck by Object	5.1%	4.8%	4.9%
Other	1.5%	1.9%	1.9%
TOTAL	100.0%	100.0%	100.0%

Source: Maryland State Trauma Registry

*Injuries sustained in "Other Transport" include injuries while boating, using personal water craft, in airplanes, etc.

Note: "Primary Admissions" refers to all patients except those treated and released from the emergency department within six hours of emergency department arrival.



Etiology Distribution for Patients with Blunt or Penetrating Injuries: Primary Admissions Only

(June 2025 to May 2026)

Etiology	Blunt Injury Percentage	Penetrating Injury Percentage
Cut/Stab	0.2%	47.5%
Fall	63.1%	1.1%
Gunshot Wound	—	43.7%
Machinery/Mechanical	0.6%	1.3%
Motor Vehicle Crash	18.8%	0.1%
Motorcycle Crash	3.3%	0.1%
Bicyclist Crash	1.5%	0.1%
Pedestrian Incident	4.3%	—
Other Transport*	0.1%	—
Natural or Environmental	0.3%	2.3%
Struck by Object	5.1%	0.4%
Other	1.6%	1.4%
Not Valued	1.1%	2.0%
TOTAL	100.0%	100.0%

Source: Maryland State Trauma Registry

*Injuries sustained in "Other Transport" include injuries while boating, using personal water craft, in airplanes, etc.

Note: "Primary Admissions" refers to all patients except those treated and released from the emergency department within six hours of emergency department arrival.

Gender of Patients: Primary Admissions Only

(June 2025 to May 2026)



Male: 55.1%



Female: 44.9%

Source: Maryland State Trauma Registry

Note: "Primary Admissions" refers to all patients except those treated and released from the emergency department within six hours of emergency department arrival.

Injury Type Distribution of Patients: Primary Admissions Only

(June 2025 to May 2026)



Blunt: 93.4%



Penetrating: 6.6%

Source: Maryland State Trauma Registry

Note: "Primary Admissions" refers to all patients except those treated and released from the emergency department within six hours of emergency department arrival.



Mode of Patient Transport to Trauma Centers

Scene Origin Cases Only
(June 2025 to May 2026)



Modality Type	BVMC	JHH	MMC	THPR	UMCRH	SH	STC	SUB	UPMCWM	TOTAL
Ground Ambulance	90.6%	75.4%	80.1%	96.0%	85.3%	93.6%	76.8%	86.0%	68.9%	84.8%
Helicopter	0.2%	0.4%	0.1%	1.6%	9.7%	0.0%	21.7%	0.0%	0.7%	4.2%
Other	9.2%	24.2%	19.8%	2.4%	5.0%	6.4%	1.5%	14.0%	30.4%	11.0%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Maryland State Trauma Registry

Note: Only patients brought directly from the scene to a trauma center are included in this table.



Origin of Patient Transport to Trauma Centers

(June 2025 to May 2026)



Origin Type	BVMC	JHH	MMC	THPR	UMCRH	SH	STC	SUB	UPMCWM	TOTAL
Scene of Injury	96.7%	77.0%	96.4%	76.1%	85.8%	89.9%	67.2%	91.5%	96.1%	84.9%
Hospital Transfer	0.1%	5.6%	0.1%	2.9%	5.7%	6.2%	32.2%	3.3%	1.2%	8.3%
Other	3.2%	17.4%	3.5%	21.0%	8.5%	3.9%	0.6%	5.2%	2.7%	6.8%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Maryland State Trauma Registry

Age Distribution of Patients: Primary Admissions Only

(June 2025 to May 2026)



**Under
1 Year**

0.1%



**1 to 4
Years**

0.3%



**5 to 14
Years**

0.8%



**15 to 24
Years**

8.9%



**25 to 44
Years**

20.7%



**45 to 64
Years**

18.9%



**65+
Years**

50.3%

Source: Maryland State Trauma Registry

Note: "Primary Admissions" refers to all patients except those treated and released from the emergency department within six hours of emergency department arrival. Only pediatric patients that were treated at adult trauma centers are included in this table. For patients treated at pediatric trauma centers, see Pediatric Trauma Statistics.

Specialty Centers

Maryland's specialty care system connects patients with hospitals equipped to provide highly specialized, time-sensitive care. Through designation and ongoing verification, MIEMSS establishes standards for trauma and specialty referral centers and works with hospitals to ensure those capabilities are maintained. The statewide network includes centers specializing in trauma, stroke, cardiac intervention, burns, pediatric and perinatal care, neurotrauma, eye and hand injuries, and other complex conditions. Together, these centers strengthen Maryland's coordinated system of care by helping EMS clinicians identify and transport patients to the most appropriate facility based on their clinical needs.

Adult Burn Centers

Johns Hopkins Bayview Medical Center

The Burn Center at Johns Hopkins Bayview Medical Center (JHBMC) serves the residents of Maryland and specific regions of adjacent states. The Burn Center provides a comprehensive, nationally recognized program of care for patients with burn injuries. In FY 2026, JHBMC treated 798 burn patients (302 inpatients and 496 outpatients), either in the emergency department or under observation.

Current initiatives include the development and implementation of protocols for enzymatic debridement, improved pain management strategies, and optimization of fluid resuscitation practices. JHBMC addressed emergency response guidelines within the Burn Intensive Care Unit, adherence to inhalational injury protocols, reduction of hospital-acquired infections, and standardized wound care protocols. Verification by the American Burn Association affirms that the Burn Center has met the highest standards of care for the burn-injured patient.

JHBMC tracks key burn care quality metrics, including treatment and throughput times, fluid resuscitation, readmission, acute respiratory distress syndrome, and hospital-acquired infections. Measures are reviewed monthly by the multidisciplinary Joint Practice Committee, with a new dashboard providing near-real-time monitoring of key quality indicators.

MedStar Washington Hospital Center

The Burn Center at MedStar Washington Hospital Center (MedStar WHC) is the only adult burn treatment center in the Washington Metropolitan area, serving the District, Southern Maryland, Northern Virginia, and Eastern West Virginia. In addition to providing care to patients with thermal, electrical, and chemical injuries, MedStar WHC Burn Center treats patients with soft-tissue injuries and diagnoses. This year, 656 acute burn-injured patients were admitted for treatment, with another 868 treated as outpatients. The Burn Center provided outpatient burn care for 2,554 patients in the Burn Clinic and 2,281 patients in the Wound Clinic. Reconstructive surgery and rehabilitation are available for patients in the post-acute and convalescent phases of their care, regardless of where they received treatment for their acute burn injury.

The Burn Center meets stringent criteria for verification by the American Burn Association for providing excellence in burn care. Its multidisciplinary team approach to burn care provides comprehensive services for patients. The Burn Center is a national leader in laser scar revision, with a practice dedicated to patients with burn and traumatic injuries. For patients suffering from pain, itching, tightness, and discoloration associated with burn or traumatic scars, the Burn Center offers multiple interventions, including compression and massage, laser scar revision, and surgical reconstruction.

Maryland Adult Burn Statistics

Total Number of Adult Burns Cases Patients Age 15 and Older Treated at Johns Hopkins Burn Center at Bayview (3-Year Comparison)	
Reporting Period	Number
June 2023 to May 2024	699
June 2024 to May 2025	651
June 2025 to May 2026	745

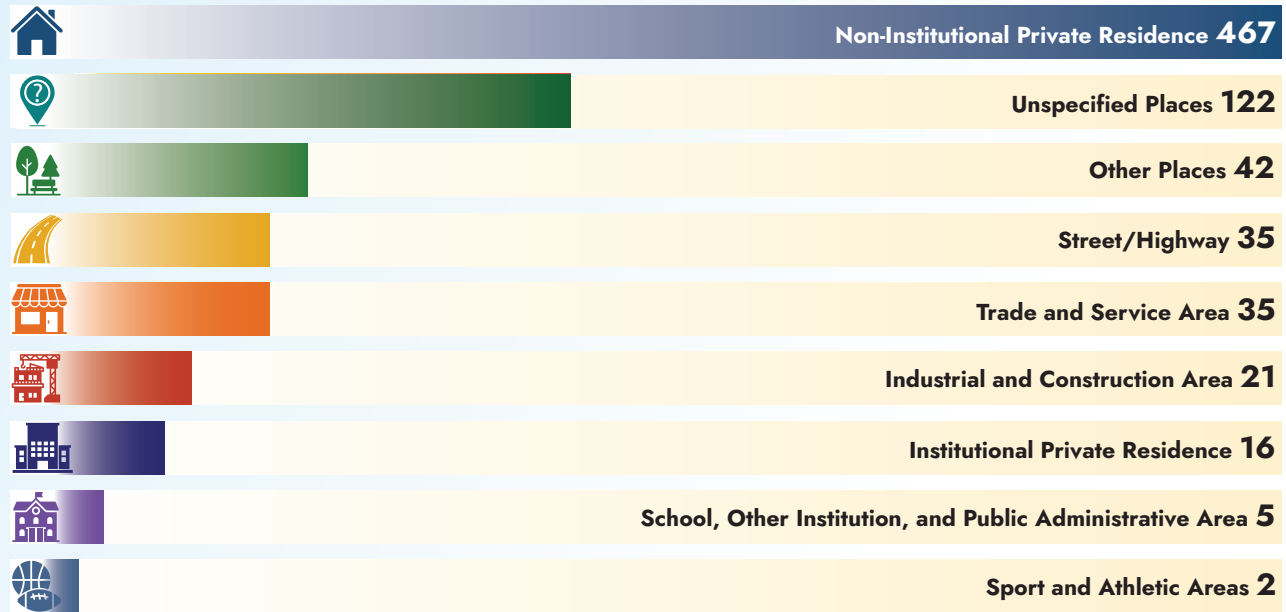
Source: Maryland State Trauma Registry

Number of Injuries by Age Patients Age 15 and Older Treated at Johns Hopkins Burn Center at Bayview (3-Year Comparison)			
Age Range	June 2023 to May 2024	June 2024 to May 2025	June 2025 to May 2026
15 to 24 Years	106	81	110
25 to 44 Years	268	263	294
45 to 64 Years	214	203	208
65 Years and Over	111	104	133
TOTAL	699	651	745

Source: Maryland State Trauma Registry

Place of Injury

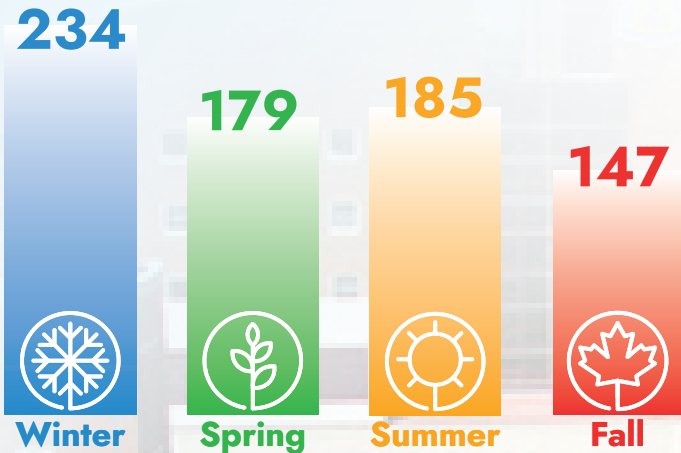
Patients Age 15 and Older Treated at Johns Hopkins Burn Center at Bayview (June 2025 to May 2026)



Source: Maryland State Trauma Registry

Season of the Year Distribution

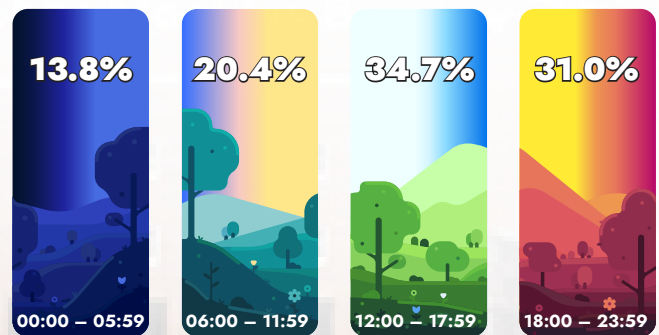
Patients Age 15 and Older Treated at Johns Hopkins Burn Center at Bayview (June 2025 to May 2026)



Source: Maryland State Trauma Registry

Time of Arrival Distribution

Patients Age 15 and Older Treated at Johns Hopkins Burn Center at Bayview (June 2025 to May 2026)



Not Valued: 0.1% | TOTAL: 745

Source: Maryland State Trauma Registry

Etiology of Injuries by Ages of Patients

Patients Age 15 and Older Treated at Johns Hopkins Burn Center at Bayview (June 2025 to May 2026)

Age Range	Electrical	Chemical	Thermal			Inhalation	Other Burn	Other Non-Burn	Unknown	TOTAL
			Flame	Contact	Scald					
15 to 24 Years	0	2	32	13	41	6	4	2	10	110
25 to 44 Years	5	8	82	49	93	7	6	9	35	294
45 to 64 Years	1	5	68	36	62	9	7	2	18	208
65 Years and Over	0	4	45	20	41	7	0	3	13	133
TOTAL	6	19	227	118	237	29	17	16	76	745

Source: Maryland State Trauma Registry



Mode of Patient Transport

Patients Age 15 and Older Treated at Johns Hopkins
Burn Center at Bayview (June 2025 to May 2026)

Modality Type	Number
Ground Ambulance	346
Helicopter	61
Other*	330
Not Valued	8
TOTAL	745

Source: Maryland State Trauma Registry

*Note: The category "Other" includes patients that were brought in by fixed wing ambulance, private or public vehicles or were walk-ins.

Gender of Patients: Primary Admissions Only (June 2025 to May 2026)



Male: 59.6%



Female: 40.4%

Source: Maryland State Trauma Registry



Final Disposition of Patients

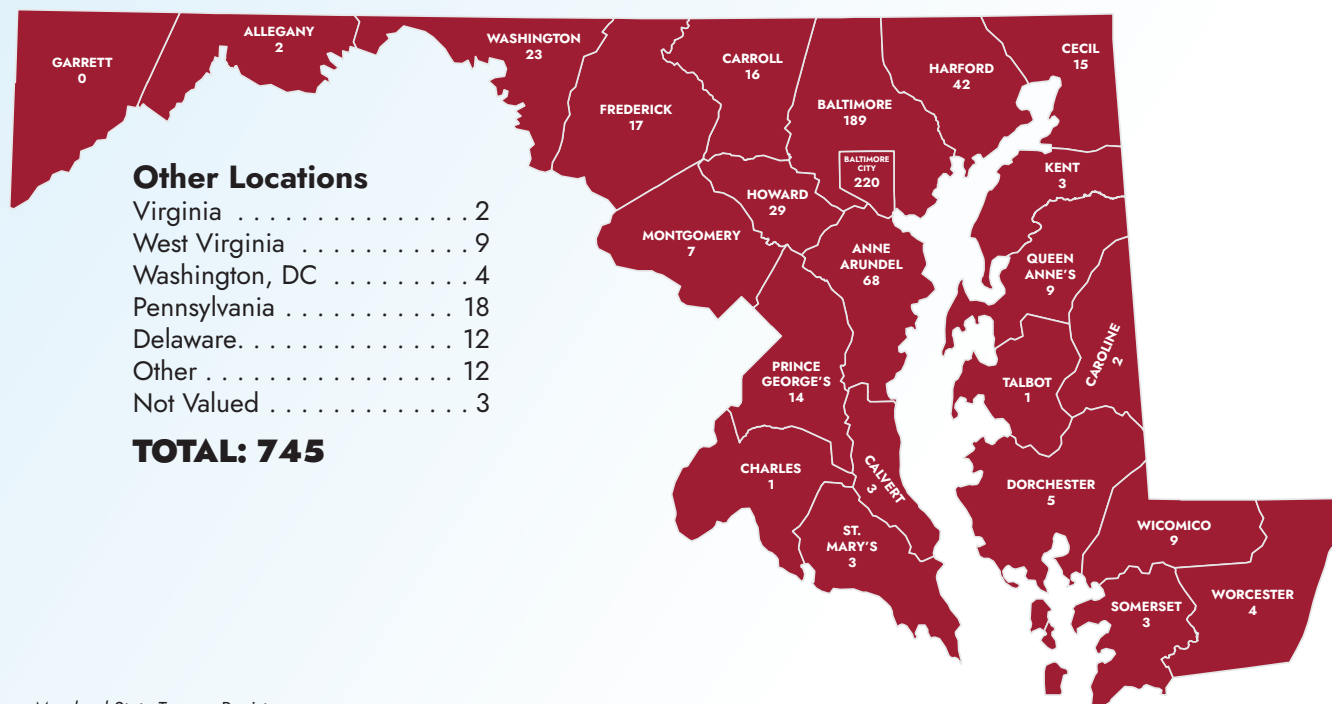
Patients Age 15 and Older Treated at Johns Hopkins
Burn Center at Bayview (3-Year Comparison)

Final Disposition	June 2023 to May 2024	June 2024 to May 2025	June 2025 to May 2026
Home	553	528	601
Home with Services	43	42	40
Transfer to Another Acute Care Facility	2	2	2
Discharge to Long- Term Care Facility	1	3	2
Rehabilitation Facility	9	6	9
Skilled Nursing Facility	23	15	36
Psychiatric Hospital	10	4	2
Morgue/Died	17	15	16
Left Against Medical Advice or Discontinued Care	23	19	14
Jail	7	7	10
Hospice	4	2	3
Other	1	1	3
Not Valued	6	7	7
TOTAL	699	651	745

Source: Maryland State Trauma Registry

Residence of Patients by County

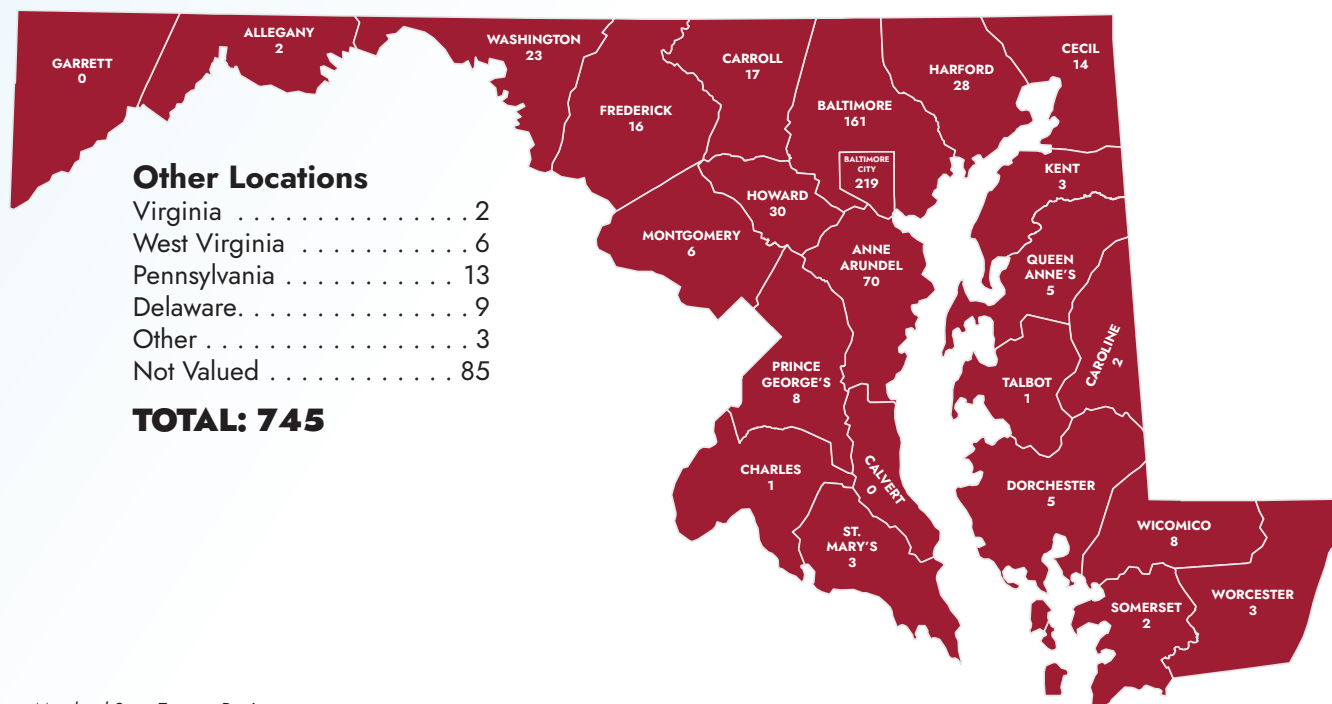
Patients Aged 15 and Older Treated at Johns Hopkins Burn Center at Bayview (June 2025 to May 2026)



Source: Maryland State Trauma Registry

Occurrence of Injury by County

Patients Aged 15 and Older Admitted to Johns Hopkins Burn Center at Bayview (June 2025 to May 2026)



Source: Maryland State Trauma Registry

Pediatric Trauma & Burn Centers

Maryland's pediatric trauma and burn system provides specialized care for injured and critically ill children through designated pediatric trauma and burn centers, supported by comprehensive transport, rehabilitation, mental health, and quality improvement programs. The system includes the Johns Hopkins Children's Center (JHCC), Maryland's designated Level I Pediatric Trauma and Burn Center, and Children's National Hospital (CNH), a designated Pediatric Trauma and Burn Center serving Maryland and the surrounding region.

Johns Hopkins Children's Center

Johns Hopkins Children's Center (JHCC) is Maryland's only designated Level I Pediatric Trauma Center as well as a MIEMSS-designated Level I Pediatric Burn Center, providing 24/7 comprehensive pediatric trauma and burn care. JHCC's continuum of care works closely with EMS, referring hospitals, and other regional partners to support pediatric emergency medicine, surgery, critical care, rehabilitation, psychology, child life, nursing, and injury prevention services.

During the reporting period, JHCC cared for more than 1,960 pediatric trauma patients and more than 470 pediatric burn patients. The burn center cared for approximately 700 children in its burn clinic and coordinated the transport of more than 160 pediatric burn patients from Maryland hospitals. The Johns Hopkins Pediatric Transport Team coordinates more than 1,000 trauma and burn transfers annually, supporting access to specialized pediatric services.

The Pediatric Base Station provides online medical direction to EMS clinicians and maintains an active quality improvement plan focused on evaluating medical direction and incorporating feedback from EMS quality improvement officers.

During this reporting period, the trauma and burn programs strengthened multidisciplinary collaboration and performance improvement, including integration with the adult burn program at Johns Hopkins Bayview Medical Center through shared case discussions and collaborative program development. In addition, these efforts expanded access to follow-up care through increased clinic availability.

JHCC integrates physical and behavioral health services into pediatric trauma and burn care. Pediatric psychology and the Pediatric After Injury Resilience (PAIR) Clinic support emotional recovery and successful reintegration following injury. The pediatric Hospital-based Violence Intervention Program (HVIP) connects children and families affected by interpersonal violence with trauma-informed support, safety planning, case management, and community resources, with longitudinal follow-up to support recovery and reduce the risk of reinjury.

Children's National Hospital

Children's National Hospital (CNH) is a Pediatric Trauma Center and Pediatric Burn Center that serves children as one of Mary-

land's two pediatric trauma centers. In this reporting period, CNH cared for more than 1,500 trauma-injured children, with 60% of those patients residing in Maryland.

CNH is designated as a Level I Pediatric Trauma Center by the American College of Surgeons. The CNH Pediatric Burn Center provided comprehensive burn care to patients through age 18. During this reporting period, the program reestablished coordinated burn surgery coverage with Washington Hospital Center, expanding surgical capacity for children throughout the region. Long-term follow-up is provided at the Friendship Heights outpatient location.

CNH integrates violence intervention and community-based services for children experiencing violent injury. Since its launch in FY 2023, the hospital's Violence Intervention Team has worked with patients at risk for recurrent violence, connecting them with services and resources to address factors contributing to violence and support long-term recovery.

The Pediatric Burn Center provides ongoing follow-up care and multidisciplinary support for children recovering from burn injuries. Its quality improvement program reviews burn patients treated in the Emergency Department and follows outpatient patients as needed to support continuity of care.

System-wide Quality Improvement

Pediatric trauma and burn centers across the region remain committed to continuous quality improvement through comprehensive case review, national benchmarking, multidisciplinary performance improvement committees, and collaboration with EMS agencies. During FY 2026, centers advanced pediatric trauma and burn care through expanded whole blood resuscitation capabilities, enhanced behavioral health services, telemedicine, statewide education, and participation in national research and quality collaboratives. Together, these efforts support high-quality, evidence-based care for Maryland children from injury through recovery and rehabilitation.

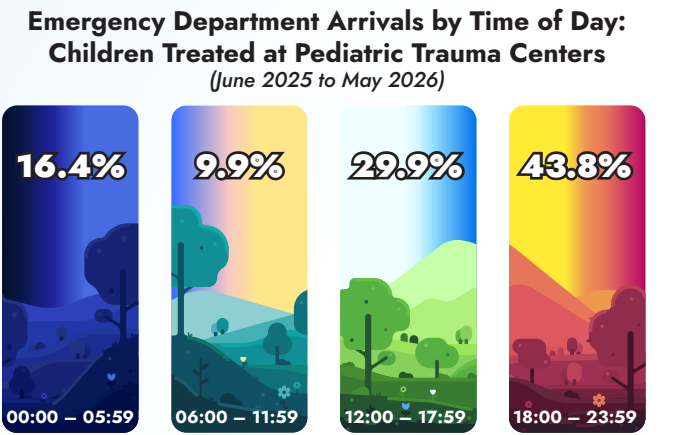
Johns Hopkins Children's Center (JHCC) recorded its highest volume of pediatric trauma patients to date. Its multidisciplinary Performance Improvement Committee meets monthly to review trauma statistics and key data, identify trends, and guide quality improvement efforts. All emergency department visits for traumatic injuries undergo review, with patient charts audited through discharge. The JHCC Pediatric Base Station maintains an active quality improvement plan to evaluate online medical direction provided to EMS clinicians, with feedback shared with jurisdictional QI officers. JHCC also participates in monthly multidisciplinary process improvement meetings and morbidity and mortality conferences to strengthen coordination across the care continuum. During the year, JHCC introduced a whole blood transfusion initiative for pediatric trauma patients, further expanding its resuscitation capabilities.

Maryland Pediatric Trauma Statistics

 Total Cases Treated at Pediatric Trauma Centers (3-Year Comparison)			
Institution	June 2023 to May 2024	June 2024 to May 2025	June 2025 to May 2026
Children's National Hospital (CNH)	978	979	1,030
Johns Hopkins Children's Center (JHCC)	1,183	1,150	1,766
TOTAL	2,161	2,129	2,796

Source: Maryland State Trauma Registry

Note: For children who were treated at adult trauma centers, see Maryland Adult Trauma Report. Children's National Health System data include patients residing in Maryland and/or injured in Maryland. For children that were burn patients at each hospital, see Maryland Pediatric Burn Center Statistics.



