Connecticut

C+

The relatively healthy lifestyles of Connecticut residents place the state among the best in the nation for *Public Health and Injury Prevention,* but a lack of liability reforms and a shortage of facilities for treating disaster victims leaves the state vulnerable in key areas.

Strengths. Connecticut has numerous strengths with regard to *Public Health and Injury Prevention*. More than 86 percent of children aged 19–35 months are immunized, for which the state ranks third in the country. Connecticut has the fourth lowest rates of obesity and smoking among adults (20.6 and 17.0 percent, respectively). The state also has relatively low rates of both fatal occupational injuries (23.8 per 1 million workers) and traffic fatalities (8.6 per 100,000 people).

There are a number of indicators that positively contribute to Connecticut's grade in *Access to Emergency Care*. Among those are the state's relatively high rates of health care professionals per capita. Connecticut falls among the top 10 states with regard to neurosurgeons; orthopedists and hand surgeon specialists; plastic surgeons; and ear, nose, and throat specialists. In addition, Connecticut has 3.1 Level I or II trauma centers for every million residents, and every resident is within 60 minutes of a Level I or II trauma center. The state also boasts the sixth lowest percentage of uninsured adults (10.5 percent) and the fifth lowest percentage of uninsured children (6.0 percent).

The state should implement a system for collecting and reviewing data on hospital diversion.

Challenges. Connecticut's most serious problems with regard to the *Medical Liability Environment* stem directly from high malpractice award payments and liability insurance premiums. The average award payment in Connecticut is $418,457, well above the average across the states of $285,218. Concurrently, the average medical liability insurance premiums for primary care physicians and specialists ($27,929 and $121,912, respectively) are significantly higher than the averages across the states ($16,042 and $65,489, respectively). Despite these high awards and premiums, Connecticut has not instituted a medical liability cap on non-economic damages or additional liability protections for EMTALA-mandated emergency care.

Emergency physicians in Connecticut have reported that boarding of patients in the emergency department and hospital crowding have become major concerns confronting the state's health care system.

Connecticut's grade for the *Quality and Patient Safety Environment* reflects the state's lack of a uniform system for providing pre-arrival instructions, a stroke system of care, and a PCI network or STEMI system of care. In addition, the state does not provide funding for quality improvement within the EMS system.

The state received a below average score in *Disaster Preparedness*, due primarily to a relatively low capacity for handling disaster patients. The state has below-average rates of burn unit and ICU beds (4.3 and 255.5 per 1 million people, respectively). Connecticut's bed surge capacity (356.9 beds per 1 million) is also significantly lower than the average among the states (673.4 beds per 1 million).

Recommendations. State policymakers should take steps to address boarding of admitted patients in the emergency department, as well as other issues related to hospital crowding, in order to ensure timely and quality care to patients. A system for collecting and reviewing data on ambulance diversions should be implemented and efforts should be made to address the low rate of staffed inpatient beds and the high hospital occupancy rate (80.4 per 100 staffed inpatient beds).

Connecticut should take immediate steps to implement major medical liability reforms. The state could benefit significantly from instituting a $250,000 medical liability cap on non-economic damages. Providing additional liability protections for EMTALA-mandated emergency care might encourage more specialists to provide on-call services for emergency patients. Connecticut could also benefit from a requirement that expert witnesses be licensed to practice medicine in the state.

	RANK	GRADE
ACCESS TO EMERGENCY CARE	15	C+
QUALITY & PATIENT SAFETY ENVIRONMENT	20	B-
MEDICAL LIABILITY ENVIRONMENT	35	D
PUBLIC HEALTH & INJURY PREVENTION	3	A
DISASTER PREPAREDNESS	29	C
OVERALL	14	C+

ACCESS TO EMERGENCY CARE	C+
Board-certified emergency physicians per 100,000 pop.	9.8
Emergency physicians per 100,000 pop.	13.4
Neurosurgeons per 100,000 pop.	2.2
Orthopedists and hand surgeon specialists per 100,000 pop.	11.2
Plastic surgeons per 100,000 pop.	2.7
ENT specialists per 100,000 pop.	4.0
Registered nurses per 100,000 pop.	992.3
Additional primary care FTEs needed	64.2
Additional mental health FTEs needed	2.9
Level I or II trauma centers per 1M pop.	3.1
% of population within 60 minutes of Level I or II trauma center	100.0
Accredited chest pain centers per 1M pop.	0.3
% of population with an unmet need for substance abuse treatment	9.2
Pediatric specialty centers per 1M pop.	3.4
Physicians accepting Medicare per 100 beneficiaries	3.1
Medicaid fee levels for office visits as a % of the national average	65.9
% change in Medicaid fees for office visits (2004-05 to 2007)	4.0
% of adults with no health insurance	10.5
% of children with no health insurance	6.0
% of adults with Medicaid	8.0
Emergency departments per 1M pop.	8.0
Hospital closures in 2006	0
Staffed inpatient beds per 100,000 pop.	276.7
Hospital occupancy rate per 100 staffed beds	80.4
Psychiatric care beds per 100,000 pop.	36.0
State collects data on diversion	No