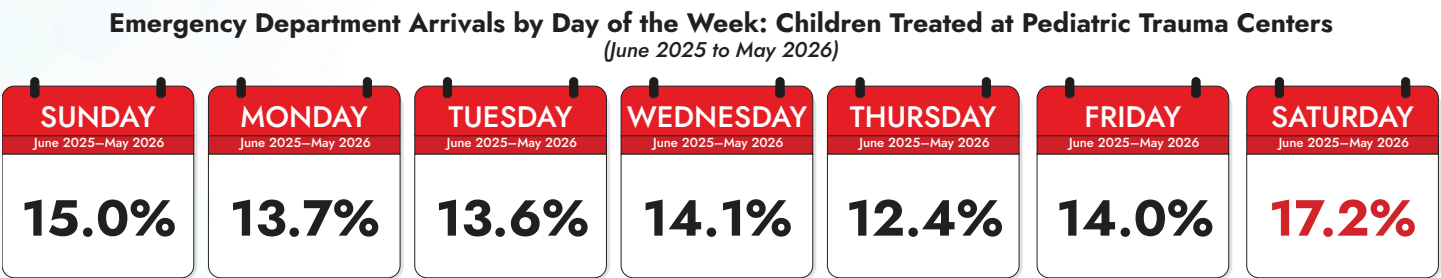
Source: Maryland State Trauma Registry

Note: For children who were treated at adult trauma centers, see Maryland Adult Trauma Report. Children's National Health System data include patients residing in Maryland and/or injured in Maryland. For children that were burn patients at each hospital, see Maryland Pediatric Burn Center Statistics.

 Etiology of Injuries by Ages of Patients Children Treated at Pediatric Trauma Centers (June 2025 to May 2026)										
Age	Motor Vehicle Crash	Motorcycle	Pedestrian	Fall	Gunshot Wound	Cut/Stab	Struck by Object	Bicyclist	Other	TOTAL
Under 1 Year	2.9%	0.0%	0.0%	10.5%	0.0%	0.0%	3.0%	1.0%	13.1%	7.2%
1 to 4 Years	18.7%	1.8%	14.0%	25.2%	15.4%	15.3%	8.0%	7.6%	27.6%	20.2%
5 to 9 Years	29.7%	14.5%	28.7%	34.2%	15.4%	27.1%	13.8%	32.4%	24.4%	28.2%
10 to 14 Years	38.1%	60.0%	40.8%	24.3%	53.8%	39.0%	37.3%	47.6%	22.1%	31.0%
15+ Years	10.6%	23.7%	16.5%	5.8%	15.4%	18.6%	37.9%	11.4%	12.8%	13.4%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Maryland State Trauma Registry

Note: For children who were treated at adult trauma centers, see Maryland Adult Trauma Report. Children's National Health System data include patients residing in Maryland and/or injured in Maryland. For children that were burn patients at each hospital, see Maryland Pediatric Burn Center Statistics.



Source: Maryland State Trauma Registry

Note: For children who were treated at adult trauma centers, see Maryland Adult Trauma Report. Children's National Health System data include patients residing in Maryland and/or injured in Maryland. For children that were burn patients at each hospital, see Maryland Pediatric Burn Center Statistics.



Number of Injuries by Age

Children Treated at Pediatric Trauma Centers
(3-Year Comparison)

Age	June 2023 to May 2024	June 2024 to May 2025	June 2025 to May 2026
Under 1 Year	204	166	206
1 to 4 Years	446	405	567
5 to 9 Years	538	627	785
10 to 14 Years	703	683	860
15+ Years	270	248	378
TOTAL	2,161	2,129	2,796

Source: Maryland State Trauma Registry

Note: For children who were treated at adult trauma centers, see Maryland Adult Trauma Statistics. Children's National Health System data include patients residing in Maryland and/or injured in Maryland. For children that were burn patients at each hospital, see Maryland Pediatric Burn Center Statistics.



Number of Deaths by Age

Children Treated at Pediatric Trauma Centers
(3-Year Comparison)

Age	June 2023 to May 2024	June 2024 to May 2025	June 2025 to May 2026
Under 1 Year	2	4	3
1 to 4 Years	6	7	3
5 to 9 Years	4	3	3
10 to 14 Years	3	5	3
15+ Years	1	3	0
TOTAL	16	22	12

Source: Maryland State Trauma Registry

Note: For children who were treated at adult trauma centers, see Maryland Adult Trauma Statistics. Children's National Health System data include patients residing in Maryland and/or injured in Maryland. For children that were burn patients at each hospital, see Maryland Pediatric Burn Center Statistics.



Final Disposition of Patients

Children Treated at Pediatric Trauma Centers
(3-Year Comparison)

Final Disposition	June 2023 to May 2024	June 2024 to May 2025	June 2025 to May 2026
Inpatient Rehab Facility	1.8%	1.2%	1.1%
Specialty Referral Center	0.2%	0.1%	0.1%
Home with Services	0.5%	0.9%	1.1%
Home	94.5%	95.0%	96.1%
Acute Care Hospital	0.9%	0.4%	0.2%
Left Against Medical Advice	0.3%	0.1%	0.2%
Morgue/Died	0.7%	1.0%	0.4%
Foster Care	0.7%	0.7%	0.4%
Jail	0.1%	0.3%	0.1%
Psychiatric Hospital	0.2%	0.3%	0.2%
Elopement	0.1%	0.0%	0.1%
TOTAL	100.0%	100.0%	100.0%

Source: Maryland State Trauma Registry

Note: For children who were treated at adult trauma centers, see Maryland Adult Trauma Report. Children's National Health System data include patients residing in Maryland and/or injured in Maryland. For children that were burn patients at each hospital, see Maryland Pediatric Burn Center Statistics.



Number of Injuries and Deaths by Age: Total and Maryland Residents Only

Children Treated at Pediatric Trauma Centers
(June 2025 to May 2026)

Age	Number of Injured Patients		Number of Deaths	
	Total	Maryland Residents	Total	Maryland Residents
Under 1 Year	206	200	3	2
1 to 4 Years	567	532	3	3
5 to 9 Years	785	754	3	1
10 to 14 Years	860	822	3	3
15+ Years	378	364	0	0
TOTAL	2,796	2,672	12	9

Source: Maryland State Trauma Registry

Note: For children who were treated at adult trauma centers, see Maryland Adult Trauma Report. Children's National Health System data include patients residing in Maryland and/or injured in Maryland. For children that were burn patients at each hospital, see Maryland Pediatric Burn Center Statistics.

Gender of Patients: Primary Admissions Only

(June 2025 to May 2026)



Male: 63.5%



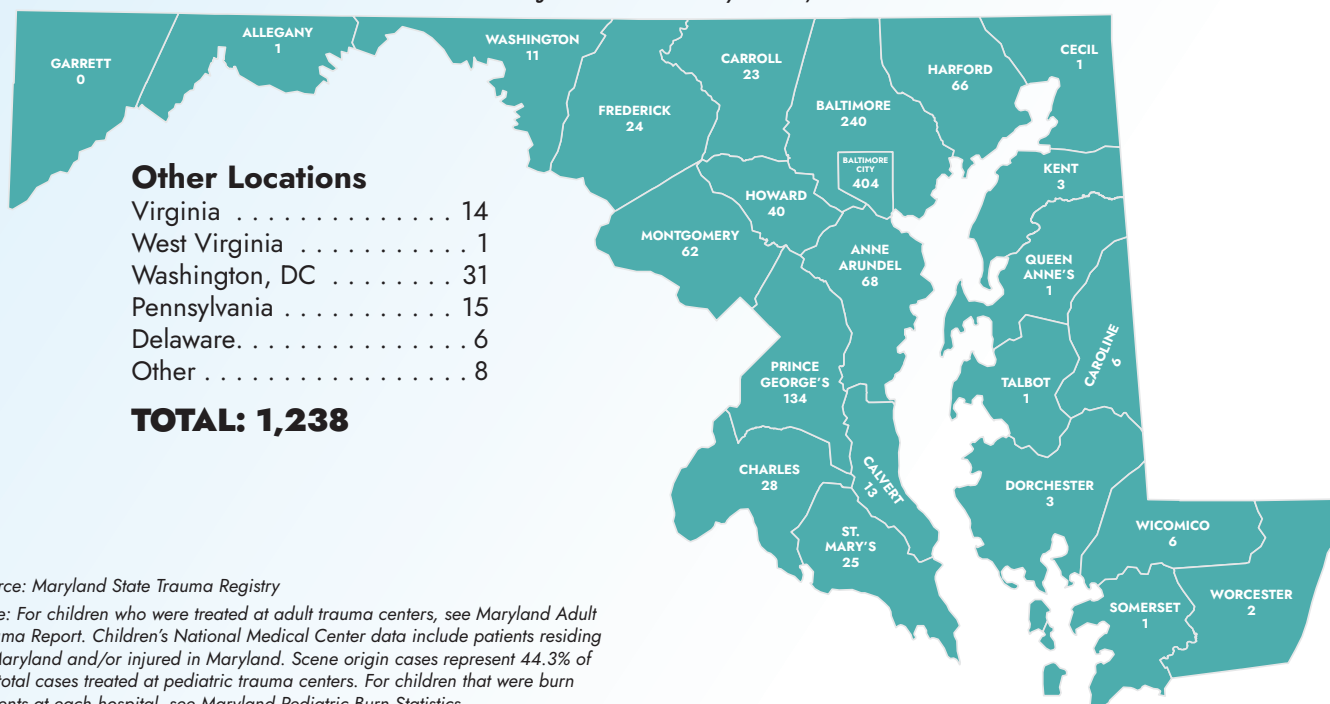
Female: 36.5%

Source: Maryland State Trauma Registry

Note: For children who were treated at adult trauma centers, see Maryland Adult Trauma Report. Children's National Health System data include patients residing in Maryland and/or injured in Maryland. For children that were burn patients at each hospital, see Maryland Pediatric Burn Center Statistics.

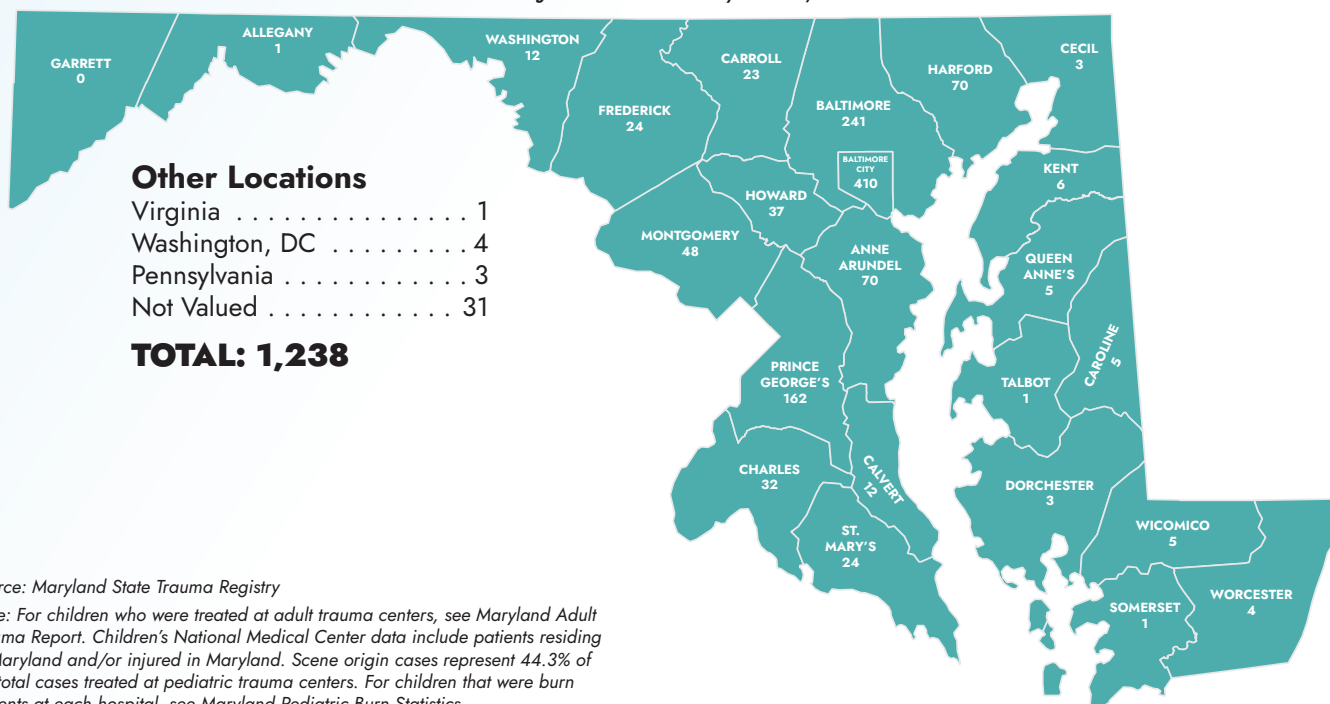
Residence of Patients by County: Scene Origin Cases Only

Children Treated at Pediatric Trauma Centers
(June 2025 to May 2026)



Occurrence of Injury by County: Scene Origin Cases Only

Children Treated at Pediatric Trauma Centers
(June 2025 to May 2026)





Children with Protective Devices at Time of Trauma Incident

Children Treated at Pediatric Trauma Centers²
(3-Year Comparison)

Protective Device	June 2023 to May 2024	June 2024 to May 2025	June 2025 to May 2026
None	49.4%	46.9%	55.8%
Seatbelt	3.8%	2.3%	2.5%
Airbag & Seatbelt	15.3%	18.4%	13.5%
Airbag Only	10.4%	8.3%	4.7%
Infant/Child Seat	10.1%	12.0%	9.0%
Protective Helmet	10.6%	11.1%	12.9%
Padding/ Protective Clothing	0.3%	0.4%	1.5%
Other Protective Device	0.1%	0.3%	0.0%
Not Valued	0.0%	0.3%	0.1%
TOTAL	100.0%	100.0%	100.0%

Source: Maryland State Trauma Registry

Note: Children were involved in motor vehicle, motorcycle, bicycle, and sports-related incidents only. For children who were treated at adult trauma centers, see Maryland Adult Trauma Report. Children's National Medical Center data include patients residing in Maryland and/or injured in Maryland. For children that were burn patients at each hospital, see Maryland Pediatric Burn Center Statistics.



Mechanism of Injury

Children Treated at Pediatric Trauma Centers
(3-Year Comparison)

Mechanism of Injury	June 2023 to May 2024	June 2024 to May 2025	June 2025 to May 2026
Cut/Stab	2.1%	1.6%	2.1%
Drowning/ Submersion	0.7%	0.7%	0.6%
Falls	32.3%	36.5%	41.1%
Fire or Flame	0.1%	0.0%	0.0%
Gun Shot Wound	2.3%	2.0%	0.9%
Machinery/ Mechanical	0.9%	0.8%	1.4%
MVT – Occupant	18.3%	18.0%	14.6%
MVT – Motorcyclist	0.8%	0.9%	2.0%
MVT – Bicyclist	4.1%	2.9%	3.8%
MVT – Pedestrian	8.4%	9.0%	5.9%
Other Transport	0.0%	0.0%	0.1%
Natural/ Environmental	7.4%	8.7%	5.8%
Struck by Object	11.2%	10.6%	12.9%
Abuse	7.3%	4.0%	3.6%
Other	2.2%	2.5%	3.0%
Not Valued	1.9%	1.8%	2.2%
TOTAL	100.0%	100.0%	100.0%

Source: Maryland State Trauma Registry

Note: For children who were treated at adult trauma centers, see Maryland Adult Trauma Report. Children's National Health System data include patients residing in Maryland and/or injured in Maryland. For children that were burn patients at each hospital, see Maryland Pediatric Burn Center Statistics.



Injury Type

Children Treated at Pediatric Trauma Centers
(3-Year Comparison)

Injury Type	June 2023 to May 2024	June 2024 to May 2025	June 2025 to May 2026
Blunt	87.2%	86.4%	90.1%
Penetrating	4.4%	3.8%	3.3%
Near Drowning	0.8%	0.7%	0.7%
Hanging	0.1%	0.3%	0.1%
Crush	0.0%	0.1%	0.2%
Animal/Human Bite	7.5%	8.5%	5.5%
Other	0.0%	0.2%	0.1%
TOTAL	100.0%	100.0%	100.0%

Source: Maryland State Trauma Registry

Note: For children who were treated at adult trauma centers, see Maryland Adult Trauma Report. Children's National Health System data include patients residing in Maryland and/or injured in Maryland. For children that were burn patients at each hospital, see Maryland Pediatric Burn Center Statistics.



Outcome Profile

Children Treated at Pediatric Trauma Centers
(June 2025 to May 2026)

Outcome	Percentage
Lived	99.6%
Died	0.4%

Source: Maryland State Trauma Registry

Note: For children who were treated at adult trauma centers, see Maryland Adult Trauma Report. Children's National Health System data include patients residing in Maryland and/or injured in Maryland. For children that were burn patients at each hospital, see Maryland Pediatric Burn Center Statistics.



Origin of Patient Transport by Center

Children Treated at Pediatric Trauma Centers
(June 2025 to May 2026)



Origin	Children's National Health System (CNHS)	Johns Hopkins Pediatric Trauma Center (JHP)	TOTAL
Scene of Injury	30.0%	52.7%	44.3%
Hospital Transfer	61.0%	32.1%	42.8%
Other*	9.0%	15.2%	12.9%
TOTAL	100.0%	100.0%	100.0%

Source: Maryland State Trauma Registry

Note: For children who were treated at adult trauma centers, see Maryland Adult Trauma Statistics. Children's National Health System data include patients residing in Maryland and/or injured in Maryland. For children that were burn patients at each hospital, see Maryland Pediatric Burn Center Statistics.

*Other: Refers to patients originating from a source other than an acute care hospital (e.g., a Kaiser facility, an urgent care center, or a physician's office), or a patient who was injured and returned home before going to the hospital.



Mode of Patient Transport by Center: Scene Origin Cases Only

Children Treated at Pediatric Trauma Centers
(June 2025 to May 2026)



Origin	Children's National Health System (CNHS)	Johns Hopkins Pediatric Trauma Center (JHP)	TOTAL
Ground Ambulance	72.7%	64.2%	66.3%
Helicopter	15.6%	8.2%	10.1%
Other	11.7%	27.6%	23.6%
TOTAL	100.0%	100.0%	100.0%

Source: Maryland State Trauma Registry

Note: Only patients brought directly to a trauma center are included in this table. For children who were treated at adult trauma centers, see Maryland Adult Trauma Statistics. Children's National Health System data include patients residing in Maryland and/or injured in Maryland. For children that were burn patients at each hospital, see Maryland Pediatric Burn Center Statistics.

*Other: Refers to fixed-wing air ambulance, non-ambulance public safety vehicle (e.g., a police car), and private vehicle/walk-in.



Maryland Pediatric Burn Statistics

Pediatric Burn Center Legend

CNH – Children’s National Health System
Pediatric Burn Center

JHCC – Johns Hopkins Children’s
Center (Burn Center)

JHBMC – Johns Hopkins Bayview Medical Center
(Burn Center)



Total Number of Pediatric Burn Cases

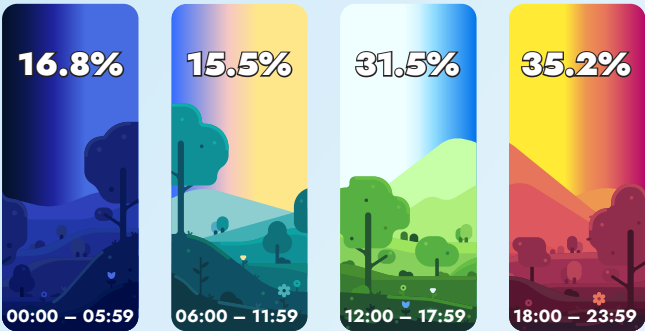
Patients Treated at Pediatric Burn Centers and Patients
Less Than Age 15 Treated at Johns Hopkins Burn Center
at Bayview (3-Year Comparison)

Institution	June 2023 to May 2024	June 2024 to May 2025	June 2025 to May 2026
CNH	247	245	277
JHCC	418	422	476
JHBMC	44	61	54
TOTAL	709	728	807

Source: Maryland State Trauma Registry

Time of Arrival Distribution

Patients Treated at Pediatric Burn Centers and Patients Less Than 15
Treated at Johns Hopkins Burn Center at Bayview
(June 2025 to May 2026)



Not Valued: 1.0% | TOTAL: 807

Source: Maryland State Trauma Registry



Total Body Surface Area (TBSA) Burned by Length of Stay in Days

Patients Treated at Pediatric Burn Centers and Patients Less Than Age 15 Treated at Johns Hopkins Burn Center at Bayview
(June 2025 to May 2026)

Length of Stay	Less Than 10% TBSA	10–19% TBSA	20% or Greater TBSA	Not Valued	TOTAL
1 Day	574	3	0	94	671
2 to 3 Days	35	2	0	15	52
4 to 7 Days	26	5	0	9	40
8 to 14 Days	12	3	1	0	16
15 to 21 Days	1	1	2	2	6
22 to 28 Days	1	1	1	0	3
Over 28 Days	0	1	2	1	4
Not Valued	14	0	0	1	15
TOTAL	663	16	6	122	807

Source: Maryland State Trauma Registry



Mode of Patient Transport to Burn Centers

Patients Treated at Pediatric Burn Centers and Patients Less
Than Age 15 Treated at Johns Hopkins
Burn Center at Bayview (June 2025 to May 2026)

Modality Type	CNH	JHCC	JHBMC	TOTAL
Ground Ambulance	52	146	4	202
Helicopter	6	13	0	19
Other*	218	309	49	576
Not Valued	1	8	1	10
TOTAL	277	476	54	807

Source: Maryland State Trauma Registry

Note: The category “Other” includes patients that were brought in by fixed wing
ambulance, private or public vehicles or were walk-ins.



Origin of Patient Transport to Burn Centers

Patients Treated at Pediatric Burn Centers and Patients Less
Than Age 15 Treated at Johns Hopkins
Burn Center at Bayview (June 2025 to May 2026)

Origin Type	CNH	JHCC	JHBMC	TOTAL
Scene of Injury	45	165	28	238
Hospital Transfer	92	165	1	258
Other	139	106	24	269
Not Valued	1	40	1	42
TOTAL	277	476	54	807

Source: Maryland State Trauma Registry



Number of Injuries by Age

Patients Treated at Pediatric Burn Centers and Patients Less Than Age 15 Treated at Johns Hopkins Burn Center at Bayview (3-Year Comparison)

Age Range	June 2023 to May 2024	June 2024 to May 2025	June 2025 to May 2026
Under 1 Year	64	85	87
1 to 4 Years	368	329	398
5 to 9 Years	148	163	188
10 to 14 Years	93	112	99
15 Years and Over	36	39	35
TOTAL	709	728	807

Source: Maryland State Trauma Registry



Final Disposition of Patients

Patients Treated at Pediatric Burn Centers and Patients Less Than Age 15 Treated at Johns Hopkins Burn Center at Bayview (3-Year Comparison)

Final Disposition	June 2023 to May 2024	June 2024 to May 2025	June 2025 to May 2026
Home	653	652	763
Home with Services	26	37	21
Transfer to Acute Care Facility	12	20	9
Rehabilitation Facility	4	9	4
Skilled Nursing Facility	0	2	0
Morgue/Died	3	1	0
Left Against Medical Advice	4	1	4
Alternate Caregiver	2	1	2
Foster Care	0	3	1
Transfer to Inpatient Psychiatric Facility	1	0	0
Not Valued	4	2	3
TOTAL	709	728	807

Source: Maryland State Trauma Registry



Etiology of Injuries by Ages of Patients

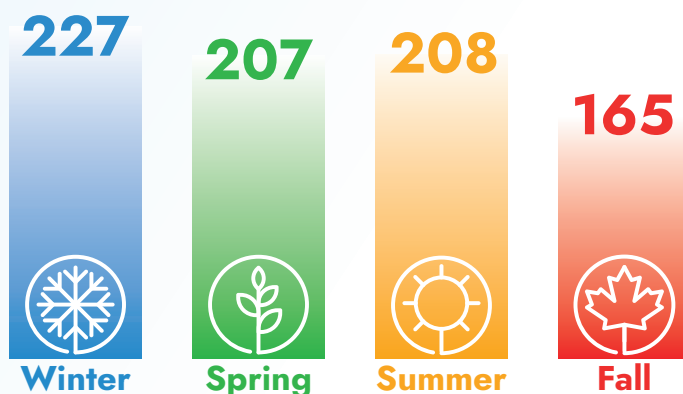
Patients Treated at Pediatric Burn Centers and Patients Less Than Age 15 Treated at Johns Hopkins Burn Center at Bayview (June 2025 to May 2026)

Age Range	Electrical	Chemical	Thermal			Inhalation	Other Burn	Other Non-Burn	Unknown	TOTAL
			Flame	Contact	Scald					
Under 1 Year	0	2	1	29	44	1	2	0	8	87
1 to 4 Years	2	3	10	180	175	2	7	1	18	398
5 to 9 Years	7	0	13	89	55	6	2	0	16	188
10 to 14 Years	2	2	15	36	33	4	1	1	5	99
15 Years and Over	1	0	6	8	13	1	5	0	1	35
TOTAL	12	7	45	342	320	14	17	2	48	807

Source: Maryland State Trauma Registry

Season of the Year Distribution

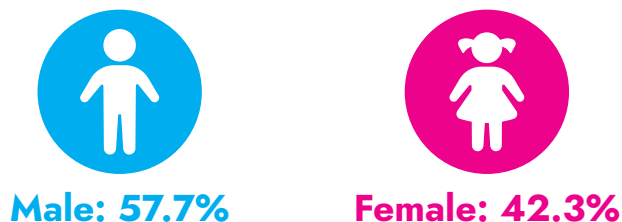
Patients Treated at Pediatric Burn Centers and Patients Less Than Age 15 Treated at Johns Hopkins Burn Center at Bayview (June 2025 to May 2026)



Source: Maryland State Trauma Registry

Gender Distribution

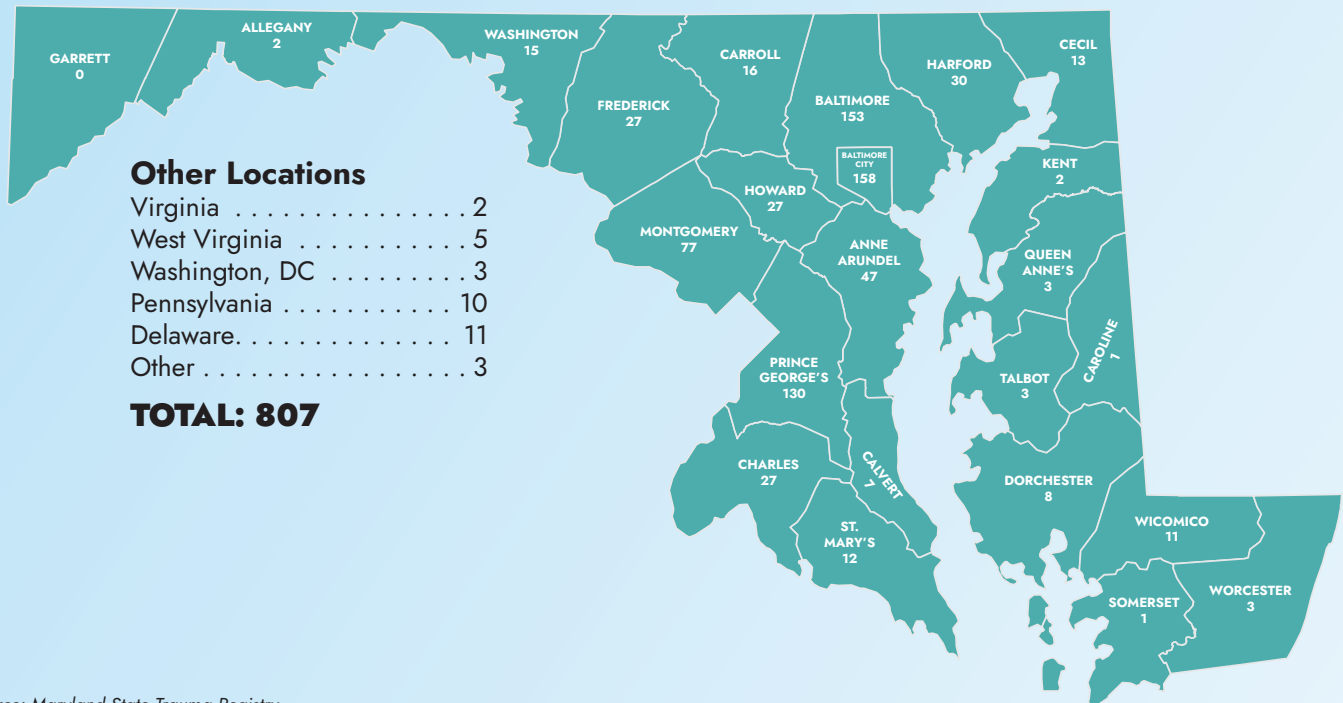
Patients Treated at Pediatric Burn Centers and Patients Less Than Age 15 Treated at Johns Hopkins Burn Center at Bayview (June 2025 to May 2026)



Source: Maryland State Trauma Registry

Residence of Patients by County

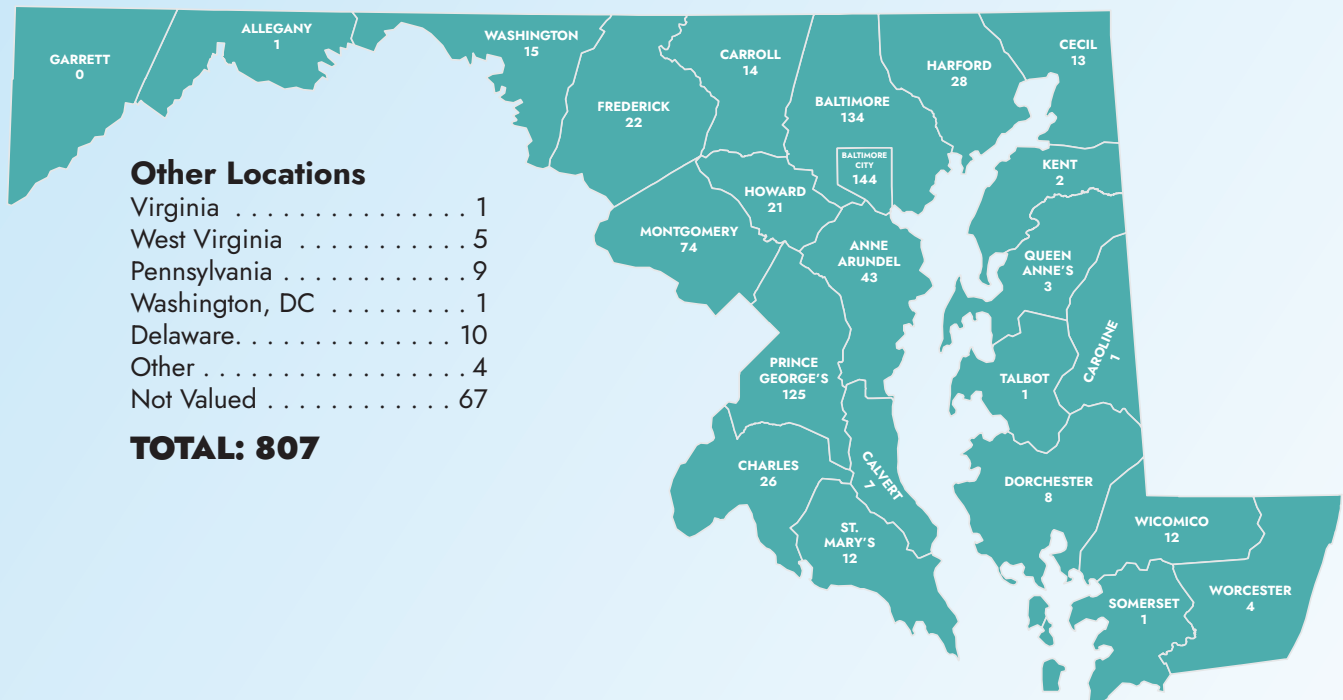
Patients Treated at Pediatric Burn Centers and Patients Less Than Age 15 Treated at Johns Hopkins Burn Center at Bayview (June 2025 to May 2026)



Source: Maryland State Trauma Registry

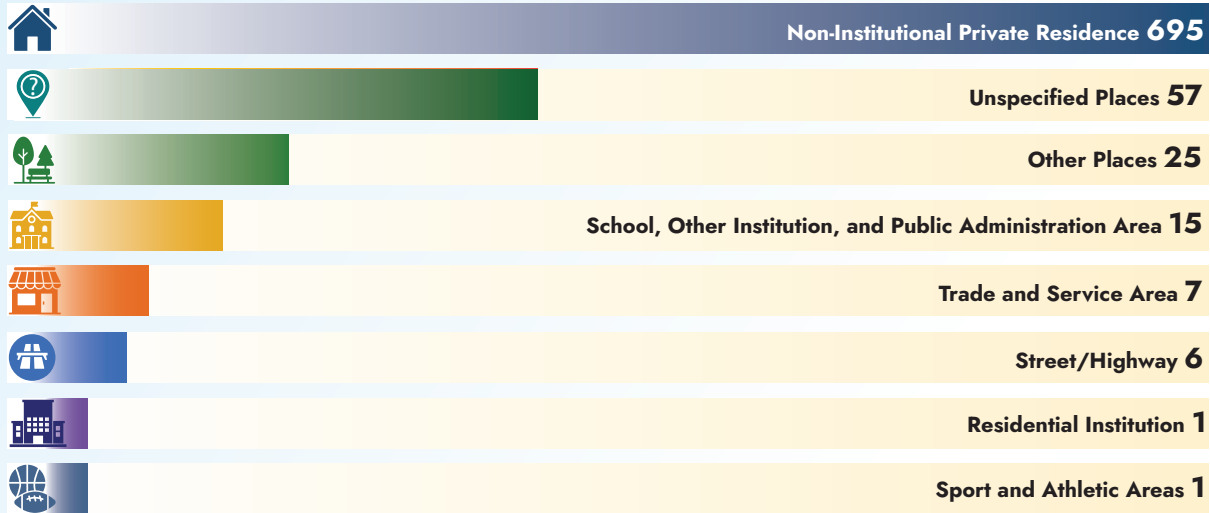
Occurrence of Injury by County

Patients Admitted to Pediatric Burn Centers and Patients Less Than Age 15 Admitted to Johns Hopkins Burn Center at Bayview (June 2025 to May 2026)



Place of Injury

Patients Treated at Pediatric Burn Centers and Patients Less Than Age 15 Treated at Johns Hopkins Burn Center at Bayview
(June 2025 to May 2026)



Source: Maryland State Trauma Registry

Number of Pediatric Burn Clinic Patients by Age

Patients Treated at Johns Hopkins Pediatric Center and Children's National Medical Center (3-Year Comparison)

Age Range	June 2023 to May 2024	June 2024 to May 2025	June 2025 to May 2026
Under 1 Year	61	88	81
1 to 4 Years	407	370	368
5 to 9 Years	180	164	165
10 to 14 Years	117	131	107
15 Years and Over	50	36	37
TOTAL	815	789	758

Source: Maryland State Trauma Registry

Number of Patients Treated at the Pediatric Burn Clinics at Johns Hopkins Pediatric Center and Children's National Medical Center

(3-Year Comparison)

Category	June 2023 to May 2024	June 2024 to May 2025	June 2025 to May 2026
Unique Patients	815	789	758
Total Pediatric Burn Clinic Visits	1,485	1,456	1,448

Source: Maryland State Trauma Registry

Gender Distribution

Patients Treated at the Pediatric Burn Clinics at the Johns Hopkins Pediatric Center and Children's National Medical Center (June 2025 to May 2026)



Male: 54.0%



Female: 46.0%

Source: Maryland State Trauma Registry

Etiology of Injuries by Ages of Patients

Patients Treated at the Pediatric Burn Clinics at Johns Hopkins Pediatric Center and Children's National Medical Center (June 2025 to May 2026)

Age Range	Electrical	Chemical	Thermal			Other Burn	Other Non-Burn	Unknown	TOTAL
			Flame	Contact	Scald				
Under 1 Year	0	1	0	24	50	2	0	4	81
1 to 4 Years	0	2	11	167	174	5	0	9	368
5 to 9 Years	3	0	11	92	53	0	0	6	165
10 to 14 Years	0	3	13	47	39	0	1	4	107
15 Years and Over	0	0	8	9	18	0	0	2	37
TOTAL	3	6	43	339	334	7	1	25	758

Source: Maryland State Trauma Registry

Adult & Pediatric Eye Trauma Center: The Johns Hopkins Wilmer Eye Institute

The Wilmer Eye Institute's Eye Trauma Center (ETC) remains Maryland's specialized center for the diagnosis, treatment, and long-term management of ocular trauma. The Wilmer Eye Trauma Center strengthens Maryland's trauma system by providing specialized, around-the-clock ophthalmic trauma services for patients of all ages, from neonates to older adults. The center collaborates closely with emergency medicine, critical care, nursing, anesthesia, and surgical teams to ensure timely access to expert ophthalmologic evaluation and treatment.

In FY 2026, Wilmer's clinical practice supported 298,674 patient visits and 14,900 eye surgeries across its statewide network of locations. The Eye Trauma Center continued to receive referrals from across Maryland and surrounding states, with Baltimore City and Baltimore County accounting for approximately 60% of in-state patient referrals.

The Eye Trauma Center maintains dedicated ophthalmology coverage 24 hours a day, seven days a week, with an in-house ophthalmologist available for emergency consultation. Ophthalmology-trained physician assistants support patient care during weekday hours, enhancing clinical capacity and access.

The Wilmer Eye Trauma Center provides coordinated, multidisciplinary care throughout the continuum of injury management, from emergency evaluation through rehabilitation and long-term recovery. It collaborates closely with Johns Hopkins emergency departments, including adult and pediatric emergency services, to streamline patient evaluation and treatment. The Patient Access Center for the Eye (PACE) clinic provides same-day and same-week appointment access for emergency department patients with non-acute eye concerns, improving continuity of care and reducing unnecessary delays.

In FY 2026, Wilmer and emergency department teams continued improving triage and consultation workflows, resulting in reduced time to ophthalmology evaluation, improved patient flow, shorter emergency department stays, and enhanced patient and family experiences.

The center provides access to comprehensive ophthalmology subspecialties, including cornea and external disease, glaucoma, retina, neuro-ophthalmology, pediatric ophthalmology, oculoplastics, ocular oncology, vision rehabilitation, and ocular trauma

Patients requiring long-term recovery support benefit from integrated services including low vision rehabilitation, occupational therapy, ocular prosthetics, and functional reconstructive surgery.



Age Range (June 2025 to May 2026)

Age Range	Percentage
1 to 4 Years	3.8%
5 to 14 Years	12.2%
15 to 24 Years	16.1%
25 to 44 Years	33.6%
45 to 64 Years	18.9%
65+ Years	15.4%
TOTAL	100.0%



Length of Stay (June 2025 to May 2026)

Number of Days	Percentage
1 Day	92.3%
2 to 3 Days	2.9%
4 to 7 Days	2.3%
8 to 14 Days	1.2%
15 to 21 Days	0.3%
22 to 28 Days	0.2%
Over 28 Days	0.8%
TOTAL	100.0%

Source: Maryland Eye Trauma Registry (n=657)

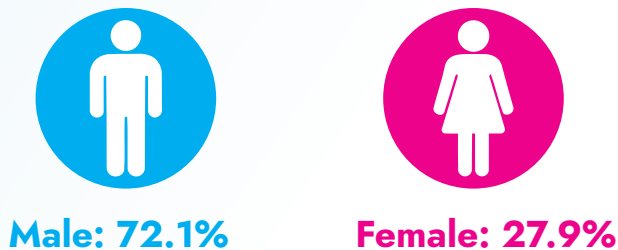
 Injury Type (June 2025 to May 2026)	
Injury Type	Percentage
BB/Pellet Gun	0.3%
Blunt Object	31.5%
Burn	7.5%
Explosion	0.5%
Fall	13.0%
Firearm	0.2%
Fireworks	0.2%
Hammer on Metal	0.3%
Lawn Equipment	0.5%
Motor Vehicle Crash	5.3%
Nail	1.1%
Sharp Object	8.8%
Other	30.8%
TOTAL	100.0%

 Final Disposition (June 2025 to May 2026)	
Final Disposition	Percentage
Acute Care Facility	0.2%
Correctional Facility / Court / Law Enforcement	3.2%
Home with Services	93.4%
Intermediate Care Facility	0.2%
Left Against Medical Advice	1.3%
Mental Health / Psychiatric Hospital (Inpatient)	0.2%
Rehabilitation (Inpatient Facility)	0.3%
Skilled Nursing Facility	1.0%
Other	0.2%
TOTAL	99.9%

Eye Protection
(June 2025 to May 2026)



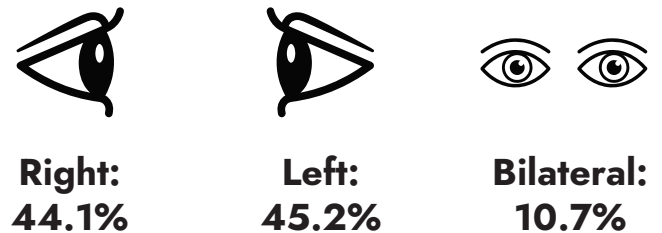
Gender of Patients
(June 2025 to May 2026)



Intentionality
(June 2025 to May 2026)

Category	Percentage
Abuse (NFS)	0.2%
Assault	19.3%
Self-Inflicted (Intentional)	0.3%
Unintentional	80.2%
TOTAL	100.0%

Eye Injured
(June 2025 to May 2026)



Day of the Week
(June 2025 to May 2026)



Curtis National Hand Center (CNHC) – Hand-and-Upper-Extremity Trauma

The Curtis National Hand Center (CNHC) at MedStar Union Memorial Hospital serves as Maryland’s referral center for complex hand, wrist, forearm, and elbow injuries. Since its collaboration with Dr. R Adams Cowley during the development of the Maryland trauma system, CNHC has remained an integral component of the state’s specialized trauma care network.

In FY 2026, CNHC’s emergency department treated 2,119 patients with acute hand injuries, with 22% arriving through public safety ambulance or medevac transport. The center’s specialized services draw patients from across Maryland and neighboring states, including Pennsylvania, Delaware, Virginia, West Virginia, and the District of Columbia.

Available 24/7/365, CNHC provides immediate access to orthopedic and plastic surgeons with advanced training in hand- and upper-extremity trauma. The dedicated hand transfer line received 555 transfer requests in FY 2026, with greater than 96% of patients accepted for transfer.

CNHC continues to serve as a regional replantation center and a member of the American Society for Surgery of the Hand/American College of Surgeons Hand Trauma Center Network, delivering advanced microsurgical reconstruction, fracture management, soft-tissue reconstruction, and limb-salvage services.

CNHC provides integrated, interdisciplinary care designed to address the complex needs of trauma patients beyond initial stabilization. CNHC’s multidisciplinary approach includes hand surgeons, orthopedic and plastic surgeons, certified hand therapists, occupational and physical therapists, orthotics/prosthetics specialists, social services, and pain psychology services.

CNHC expanded coordinated care through a dedicated upper-extremity amputation clinic integrating surgery, rehabilitation, prosthetics, therapy, and social services. Additionally, it expanded peripheral nerve and spasticity services, as well as a bone health program addressing fragility fractures and recovery challenges. The bone health program experienced a 50% increase in patient volume, serving nearly 500 patients through collaboration among hand surgery, orthopedics, endocrinology, geriatrics, rehabilitation, and primary care.

Source: The Curtis National Hand Center (n=2,119)

Gender Distribution
(July 2025 to June 2026)



Male:
67.1%



Female:
32.9%

Work-Related
(July 2025 to June 2026)



Yes:
16.4%



No:
83.6%

Injury Type (July 2025 to June 2026)	
Injury Type	Percentage
Blunt	16.5%
Burn	0.5%
Crush	14.0%
Deglove	1.1%
Exposure	0.4%
Infection	20.4%
Laceration	27.4%
Other	11.7%
Penetrating	4.6%
Slice	3.4%
TOTAL	100.0%

Age Range (July 2025 to June 2026)	
Age Range	Percentage
Under 1 Year	0.1%
1 to 4 Years	0.3%
5 to 9 Years	0.6%
10 to 14 Years	1.7%
15 to 24 Years	12.6%
25 to 44 Years	35.2%
45 to 64 Years	31.1%
65+ Years	18.4%
TOTAL	100.0%

Transport Mode (July 2025 to June 2026)	
Transportation Mode	Percentage
Helicopter	2.3%
Ambulance	18.4%
Private Vehicle	49.0%
Walk-In	29.9%
Other	0.4%
TOTAL	100.0%

Neurotrauma Center, R Adams Cowley Shock Trauma Center, Baltimore

The Neurotrauma Center at the University of Maryland R Adams Cowley Shock Trauma Center provides specialized, comprehensive care for patients with complex injuries involving the brain, spinal cord, and spinal column as part of Maryland's coordinated trauma system.

The 12-bed Neurotrauma Critical Care Unit (NTCC) provides advanced critical care for patients with severe central nervous system injuries. Specialized monitoring capabilities include Intracranial pressure monitoring, cerebral oxygen monitoring, continuous electroencephalogram monitoring, and advanced neurological assessments to identify and prevent secondary brain injury. Neurosurgical expertise is available for advanced procedures, including hematoma evacuation, gunshot wound management, depressed skull fracture repair, decompressive craniectomy, and cranioplasty.

The 24-bed Neurotrauma Intermediate Care Unit (NTIMC) provides continued interdisciplinary care for patients requiring specialized monitoring and intensive nursing support. Evidence-based protocols guide management of traumatic brain and spinal cord injuries, including treatment approaches for agitation following brain injury.

During this reporting period, NTC expanded treatment capabilities through the reinvigoration of its diaphragmatic pacer program for patients with high cervical spinal cord injuries who lack diaphragm control. The program included updated clinical protocols, staff education, patient resources, and successful implantation of diaphragmatic pacers in three patients.

NTC maintained strong partnerships supporting the continuum of trauma care, including organ donation services. The NTCC achieved a 100% organ referral rate with no missed referrals and received the Tyree Nutter Legacy of Life Award from Infinite Legacy for its commitment to donation excellence.

NTC provides coordinated, patient-centered care throughout the entire trauma continuum, from emergency treatment through rehabilitation and long-term recovery. Care is supported by an interdisciplinary team addressing the complex medical, functional, emotional, and social needs of neurotrauma patients. Rehabilitation begins immediately following stabilization, with early mobility and functional recovery incorporated into the treatment plan.

NTC's commitment to comprehensive care was recognized nationally in FY 2026, with both NTCC and NTIMC receiving the

American Association of Critical Care Nurses Silver Beacon Award for Excellence, the University of Maryland Medical Center Daisy Team Award, Chief Nursing Officer Award for Team Excellence, and *Baltimore Magazine* Excellence in Nursing Awards.

Maryland Poison Center, University of Maryland School of Pharmacy

The Maryland Poison Center (MPC) provides 24/7 emergency poison information and treatment guidance to the public and health professionals throughout Maryland and the District of Columbia. Designated by MIEMSS as a specialty referral center and by the Maryland Department of Health as a regional poison center, MPC supports emergency response, clinical decision-making, education, and prevention efforts related to poisonings and overdoses.

A division of the University of Maryland School of Pharmacy, MPC has provided poison treatment advice, education, and prevention services since 1972. MPC is certified by the American Association of Poison Control Centers (AAPCC), with poison specialists—including pharmacists and nurses certified as specialists in poison information—providing expert consultation around the clock. MPC's 21 specialists bring more than 230 years of combined poison center experience to assist callers, EMS clinicians, and healthcare providers.

During this reporting period, Poison Consultation and Emergency Support managed more than 57,000 cases across Maryland and the District of Columbia. Of these, approximately 47,000 involved human exposures, while the remaining cases involved information requests or animal exposures. Children under 6-years-old accounted for 36% of reported poison exposures.

The most common causes of poisoning included analgesics, household cleaning products, antidepressants, cardiovascular medications, cosmetics, and personal care products. More than 71% of reported cases were successfully managed outside a healthcare facility, including at homes, schools, and workplaces. By providing immediate expert guidance, MPC helps prevent unnecessary emergency department visits and transports while supporting safe, evidence-based care.

Maryland EMS clinicians consulted MPC for approximately 1,900 cases in CY 2025. Based on MPC recommendations, 20% of these cases did not require EMS transport to a healthcare facility, reducing unnecessary use of healthcare resources while ensuring appropriate patient management.

UNIVERSITY OF MARYLAND
SCHOOL
OF PHARMACY

Rehabilitation Services

Rehabilitation is a critical component of the continuum of care for individuals who survive traumatic injury. Designated trauma centers within the Maryland EMS system are required to ensure that patients have access to appropriate rehabilitation services, whether provided directly within the facility or through partnerships with specialized rehabilitation centers.

Rehabilitation begins as early as possible after admission and may continue through both inpatient and outpatient settings. Patients who experience multiple traumatic injuries (particularly those resulting in temporary or long-term disability) benefit from comprehensive rehabilitative services designed to help them return to active, independent lives. Common injuries requiring rehabilitation include spinal cord injuries, traumatic brain injuries, fractures, amputations, and gunshot wounds. The primary goal is to help patients regain their highest possible level of functioning by restoring strength, mobility, and cognitive abilities.

An individualized, interdisciplinary treatment plan is developed with each patient to address their specific needs and goals. The initial rehabilitation team evaluates and monitors the patient, focusing on preventing complications related to immobility, positioning, and nutrition. Rehabilitation services provided during hospitalization also support long-term planning, prognosis, and continuity of care.

After the acute care phase, trauma centers assist patients and families in determining the most appropriate rehabilitation setting. Factors such as expected functional outcomes, social needs, financial considerations, geographic location, and eligibility requirements all influence placement decisions.

Three primary types of rehabilitation therapy support the patient’s recovery:

Physical Therapy: Physical therapy focuses on reducing pain and improving movement, strength, balance, and flexibility after injury. Physical therapists work with patients at the bedside or in a dedicated therapy setting during hospitalization. Their efforts help minimize permanent disability and support a return to daily activities. They treat patients with injuries involving bones, muscles, nerves, the spinal cord, and the brain. After discharge, patients may continue physical therapy at home or in an outpatient facility.

Occupational Therapy: Occupational therapy helps patients regain the ability to perform essential self-care tasks, recreational activities, and daily routines such as dressing, eating, driving, and bathing. Depending on the patient’s condition, occupational therapy may occur in the acute care hospital, at an outpatient center, or in the home. The goal is to restore independence and enable patients to safely return to meaningful everyday activities.

Speech Therapy: Speech therapy addresses communication and language abilities by focusing on both the mechanics of speech and the cognitive processes involved in understanding and using language. Speech therapists treat issues related to communication, voice, swallowing, and articulation. These services are especially important after traumatic brain injury. Speech therapists help patients relearn how to swallow and eat safely, improve comprehension, and enhance overall communication skills. Therapy may take place in the hospital, at home, or in an outpatient setting, depending on the patient’s needs and recovery goals.

Rehabilitation plays a vital role in Maryland’s trauma care system and the continuum of care, serving as a critical bridge between acute treatment and a patient’s return to independent living. Across the state’s hospitals, early rehabilitation is emphasized to improve recovery outcomes, reduce complications, and restore mobility, communication, and self-care abilities. Through coordinated, interdisciplinary teams of physicians, therapists, and specialists, Maryland hospitals deliver individualized care plans that extend from the bedside to outpatient and community settings. These programs—ranging from advanced neuro and orthopedic rehabilitation to burn, pediatric, and visual recovery—reflect a shared statewide commitment to maximizing function, promoting wellness, and helping trauma survivors regain quality of life and reintegrate into their communities.



**Top Destinations of Patients Who Went to Inpatient Rehabilitation Facilities:
Patients Age 15 and Over**
(June 2025 to May 2026)

Rehabilitation Center	Number
Adventist HealthCare Rehabilitation	169
Bay Harbor Post Acute	30
Encompass Health	383
Genesis Healthcare	12
Inpatient Rehabilitation Center at MedStar Good Samaritan Hospital	12
Johns Hopkins Bayview Specialty Hospital Programs	32
MedStar National Rehabilitation Hospital	44
PAM Health	100
Rehabilitation Institute at Sinai	66
The Johns Hopkins Hospital Comprehensive Inpatient Rehabilitation Unit	43
University of Maryland Rehabilitation and Orthopaedic Institute	308

Source: Maryland State Trauma Registry
Note: Total patients age 15 and over that went to a rehabilitation center = 1,973.



**Top Destinations of Patients Who Went to Inpatient Rehabilitation Facilities:
Patients Age 14 and Under**
(June 2025 to May 2026)

Rehabilitation Center	Number
Adventist HealthCare Rehabilitation	1
Children’s National Rehabilitation and Specialized Care	1
The HSC Pediatric Center, DC	3
Kennedy Krieger Institute	5
MedStar National Rehabilitation Hospital	5
Mount Washington Pediatric Hospital	15
Nemours Children’s Health, DE	1

Source: Maryland State Trauma Registry
Note: Total patients age 14 and under that went to a rehabilitation center = 31.