MEDICAL LIABILITY ENVIRONMENT	D
Lawyers per 10,000 pop.	23.0
Lawyers per physician	0.6
Lawyers per emergency physician	17.1
ATRA judicial hellholes (range 0 to -7)	0
Malpractice award payments/100,000 pop.	1.6
Average malpractice award payments	$418,457
Databank reports per 1,000 physicians	15.7
Patient compensation fund	No
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	4.9
Average medical liability insurance premium for primary care physicians	$27,929
Average medical liability insurance premiums for specialists	$121,912
Pretrial screening panels	Voluntary
Are pretrial screening panels' findings admissible as evidence?	No
Periodic payments	Upon request or agreement of party(ies)
Medical liability cap on non-economic damages	No
Additional liability protection for EMTALA-mandated emergency care	No
Joint and several liability abolished	Yes
State provides for case certification	Yes
Expert witness required to be of the same specialty as the defendant	Yes
Expert witness must be licensed to practice medicine in the state	No

QUALITY & PATIENT SAFETY ENVIRONMENT	B-
Funding for quality improvement within the EMS system	No
Funded state EMS medical director	Yes
Emergency medicine residents per 1M pop.	22.8
Adverse event reporting required	Yes
Hospital-based infections reporting required	Yes
Mandatory quality reporting requirement	Yes
% of counties with E-911 capability	100.0
Uniform system for providing pre-arrival instructions	No
State has or is working on a stroke system of care	No
State has or is working on a PCI network or a STEMI system of care	No
Statewide trauma registry	Yes
% of hospitals with computerized practitioner order entry	58.8
% of hospitals with electronic medical records	46.9
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	58
Number of Joint Commission reviewed sentinel events per 1M pop. (1995–2006)	12

PUBLIC HEALTH & INJURY PREVENTION	A
Traffic fatalities per 100,000 pop.	8.6
% of traffic fatalities alcohol related	43.0
Front occupant restraint use (%)	85.8
Helmet use required for all motorcycle riders	No
Child safety seat/seat belt legislation (10 points possible)	6
% of children immunized, aged 19–35 months	86.2
% of adults aged 65+ who received flu vaccine in the last 12 months	71.1
% of adults aged 65+ who ever received pneumococcal vaccine	68.1
Fatal occupational injuries per 1M workers	23.8
Homicides and suicides (non-motor vehicle) per 100,000 pop.	11.5
Unintentional fall-related fatal injuries per 100,000 pop.	6.3
Unintentional fire/burn-related fatal injuries per 100,000 pop.	0.9
Unintentional firearm-related fatal injuries per 100,000 pop.	0.1
Gun-purchasing legislation (8 points possible)	6
% of tobacco settlement funds spent on health-related services and programs	1.8
Total injury prevention funds per 1,000 pop.	$164.45
Unintentional injury prevention funds per 1,000 pop.	$30.84
Intentional injury prevention funds per 1,000 pop.	$96.21
Fall injury prevention funds per 1,000 pop.	$6.28
Infant mortality rate per 1,000 live births	5.8
% of adults with BMI > 30	20.6
Current smokers, % of adults	17.0
Binge alcohol drinkers, % of adults	14.5

DISASTER PREPAREDNESS	C
Per capita federal disaster preparedness funds	$8.02
Disaster preparedness funds used specifically for health care-related preparedness are tracked	Yes
All-hazards medical response plan or ESF-8 plan?	Yes
Plan shared with all EMS and essential hospital personnel?	Yes
Public health and emergency physician input into the state planning process	Yes, Yes
Public health and emergency physician input into the daily operations of the SEOC	Yes, Yes
Written plan for the coordination of the SEOC or local EMAs to provide security to hospitals in case of emergency events	NR
Number of drills and exercises conducted involving hospital personnel, equipment, or facilities	29
Accredited by the Emergency Management Accreditation Program	No
Written plan specifically for special needs patients	Yes
Written plan to supply medications for chronic conditions	Yes
Written plan to supply dialysis for patients	Yes
Real-time notification system in place to notify identified health care providers of an event	Yes
"Just-in-time" training systems in place	NR
Statewide medical communication system with one layer of redundancy	Yes
Statewide patient tracking system	No
Statewide victim tracking system	No
Statewide real-time or near real-time syndromic surveillance system	Yes
Real-time surveillance system in place for common ED presentations	Yes
Bed surge capacity per 1M pop.	356.9
Burn unit beds per 1M pop.	4.3
ICU beds per 1M pop.	255.5
Verified burn centers per 1M pop.	0.3
State able to verify credentials and assign volunteer health professionals to four ESAR-VHP levels	Yes
Nurses registered in ESAR-VHP per 1M pop.	NR
Physicians registered in ESAR-VHP per 1M pop.	NR
Training required in disaster management and response to bio- and chem terrorism for essential hospital personnel, EMS personnel	Yes, Yes
State or regional strike teams or medical assistance teams	Yes
Additional liability protections for health care workers during a disaster	Yes, civil
% of RNs that received any emergency training	35.0
State requires EMS and essential ED personnel to be NIMS compliant	Yes

Improved since 2006
Worsened since 2006
No change since 2006
NR Not reported
N/A Not applicable
See *Summary Statistics for State Comparisons*