Maryland Trauma and Specialty Rehabilitation Services

Primary Adult Resource Center & LEVEL I Trauma Centers



R Adams Cowley Shock Trauma Center Neurotrauma Center



- Rehabilitation begins immediately upon arrival with early mobilization
- Interdisciplinary team of physicians, nurses, therapists, social workers, dietitians, and more
- Reduces morbidity and improves recovery after neurologic injury
- Post-acute rehab through UMMC Rehabilitation and Orthopaedic Institute



R Adams Cowley Shock Trauma Center Trauma Rehabilitation



- ATLS rehabilitative process begins with early patient mobilization and functional training
- Interdisciplinary team includes physicians, nurses, therapists, and ancillary care providers
- Extensive daily interactions and disposition rounds address problems and set clinical plan for complex patients
- Post-acute inpatient and outpatient services provided by UMMC Rehabilitation & Orthopaedic Institute and UMMC Midtown Campus



The Johns Hopkins Hospital 18 - Bed comprehensive Inpatient Rehabilitation Program



- 3 hours of intensive therapy, 5-7 days per week
- Mock apartment and "streetscape" for real-world practice
- Advanced tele-rehabilitation for continued care
- National leader in early ICU mobilization, virtual reality, and wearable technology

LEVEL II Trauma Centers



Johns Hopkins Bayview Medical Center



- 1/3 of admitted trauma patients require rehab care
- Inpatient acute rehab center on campus for coordinated care within the system
- Social work/case management address needs before discharge for safe transitions



Sinai Hospital of Baltimore



- Early mobilization, dysphagia management, cognitive & functional recovery
- Advanced technology: Body-weight supported gait, virtual reality, instrumented gait analysis
- Specialized programs: TBI, vestibular rehab, return-to-work, prosthetics, pain management
- Research and clinician training to advance rehabilitations



University of Maryland Capital Region Medical Center



- PM&R team works with trauma team for early ambulation and discharge
- Physical therapy, occupational therapy, and speech-language therapy
- Continued collaboration to improve functional outcomes



Johns Hopkins Suburban Hospital



- PT, OT, and speech therapy provided onsite during hospitalization
- Case managers and social workers coordinate referrals to appropriate rehab facilities
- Partnerships with Adventist HealthCare Rehab Center for specialty services

LEVEL III Trauma Centers



UPMC Western Maryland



- Interdisciplinary teams create individualized rehab plans
- Focus on independence, mobility, communication, and quality of life
- Comprehensive therapy and coordinated discharge planning



Meritus Medical Center



- Region's largest, most comprehensive rehab network with multiple locations
- PT, OT, and speech therapy services
- Aquatic therapy with warm-water pool, lift, and handrails
- New Sports Medicine/Physical Therapy Center with leading-edge technology



Peninsula Regional (TidalHealth)



- In-home PT, OT, and speech therapy program
- Alice B. Tawes Nursing & Rehab specialist
- Partnerships with Encompass Health Rehab Hospital and other facilities for continued recovery

Specialty and Referral Centers



Johns Hopkins Children's Center

- Pediatric inpatient and outpatient rehab for traumatic and burn injuries
- Multidisciplinary rehabilitation specialist teams
- Pediatric burn clinic occupational therapy: range of motion, scar care, adaptive strategies, and return to age-appropriate activities
- Partnerships with Mount Washington Pediatric Hospital for intensive inpatient rehab



Johns Hopkins Bayview Burn Center

302

Inpatients evaluated by PT/OT within 24 hours (FY 2026)

- Daily rehab in gym or in-room
- Research on early ambulation in burn patients
- Multidisciplinary conferences and care coordination
- Nurse Navigator supports follow-up after discharge



MedStar Washington Hospital Center Burn Center



- Dedicated Burn Rehabilitation Gym with specialized PT/OT
- Reconstructive surgery and rehab through all phases of recovery
- Integrated with comprehensive burn care
- Burn rehab therapy gym included in facility renovation



Curtis National Hand Center



- Specialized hand therapy with individualized treatment plans
- Custom splinting, therapeutic exercise, nerve re-education, and more
- In-person and telehealth visits for continuity of care
- Pain psychology and CBT available through MedStar National Rehab Hospital

OT = Occupational Therapy
PT = Physical Therapy



Emergency Medical Services for Children (EMSC) – Systems of Care

MIEMSS continues to strengthen Maryland's pediatric emergency care system by developing coordinated infrastructure, improving pediatric readiness, and supporting consistent standards across EMS agencies and healthcare facilities. The Maryland EMS for Children (EMSC) State Partnership Program supports statewide implementation of pediatric readiness initiatives aligned with national EMSC performance measures and Maryland EMS Vision 2030 priorities.

Pediatric Facility Recognition Program

The Pediatric Facility Recognition Program formally recognized pediatric readiness among hospital emergency departments and freestanding emergency centers. Based on the National Pediatric Readiness Project and national recommendations from the American Academy of Pediatrics, American College of Emergency Physicians, American College of Surgeons, and Emergency Nurses Association, the program supports hospitals in improving pediatric capabilities while helping EMS clinicians make informed destination decisions for pediatric patients. Twenty-one hospitals submitted letters of intent to participate, and six facilities have achieved recognition at one of three levels: Pediatric Ready Emergency Department, Pediatric Resource Hospital, or Comprehensive Pediatric Hospital.

MIEMSS continues to support pediatric readiness across the continuum of care through the Pediatric Nurse and Physician Champion Programs. The Pediatric Readiness Emergency Department Collaborative includes designated champions from Maryland emergency departments and representatives from professional organizations. In FY 2026, 100% of Maryland hospitals participated in the National Pediatric Readiness Project reassessment, providing facilities with updated performance information to guide future improvement efforts.

Prehospital Pediatric Readiness

Through pediatric disaster preparedness initiatives, quality improvement activities, and statewide collaboration, MIEMSS continues to build a resilient pediatric system of care. EMSC supports leadership and collaboration at the national level through participation in the National Association of State EMS Officials (NASEMSO) Pediatric Emergency Care Council and the Committee for the Safe Transport of Children in Ambulances.



Integration of Health Services

Pediatric Readiness

The EMS for Children (EMSC) Program at MIEMSS advances integrated health services by leading and coordinating resources to address the unique needs of children and families across Maryland. The advancements focus on injury and illness prevention, clinical protocols, standards of care, facility recognition, quality improvement, data analysis, interagency collaboration, and professional education. The goal is to enhance the efficient and effective delivery of out-of-hospital, hospital, and restorative care, promoting the health and well-being of children, youth, and families statewide.

Maryland EMSC State Partnership Grant

For 37 consecutive years, EMSC has received the EMS for Children State Partnership Grant from the Maternal and Child Health Bureau/Health Resources and Services Administration. The grant supports pediatric readiness across Maryland's emergency departments and EMS agencies. Funding supports the integration of hospital departments and EMS pediatric readiness to meet federal Performance and Maternal Child Health Core Performance Measures. Beyond pediatric readiness, a focus on pediatric disaster preparedness and family advocacy works to expand the Right Care When It Counts initiative. This work includes the leadership of three Pediatric Champion teams focused on EMS, emergency department nursing, and emergency department physicians.

In April 2025, the Pediatric Facility Recognition program began to recognize pediatric readiness in both hospital emergency departments and freestanding emergency centers. This program follows the National Pediatric Readiness Project on Pediatric Readiness in Emergency Departments. This joint statement was created by the American Academy of Pediatrics, American College of Emergency Medicine, American College of Surgeons, and Emergency Nursing Association. The program prepares hospitals to better care for children and empowers EMS clinicians to choose the best destinations for their patients.

The Pediatric Facility Recognition Program in Maryland is voluntary. In this reporting period, 21 hospitals have submitted letters of intent to participate. Of those, 6 hospitals have completed the program and been recognized by MIEMSS for one of 3 levels of care.

- Pediatric Ready Emergency Department,
- Pediatric Resource Hospital, and
- Comprehensive Pediatric Hospital.

The program continues to process applications and recognize facilities. Facilities seeking assistance with the process are invited to ongoing consultation through EMSC Office Hours and site visits.

Pediatric Readiness in Emergency Departments

The Pediatric Readiness Emergency Department collaborative group includes the designated Pediatric Champion from each of the state's 49 emergency departments along with members from the Maryland Emergency Nursing Association (ENA), the Maryland American Academy of Pediatrics (AAP), and the Maryland American College of Emergency Physicians (ACEP). This

group's efforts include quarterly webinars for nurse and physician champions to ensure high-quality, specialized emergency care for children.

Pediatric Nurse and Physician Champions

Based upon the revised Joint Policy Statement and Technical Report for Pediatric Readiness in the Emergency Department, Maryland hospitals and freestanding emergency centers participated in the 2026 National Pediatric Readiness Project reassessment survey. Revised by the American Academy of Pediatrics, American College of Emergency Medicine, the American College of Surgeons, and Emergency Nursing Association, national recommendations based on survey results were published in February 2026 and serve as the foundation for federal EMSC performance measures. All Maryland hospitals and emergency departments participated in this reassessment and have compiled summary reports to further develop their pediatric initiatives.

During this fiscal year, EMSC partnered with specialty center faculty to present a Pediatric Simulation training winter workshop. Six scenarios introduced physician and nurse Pediatric Champions to manikin and simulation monitors.

Mobile Integrated Health

Mobile Integrated Health (MIH) expands the role of EMS beyond emergency response by connecting patients with healthcare and community resources in their homes. This year, 14 Maryland EMS jurisdictions and one commercial ambulance service conducted 4,704 home visits, providing services that included post-hospital follow-up, fall-risk assessments, medication assistance, chronic disease support, and connections to community resources.

Pediatric Nurse Champions

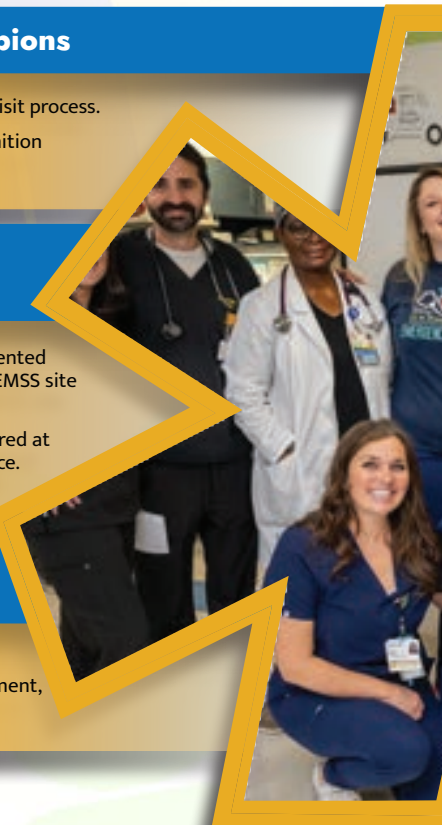
- In-person workshops for the site visit process.
- Maryland Pediatric Facility Recognition program.

Sharing Best Practices & Resources

- 3 Pediatric Nurse Champions presented best practices developed from MIEMSS site visits.
- Pediatric reference tools were shared at forums and ACEP annual conference.

Pediatric Physician Champions

Quarterly virtual forums featured emergency department care, assessment, and management.



In January 2026, Maryland MIH programs hosted their inaugural educational seminar at the Winterfest EMS Conference. Over 40 attendees heard from multidisciplinary presenters and panelists from MIH programs and health systems. Topics included the importance of medication reconciliation and education, fall prevention strategies, and non-traditional health care routes for patients with chronic and complex diseases. Clinicians learned about creative solutions for managing patients with complex medical, social, and financial needs. The Maryland MIH programs are already planning an event for next year.

In FY 2026, MIEMSS expanded innovative approaches to low-acuity 9-1-1 response, opioid use disorder treatment, fall prevention, and follow-up for patients who decline EMS transport. These efforts help identify and address health and social needs before they become emergencies while reducing unnecessary EMS and emergency department resources. MIEMSS continued to support the growth of MIH through education, collaboration, and statewide data collection.

**Chesapeake Regional Information System
for our Patients (CRISP) and eMEDS®
Integration Project**

In FY 2026, MIEMSS continued expanding the integration of eMEDS® with Maryland’s statewide health information

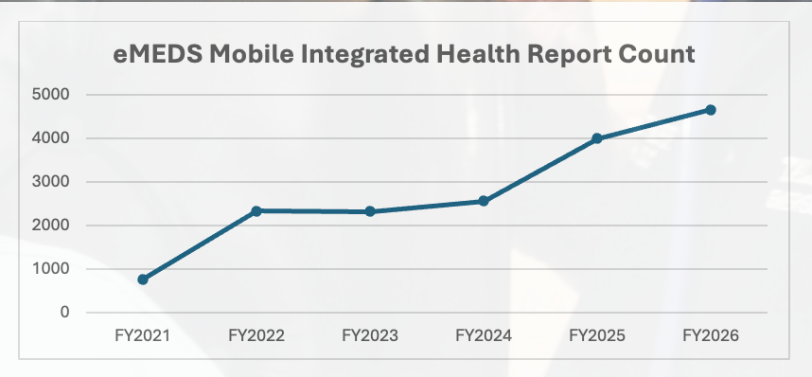
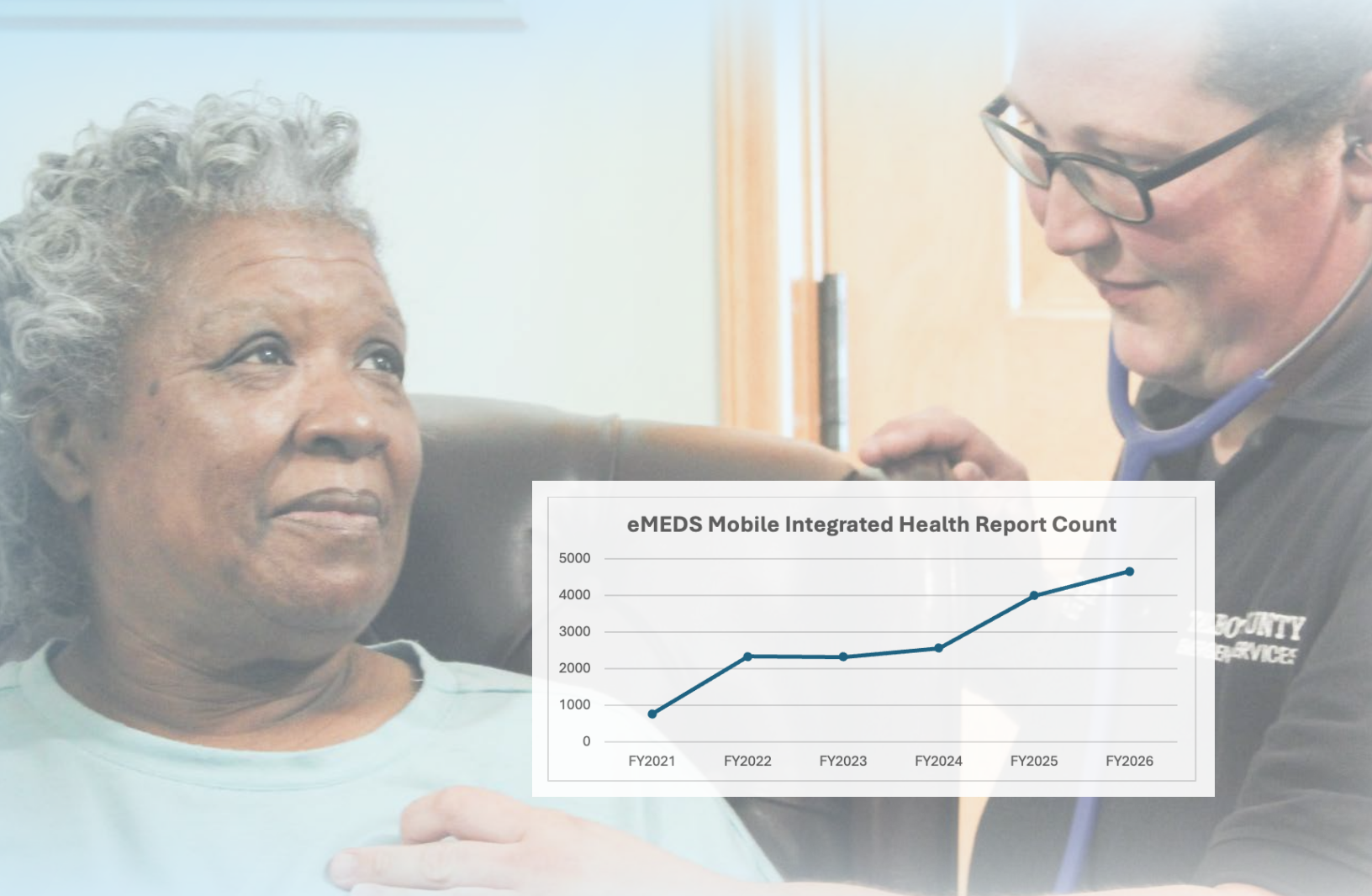
exchange, allowing EMS patient care reports to be securely shared with hospitals and healthcare providers in near-real time. This integration improves continuity of care by ensuring clinicians across the healthcare system have timely access to prehospital patient information while laying the foundation for future two-way information sharing that will provide EMS clinicians with important patient medical history and medication information in the field.

Supporting Public Health

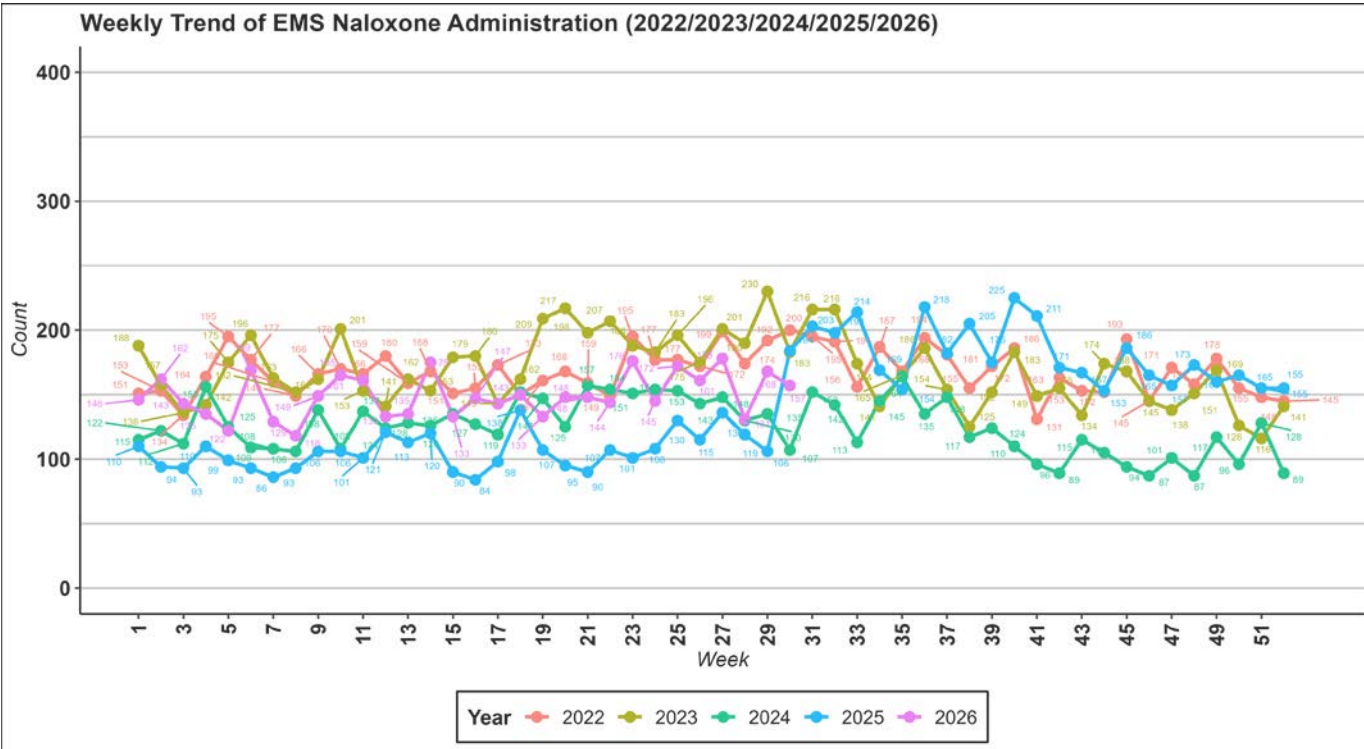
MIEMSS continued to provide EMS overdose data to statewide public health partners through the Overdose Detection Mapping Application Program (ODMAP) during this reporting period. These data support real-time monitoring of overdose trends and help inform coordinated statewide responses to the opioid epidemic. Working alongside the Maryland Department of Health and other partner agencies, MIEMSS contributes critical information that enables data-driven public health planning and resource deployment.

Naloxone and AED Co-Location Initiative

MIEMSS is supporting implementation of Maryland Senate Bill 1099, which requires the State EMS Board, in collaboration with the Maryland Department of Health, to develop and implement



an initiative to co-locate naloxone with automated external defibrillators (AEDs) in designated public buildings. The initiative builds upon the existing Maryland Public Access AED Program administered by MIEMSS, which provides oversight and registration of publicly accessible AEDs throughout the state. The Maryland AED Registry currently includes 8,545 locations and 16,963 AEDs statewide. Under SB 1099, MIEMSS is working with the Maryland Department of Health and participating organizations to expand access to naloxone by placing up to two doses in a visible, clearly identified location near AEDs in eligible public buildings. MIEMSS has completed 41 requests from 39 organizations, supporting 1,885 naloxone placements and the distribution of 3,770 individual naloxone doses, 1,971 identification signs, and 1,953 storage cases. These efforts support the goal of making naloxone readily available alongside other lifesaving emergency equipment and complement MIEMSS' broader opioid overdose response activities. The initiative continues to work toward the statewide goal of co-locating naloxone with AEDs in eligible public buildings by October 1, 2027.



Naloxone Administration

Every EMS encounter in Maryland is documented in a statewide EMS medical record system (eMEDS®). The information gathered can be helpful in assessing the overall burden of specific healthcare challenges in the community. Among them is the incidence of opioid overdose. Each week, MIEMSS shares the EMS experience with naloxone, an opioid overdose reversal agent administered throughout the state. This information is used by the Maryland Office of Overdose Response and the Maryland Department of Health as part of public health surveillance efforts. This information is merely one aspect of monitoring progress toward attenuating the opioid overdose problem.

Communications

Pennsylvania

Every county and town in Maryland must have a well-functioning, up-to-date, and accessible EMS communications and response system. MIEMSS Communication Engineering Services (CES) continuously evaluates and maintains the statewide system, providing the equipment, support, and expertise necessary for reliable, resilient, and interoperable communications. Strong partnerships with Maryland State Police, Maryland State Highway Administration, Department of Natural Resources Police and Forestry, Maryland Department of Transportation and the Transportation Authority, Maryland Department of Emergency Management, the US Departments of Homeland Security and Customs and Border Protection, and local 9-1-1 centers and counties connect EMS clinicians, hospitals, aviation assets, and public safety agencies across the State. Through continued investment in communications infrastructure and collaboration with federal, state, and local agencies, MIEMSS supports uninterrupted emergency response 24 hours a day, 365 days a year.

West Virginia

Statewide Communications Modernization

During this reporting period, MIEMSS continued advancing Maryland's transition to a modern, resilient IP-based communications network through ongoing implementation of the Communications Upgrade Project (CUP). These improvements strengthen reliability, reduce dependence on aging infrastructure, and enhance statewide interoperability.

Major accomplishments included:

- Under CUP, Region IV gained EMRC capability with eight new consoles at the new EMRC and updated four consoles at the old EMRC center, which is used as the primary backup for the new EMRC.
- Integration and migration to a web-based form of enhanced monitoring and alarm management systems
- Continued migration toward newer digital communications technologies that moves toward IP-based digital systems from T1 analog lines.
- Improved network resiliency through flexible redundant communications pathways based on continual assessment of system speed, throughput, latency, etc.

Expanding Statewide Interoperability

MIEMSS continued to play a leading role in Maryland First Responder Interoperable Radio System Team (MFiRST), the State's encrypted public safety radio network, in FY 2026. Expansion of aviation communications (AVTac) channels and continued deployment of P25 Phase II capabilities improve coordination among EMS, law enforcement, fire, and aviation partners while enhancing statewide coverage and reducing communication gaps.

Currently, 14 Maryland counties have implemented AVTac capabilities, with additional jurisdictions planned as statewide deployment continues.

Strengthening Critical Infrastructure

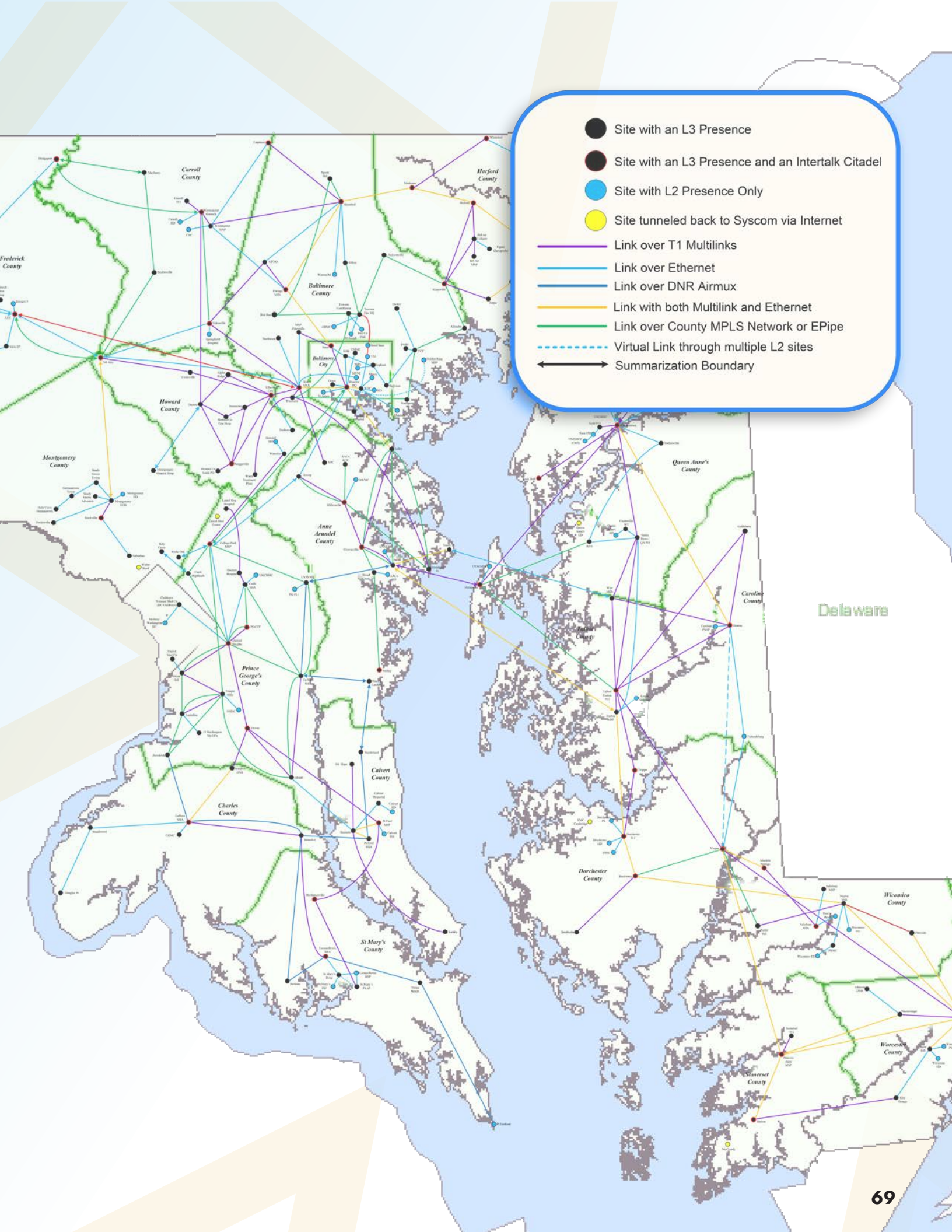
CES oversees and maintains 32 towers and deploys equipment at over 245 facilities across Maryland. MIEMSS maintains a microwave communications network that spans all of Maryland as well as parts of West Virginia, Delaware, and the District of Columbia, providing essential connectivity for MIEMSS, Maryland State Police, local jurisdictions, hospitals, and other public safety partners. During FY 2026, multiple microwave links were upgraded or replaced to improve network reliability, increase bandwidth, and support long-term sustainability of the EMS communications system. This year, CES upgraded a total of 9 microwave links in Baltimore City, Washington, Frederick, and Allegany Counties.

Additional infrastructure improvements included:

- Replacement of networking equipment that is no longer supported by Cisco, including approximately 175 switches, routers, firewalls, and other equipment
- Expansion of Ethernet-capable microwave systems at 11 hops
- Continued support for legacy communications systems while transitioning to next-generation technologies

Collaboration Across Maryland

Successful statewide emergency communication depends on close collaboration among numerous public safety partners. CES continues to work with Maryland State Police Aviation Command, Maryland Department of Transportation, Department of Natural Resources, Maryland Department of Emergency Management, local 9-1-1 centers, county governments, hospitals, and other public safety agencies to ensure reliable communications during both routine operations and major incidents. This year, MIEMSS, within its continuity of operations plan, developed methods to ensure that emergency services are able to maintain communications in their EMRC. For example, if a hospital loses network capability, four portable emergency communications systems that include a MiFi, ASA switch "firewall", and a DEMSTEL phone are deployed.



Site with an L3 Presence

Site with an L3 Presence and an Intertalk Citadel

Site with L2 Presence Only

Site tunneled back to Syscom via Internet

Link over T1 Multilinks

Link over Ethernet

Link over DNR Airmux

Link with both Multilink and Ethernet

Link over County MPLS Network or EPipe

Virtual Link through multiple L2 sites

Summarization Boundary



EMRC / SYSCOM

The Emergency Medical Resource Center (EMRC) and Systems Communications (SYSCOM) form the communications hub for the Maryland EMS system. Both EMRC and SYSCOM function 24 hours a day, 365 days a year.

EMRC manages communications between prehospital EMS clinicians and emergency departments, trauma centers, and specialty centers to facilitate medical consultations. During major medical incidents, EMRC shares current situational awareness regarding the activities, capabilities, and capacities of hospitals and the prehospital system. EMRC deploys initial alerting, coordinates resources, and manages patient distribution.

This year, EMRC had 222,859 telephone and radio calls. These calls included communications involving administrative/operational support issues, incidents involving single and multiple patients, and calls requiring online medical direction. With integration of the Emergency Department Advisory System (EDAS), the center monitors and shares hospital status information with 9-1-1 centers, EMSOPs, MIEMSS officials, and hospitals.

SYSCOM manages requests from EMS, law enforcement, homeland security, and disaster management. It coordinates helicopter resources for medevac and other missions. Maryland State Police Aviation Command (MSPAC) Duty Officers coordinate missions from the Operational Control Center, located within SYSCOM. This year, SYSCOM coordinated 4,865 flight requests for law enforcement, search-and-rescue, and medevac, resulting in 2,062 patients flown to specialty referral centers.

EMRC / SYSCOM

216,757

2024–25 EMRC Connections

222,859

2025–26 EMRC Connections

2024–25 Flight Requests

Total Number of Requests – 4,748

Completed Patient Transfers – 1,940

2025–26 Flight Requests

Total Number of Requests – 4,865

Completed Patient Transfers – 2,062

Preparedness and Response

Building a More Resilient EMS System FY 2026 Statewide Preparedness Initiatives



EMS Preparedness and Operations

Delivers 24/7 support for emergency management, system coordination, data integration, and situational awareness.

- ASPR/HHS Hospital Preparedness Program
- MEMRAD
- eMEDS® interface with ESSENCE
- CHEMPACK and National Disaster Medical System preparedness
- Healthcare facility evacuation exercises
- MIEMSS Incident Management Team

Coordinates hospital and EMS intelligence, EMRC incident reporting, and agency Continuity of Operations (COOP) planning.



Continuity of Operations (COOP) and Backup Communications

MIEMSS continued development of a geographically separate backup center for EMRC and SYSCOM operations.

A new console was implemented at the Harford County 9-1-1 Center, with additional equipment needed as a critical step toward reaching full backup capability.



CHEMPACK

In collaboration with the Office of the State EMS Medical Director, the EMS Preparedness and Operations team oversees Maryland's CHEMPACK program for first responders.

Provides EMS clinicians with rapid access to antidotes for nerve agent attacks and large-scale organophosphate poisonings. Strategically located supplies are monitored and maintained for rapid deployment.



Regional Coordination and Councils

MIEMSS regional offices are strategically located in each region and staffed by coordinators who monitor EMS operations, provide technical assistance to EMS jurisdictions and hospitals, and support system development, training, exercises, and Mobile Integrated Health programs.

Regional councils review performance data, identify training needs, and support dissemination and implementation of protocol updates.



Critical yearly Maryland Medical Protocols for EMS trainings included adult and pediatric High-Performance CPR.



Active Assailant Interdisciplinary Work Group

MIEMSS co-chairs the Active Assailant Interdisciplinary Work Group, which brings together subject matter experts from across Maryland to develop and share best practices for preventing, preparing for, responding to, and recovering from active assailant incidents.



MIEMSS maintains the aaiwg.maryland.gov website.



to Extraordinary Events

Maryland-National Capital Region Emergency Response System (MDERS) FY 2026 Investment Overview



Emergency Management Response & Recovery — *Enhances situational awareness, coordination, and community resilience*

Supported preparedness, planning, and exercises • Prince George's County: Community Lifelines app, EOC dashboards, COOP, and damage assessment tools • Montgomery County: engaged ~ 10,000 residents through outreach & symposium



Emerging Homeland Security Technology — *Evaluates and deploys innovative solutions to enhance operations*

5% of annual budget invested in emerging technology • StarChase pursuit technology for MCPD • Equipment cleaning systems for MCPD and PGCPD • Computer hardware for PSJOC



Regional Preservation and Advocacy — *Represents stakeholder interests and supports regional funding opportunities*

Active participation in MWCOG committees and regional working groups • Includes RESF committees, NCR Emergency Response System, and HSEC



Training and Exercises — *Builds skills, tests plans, and bolsters readiness*

Supported 26 conferences and 32 training opportunities • Topics: tactical operations, rescue, austere care, public safety, and more • Exercises: rail incidents, active assailant, public order, and cybersecurity



Structural Collapse Equipment — *Enhances operations in confined spaces and improves responder safety and effectiveness*

Portable cutting tools and torches • Night-vision binoculars • Paratech Rescue Guardian systems • Training manikins



Evolv Detection System — *Improves threat detection and helps prevent hostile acts in healthcare facilities*

Two systems procured for hospital security • Located at Adventist HealthCare's White Oak Medical Center and Fort Washington Medical Center



Prince George's County Hazardous Weather Preparedness — *Strengthens monitoring, modeling, and early warning capabilities*

Weather stations with flood sensors, rain gauges, and cameras • Deployed in high-risk, floodprone areas



EMS Mobile Clinical Competency — *Expands access to quality training and reduces travel*

Upfitted training van with storage • Medical supplies and patient litters • 3D printer for custom training equipment



Command Competency Lab Enhancements — *Enhances training realism and officer decision-making*

Tablet for mobile evaluations • Thermal imagers, entry props, and smoke machines • Generator and storage solutions



Law Enforcement & Specialized Response — *Strengthens law enforcement capabilities and officer safety*

Logistics van and vehicle upfits for MCPD • Body armor plates and elevated surveillance towers for PGCPD



Emergency Operations Enhancements — *Improves coordination and information sharing across agencies*

Supported Montgomery County Public Safety Joint Operations Center (PSJOC) • Secured IT platforms and technology to integrate multiple public safety functions



Acts of Violence Incident Training Lab — *Improves integration of medical personnel with law enforcement in high-threat environments*

Medical supplies • Training manikins • Bleeding control trainers



26
Conferences
Supported

32
Training
Opportunities

Partnerships with
County, Regional, &
Healthcare Agencies



**Exercises
Developed &
Supported**

Rail, Active Assailant,
Public Order, Cyber-
security & more



512
Stakeholders
Supported

Resource Management

Maryland's EMS resources include more than 1,300 public safety ambulances and nearly 500 commercial ambulances that provide most interfacility patient transports. The Maryland State Police provide air medical support for EMS response, while commercial air medical services provide air critical care interfacility transport.

Commercial Ambulance Coordination

The State Office of Commercial Ambulance Licensing and Regulation (SOCALR) provides statewide oversight of Maryland's commercial ambulance industry through licensing, inspections, regulatory compliance, and data quality initiatives.

SOCALR supports advancements to operations that protect the health, safety, and welfare of patients. The office promotes consistent and equitable regulations across Maryland through statewide review of regulations for commercial ambulance services and vehicles.

Key highlights of this work include licensing 38 commercial ambulance services operating 494 commercial ambulances, which transported more than 290,000 patients.

Online systems for registration and maintenance of information for commercial services and vehicles continued improvements for productivity and reporting through an online dashboard. This gives services access to licensing data and registration and renewal processes. To ensure accurate and efficient data transfer, SOCALR connects services with third-party electronic patient care records (ePCR) vendors, and quality is assessed by random samples of patient care reports. This practice improves patient care through standardized data collection.

All commercial ambulances are inspected at least once per year, with additional random unit inspections. During FY 2026, random inspections included 48 units and 366 sites. In compliance with COMAR 30.09, follow-up reports are drafted with corrective actions outlined as needed. SOCALR conducted 8 neonatal program transport and equipment inspections for MIEMSS Care Integration.

Commercial Ambulance Services



31 Licensed Ground Services

7 Licensed Air Services

2,400 Clinicians Working for Commercial Services

494 Licensed Commercial Ambulances in Maryland

ALS – Advanced Life Support **183**

BLS – Basic Life Support **311**

292,037 Annual Patient Transports



47 Scheduled Inspection Days



9 Surveys of Commercial Services Bases



494 Annual Ambulance Inspections and 48 Random Ambulance Inspections



366 Statewide Random Site Visits

Jurisdictional EMS Operational Programs

Maryland's 29 Jurisdictional EMS Operational Programs (JEMSOPs) provide 9-1-1 emergency medical response across the State. MIEMSS supports these agencies through statewide coordination, policy development, protocol implementation, and operational planning.

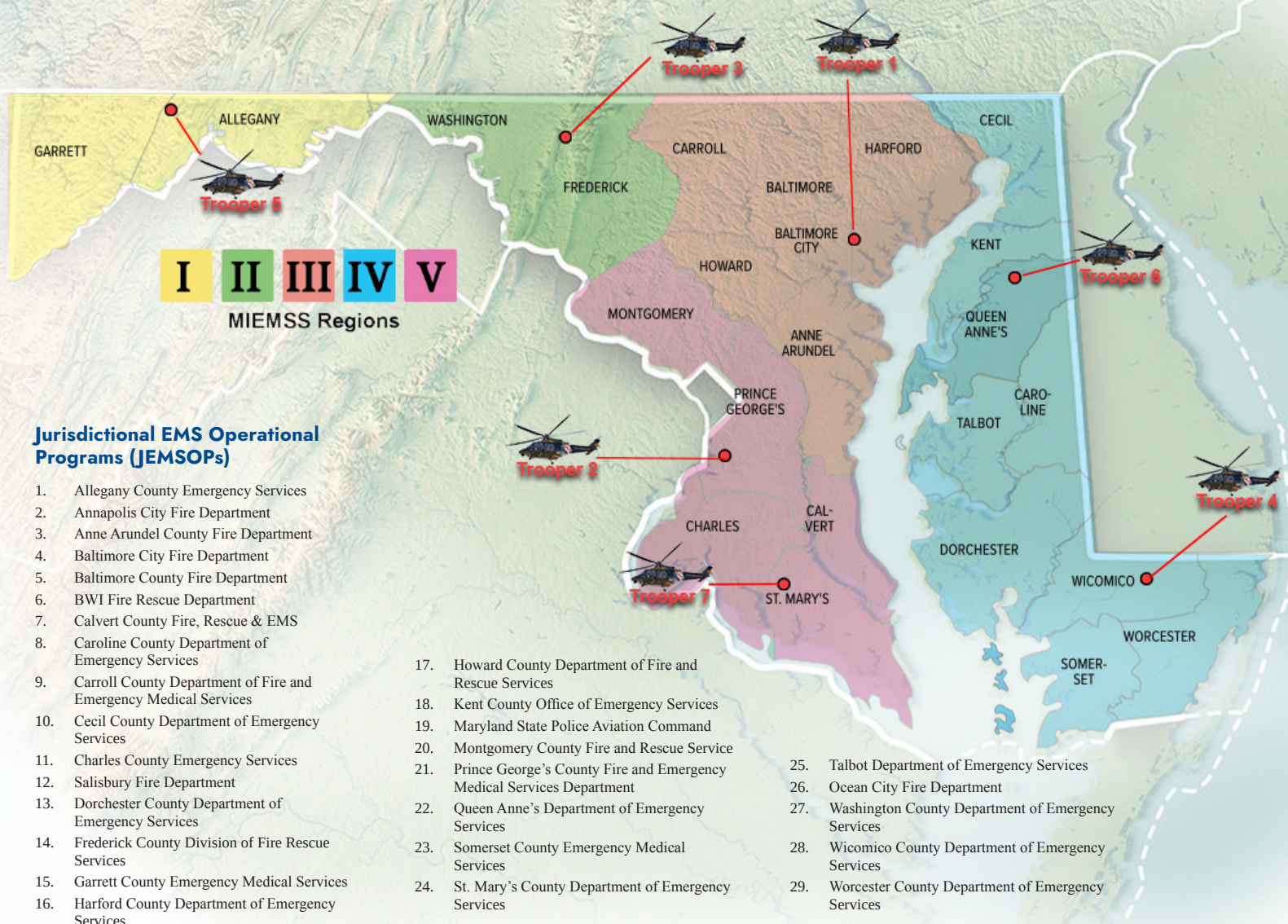
Through the Jurisdictional Advisory Committee (JAC), EMS leaders collaborate to:

- Share best practices
- Coordinate statewide initiatives
- Implement new EMS protocols
- Assess statewide EMS resource capacity, and
- Identify emerging operational needs.

Annual statewide resource surveys continue to provide valuable information that helps ensure Maryland's EMS system remains resilient, appropriately staffed, and prepared to meet future demands.

Maryland State Police Aviation Command

The Maryland State Police Aviation Command provides 24-hour statewide aeromedical transport and emergency response in coordination with MIEMSS and SYSCOM. MSPAC crews transport critically ill and injured patients to Maryland trauma and specialty centers while also supporting neonatal and pediatric transfers, search-and-rescue, disaster response, and other public safety missions.



Public Safety EMS Units

Patient Transportation Vehicles

Region	Ambulances								Ambulance Buses	
	BLS				ALS				Type I	Type II
	In-Service	Peak Hours	Ready Reserve	Unstocked, Unequipped Reserve	In-Service	Peak Hours	Ready Reserve	Unstocked, Unequipped Reserve	20+ Patients	10–19 Patients
Region I	0	0	1	0	18	0	13	0	0	0
Region II	28	28	5	10	14	2	6	0	0	1
Region III	55	19	20	35	123	32	34	77	0	2
Region IV	8	1	13	3	64	34	62	11	0	1
Region V	67	12	84	27	51	2	8	26	0	1
STATEWIDE TOTAL	158	60	123	75	270	70	123	114	0	5

NOTE: Excludes federal EMS Operational Programs.

Source: Vehicle data reported by the EMS Operational Programs

Patient Transportation Vehicle Definitions:

Basic Life Support (BLS) Transport Vehicle: A vehicle equipped to carry and treat a patient per EMT Protocols.

Advanced Life Support (ALS) Transport Vehicle: A vehicle equipped to carry and treat a patient per Cardiac Rescue Technician (CRT, CRT99) or Paramedic protocols.

Total Equipped: Includes units that are equipped as either BLS or ALS and that are available for staffing in the event of system surge.

Staffed 24/7: EMS clinicians assigned and ready to respond to a 9-1-1 call.

Ambulance Bus: A passenger bus configured or modified to transport as many as 20 patients on stretchers.

Public Safety/Non-Transportation Vehicles

Region	Non-Transport Support				Disaster Supplies		
	BLS Capable First Responder		ALS Capable First Responder		MCSU Type I	MCSU Type II	MCSU Type III
	Non-Suppression	Suppression	Non-Suppression	Suppression	100+ Patients	50 Patients	25 Patients
Region I	6	24	9	0	0	0	2
Region II	26	56	17	5	0	2	1
Region III	80	179	34	26	2	4	4
Region IV	53	81	20	4	0	3	4
Region V	24	58	21	56	1	3	0
STATEWIDE TOTAL	189	398	101	91	3	12	11

NOTE: Excludes federal EMS Operational Programs.

Source: Vehicle data reported by the EMS Operational Programs

MCSU = Mass Casualty Support Unit

Public Access, Education & Prevention

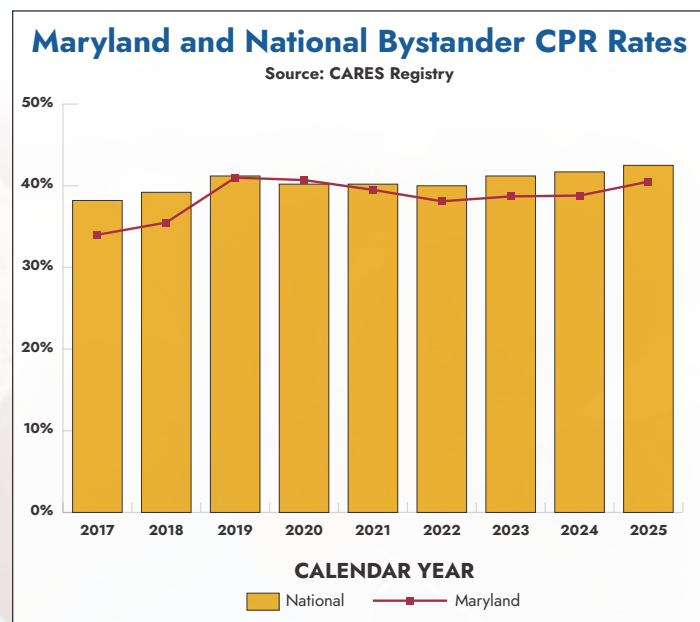
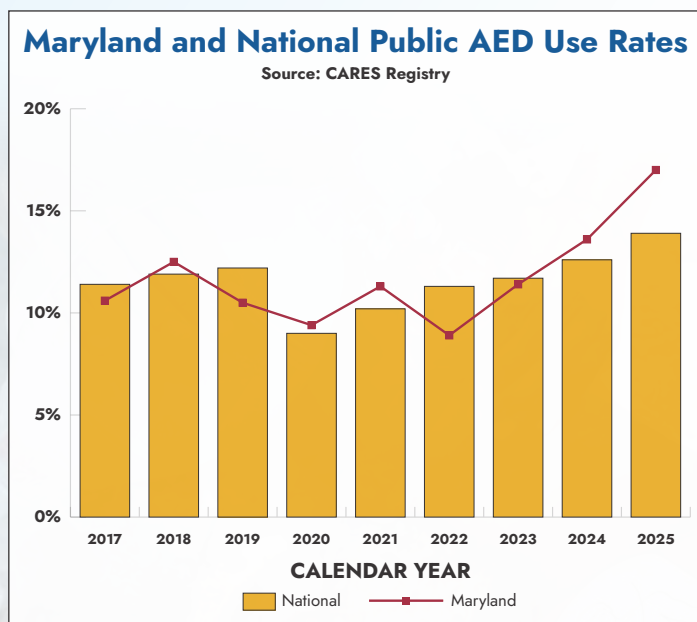
Public access to emergency medical services in every jurisdiction in Maryland is enabled through calls to 9-1-1 centers. Several have undergone recent technology updates as the patterns of callers have evolved, meaning calls from wireless devices exceed those from landline telephones in many areas. Resources are being made available to begin implementation of Next Generation 9-1-1, which is intended, in part, to facilitate access and information transfer by means other than voice communications.

Automated External Defibrillator (AED) Program

Maryland requires AEDs in certain public settings, including public schools, county- or municipality-operated swimming pools, and qualifying grocery stores and restaurants. The Maryland Public Access AED Program allows eligible facilities to voluntarily register an AED for use for sudden cardiac arrest prior to EMS arrival. Through the upgraded online Maryland AED Registry,

MIEMSS received and approved 295 public access AED applications during FY 2026. As of June 30, 2026, 11,613 locations statewide had AEDs registered on-site, representing a total of 19,026 registered AEDs.

In 2025 Maryland EMS responded to 6,877 out-of-hospital cardiac arrests, situations when a person's heart suddenly stops beating effectively. In 830 cases (12.1%) an AED was applied by a bystander prior to EMS arrival. By comparison, the national experience in 2025 was that bystanders applied an AED in 7.1% of cases. Survival from a cardiac arrest was only 3.2% if the event was unwitnessed by a bystander, such as when a person is discovered at home. However, if a cardiac arrest was witnessed by a bystander, survival increased to 13.9%. In those cases an AED was used 17% of the time. If the cardiac arrest was witnessed, in a public place, the first documented cardiac rhythm was "shockable," and the bystander performed CPR and/or used an AED, survival increased to 36.0%.



See pages 16–17 for additional CARES data.

Bystander Intervention Rates are calculated as follows:

Public AED Use: Arrests that occurred before the arrival of First Responders/EMS and that did not occur in a home/residence, nursing home, health care facility, physician's office or clinic, in which AEDs were initially applied by laypersons out of all arrests that occurred before the arrival of First Responders/EMS and that did not occur in a home/residence, nursing home, health care facility, physician's office, or clinic.

Bystander CPR: Arrests that occurred before the arrival of First Responders/EMS and that did not occur in a nursing home, health care facility, physician's office or clinic, in which CPR was initiated by laypersons, out of all arrests that occurred before the arrival of First Responders/EMS and that did not occur in a home/residence, nursing home, health care facility, physician's office, or clinic.

Modernizing 9-1-1

Maryland's 9-1-1 centers serve as the gateway to emergency medical care. As communications technology evolves, MIEMSS continues to support statewide modernization efforts that improve reliability, resiliency, and information sharing.

This year included continued advancement toward Next Generation 9-1-1, enhanced network and alarm monitoring capabilities, improved system reliability and faster identification of communication issue, and ongoing support for evolving public communication technologies.

Emergency Medical Services for Children (EMSC)

EMSC continued statewide injury prevention and family education through Safe Kids Maryland, Maryland RISK WATCH®, and the Family Advisory Network. Public outreach addressed child passenger safety, heatstroke prevention, seasonal safety, and other common childhood injury risks through community events, educational displays, prevention materials and partner organizations. The “Steps to Safety” program provided interactive injury-prevention education for children, caregivers, and community safety advocates, while the Right Care When It Counts program recognized children and youth who demonstrated appropriate actions during emergencies. EMSC continued to promote year-round safety messaging and family resources through its statewide network of community and healthcare partners.

The Child Passenger Safety and Occupant Protection Healthcare Project continued statewide education and outreach during this fiscal year. Funded by the Maryland Highway Safety Office, the project promoted proper use of child safety seats and seat belts and supported healthcare and EMS clinicians, caregivers, and families with resources to improve the safe transportation of children.

This project, now in its 26th consecutive year, continued to support Child Passenger Safety Technician certification, community car-seat check events and education for healthcare professionals on the safe transport of children, including those with special medical needs. Outreach included multilingual educational materials and training for EMS and hospital personnel. Partnerships with Maryland Kids in Safety Seats, Safe Kids Maryland®, CPS instructors, and other organizations expanded access to child passenger safety resources.

Public education remained a key component of the project, including continued messaging about the dangers of leaving children unattended in vehicles. Temperature displays demonstrating how quickly vehicle interiors can become dangerously hot were used at community health and safety events to reinforce the message, “Never Leave a Child Alone in a Vehicle.” The project continued developing and distributing educational resources to support safe transportation of children in ambulances and other vehicles.

“Safeguarding Our Future: Best Practices for Transporting Preschool Children with a Focus on Safety Standards and Accessibility”, held on Thursday, August 28, 2025, addressed children from birth to kindergarten age attending school-based programs and relying on public transportation. This webinar discussed new

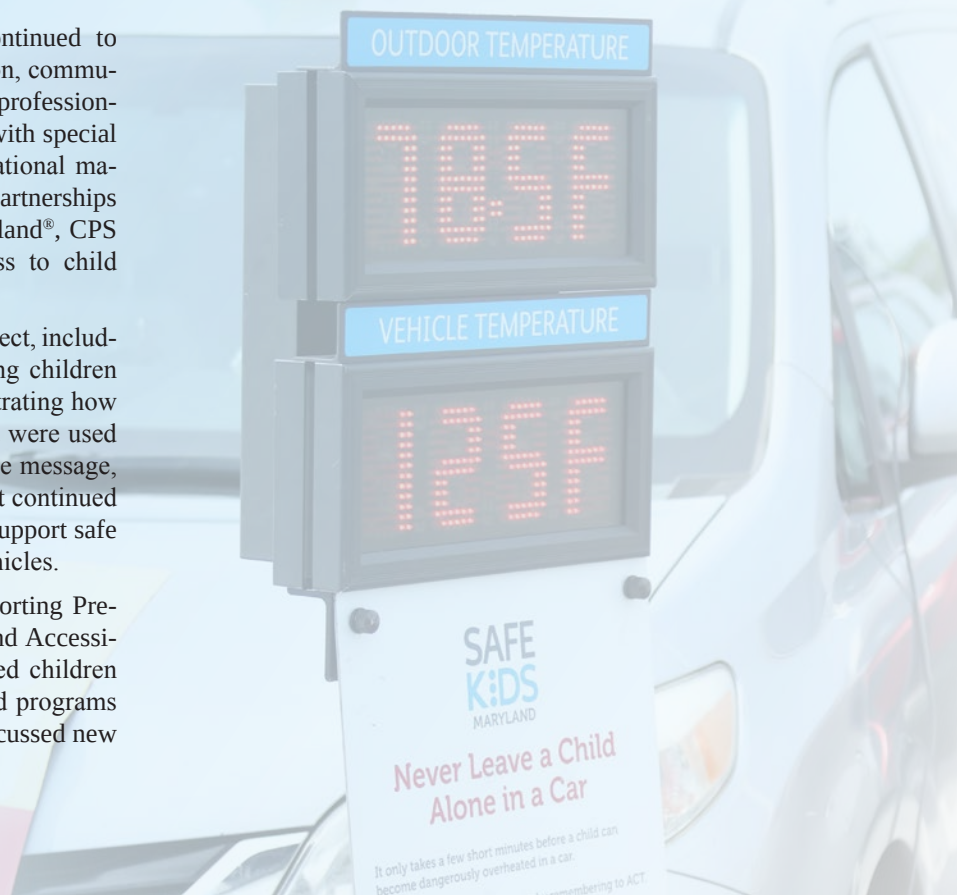
voluntary student transportation safety standards developed in May 2024 and the updated federal regulation that establishes a category for child restraints made specifically for school buses. This webinar offered Maryland EMS clinicians continuing education credit through MIEMSS and 1.5 CEUs for Child Passenger Safety Technicians through Safe Kids Worldwide®.

Safe Kids Maryland® and Maryland RISK WATCH® is led by MIEMSS for the Safe Kids Maryland® state coalition. Safe Kids Maryland® hosted statewide educational meetings with seven local coalitions and 15 community partners. EMSC supported the March 2026 Public Fire & Life Safety Educators Seminar with the Maryland State Firefighters Association and the Office of the State Fire Marshal. EMSC provided the Grandparents Toolkit as a resource to help families and caregivers promote home safety around young children.

Maryland RISK WATCH®, led by EMSC and the Family Advisory Network, continued year-round injury prevention outreach with state and local partners. At the 2026 MSFA Convention and Conference, the Steps to Safety program featured 10 interactive displays addressing high-risk injuries and providing resources for children, caregivers, and community educators. New activities included a helmet-matching injury prevention station and an expanded Clear the Crib Challenge promoting safe sleep practices for infants. Supporting both the Safe Kids Worldwide® grant for bike helmets and the FAN EMSC grant, 80 helmets were distributed with educational information.

The Right Care When It Counts

Maryland EMSC and the Family Advisory Network (FAN) Council annually recognize children and youth in Maryland who have demonstrated “the right steps to take” in an emergency or preparedness for an emergency. In May 2026, “The Right Care When It Counts” awards recognized eight children for their quick thinking and swift action during an emergency.





Trauma and Specialty Center Public Education and Prevention

Maryland's trauma and specialty centers extend their role beyond the hospital through public access, professional education, and injury prevention. Common efforts include providing community members with information and resources to prevent injury, promoting lifesaving skills such as Stop the Bleed®, participating in public awareness campaigns, and working with schools, community organizations, and EMS agencies. Centers also support the broader trauma system through continuing education, case reviews, conferences, simulation, clinical training and other opportunities for EMS and healthcare professionals. Prevention efforts address common causes of injury, including falls, motor-vehicle and pedestrian injuries, violence, firearm injuries, burns, drowning, bicycle injuries, and other preventable trauma. Collectively, these activities help extend the reach of Maryland's trauma system from the hospital into the communities it serves.

R Adams Cowley Shock Trauma Center for Injury Prevention and Policy provides a particularly broad statewide prevention program. In FY 2026, CIPP participated in more than 1,000 events reaching more than 26,000 Marylanders and all 24 jurisdictions. In addition to Stop the Bleed®, programming included violence prevention, intimate partner violence, ThinkFirst, trauma survivor support, and impaired-driving prevention. More than 3,000 school staff received Stop the Bleed® training, while more than 3,400 teens received education focused on head-injury prevention and risky behaviors.

The Johns Hopkins Hospital expanded its system-wide Injury Prevention Collaborative, bringing together programs addressing violence, firearm safety, falls, motor-vehicle and pedestrian injuries, child passenger safety, and Stop the Bleed®. Since FY 2024, these efforts have generated more than 784,000 outreach encounters, demonstrating the scale of the health system's community prevention activities.

Johns Hopkins Bayview Medical Center conducted its sixth annual Stop the Bleed® training marathon and expanded firearm-injury prevention through the ACTFAST initiative, which incorporates firearm safety and safe-storage counseling into trauma care. Additionally, the center provided fall-prevention education through partnerships with local senior communities and continued regional EMS education through its Topics in EMS conferences.

University of Maryland Capital Region Medical Center distinguished itself through the breadth of its community programming, educating more than 2,485 people through injury prevention activities. Programs included Stop the Bleed®, fall prevention, bicycle safety, child passenger safety, and violence-prevention initiatives, complemented by continuing education and case-review activities for EMS and healthcare professionals.

Suburban Hospital combined community injury prevention programming with a strong public-awareness component, conducting 28 prevention events that reached more than 817 people in person and generating more than 10,500 social media encounters. Its efforts focused on Stop the Bleed®, fall prevention, distracted driving, and family safety.

UPMC Western Maryland extends education beyond its immediate service area through regional EMS and healthcare-provider training serving Western Maryland and neighboring Pennsylvania and West Virginia. Its advanced simulation laboratory provides high-fidelity training for hundreds of learners each year, supporting trauma, emergency, and critical care preparedness across the region.

Meritus Medical Center combines community injury prevention with a substantial professional education program. In addition to programs addressing Stop the Bleed®, falls, distracted driving, child passenger and bicycle safety, the center provides free trauma conferences, TNCC and ENPC courses, EMS case reviews, and ongoing clinical education.

Peninsula Regional (TidalHealth)'s efforts reflect its role as a regional resource for the Delmarva Peninsula, with prevention



and education activities extending across Maryland’s Eastern Shore and into neighboring Delaware and Virginia. Its programming includes water, bicycle, pedestrian and fall safety, distracted-driving education, and Stop the Bleed® training conducted in partnership with EMS and fire agencies.

The Johns Hopkins Children’s Center Pediatric Injury Prevention Program (PIPP) works with hospital, community, and statewide partners to reduce preventable childhood injuries. During FY 2026, PIPP participated in 127 community outreach events and reached more than 110,000 people through social media and digital education. Child Passenger Safety Technicians completed 161 car seat fittings and installations and distributed 100 car seats to eligible families. PIPP also launched the Hopkins Injury Prevention Assessment Tool (HIPAT) to assess caregiver knowledge and provide targeted education. Additional efforts focused on burn and fire safety, safe sleep, violence prevention, and other common childhood injuries.

Children’s National Hospital Pediatric Burn Center hosted its first onsite Injury Prevention Fair, providing more than 500 patients and families with hands-on education and resources focused on bicycle, firearm, home, and first aid safety. CNH staff supported Stop the Bleed® and firearm safety initiatives throughout the District of Columbia. The Pediatric Burn Center also launched a burn prevention social media campaign to promote burn safety throughout the hospital’s service area.

MedStar Washington Hospital Center Burn Center’s regional role extends beyond acute treatment to comprehensive rehabilitation, follow-up and burn education. As the only adult burn treatment center in the Washington metropolitan area, it serves patients across the District, Southern Maryland, Northern Virginia and Eastern West Virginia.

Wilmer Eye Trauma Center provides specialized injury-prevention education focused on eye trauma, using injury data to guide

public messaging on workplace eye safety, sports, children’s toys, and fireworks. The center also provides eye-trauma education across the Johns Hopkins Health System through lectures, conferences, online education, and staff orientation.

Curtis National Hand Center supplements professional education with targeted public messaging addressing hand and upper-extremity injuries. Prevention efforts include falls, bone health, lawnmower, fireworks, and snowblower safety, supported by community messaging and educational displays.



1089.5	Hours Invested
13,883	Participants Trained
656	Classes Held
9,171	Tabling Encounters
63	Tabling Events
5	Media Posts

Source: Trauma Quality Improvement Committee



Maryland Medical Orders for Life-Sustaining Treatment (MOLST)

The Maryland Medical Orders for Life-Sustaining Treatment (MOLST) is a portable, enduring medical order that documents a patient's wishes regarding cardiopulmonary resuscitation and other life-sustaining treatments. The form consolidates treatment preferences into standardized medical orders that remain valid across the continuum of care and are honored by healthcare providers and EMS clinicians.

MOLST orders may be signed by a physician, nurse practitioner, or physician assistant and do not expire. For EMS, the 2026 *Maryland Medical Protocols for Emergency Medical Services* specify how MOLST and acceptable EMS/DNR orders are applied when a patient is in cardiac or respiratory arrest or cannot communicate healthcare decisions. The current MOLST form, instructions, and educational resources are available at <https://marylandmolst.org/>.

Media Services and Public Information

MIEMSS Media Services supported the production of multimedia communications, educational resources, and technical event services that strengthened statewide EMS education and public outreach. The department collaborated with programs across the agency to produce instructional videos, publications, photography, graphic design, and digital content while providing audiovisual support for conferences, webinars, meetings, and public events. Additionally, Media Services maintains agency multimedia systems, studio facilities, conference technology, and web resources, ensuring reliable communication and professional presentation of information to EMS clinicians, healthcare partners, government officials, and the public.

Website User Activity Over Time

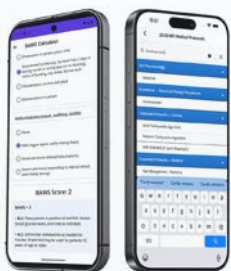
miemss.org | FY 2026



Agency initiatives:

- Maintaining, expanding, and supporting the Maryland Medical Protocols for Emergency Medical Services Phone App (iOS and Android), the MIEMSS website, and web applications and digital information resources for EMS, MIEMSS partners, and the public.
- Producing educational and training videos for EMS clinicians and healthcare professionals.
- Providing photography and videography coverage of agency events, conferences, training programs, award ceremonies, and statewide EMS initiatives.
- Updating, designing, and producing publications, brochures, posters, infographics, annual reports, and promotional materials.

EMS Protocols Apps FY 2026



1,900

New iOS installations
between versions

+49%

Increased footprint in active
Android devices over FY 2025

Trauma Quality Improvement Committee Media Outreach

Types of Media and Media Topics | FY 2026

563,775

Reach

96

Social Media*

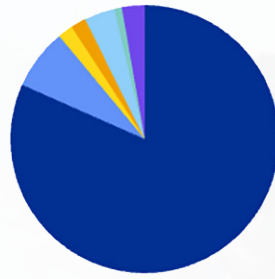
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Traditional Media**

***Social Media** is the use of websites and apps to share educational, awareness, or engagement content through stories and posts.

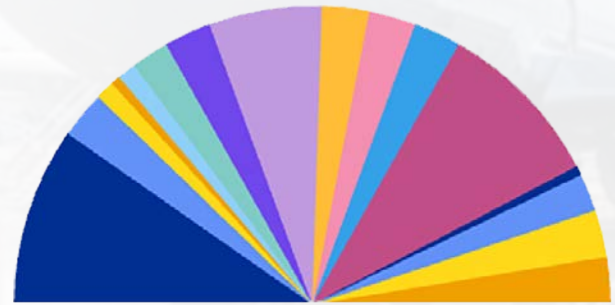
****Traditional Media** is the use of press or other news outlets (TV, radio, podcasts) to share information with the public through press releases, story pitches, or earned coverage.

FY 2026 Type of Media



● Instagram
● Facebook
● Twitter/X
● LinkedIn
● TV Interview
● Podcast
● Other

FY 2026 Media Topics



● Burn/Fire Safety ● Drowning Prevention/Water Safety ● Gun Safety/Violence Protection ● Pedestrian Safety
● Child Passenger Safety ● Concussion Prevention ● Heatstroke ● Poison Prevention
● CO Exposure ● Emergency Preparedness ● Helmet & Protective Equipment ● Rolling Type Vehicles
● Motor Vehicle Occupant Protection ● Safe Sleep ● Stop the Bleed

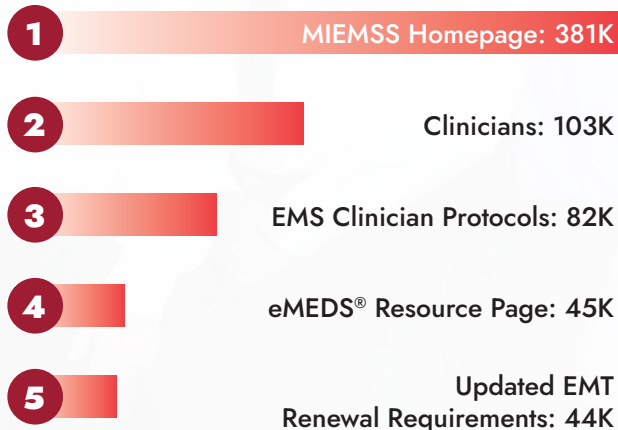
Source: Trauma Quality Improvement Committee

- Developing graphics and visual content for websites, digital communications, social media, presentations, and public education campaigns.
- Providing audiovisual production and technical support for conferences, meetings, webinars, livestreams, and hybrid events.
- Maintaining agency studios, conference technology, audio-visual equipment, and multimedia production systems.
- Collaborating with subject matter experts to transform complex medical and operational information into clear, engaging educational materials.
- Preserving the agency's photographic and video archive documenting significant EMS programs and events throughout Maryland.

Website Traffic and Statistics

miemss.org | FY 2026

Top 5 Website Destinations



MIEMSS.org by the Numbers

328K

Active Users

863K

Page Views

2.5M

User Interactions

+23%

Increase in Avg. Weekly Users Over FY 2025

Information Systems

MIEMSS creates, manages, and leverages interconnected applications and information sources to convert data into usable content for the improvement of the EMS system. In managing these connections, MIEMSS focuses on enhancing system usability, data reliability, and security.

Emergency Department Advisory System (EDAS)

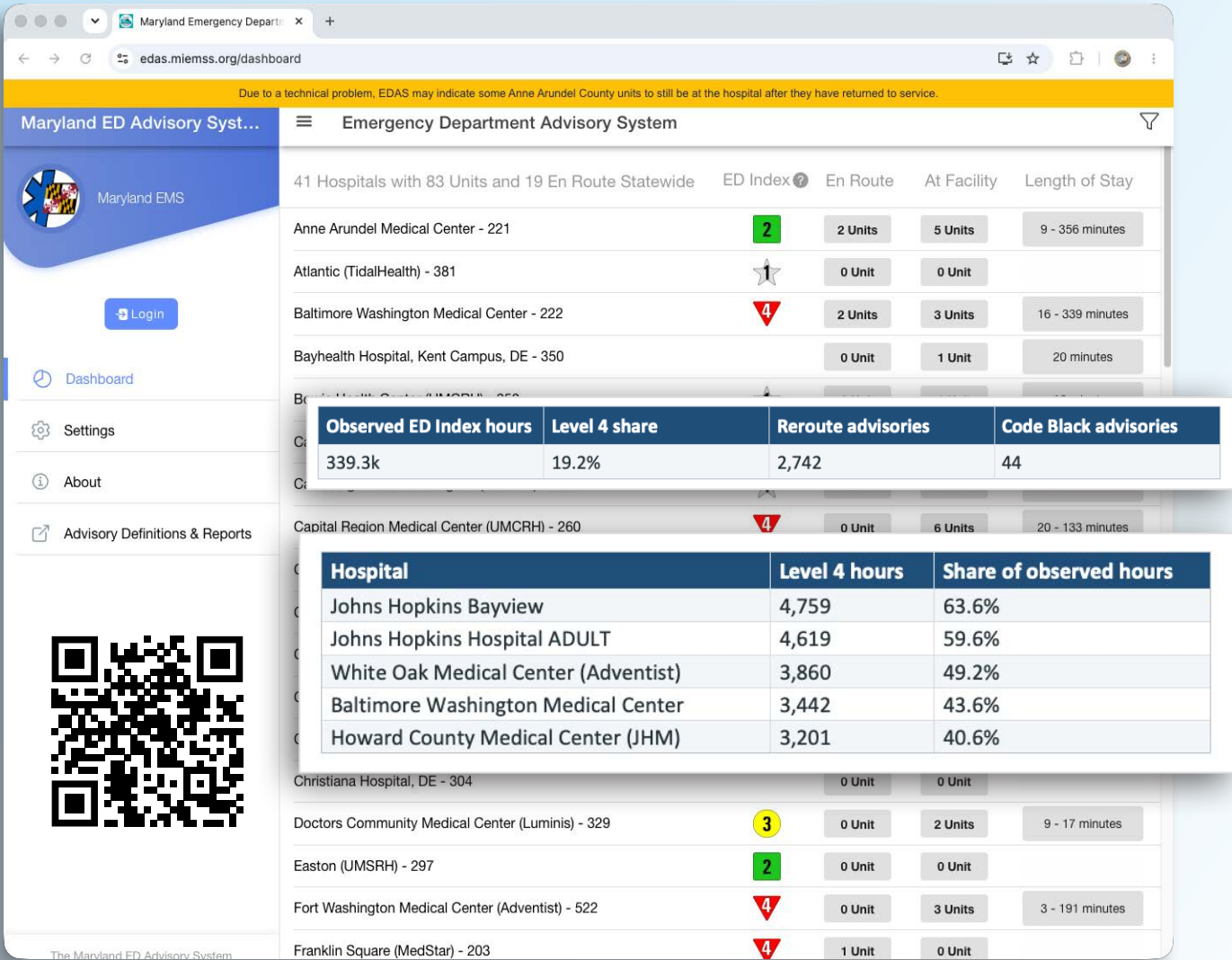
The Emergency Department Advisory System (EDAS) replaced the legacy @HA, CHRS, and CHATS system in August 2025. This monitoring, coupled with hospital strategies that address the high demand for emergency department services, helps improve the availability of this vital service system-wide. The new EDAS system utilizes an ED Census Index Score indicating the occupancy of the emergency department, coupled with specialty diversions such as Trauma Bypass, as well as an EMS-Initiated Reroute. The EDAS application displays information about ambulances located at the hospitals, including the hospital name, number of ambulance units, alert status, and length of stay based on data received from the EMSOP's Computer-Aided Dispatch

(CAD) Systems. With the rollout of the new EDAS system, the functionality was expanded to include not only the number of units currently at a hospital, but also the number of units currently going to each hospital from the 9-1-1 call scene to better enhance system awareness.

Emergency Department Advisory System Modernization

The former Red, Yellow, and Blue alerts used to describe hospital business were discontinued. EDAS retained operational advisories including Reroute, Trauma Bypass, and Code Black and introduced the ED Census Indicator Score (ED Index). The ED Index describes the number of patients being cared for relative to an emergency department's routine capacity: Level 1 is 0-75 percent occupied, Level 2 is 76-100%, Level 3 is 101-130%, and Level 4 is 131% or more.

From implementation through June 30, 2026, Maryland hospitals reported over 339,000 reconciled facility-hours of ED Index status. Level 1 accounted for 42.5% of observed hours, Level 2 for 18.9%, Level 3 for 19.4%, and Level 4 for 19.2%. Levels 3 and 4 together accounted for 38.6% of observed time.



Aligned monthly views of Reroute events and the Level 4 share of observed facility-hours.

Monthly Reroute activity and Level 4 census share

Maryland Regions I–V; aligned panels show the common winter peak without implying causation

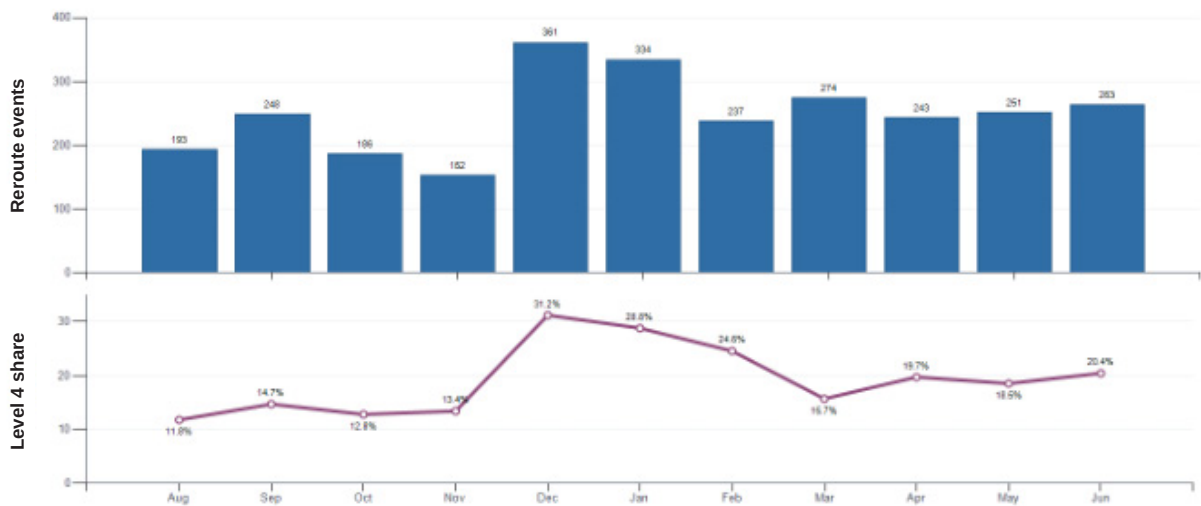


Figure 1. Aligned monthly views of Reroute events and the Level 4 share of observed facility-hours.

Monthly ED Census Indicator distribution

Maryland Regions I–V; percent of reconciled observed facility hours, Aug. 4, 2025–June 30, 2026

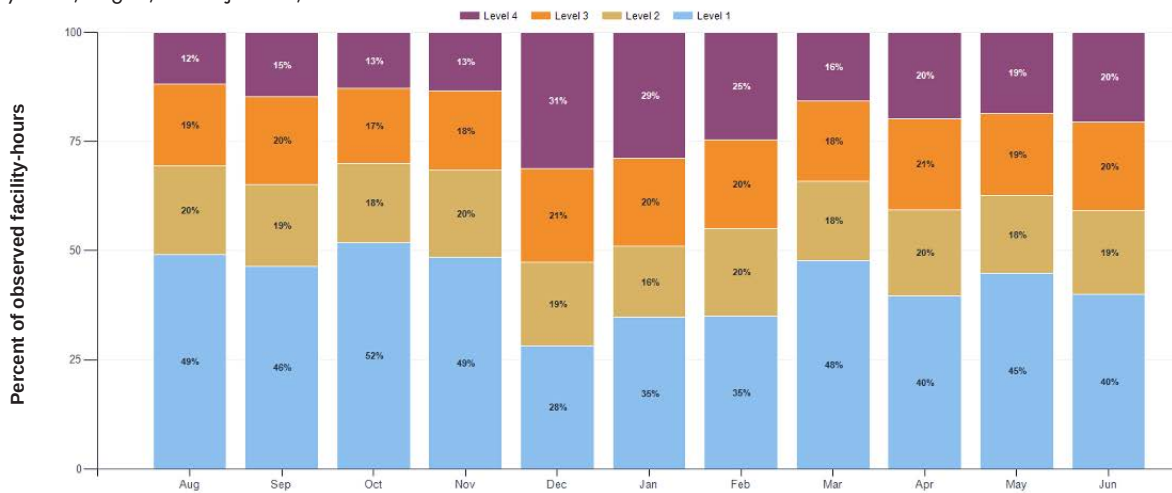


Figure 2. Monthly share of reconciled observed facility-hours at each ED Index level. July 2025 is omitted because EDAS was implemented on August 4.

Census pressure increased during winter as the Level 4 share rose from 13.4% in November to 31.2% in December, remained elevated at 28.8% in January, and was 24.6% in February. This seasonal concentration identifies the winter months as the most important period for continued monitoring and operational coordination.

Reroute activity peaked with winter census pressure at Maryland EMS-Initiated 2,742 Reroute advisories totaling 6,518.7 hours. The median Reroute lasted 1.53 hours, and 90% lasted no more than 4.25 hours. Monthly Reroute events reached 361 in December and 334 in January. The Level 4 share and Reroute activity moved together at the monthly level, but this association should not be interpreted as causal.

In terms of facility and regional concentration, Region III recorded the highest Level 4 share at 24.0%, followed by Region V at 19.2%. The table lists the hospitals with the largest Level 4 burden in total hours; the percentages use each facility's reconciled observed hours as the denominator.

Other EDAS advisories: Hospitals reported 496 Trauma Bypass advisories, totaling 1,021.0 hours, and 44 Code Black advisories, totaling 166.2 hours. Code Black was uncommon but variable in duration; the median was 1.44 hours, with the longest episode lasting 42.08 hours.

Maryland Emergency Medical Resource and Alerting Database (MEMRAD)-NG

The Maryland Emergency Medical Resource Alerting Database (MEMRAD) serves as Maryland's statewide health and medical alert and resource tracking system. Administered by MIEMSS, this system connects hospitals, EMS, Public Health, Emergency Management and other local, state, and federal partners for near-real-time information sharing. MEMRAD-Next Generation (NG) provides advanced alerting and notification systems, resource tracking, and information sharing. The new MEMRAD-NG integrates seamlessly into the Emergency Department Advisory System (EDAS), and has been expanded over this reporting period to include additional users and partner agencies.

Electronic Maryland EMS Data System (eMEDS®)

The electronic Maryland EMS Data System (eMEDS®) is one of the few statewide comprehensive prehospital patient care reporting systems in the United States. eMEDS® relies on an ImageTrend software product that complies with the latest standards set by the National Emergency Medical Services Information System (NEMSIS). MIEMSS holds a statewide site license for eMEDS®, offering it at no cost to local jurisdictions. All Maryland jurisdictional EMS operational programs (JEMSOPs) and approximately 20% of commercial ambulance companies submit patient care reports directly into eMEDS®, while most commercial service reports are automatically imported into eMEDS® from

third-party electronic health platforms. All Maryland health-care facilities have access to the prehospital patient care reports through the Hospital Hub online application.

eMEDS® supports several key goals, including:

Uniform Data Collection: Ensures consistent reporting of prehospital care by Maryland's EMS clinicians.

Performance Measurement: Provides a basis for evaluating patient care and compliance with protocols by local departments, EMSOPs, regional medical directors, and MIEMSS.

Standardized Reporting: Facilitates compliant data reporting to the National EMS Information System (NEMSIS)

Data Integration: Supports integration with statewide systems such as Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE), Chesapeake Regional Information System for Patients (CRISP), Overdose Detection Mapping Application Program (ODMAP), Maryland Trauma Registry, Cardiac Arrest Registry to Enhance Survival (CARES), Emergency Department Advisory System (EDAS), and MIEMSS' eLicensure® System.

Local EMSOP Integration: Includes integration with 9-1-1 center computer-aided dispatch (CAD) systems, exports to third-party billing vendors for reimbursement, and data sharing with third-party vendors for local reporting, dashboard creation, and fire incident reporting.

Maintaining and Updating EMS Systems: Updated to version 3.5 in 2023, eMEDS® 3.5.1 is under review for implementation to maintain NEMSIS compliance.

Patient Care Reporting Records Submitted to MIEMSS by Maryland Jurisdictions

Fiscal Year	Qtr1 (Jul-Sept)	SFY Qtr2 (Oct-Dec)	SFY Qtr3 (Jan-Mar)	SFY Qtr4 (Apr-Jun)	Total
FY 2013			205,278	212,297	417,575
FY 2014	239,810	234,029	231,699	232,470	938,008
FY 2015	262,197	263,515	256,475	273,403	1,055,590
FY 2016	271,193	267,467	270,538	277,714	1,086,912
FY 2017	285,611	278,493	281,211	301,832	1,147,147
FY 2018	297,614	289,044	290,157	291,666	1,168,481
FY 2019	288,151	285,788	267,566	276,245	1,117,750
FY 2020	278,630	264,598	257,723	219,655	1,020,606
FY 2021	256,887	252,341	248,229	273,306	1,030,763
FY 2022	278,362	273,760	252,406	273,778	1,078,306
FY 2023	282,893	279,324	260,853	277,455	1,100,525
FY 2024	286,538	285,483	273,782	285,906	1,131,709
FY 2025	289,059	289,699	282,715	281,057	1,142,530
FY 2026	289,440	281,429	272,772	283,547	1,127,188
Grand Total	3,606,385	3,544,970	3,651,404	3,760,358	14,563,117

eMEDS® Records Submitted to MIEMSS per Fiscal Year 2026 Quarter

Reporting Between: 07/01/2025 - 06/30/2026

EMSOP	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Total
Airports: BWI & Martin	1,676	1,509	1,394	1,471	6,050
Allegany County	3,994	4,036	3,911	3,910	15,851
Annapolis, City of	2,581	2,469	2,333	2,434	9,817
Anne Arundel County	18,566	18,360	17,769	19,031	73,726
Baltimore City	57,643	55,660	51,618	52,576	217,497
Baltimore County	35,807	36,698	35,534	35,856	143,895
Calvert County	4,567	4,278	4,046	4,415	17,306
Caroline County	1,934	1,831	1,856	1,991	7,612
Carroll County	6,359	6,511	6,333	6,557	25,760
Cecil County	4,378	4,396	4,318	4,512	17,604
Charles County	8,567	8,630	8,429	8,782	34,408
Dorchester County	1,930	1,976	1,808	2,011	7,725
Frederick County	14,757	14,744	13,880	14,891	58,272
Garrett County	1,499	1,377	1,377	1,209	5,462
Harford County	8,905	8,695	8,398	8,918	34,916
Howard County	9,394	9,103	9,052	9,544	37,093
Kent County	1,475	1,339	1,138	1,263	5,215
Montgomery County	23,934	24,553	23,977	24,317	96,781
MSP Aviation Command	613	465	375	670	2,123
Ocean City, Town of	2,737	1,097	1,033	1,880	6,747
Other EMSOPs	1,488	1,343	1,408	1,397	5,636
Prince George's County	48,375	44,270	45,629	47,215	185,489
Queen Anne's County	2,299	2,403	2,065	2,503	9,270
Salisbury, City of	3,334	3,322	3,416	3,492	13,564
Somerset County	954	1,107	1,147	1,236	4,444
St. Mary's County	6,164	5,961	6,008	6,105	24,238
Talbot County	2,031	2,054	1,882	1,931	7,898
Washington County	9,453	9,279	8,706	9,319	36,757
Wicomico County	1,905	1,823	1,828	1,925	7,481
Worcester County	2,121	2,140	2,104	2,186	8,551
Grand Total	289,440	281,429	272,772	283,547	1,127,188

eMEDS® Mobile Integrated Health (MIH) Module

MIEMSS continues to support enhancements to the Mobile Integrated Health (MIH) module, released in 2020, to improve data collection and guide future MIH efforts. At the end of FY 2026, over 17,200 reports have been recorded using the MIH module. MIEMSS continues to work with CRISP to export MIH data to the state's recognized health information exchange.

eMEDS® Support, Governance, Improvement

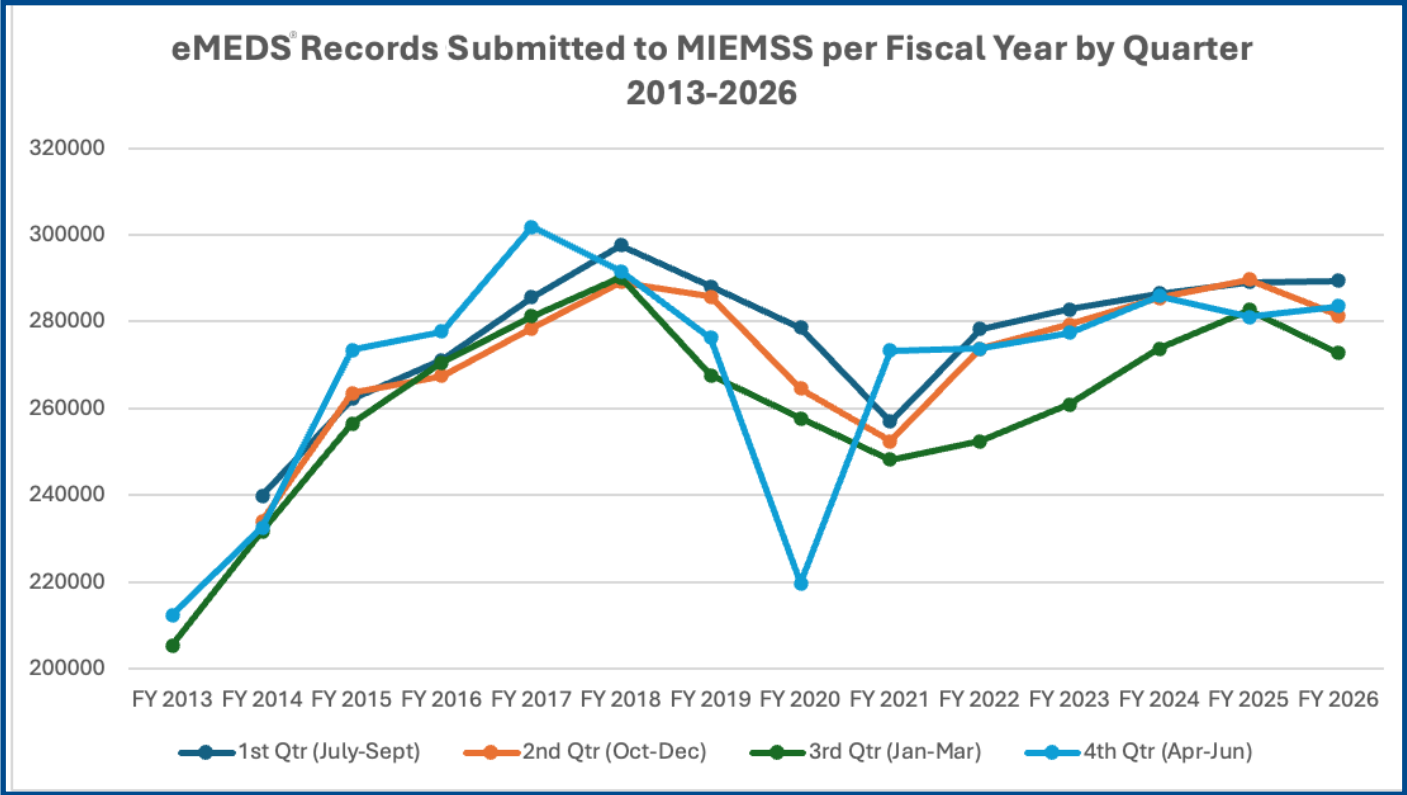
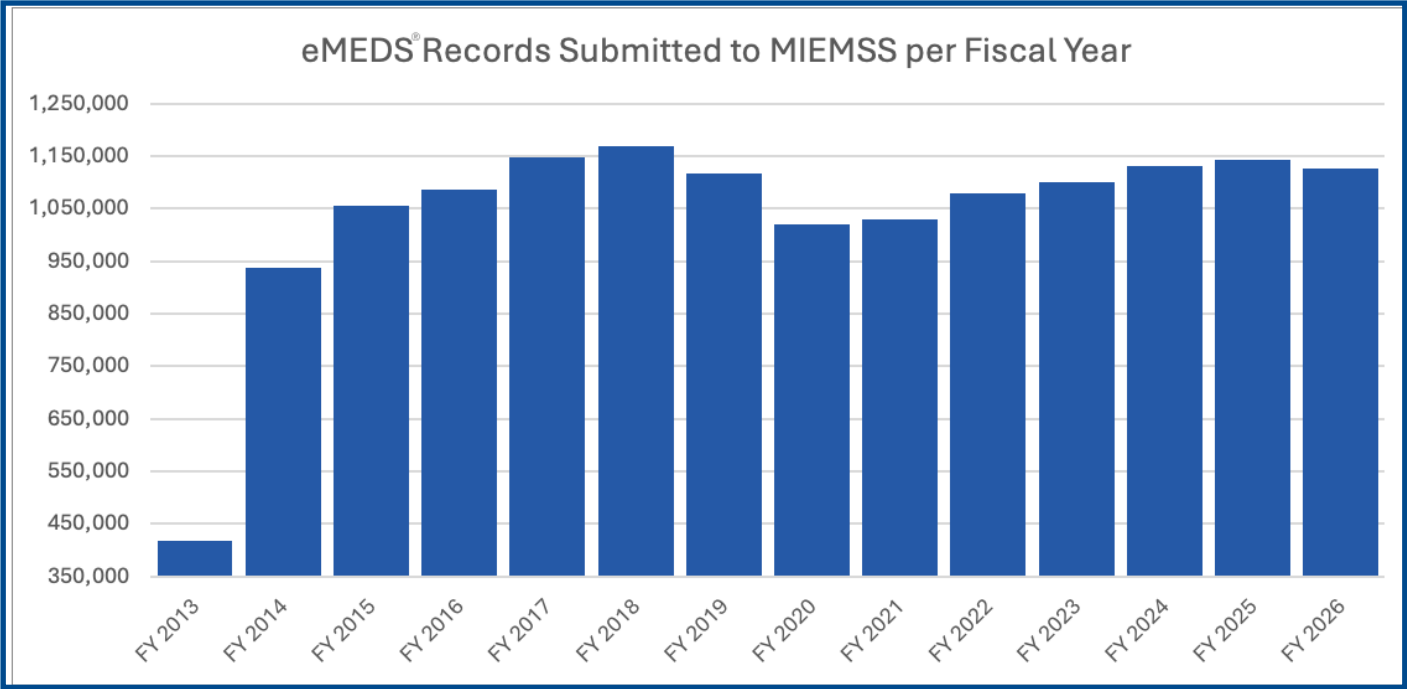
MIEMSS manages a support desk specific to the eMEDS® application that handles requests from EMS clinicians, EMS Operational Program (EMSOP) administrators, and healthcare facility personnel across the state. Common issues include password resets, login problems, access level questions, report writer functionality, EMSOP integrations, and general application inquiries. During the FY 2026, the support desk processed over 1,800 support tickets.

Cardiac Arrest Registry to Enhance Survival (CARES)

MIEMSS continues to work with the Cardiac Arrest Registry to Enhance Survival (CARES) to measure, and ultimately improve, emergency cardiac care in Maryland. CARES is an out-of-hospital cardiac arrest registry that enables uniform data collection and quality improvement in each state and nationally.

Through an eMEDS®/CARES data integration, prehospital cardiac arrest information is directly exported to the registry when it is first entered in the patient care report. Maryland was among the first to implement this process on a statewide basis.

Since January 2017, all 29 public safety EMSOPs and Maryland health care facilities have submitted their cardiac arrest data into CARES. Statewide data for calendar years 2017 to 2025 is now included in CARES National Reports.



Trauma Registry

The Maryland Trauma System uses a multidisciplinary approach to caring for injured patients, supported by the Maryland Trauma Registry (MTR) hosted by MIEMSS. All designated Maryland trauma centers collect, abstract, and enter patient data into the MTR, creating a standardized and streamlined process for identifying patients and defining injuries. The registry provides a foundation for evaluating and strengthening the continuum of trauma care throughout Maryland. Consistent, reliable data from the MTR supports public health surveillance, data analysis, and research; performance improvement and outcome assessment; injury prevention; education and dissemination of best practices; and ongoing development of the trauma center system.

Maryland trauma centers also submit registry data to the National Trauma Data Bank, allowing trauma programs to benchmark their performance and outcomes against trauma centers nationally.

Maryland Traffic Records Assessment

In the fall of 2024, Maryland volunteered for a National Highway Traffic Safety Administration (NHTSA) peer-review assessment of its management and use of motor vehicle crash-related data. Two EMS-related programs contribute essential data to the state's injury surveillance system as defined by NHTSA. This includes all traffic-related etiology records entered into eMEDS® or the Maryland Trauma Registry. Of the 46 assessment questions pertaining to MIEMSS programs, 43 received a "Meets Advisory Ideal" rating, one received a "Partial" rating, and two received a "Does Not Meet" rating. These findings are exceptional when compared to other state assessments. One of the key findings found under assessment "Strengths" was that Maryland continues to support and improve all components of a comprehensive statewide injury surveillance system, and Maryland has a long history of integrating multiple transportation safety-related datasets.

Helicopter Utilization Database (HUD)

MIEMSS maintains several EMS system surveillance priorities based on routine data review, customer requests, and research outcomes. The Helicopter Utilization Database (HUD) accounts for all helicopter requests for transport independent of actual transport mode outcome, and permits requesting EMS managers and medical directors to conduct case reviews. HUD data analysis supports MIEMSS' efforts to utilize aerial transportation for only the most severe, time-critical incident scene patients statewide.

Flight Vector

MIEMSS continued to support and enhance Flight Vector, the computer-aided dispatch system used in coordination with the Maryland State Police Aviation Command (MSPAC) to request, assign, and track medevac aircraft. In collaboration with MSPAC, MIEMSS upgraded the system at EMRC/SYSCOM, MSPAC sites, and affiliated locations to include InterTalk radio dispatch messaging into Flight Vector. This work supports a geographically separate disaster recovery environment that increases system reliability and flight safety.

EMS Audio Recording

MIEMSS collaborated with vendors to modernize the security protocols and methods for the EMS Audio Recording (EMSAR) system, allowing hospitals to securely access EMS and hospital consultation recordings. MIEMSS developed a new method for securely managing individual requests for EMS recordings with online access to those recordings.

Information Security

MIEMSS strengthened the security of its information systems, networks, and facilities through enhanced cybersecurity monitoring, vulnerability protection, and security infrastructure. The agency continuously advances physical and cybersecurity measures aligned with Maryland State guidelines and the MIEMSS Continuity of Operations Plan.



Research and Evaluation

Maryland's integrated EMS system provides a strong foundation for research through comprehensive prehospital and hospital data, statewide systems of care, and collaborative partnerships with leading academic institutions. MIEMSS continues to advance evidence-based emergency medical services by supporting research, protecting the integrity and confidentiality of EMS data, and fostering collaboration among clinicians, researchers, and healthcare organizations. At the same time, trauma registries, quality metrics, benchmarking, case review, and performance improvement processes help centers identify opportunities for improvement and measure the impact of changes in care.

Data Access and Research Interest Group

The MIEMSS Data Access Committee continued to facilitate timely access to EMS data for approved research while maintaining rigorous standards for patient and clinician confidentiality. The Maryland Research Interest Group (RIG), in collaboration with the National Study Center for Trauma and EMS, the University of Maryland, Johns Hopkins University, and regional partners, advanced multiple research initiatives, including studies on cardiac arrest, medication effectiveness, and EMS transfer of care. Research findings continue to inform EMS protocols, trauma system improvements, and statewide patient care initiatives while strengthening Maryland's national leadership in EMS research.

National Study Center (NSC) FY 2026 Research and Innovation

The Charles "McC." Mathias, Jr., National Study Center for Trauma and EMS (NSC) was established at the University of Maryland by the US Congress in 1986 as the research arm of the State EMS system. In 2009, the University of Maryland School of Medicine (UMSOM) designated NSC as part of the Shock, Trauma, and Anesthesiology Research Organized Research Center (STAR-ORC) to further basic, translational, and clinical studies in injury research.

New Awards

1.25M+

MORE than \$1.25 MILLION AWARDED in new funding awards, including:



Health Impact Collaborative – Enhancing Baltimore's Safety Action Plan (\$802,950, US Department of Transportation Safe Streets and Roads)



Artificial Intelligence for Life-Saving Interventions and Trauma Severity (\$40,000, University of Maryland Institute for Clinical and Translational Research (ICTR) Accelerated Translational Incubator Pilot (ATIP) program)



2026 DC Seat Belt Study (\$200,000, District of Columbia Highway Safety Office)



Impact Analysis Using Maryland Traffic Telematics Data (\$33,784, Maryland Highway Safety Office)

Ongoing / Completed Awards

Triage Clinical Decision Support for Prolonged Field Care Scenarios

NSC Director Dr. William Teeter's United States Air Force (USAF)-funded program continued its study of thousands of trauma patients to develop clinical decision support (CDS) tools to assist with triage and identification of patients who need Life Saving Interventions (LSI). Additionally, Dr. Teeter and his collaborator, Dr. Shiming Yang, were awarded an additional \$2 million under the CDS program for two new projects conducted in collaboration with the Precision in Medicine and Engineering Research Laboratory (PRIME-AI):



Forecasting Outcomes and Risks of Events in Critical Acute-Care for Safe Transport (FORECAST)



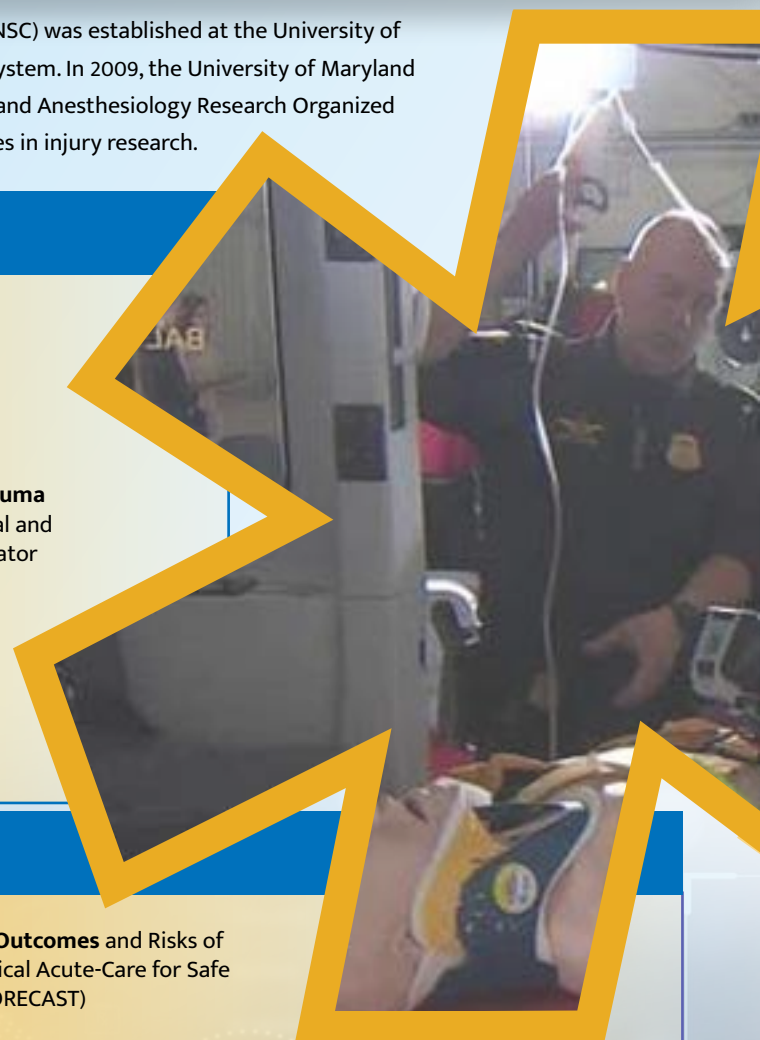
Flight-Readiness Network for Evacuation and Triage (FLIGHTNET)



A Rapid, Automated Method for Determining Lung-to-Periphery Oxygenation Delay. Dr. Teeter's USAF-funding program is ongoing and pending the start of enrollment.



Other awards, including Dr. Deborah M. Stein's National Highway Traffic Safety Administration (NHTSA) funding for the Crash Injury Research and Engineering Network (CIREN), continue.



Completed Research Grants



**Traffic Safety
Citations Analysis**

**\$258,583
MHSO**



**Seatbelt
Observation Project**

**\$168,999
MHSO**



**FY 2025 DC
Seatbelt Study**

**\$250,000
DCHSO**

Faculty Expansion (FY 2026)

New Adjunct Faculty

- **Matthew J. Levy, DO, MSc** Professor of Emergency Medicine, Johns Hopkins University
- **R. Noel Britton, PhD, MPH** Asst. Prof., Anesthesiology & Epidemiology, UIMSOM
- **Douglas J. Floccare, MD, MPH** Asst. Prof. of Emergency Medicine, UMSOM

Continuing Faculty

- **Shiming Yang, PhD** PRIME-AI Co-Director, UM-IHC Core Investigator
- **Deborah M. Stein, MD, MPH** Professor of Surgery
- **Peter F. Hu, PhD** Chief Technologist, NSC, UM-IHC Core Investigator
- **Elizabeth Powell, MD** Assoc. Prof. of Emergency Medicine and Surgery

NSC Network & Collaboration



LITES Network

Serves as active study site for collaborative injury care and outcomes research by this network of medical professionals, prehospital clinicians, and emergency medical services, with goal of informing clinical practice guidelines and updating existing standards of care for traumatic injuries. Its various research projects focus on trauma, blood and whole blood, traumatic brain injury, airway management, and hemorrhagic shock.



CAVALIER Study

Collaborates with Maryland State Police Aviation Command (MSPAC) as a clinical site for CAVALIER, which evaluates administration of prehospital calcium and in-hospital administration of vasopressin in subjects at risk of hemorrhagic shock requiring blood transfusion and early operative procedures during the early in-hospital phase of care. CAVALIER enrollment began in May 2026, with prehospital enrollment conducted by MSPAC and in-hospital enrollment at the R Adams Cowley Shock Trauma Center.



CIREN Partnership

Crash Injury Research and Engineering Network (CIREN) is the leading participant with STC in NHTSA-funded program. Enrollment of MVC occupants continued at goal; enrolled occupants underwent comprehensive investigation and review. CIREN cases provide valuable biomechanical insights into crash injury mechanisms and inform improvements in vehicle safety and trauma care.



AI & Data Science

- AI and machine learning applied to crash reports to predict injury risk and identify factors in injury severity.
- Findings presented at Lifesavers, AIM, and AAAM conferences.
- Secured MHOS funding for impact analysis using telematics data.
- Completed 2026 DC and Maryland statewide seatbelt studies, both certified by NHTSA.



IODES: Injury Data Census

- Developing Injury Outcomes Data Evaluation System to create a census of injury data in Maryland.
- Added Western Trauma Association sub-study (early trauma-induced coagulopathy).
- Linked HSCRC data (2016-2026) and completed Data Use Agreement with OCME.
- Together with eMEDS® data, IODES can provide a complete picture of injuries in Maryland.



CISIR Platform

- Platform where IODES data will be made available to researchers.
- Repository of UMMS EHR data on trauma and ED visits.
- Expanded in FY 2026 to include three new populations:
 - Critical Care Resuscitation Unit
 - Soft-Tissue Surgery service
 - Acute Care and Emergency-Surgery at STC



Presentations

- ATSSIP Traffic Records Forum (Boston, MA)
- AAAM Conference (Indianapolis, IN)
- Lifesavers Conference (Baltimore, MD)
- AIM Conference (San Francisco, CA)
- Maryland Traffic Records Coordinating Committee Technical Council

Registry and Data Support



NSC extracts data from the R Adams Cowley Shock Trauma Registry (STCTR) for research protocols, and analytic support continued throughout FY 2026. The STCTR is used to generate patient population estimates for research proposals to ensure sufficient eligible patients will be admitted to meet study inclusion and exclusion criteria.



Hospital Research and Evaluation

R Adams Cowley Shock Trauma Center maintains one of the nation's most extensive trauma research programs, with more than 20 ongoing or upcoming clinical studies in FY 2026. Research spans traumatic brain injury, hemorrhagic shock, spinal cord injury, crash biomechanics, pelvic fracture and hemorrhage, big data initiatives, artificial intelligence, and augmented reality. Major studies include STC RITMO, CAVALIER, TROOP, CIREN, Hypothermia-SCI, HOBIT, and MAUI, with research conducted in partnership with federal agencies, academic institutions, and industry.

The Johns Hopkins Hospital conducts research across clinical outcomes, implementation science, injury prevention, violence intervention, disaster response, education, and survivorship. Current projects include trauma recovery and patient storytelling, artificial intelligence for disaster triage, prehospital antibiotics, geographic access to trauma care, motor vehicle crash mortality, and surgical care in austere environments. Research is closely connected to quality improvement, with registry data, patient-safety findings, and community trends informing practical interventions.

Johns Hopkins Bayview Medical Center provides opportunities for clinicians to participate in research focused on trauma care, quality improvement, patient safety, and clinical outcomes. The Burn Center conducts sponsored clinical trials, federally funded multicenter studies, investigator-initiated research, and laboratory research addressing burn wound healing, optimal excision timing, pain and psychological distress among burn survivors, medication management, and hospital-acquired infections.

Sinai Hospital supports trauma research through LifeBridge Health and multidisciplinary collaboration with geriatric surgery, orthopedics, rehabilitation, and other specialties. Current work includes rib-fracture management using the Rib Injury Guidelines (RIG) score, evaluation of cryoneurolysis for pain control and length of stay, and research addressing balance, mobility, dysphagia, traumatic brain injury, vestibular rehabilitation, and functional recovery.

University of Maryland Capital Region Medical Center uses its trauma registry and Acute Care Surgery program to support internal, local, and multi-institutional research examining injury trends, patient outcomes, and injury prevention. During FY 2026, collaboration with the R Adams Cowley Shock Trauma Center and the University of Maryland School of Public Health focused on violence intervention and recidivism, contributing to increased funding for the Violence Intervention Program.

Meritus Medical Center continued to integrate research with clinical performance improvement. The Division of Trauma and Acute Care Surgery held monthly research meetings and presented research at TraumaCon, including work examining ground-level falls, which account for approximately 30–40% of the center's trauma population. The division also reported improvements in trauma resuscitation and discharge times associated with implementation of the Toyota Kata method.

Peninsula Regional (TidalHealth) advances research through the Richard A. Henson Research Institute, which supports clinical research, clinical trials, population health initiatives, and ev-

idence-based practice throughout the Delmarva Peninsula. The Institute provides research infrastructure and mentorship for physicians, residents, fellows, students, and other health professionals while expanding access to academic-level research opportunities in the region.

Johns Hopkins Children's Center Pediatric Trauma Program maintains a broad research portfolio spanning clinical, translational, and basic science. Research addresses pediatric injury outcomes, trauma recidivism, firearm and non-accidental injuries, performance improvement, injury prevention, and multidisciplinary trauma care. An NIH-funded laboratory also investigates the gut-brain axis in traumatic brain injury and the potential use of transcutaneous auricular vagus nerve stimulation to improve neurologic recovery.

Johns Hopkins Children's Center Pediatric Burn Program participates in national research and quality improvement initiatives, including the Pediatric Injury Quality Improvement Collaborative. Current research examines quality of life following pediatric burn injury, parent psychological distress and support needs, adolescent substance-use screening, hot-beverage scald prevention, and barriers to follow-up care. The program uses collaborative benchmarking and outcome evaluation to identify opportunities for improvement in pediatric burn care.

Children's National Hospital participates in the MATIC2 clinical trial, evaluating whole blood compared with standard blood component therapy and examining the use of tranexamic acid for pediatric patients experiencing acute hemorrhage. Its Pediatric Burn Center uses comprehensive patient review and national benchmarking to evaluate performance and identify opportunities for improvement.

Wilmer Eye Trauma Center combines clinical research with ongoing evaluation of trauma care. FY 2026 research included studies of national clinical and demographic trends in ophthalmic injuries, comparative effectiveness, tissue engineering, surgical management, antibiotic prophylaxis, and opportunities to address health disparities. The center also conducts monthly surveillance of key performance indicators, analyzes demographic and injury trends, maintains the Eye Trauma Web Registry, and participates in formal program evaluation.

Curtis National Hand Center has expanded its research in microsurgery, peripheral nerve recovery, bone and soft-tissue injury, trauma evaluation and triage, chronic pain, reconstruction, and health services research. FY 2026 efforts included clinical trials, big-data initiatives, evaluation of care quality and policy, improved triage and follow-up, and use of wearable technology to remotely monitor patient recovery and identify challenges after injury.

The Neurotrauma Center (NTC) at the R Adams Cowley Shock Trauma Center continues research and publication in traumatic brain and spinal cord injury, including subdural hematoma treatment, neurocritical care monitoring, machine learning, and operational neurotrauma. FY 2026 work included substantial investigation into middle meningeal artery embolization and other emerging approaches to chronic and non-acute subdural hematoma management.

Evaluation Across the System

In addition to center-specific research, Maryland trauma centers maintain robust performance improvement and evaluation programs. These include trauma registry data quality, national benchmarking through programs such as ACS TQIP, multidisciplinary case and peer review, monitoring of clinical outcomes and key performance indicators, and structured follow-up of corrective actions. Examples include improvements in trauma registry timeliness at Johns Hopkins, reductions in CT and operating-room times at Meritus, and ongoing multidisciplinary review and benchmarking at pediatric and specialty trauma centers.

FY 2026 Highlights by Hospital and Specialty Center



R Adams Cowley Shock Trauma Center

Research: 20+ ongoing or upcoming clinical studies in TBI, hemorrhagic shock, spinal cord injury, crash biomechanics, pelvic fracture/hemorrhage, big data, AI, and augmented reality.

Evaluation: Comprehensive quality management with peer review, outcome monitoring, and initiatives to reduce complications, LOS, VTE, and readmissions.



Johns Hopkins Hospital

Research: Projects in clinical outcomes, implementation science, injury prevention, violence intervention, disaster response, education, and survivorship, including AI disaster triage, rehospital antibiotics, geospatial access, MVC mortality, and austere care.

Evaluation: TQIP benchmarking, registry and patient safety data, and multidisciplinary review to drive improvement. Trauma registry chart closure improved to 17 days with 100% compliance.



Johns Hopkins Bayview Medical Center

Research: Opportunities in trauma care, quality improvement, patient safety, and clinical outcomes. Burn Center conducts clinical trials, multicenter studies, and investigator-initiated and laboratory research on burn care, pain, infection, and wound healing.

Evaluation: Ongoing performance monitoring, quality initiatives, and participation in national benchmarking.



Sinai Hospital of Baltimore

Research: Rib-fracture care using RIG score, cryoneurolysis for pain and LOS, and studies in balance, mobility, dysphagia, TBI, vestibular rehabilitation, and functional recovery.

Evaluation: TQIP participation with risk-adjusted outcome review, registry data validation, and data-driven performance improvement.



UM Capital Region Medical Center

Research: Registry and ACS program support research on injury trends, outcomes, and prevention. Collaboration with Shock Trauma and UMD School of Public Health on violence intervention and recidivism.

Evaluation: Monthly case and peer review, loop closure, and process improvement initiatives.



Meritus Medical Center

Research: Monthly research meetings; studies include ground-level falls (30-40% of trauma population). Toyota Kata work improved trauma resuscitation and discharge times.

Evaluation: Tracks trauma room workflow, CT/OR times, ED LOS, hip-fracture outcomes, and transfers. Participates in ACS TQIP benchmarking.



Peninsula Regional (TidalHealth)

Research: Richard A. Henson Research Institute supports clinical research, clinical trials, population health, and evidence-based practice with infrastructure, mentorship, and academic research opportunities.

Evaluation: Research infrastructure supports evaluation of clinical programs and population health initiatives.



Johns Hopkins Children's Center Pediatric Trauma

Research: Clinical, translational, and basic science in pediatric injury outcomes, TBI, neuroinflammation, recidivism, firearm injury, and non-accidental trauma. NIH-funded lab exploring gut-brain axis and taVNS for recovery.

Evaluation: Performance improvement, trauma resuscitation checklist adherence, and outcome tracking.



Johns Hopkins Children's Center Pediatric Burn

Research: Quality of life after burn injury, parent PTSD/depression, adolescent substance screening, hot-beverage scald prevention, and follow-up care compliance.

Evaluation: Monthly performance reports, chart review, morbidity/mortality review, and participation in the seven-center PIQIC for benchmarking.



Children's National Hospital

Research: Participates in the MATIC2 trial evaluating whole blood vs. standard therapy and tranexamic acid for pediatric hemorrhage.

Evaluation: Comprehensive review of burn patients and participation in a national pediatric burn benchmarking consortium.



Curtis National Hand Center

Research: Microsurgery, nerve recovery, bone/soft-tissue injury, chronic pain, reconstruction, and health-services research. Includes clinical trials, big data analytics, core quality, and wearable technology monitoring.

Evaluation: Uses Studies of triage, follow-up, policy, and patient outcomes to improve care delivery.



Wilmer Eye Trauma Center

Research: Studies of ophthalmic injury trends, comparative effectiveness, tissue engineering, surgical outcomes, antibiotic prophylaxis, and health disparities.

Evaluation: Monthly KPI surveillance, demographic and injury trend analysis, trauma case review, Eye Trauma Web Registry reporting, and formal program evaluation.



R Adams Cowley Neurotrauma Center

Research: Publications and research in TBI, SDH, neurocritical care, machine learning, and operational neurotrauma, including middle meningeal artery embolization, and other emerging treatment strategies.

Evaluation: Monthly KPI surveillance, demographic and injury trend analysis, trauma case review, Eye Trauma Web Registry reporting, and formal program evaluation.

Legislation and Regulation

Maryland Education Article §13-501 through §13-517 provide the statutory basis for the statewide EMS system and the Maryland Institute for Emergency Medical Services Systems (MIEMSS). The Code of Maryland Regulations (COMAR) Title 30 provides the regulatory framework for MIEMSS to fulfill its responsibilities for the EMS system. Regulations may be promulgated and revised in accordance with the Administrative Procedure Act, State Government Article §10-101 through §10-117. State agency regulations undergo structured review every eight years.

Attorney General's Office

The Attorney General's Office (OAG) provides legal advice to the State EMS Board, the Statewide EMS Advisory Council, and MIEMSS on all aspects of EMS, the agency's administrative functions, and the regulation of commercial ambulance services. The Office supports the promulgation and implementation of MIEMSS regulations, procurement, personnel matters, contracts, technology initiatives, and the administration of state and federal grant programs.

Additionally, the Office supports the safety and reliability of the Maryland EMS system by advising the MIEMSS Office of Integrity on EMS clinician compliance and prohibited conduct. It serves as the administrative prosecutor for cases involving allegations of prohibited acts by EMS clinicians before the EMS Provider Review Panel, the EMS Board, and the Office of Administrative Hearings.

Legal support for the State Office of Commercial Ambulance Licensing and Regulation (SOCALR) in FY 2026 included compliance matters, regulatory interpretation, and support for the Commercial Ambulance Services Advisory Committee. Throughout the year, attorneys assisted SOCALR with regulatory amendments that expanded access to care by updating staffing standards for advanced life support ambulances. The Office of Care Integration also received legal guidance on compliance requirements for specialty referral centers, the Maryland Public Access Defibrillation program, and the AED Registry.

The Office of EMS Clinician Services received assistance with regulatory amendments updating licensure, certification, and renewal requirements, as well as implementation of new laws restricting the use of Social Security numbers in the licensure process.

In addition, legal counsel supported MIEMSS' efforts in public education and research by providing guidance on data and information access. Attorneys advised on sharing information with the public and EMS stakeholders while maintaining patient confidentiality and negotiated data use agreements to support research projects using EMS data.

The Office also supports Maryland Orders for Life-Sustaining Treatment (MOLST), which provides patients with a legal means of communicating their medical care wishes to EMS and other health care professionals. The MOLST form is available for download from the MIEMSS website, and hard copies are provided by MIEMSS for individuals without internet access.

Office of Governmental Affairs

MIEMSS partners with key stakeholders to develop and advance statutory and regulatory policies that support the statewide EMS system, emergency care, and Maryland's broader healthcare system. In this report, the Office of Governmental Affairs has summarized key EMS-related bills considered by the Maryland General Assembly during the 2026 legislative session, which are categorized by those which were passed and signed into law and those which did not advance.

Legislation & Advocacy

During FY 2026, Maryland's trauma system continued to support legislation and public policy initiatives aimed at strengthening injury prevention, trauma readiness, and the sustainability of trauma care. The R Adams Cowley Shock Trauma Center's Legislative Committee testified in support of Maryland's helmet safety laws and advocated with members of Congress for sustained federal trauma funding, including support for the Mission Zero initiative and other national trauma grant programs. Neurotrauma Center clinicians provided state-level testimony opposing House Bill 639, which proposed repeal of Maryland's mandatory motorcycle helmet law.

2026 Legislative Report

The 2026 legislative session of the Maryland General Assembly convened on January 14, 2026, and adjourned on April 13, 2026. During this time, the House and Senate considered hundreds of bills, including those impacting Maryland EMS. The following are nine key EMS-related bills that passed during the session.

HB 276 / SB 24 (MIEMSS Departmental Legislation) – *State Emergency Medical Services Board – Public Access Automated*

External Defibrillator Program – Revisions. This legislation makes revisions to the Public Access Automated External Defibrillator (AED) Program by establishing requirements regarding an automated external defibrillator (AED) coordinator, repealing obsolete provisions of law regarding regional council AED committees, and exempting certain law enforcement agencies from being required to obtain a certificate for an AED deployed in a patrol vehicle of the law enforcement agency. [Enactment Date: October 1, 2026]

SB 111 – Vehicle Laws – Out-of-State Vehicles – Improper Registration. This legislation authorizes the Motor Vehicle Administration (MVA) and agents and employees of State agencies and political subdivisions to take possession of certain vehicle registration cards and plates under circumstances, including improper registration in another state by a Maryland resident; authorizes the MVA to enter into reciprocal agreements, arrangements, or declarations to provide for reciprocal enforcement of certain automated enforcement violations; exempts certain vehicles from the requirement to be registered in the State; exempts certain vehicles from a certain tax under certain circumstances; prohibits a title service agent from selling or offering for sale a certain vehicle registration; and establishes a certain process for bringing vehicles owned by State residents that are improperly registered in another state into compliance with the Maryland law. With this bill’s passage, it is estimated that MEMSOF revenues will increase by an estimated \$950,000 annually through MVA enforcement efforts, providing additional resources for the Maryland EMS system. [Enactment Date: October 1, 2026]

SB 159 – Emergency Medical Services – Vehicles and Ambulances – Required Supplies. This legislation requires the Executive Director of MIEMSS to coordinate, with Jurisdictional Emergency Medical Services Operating Programs, the minimum equipment, supplies, and medications needed for early childhood care, including neonatal care, to be available on emergency medical services vehicles. [Enactment Date: July 1, 2026]

SB 439 – Employment Discrimination – Fire and Rescue Public Safety Employees – Use of Medical Cannabis. This legislation prohibits employers from taking certain discriminatory employment actions against a fire and rescue public safety employee based on the employee’s use of medical cannabis. It also requires an employer to report an incident of a fire and rescue public safety employee reporting for work while impaired by cannabis to the State EMS Board. [Enactment Date: October 1, 2026]

SB 242 / HB 420 & SB 418 / HB 1120) – Professional Licensing Portability. These companion bills authorize active service members, foreign service members, and their spouses to practice in Maryland under an occupational or professional license issued in another state. Further, these bills establish an application process to enable such practice in Maryland and provide that a professional so practicing be subject to the same disciplinary authority of a Licensing Authority as an individual licensed by the Licensing Authority in the State. [Enactment Date: October 1, 2026 (for both sets of legislation)]

The following bills did not advance:

HB 32 – Local Law Enforcement Vehicles – Requirements – Automated External Defibrillators. This legislation sought to require that all local law enforcement vehicles carry an AED and that each local law enforcement agency maintain the functionality of AEDs carried by a local law enforcement vehicle. This bill did not receive a vote in committee.

HB 110 – Motor Vehicles – School Buses – Seat Belts. This legislation sought to require the public-school safety education program to include student instruction concerning school bus safety and the proper use of seat belts on school buses. It would have also required that school buses purchased after July 1, 2030, and registered in the State be equipped with, for every seat on the school bus, three-point seat belts that are accessible to passengers, and prohibited a civil action for damages based on the failure of a school bus operator to ensure that an occupant of a school bus was wearing a seat belt. This bill did not receive a vote in committee.

HB 117 / SB 219 – Public Schools – Airway Clearing Device Availability and Use – Policy (Bowen Levy Airway Clearing Device Act). These bills sought to require each county board of education to establish a policy to obtain at least one airway-clearing device per school and to authorize school nurses and other school personnel to use an airway-clearing device in certain emergency situations. They would have also required the State Department of Education to develop and disseminate a form for public schools to report each incident requiring the use of an airway-clearing device. These bills did not receive a vote in the House and Senate committees to which they were assigned.

SB 195 – Protective Headgear Requirement – Exception (In Remembrance of Gary “Pappy” Boward). This legislation would have provided an exception to the prohibition against operating or riding on a motorcycle without certain protective headgear for an individual at least 21-years-old who has been licensed to operate a motorcycle for at least two years or has completed a certain motorcycle safety course and for the individual’s passenger. This bill did not receive a vote in committee.

Systems Finance

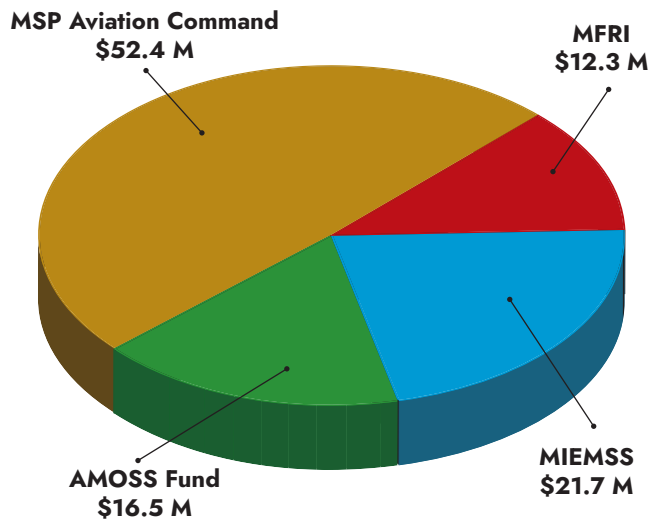
Funding for Maryland's EMS system is provided from a variety of sources. The Maryland Emergency Medical Services Operation Fund (MEMSOF) provides support for EMS partners in the state's budget, annually. The MEMSOF derives its revenue primarily from a \$24.50 yearly motor vehicle registration surcharge and \$7.50 moving violation surcharge. This fund supports the operations of the Maryland Institute for Emergency Medical Services Systems (MIEMSS), the medically oriented missions of Maryland State Police Aviation Command (MSPAC), the Maryland Fire and Rescue Institute (MFRI), an operating subsidy to the R Adams Cowley Shock Trauma Center, and grants (Amoss Fund) to local jurisdictions for the purchase of EMS, fire, and rescue equipment and building rehabilitation.

Administration / Finance

The Procurement Unit obtains all necessary supplies, materials, and services required by MIEMSS to fulfill its mission in accordance with all applicable state procurement laws and regulations. The Procurement Unit is responsible for contract and grant administration.

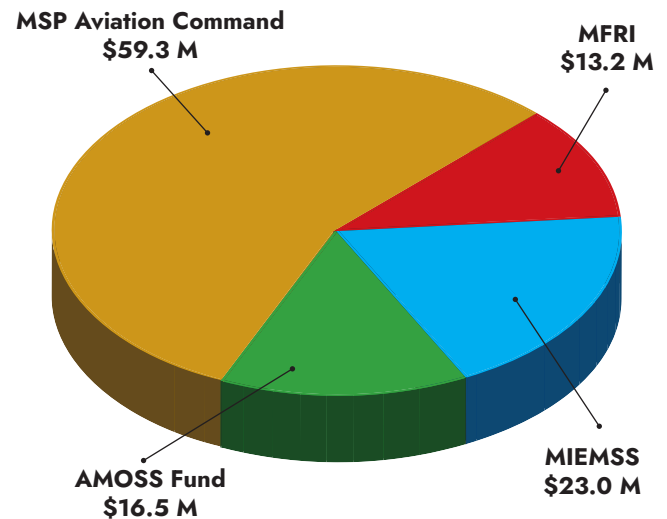
Administration's other responsibilities include inventory control, fleet management, travel services, and building operations and maintenance. In addition, Administration supports legislative and regulatory initiatives and provides financial data relevant to the legislative actions that support the Maryland Emergency Medical Services Operations Fund.

**Maryland EMS Operational Fund
FY 2025-2026**



\$105,866,274

**Maryland EMS Operational Fund
FY 2026-2027**

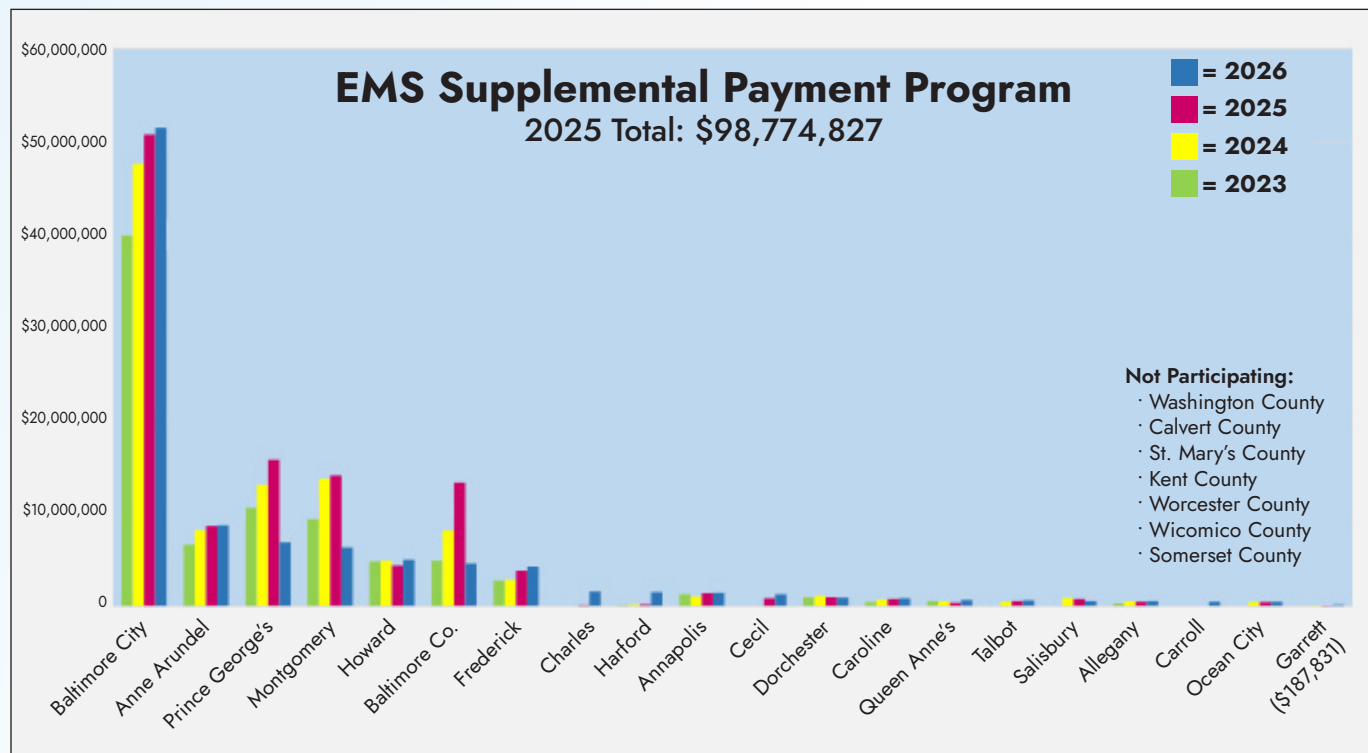


\$112,882,195

Region	Cardiac Devices Grant	ALS Training Funds	Emergency Dispatch Programs	Totals by Region
Region I	\$5,056	\$28,000	\$0	\$33,056
Region II	\$31,164	\$28,000	\$4,054	\$63,218
Region III	\$140,850	\$98,000	\$2,151	\$241,001
Region IV	\$119,350	\$68,000	\$6,511	\$193,861
Region V	\$128,580	\$52,000	\$0	\$180,580
TOTAL	\$425,000	\$274,000	\$12,716	\$711,716

MIEMSS Grants Awarded by Region (FY 2026)

In FY 2026 MIEMSS awarded \$711,716 in grant funding to support EMS equipment, training, and emergency dispatch programs across Maryland's five MIEMSS regions. Funding was made available for Cardiac Devices, AEDs, and cardiac monitors with defibrillation capability to help EMS clinicians treat patients experiencing out-of-hospital cardiac arrest; ALS Training and continuing education to strengthen the knowledge and skills of EMS clinicians; and Emergency Dispatch to help strengthen the coordination and delivery of emergency medical services.



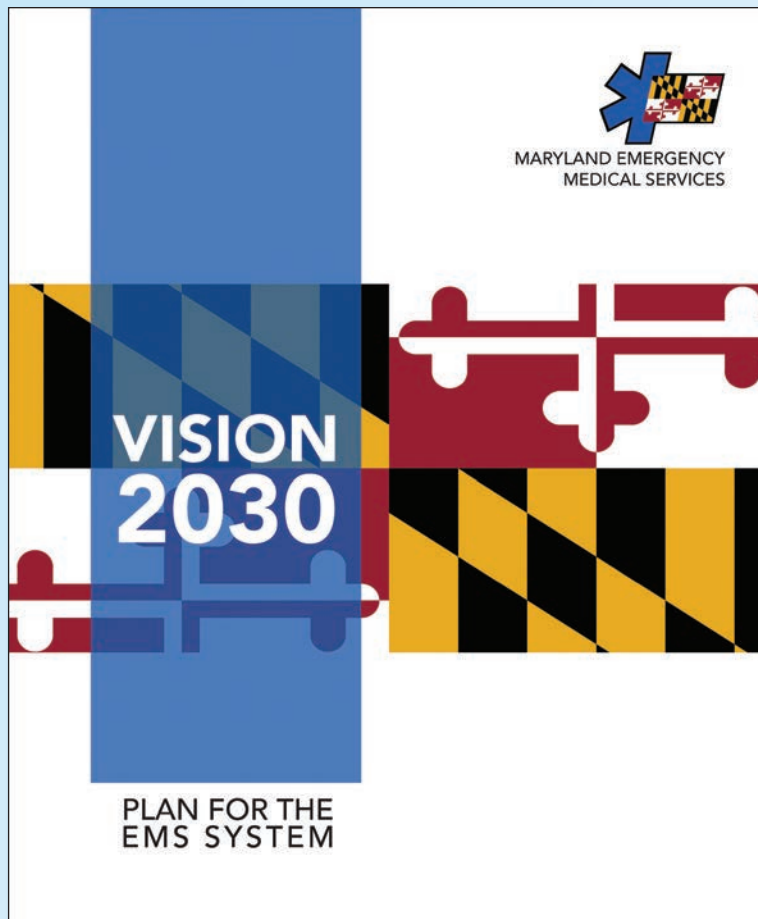
Emergency Services Transporter Supplemental Payment Program (ESPP)

The Emergency Services Transporter Supplemental Payment Program (ESPP) provides funding to Jurisdictional EMS Operational Programs (JEMSOPs) to offset some of the difference between the true costs of providing service to Medicaid beneficiaries and what they were actually compensated. Funding comes from the Centers for Medicare and Medicaid Services (CMS), and is meant to reimburse JEMSOPs for the federal share of otherwise unrecovered certified public expenses they incurred in treating Medicaid beneficiaries.

The program began on October 1, 2020. Since then, it has provided more than \$400,000,000 to EMS jurisdictions. Each year, additional JEMSOPs have qualified for participation, expanding the importance, reach, and benefits of the program.

As of September 30, 2026, participating JEMSOPs have not yet received the current year's allocation, while CMS and Maryland Medicaid work to reconcile interpretations of expense eligibility for reimbursement.

Epilogue



Consistent with Maryland law and guided by the Vision 2030 as our roadmap, MIEMSS strives to fulfill its mission of reducing preventable deaths, disability, and discomfort among the citizens and visitors of Maryland. For questions regarding any of MIEMSS' services and functions, please visit www.MIEMSS.org.



For more information regarding Vision 2030, please scan the QR code.

State EMS Board / SEMSAC

GOVERNOR OF MARYLAND
Wes Moore

LIEUTENANT GOVERNOR
Aruna Miller

MARYLAND EMS BOARD (July 2025–June 2026)

Public at Large

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University of Maryland Baltimore Designee

Thomas Scalea, MD

Hospital Administrator

James Scheulen, PA, MBA

Volunteer Firefighter

Stephan Cox

Emergency Medical Services Physician

William Frohna, MD

SEMSAC Chairman

Scott Haas

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Emergency Medical Services Nurse

Jeff Hobbs, BSN

Trauma Physician

Dany Westerband, MD, FACS

MDH Secretary Designee

Deputy Secretary Meg Sullivan, MD

Career Firefighter

Chief Trisha Wolford, MBA, MS

STATEWIDE EMS ADVISORY COUNCIL (July 2025–June 2026)

EMS Region I Advisory Council

Doug Beitzel

EMS Region II Advisory Council

Eric Smothers

EMS Region III Advisory Council

Danielle Knatz

EMS Region IV Advisory Council

Scott A. Haas, *Chairman*

EMS Region V Advisory Council

Chief Ben Kaufman

R Adams Cowley Shock Trauma Center

Kristie Snedeker, DPT

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Tony Rose

Volunteer Field Provider

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Board of Physicians

Vacant

Maryland Fire and Rescue Institute

Michael Cox

Regional Medical Directors

Jeffrey L. Fillmore, MD

Representative of a Maryland Commercial Ambulance

Danny Platt

American College of Surgeons, Maryland Chapter

Farheen A. Qurashi, MD

MedChi, The Maryland State Medical Society

Jeffrey Sagel, DO

General Public

Lisa Tenney, BSN, RN

General Public (County Population of <175,000)

Wayne Dyott

General Public

Kathleen Grote

Aviation Division, Maryland State Police

Major Michael Tagliaferri

Maryland Society of Anesthesiologists

Linda W. Young, MD, MS

Association of Critical Care Nurses

Vacant

Maryland TraumaNet

Elliott R. Haut, MD, PhD

Office of Traffic and Safety,

Maryland Department of Transportation

Timothy J. Kerns, PhD

National Study Center for Trauma and EMS (Director)

William Teeter, MD

Maryland Hospital Association

Kathryn M. Burroughs, MS, PA-C

Maryland Emergency Nurses Association

Lisa Lisle

American Academy of Pediatrics, Maryland Chapter

Bruce Klein, MD

Maryland State Firefighters Association

Susan Mott

American College of Emergency Physicians

Matt Levy, DO

Professional Firefighters of Maryland

Vacant

Helicopter Pilot

Niklas Brandt

MARYLAND INSTITUTE FOR EMERGENCY MEDICAL SERVICES SYSTEMS (MIEMSS)

Theodore R. Delbridge, MD, MPH, FACEP, FAEMS – *Executive Director*
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